Norfolk and Suffolk NHS Foundation Trust

Quality Report

Hellesdon Hospital
Drayton High Road
Norwich
NR6 5BE
Tel: 01603 421421
Website:www.nsft.nhs.uk

Date of inspection visit: 10 to 20 July, 25, 26 and 28 July 2017
Date of publication: 13/10/2017

Core services inspected	CQC registered location	CQC location ID
Acute and psychiatric intensive care units	Fermoy Unit	RMYXX
Acute and psychiatric intensive care units	Northgate Hospital	RMY03
Acute and psychiatric intensive care units	Woodlands	RMYX1
Acute and psychiatric intensive care units	Wedgwood House	RMYX5
Acute and psychiatric intensive care units	Hellesdon Hospital	RMY01
Child and adolescent mental health wards	Lothingland	RMYX2
Specialist community mental health services for children and young people	Trust Headquarters - Hellesdon Hospital	RMY01
Forensic inpatient/secure wards	Hellesdon Hospital	RMY01
Forensic inpatient/secure wards	Norvic Clinic	RMY04
Forensic inpatient/secure wards	St Clements Hospital	RMYX3
Long stay/rehabilitation mental health wards for working age adults	St Clements Hospital	RMYX3

Summary of findings

Long stay/rehabilitation mental health wards for working age adults	St Catherine's	RMYXY
Wards for people with learning disabilities	Walker Close	RMYMW
Wards for people with learning disabilities	Lothingland	RMYX2
Community mental health services for people with learning disabilities and autism	Trust Headquarters - Hellesdon Hospital	RMY01
Wards for older people with mental health problems	Julian Hospital	RMY02
Wards for older people with mental health problems	Carlton Court	RMY13
Wards for older people with mental health problems	Woodlands	RMYX1
Wards for older people with mental health problems	Wedgwood House	RMYX5
Community-based mental health services for older people	Trust Headquarters - Hellesdon Hospital	RMY01
Community-based mental health services for adults of working age	Trust Headquarters - Hellesdon Hospital	RMY01
Mental health crisis services and health-based places of safety	Trust Headquarters - Hellesdon Hospital	RMY01
Mental health crisis services and health-based places of safety	Hellesdon Hospital	RMY01
Mental health crisis services and health-based places of safety	Northgate Hospital	RMY03
Mental health crisis services and health-based places of safety	Fermoy Unit	RMYXX
Mental health crisis services and health-based places of safety	Wedgwood House	RMYX5
Mental health crisis services and health-based places of safety	Woodlands	RMYX1

This report describes our judgement of the quality of care at this provider. It 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.

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.

Overall rating for services at this Provider	Inadequate 
Are services safe?	**Inadequate** 
Are services effective?	**Requires improvement** 
Are services caring?	**Good** 
Are services responsive?	**Requires improvement** 
Are services well-led?	**Inadequate** 

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

Page

Overall summary 5

The five questions we ask about the services and what we found 6

Our inspection team 10

Why we carried out this inspection 10

How we carried out this inspection 10

Information about the provider 11

What people who use the provider's services say 12

Good practice 13

Areas for improvement 14

Detailed findings from this inspection

Mental Health Act responsibilities 16

Mental Capacity Act and Deprivation of Liberty Safeguards 17

Findings by main service 18

Action we have told the provider to take 50

Summary of findings

Overall summary

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

We rated Norfolk and Suffolk NHS Foundation Trust as inadequate overall because:

- The board had failed to address all the serious concerns that had been reported to them since 2014. The breaches of regulation identified at our previous inspections had not been resolved. The board did not ensure that the services provided by the trust were safe. They had not taken action to ensure that unsafe environments were made safe and promoted the dignity of patients. They had not ensured that there were sufficient staff to meet patients' needs safely. They had not ensured that unsafe seclusion and restrictive practices were minimised or eradicated. The trust was not safe, effective or responsive at all services. The board needed to take further and more timely action to address areas of improvement.
- We had a lack of confidence that the trust was collecting and using data about performance to assure itself that quality and safety were satisfactory. The direction of travel could not be determined due to the contradictory nature of the data. Information was not always robust. The board needed to ensure that their decisions were implemented and brought about positive improvement.
- Performance improvement tools and governance structures had not facilitated effective learning or brought about improvement to practices in all areas.
- Key mandatory training was below acceptable levels. Many staff had not received regular supervision and appraisal.
- A lack of availability of beds meant that people did not always receive the right care at the right time and sometimes people had been moved, discharged early or managed within an inappropriate service.
- Community and crisis teams' targets for urgent and routine assessments following referral were not always being met in all areas.
- The poor performance of the single electronic records system had a negative impact had on staff and patient care.
- There were errors in the application of the Deprivation of Liberty Safeguards and the Mental Health Act.

However:

- Morale was found to be good across the trust. This was supported by the staff survey and the staff element of the Friends and Family Test.
- We observed some positive examples of staff providing emotional support to people.

On the basis of this report we are recommending that the trust is placed into special measures.

Summary of findings

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

We always ask the following five questions of the services.

Are services safe?

Inadequate 

We rated Norfolk and Suffolk NHS Foundation Trust as inadequate overall for safe because:

- We found a number of environmental safety concerns. Not all potential ligature risks had been removed or managed effectively. The layout of some wards did not facilitate the necessary observation of patients.
- The breaches of regulation identified at our previous inspections had not been resolved.
- Seclusion rooms were not fit for purpose and did not meet guidance laid down to ensure safe seclusion practice. Seclusion was not always managed and recorded in line with the safeguards of the Mental Health Act Code of Practice.
- The trust had not fully eliminated mixed sex accommodation.
- Some acute services continued to have shared dormitories.
- Staffing levels, including medical staff and other healthcare professionals, were not sufficient at a number of inpatient wards and community teams across the trust. The trust was consistently not meeting their planned fill rate for qualified nurses.
- The trust had not ensured that all staff had sufficient mandatory training in all key courses. Of particular concern were levels of training in suicide prevention and life support.
- The trust had not ensured that all risk assessments were in place, updated consistently in line with changes to patients' needs or risks, or reflected patient's views on their care.
- Restrictive practices, particularly seclusion, long term segregation and rapid tranquilisation particularly in acute services must be reduced.
- Physical health checks required following rapid tranquilisation had not been undertaken as required.
- Not all services had access to a defibrillator. Staff were unclear about alternative arrangements for life support in the event of an emergency.
- The numbers of serious incidents at the trust remain high.

However:

- The trust was meeting its obligations under Duty of Candour regulations.
- The trust had contingency plans in place in the event of an emergency.

Summary of findings

Are services effective?

Requires improvement

We rated Norfolk and Suffolk NHS Foundation Trust as requires improvement overall for effective because:

- While access to a single record had been addressed by the application of the electronic system, we remain concerned about the performance of this system and the impact this had on staff.
- Care plans were not always in place or updated when people's needs changed in crisis, child and adolescent and adult community teams and acute services. People's involvement in their care plans varied across the services.
- Not all staff had received appraisal or supervision. The system for recording levels of supervision was not effective.
- We found continued concerns about the application of the Deprivation of Liberty Safeguards and the Mental Health Act.
- Staff did not always complete or record physical healthcare checks in acute wards, and adult and children and adolescent community teams

However:

- Generally, people received care based on a comprehensive assessment of individual need and services used evidence based models of treatment.
- The trust had participated in a range of patient outcome audits.

Are services caring?

Good

We rated Norfolk and Suffolk NHS Foundation Trust as good overall for caring because:

- Staff showed us that they wanted to provide high quality care. We observed some very positive examples of staff providing emotional support to people.
- Most people we spoke with told us they were involved in decisions about their care and treatment and that they and their relatives received the support that they needed.
- We heard that patients were well supported during admission to wards and found a range of information available for service users regarding their care and treatment.
- The trust had an involvement policy which set out the trust's commitment to working in partnership with service users. The trust told us about a number of initiatives to engage more effectively with users and carers.

However:

- 21 out of 76 care plans on acute wards did not demonstrate patient involvement.

Summary of findings

Are services responsive to people's needs?

Requires improvement

We rated Norfolk and Suffolk NHS Foundation Trust as requires improvement overall for responsive because:

- Bed occupancy rates at the trust were high, particularly in acute services leading to a large number of patients had been treated outside the trust, moved, discharged early or managed within an inappropriate service.
- Community and crisis teams did not always meet targets for urgent and routine assessments following referral.
- Access to the crisis service out of hours for people over the age of 65 with dementia was not commissioned in some areas. Some patients and their relatives told us that they had not been able to get hold of someone in a crisis.
- The trust continued to have no overarching operating procedure for crisis services that clearly defined key performance indicators and targets for the services.

However:

- Most units had access to grounds or outside spaces and generally had environments that promoted recovery and activities.
- The trust had an effective complaints process. We found that patients knew how to make a complaint and many were positive about the response they received.
- We found a range of information available for service users regarding their care and treatment and many of the leaflets were available in other languages and an accessible format.

Are services well-led?

Inadequate

We rated Norfolk and Suffolk NHS Foundation Trust as inadequate overall for well led because:

- The board needed to take further and more timely action to address areas of improvement and to demonstrate leadership in ensuring safety for patients. The service was not yet fully safe, effective or responsive at all services. The breaches of regulation identified at our previous inspections had not been resolved. Patients do not benefit from safe services in all areas.
- The trust leadership did not demonstrate a safety narrative running through the organisation.
- Information was not always robust. The board needed to ensure that their decisions were implemented and brought about positive improvement. Data was not effectively captured and showed a lack of rigour.

Summary of findings

- Performance improvement tools and governance structures did not facilitate effective learning and did not bring about improvement to practices in all areas.
- Work was required to ensure that all risks were fully captured and understood by the board and that actions were taken in a timely way to address these.

However:

- Morale was found to be good across the trust. This was supported by the staff survey and the staff element of the Friends and Family Test.
- The trust had improved arrangements to engage service users and staff in the planning and development of the trust.

Summary of findings

Our inspection team

Our inspection team was led by:

Chair: Dr Paul Lelliott Deputy Chief Inspector, Care Quality Commission (CQC)

Shadow chair: Paul Devlin, Chair of Lincolnshire Partnership NHS Foundation Trust

Team Leader: Julie Meikle, Head of Hospital Inspection (mental health) CQC

Inspection Manager: Lyn Critchley, Inspection Manager mental health hospitals.

The team included CQC inspection managers, mental health inspectors, assistant inspectors, pharmacy inspectors, Mental Health Act reviewers, support staff, a variety of specialists, and experts by experience who had personal experience of using or caring for someone who uses the type of services we were inspecting.

Why we carried out this inspection

We inspected this trust as part of our ongoing comprehensive mental health inspection programme.

How we carried out this inspection

When we inspect, we always ask the following five questions of every service and provider:

• Is it safe?

• Is it effective?

• Is it caring?

• Is it responsive to people's needs?

• Is it well-led?

Before visiting, we reviewed a range of information we hold about Norfolk and Suffolk NHS Foundation Trust and asked other organisations to share what they knew.

We carried out an announced visit between 10 and 20 July 2017. Unannounced inspections were also carried out between 25 and 28 July 2017.

Prior to and during the visit the team:

- Met with 80 patients and carers via four patient focus groups and seven local user and carer forums.
- Asked a range of other organisations that the trust worked in partnership with for feedback. These included NHS England, local clinical commissioning groups, Monitor, Healthwatch, local authorities overview and scrutiny committees, Health Education England, and other professional bodies.
- Met with local stakeholders and user groups.
- Held focus groups with32 different groups of staff, including administration staff, both qualified and non-qualified nursing staff, doctors, allied health professionals, the trust's governors, non-executive directors and union representatives.
- Visited 31 wards and 55 community locations.
- Talked privately with more than 220 patients and 90 carers and family members.
- Collected feedback using comment cards.
- Observed how staff were caring for people.
- Attended 15 community treatment appointments.
- Attended 40 multi-disciplinary team meetings.
- Looked at the personal care or treatment records of more than 500 patients.
- Looked at 150 patients' legal documentation including the records of people subject to community treatment under the Mental Health Act.
- Interviewed more than 500 staff members and 90 team managers.
- Interviewed senior and middle managers.

Summary of findings

- Met with the council of governors.
- Met with the Mental Health Act hospital managers.
- Reviewed information we had asked the trust to provide.

Following the announced inspection:

- We made unannounced inspections to two crisis teams, two psychiatric liaison services, one health based place of safety and one forensic unit.
- A number of data requests were also met by the trust.
- We received an update from the trust regarding the immediate actions taken as a result of the high level feedback provided at the end of the inspection.

We inspected all mental health inpatient services across the trust including adult acute services, psychiatric intensive care units (PICUs), rehabilitation wards, secure wards, older people's wards, and specialist wards for children and adolescents and people with a learning disability. We looked at the trust's places of safety under section 136 of the Mental Health Act. We inspected a sample of community mental health services including the trust's crisis and home treatment services, children and adolescents services, learning disability services, older people's and adult community teams.

The team would like to thank all those who met and spoke to inspectors during the inspection and were open and balanced with the sharing of their experiences and their perceptions of the quality of care and treatment at the trust.

Information about the provider

Norfolk and Suffolk NHS Foundation Trust was formed when Norfolk and Waveney Mental Health NHS

Foundation Trust and Suffolk Mental Health Partnership NHS 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. A number of specialist services are also delivered including a community based eating disorder service.

The trust is the seventh largest mental health trust in the UK. The trust has 399 beds and runs over 70 community services from more than 50 sites and GP practices across an area of 3,500 square miles. The trust serves a population of approximately 1.6 million and employs just under 4,000 staff including nursing, medical, psychology, occupational therapy, social care, administrative and management staff. It had a revenue income of £213 million for the period of April 2016 to March 2017. In 2016/17, the trust staff saw over 60,000 individual patients.

Norfolk and Suffolk NHS Foundation Trust has a total of 13 locations registered with CQC and has been inspected 17 times since registration in April 2010.

We had inspected the trust in October 2014 under CQC's comprehensive inspection programme. The trust was rated inadequate overall and was placed in special measures by Monitor following recommendation by CQC. Monitor appointed an improvement director who worked with the trust to assist with improvement.

We re-inspected the trust in July 2016. The trust had made some improvement but further work was required. The trust was rated 'requires improvement' overall and inadequate for the safe domain. The trust was removed from special measures, but with the need for additional support.

During this inspection we reviewed the five CQC domains of safe, effective, caring, responsive and well led. We also considered all areas of previous non-compliance. A number of areas of further non-compliance were identified. We told the trust that they must:

- The trust must ensure that action is taken to remove identified ligature anchor points and to mitigate risks where there are poor lines of sight.

Summary of findings

- The trust must ensure that action is taken so that the environment does not increase the risks to patients' safety.
- The trust must ensure that all mixed sex accommodation meets Department of Health and Mental health Act code of practice guidance and promotes safety and dignity.
- The trust must ensure that seclusion facilities are safe and appropriate and that seclusion and restraint are managed within the safeguards of national guidance and the MHA Code of Practice.
- The trust must ensure all staff including bank and agency staff have completed statutory, mandatory and where relevant specialist training, particularly in restrictive intervention and life support.
- The trust must ensure there are enough personal alarms for staff and that patients have a means to summon assistance when required.
- The trust must ensure there are sufficient staff at all times, including medical staff, to provide care to meet patients' needs.
- The trust must ensure that all risk assessments and care plans are in place, updated consistently in line with multidisciplinary reviews and incidents and reflect the full and meaningful involvement of patients.
- The trust must ensure that medicines prescribed to patients who use the service are stored, administered, recorded and disposed of safely.
- The trust must ensure it is compliant with Controlled Drug legislation when ordering controlled drug medication from another trust.
- The trust must ensure that the prescribing, administration and monitoring of vital signs of patients are completed as detailed in the NICE guidelines [NG10] on violence and aggression: short-term management in mental health, health and community settings.
- The trust must consistently maintain medication at correct temperatures in all areas and ensure action taken if outside correct range.
- The trust must undertake an immediate review into clinical information handling and information systems so that risks can be identified in order to protect patient safety.
- The trust must ensure that all staff receive regular supervision and annual appraisals, and that this is recorded.
- The trust must carry out assessments of capacity for patients whose ability to make decisions about their care and treatment is in doubt and record these in the care records.
- The trust must ensure that procedures and safeguards required under the Mental Health Act Code of Practice are adhered to.
- The trust must ensure that people receive the right care at the right time by placing them in suitable placements that meet their needs and give them access to 24 hour crisis teams.
- The trust must ensure that there are systems in place to monitor and learn for quality and performance information.
- The trust must ensure that governance processes capture and learn from adverse incidents.

We also told the trust that they should:

- Ensure that the recommendations of the report into unexpected deaths at the trust are fully implemented and learnt from.

What people who use the provider's services say

- We interviewed more than 220 patients and 90 carers or family members. We met with seven groups of patients and community forums, two carers groups and two stakeholder groups.
- Most patients on the wards told us that staff were good, kind and supportive. Patients told us they felt supported and had good relationships with staff. A number said they felt genuinely cared for.

Summary of findings

- Patients told us that the wards were usually clean and well furnished. Most patients stated that staff protected their dignity and that they felt safe on the wards. Some patients said that they felt less safe when there was a reduced number of staff on the ward.
- Generally food was considered to be good. However, patients at the Norvic clinic described the food as bland. A number told us they had chosen to eat Halal food as it was much tastier.
- Patients on the wards told us that they were usually informed about their care and invited to multidisciplinary meetings.
- Some patients on the wards had been involved in recruitment of new staff and redesigning care plans, which they valued.
- Most patients were aware of the complaints process. However, we met some carers who felt there was limited information available about the complaints process.
- Generally patients told us that their relatives were encouraged to be involved in their care. However, a number of carers told us that they did not feel fully involved in the planning of their loved ones care. Some carers expressed frustration at the lack of recognition they received for the level of support they gave to their loved one.
- In child and adolescent services, some carers told us that there were issues with accessing services. However, most felt that the care provided by the community teams was good once referral had been accepted. Then the care was said to be comprehensive. Both patients and carers were complimentary about the Dragonfly unit.
- In crisis and community services people told us that appointments generally ran on time and they were kept informed if there were any unavoidable changes. Some told us they saw different members of staff due to the nature of the service which meant they had to repeat information.
- In most community teams patients told us that staff were responsive to their needs, were caring and treated them politely. Patients gave examples of where staff had offered support and encouragement to attend groups and reintegrate into their local community, and offered support in times of crisis.
- However, in some community teams patients told us that in the event of requiring crisis support there could be a delay in services or support being put in place.
- We also heard how some families who had found it difficult to get their loved one accepted into the service and only after significant deterioration. Some carers spoke of their own stress as a consequence of this.
- Some carers and patients told us that while they appreciated the short interventions being offered by community teams they felt let down and back at square one when that intervention ended.

Good practice

- At the Dragonfly unit we saw sensitive handling of difficult issues. Staff understood individual needs of patients. We saw staff show exceptional care and respect for a patient who was distressed. We saw a parent who was upset and staff sensitively routed other people away to allow privacy. The unit staff offered a range of therapeutic interventions in line with National Institute for Health and Care Excellence guidelines. One patient told us they had asked for another therapy session between school and suppertime and staff immediately arranged an additional therapy session. Another patient told us there was lots of therapy. We heard how staff regularly presented to other units and encouraged improvements across children's and young people's services.
- The trust actively participated in the Green Light Toolkit which was a yearly audit to check how well mental health services were meeting the needs of people with learning disabilities and autism. The trust had recruited and trained 128 champions to deliver this agenda. The trust was rated above average for 24 of the 27 standards.

Summary of findings

- The peer support worker role was imbedded into community teams. A new 'peer support navigator' role was being trialled in adult community teams. This offered patients up to six sessions with the staff member to prepare for discharge and aid reintegration into their local community. This role offered patients the opportunity to work with a staff member with lived experience of being discharged from services, and offered great insight and understanding of the anxieties patients could be experiencing at this time of change.
- The trust had continued to develop 'The Compass' centre. This centre provided a therapeutic education service for young people who might otherwise be placed in schools out of area. The compass centre was a partnership between Norfolk County Council children's services and Norfolk and Suffolk NHS Foundation trust.

Areas for improvement

Action the provider MUST take to improve

- The trust must ensure that all services had access to a defibrillator and that staff are aware of arrangements for life support in the event of an emergency
- The trust must ensure that action is taken to remove identified ligature anchor points and to mitigate risks where there are poor lines of sight.
- The trust must ensure that all mixed sex accommodation meets Department of Health and Mental Health Act code of practice guidance and promotes safety and dignity.
- The trust must review the continued use of bed bays in the acute wards and work with commissioners to provide single room accommodation.
- The trust must ensure that seclusion facilities are safe and appropriate and that seclusion and restraint are managed within the safeguards of national guidance and the Mental Health Act Code of Practice.
- The trust must fully implement guidance in relation to restrictive practices and reduce the number of restrictive interventions
- The trust must ensure there are enough personal alarms for staff and that patients have a means to summon assistance when required.
- The trust must ensure there are sufficient staff at all times, including medical staff and other healthcare professionals, to provide care to meet patients' needs.
- The trust must ensure all relevant staff have completed statutory, mandatory and where relevant specialist training, particularly in suicide prevention and life support.
- The trust must ensure that all risk assessments, crisis plans and care plans are in place, updated consistently in line with multidisciplinary reviews and incidents and reflect the full and meaningful involvement of patients.
- The trust must ensure that the prescribing, administration and monitoring of vital signs of patients are completed as detailed in the NICE guidelines [NG10] on violence and aggression: short-term management in mental health, health and community settings.
- The trust must ensure that the temperature of medicines storage areas is maintained within a suitable range, and that the impact on medicines subject to temperatures outside the recommended range is assessed and acted on.
- The trust must ensure that all staff have access to clinical records and should further review the performance of the electronic system
- The trust must ensure that there is full and clear physical healthcare information and that patients physical healthcare needs are met
- The trust must ensure that all staff receive regular supervision and annual appraisals, and that the system for recording levels of supervision is effective and provides full assurance to the trust board

Summary of findings

- The trust must ensure that patients are only restricted within appropriate legal frameworks.
- The trust must ensure that people receive the right care at the right time by placing them in suitable placements that meet their needs and give them access to 24 hour crisis services.
- The trust must minimise disruption to patients during their episode of care and ensure that discharge arrangements are fully effective
- The trust must ensure that there are clear targets for assessment and that targets for waiting times are met. The trust must ensure that people have an allocated care co-ordinator
- The trust must ensure that they fully address all areas of previous breach of regulation
- The trust must ensure that data is being turned into performance information and used to inform practices and policies that bring about improvement and ensure that lessons are learned

Action the provider SHOULD take to improve

- The trust should ensure that the work undertaken in relation to deaths is learnt form to ensure that there are not missed opportunities that would prevent serious incidents.
- The trust should review the audit trail for medicines held at community clinics for administration or supply to service users
- The trust should review the arrangements to support people in the rehabilitation and recovery service to manage their own medicines in preparation for discharge
- The trust should review the training provided to staff in St Catherine's who handle medicines.

Norfolk and Suffolk NHS Foundation Trust

Detailed findings

Mental Health Act responsibilities

The trust had governance arrangements to monitor and review the way that functions under the Mental Health Act were exercised on its behalf. The mental health law forum had oversight of the application of the Act within the trust. The forum, which met bi-monthly, had responsibility for reviewing and ensuring compliance with the legal and statutory requirements of the Mental Health Act. The mental health law forum reported to the quality governance committee, which in turn reported to the board of directors.

The trust had 40 associate hospital managers, approximately half of whom were recent recruits. They told us the latest recruitment campaign was organised in an effort to attract a diverse group of applicants and induction training was good. The trust chair, chaired the managers' quarterly committee meetings. The associate managers had an escalation route for concerns. The Board of Directors approved the re-appointment of associate hospital managers.

There was a Mental Health Act administration manager with Mental Health Act administrators at most of the inpatient locations. Staff across the trust told us they knew who to go to for advice and support about the Mental Health Act.

The team carried out a daily ward check of the number of detained patients, admissions, discharges and transfers. As at 11 July 2017, there were 100 inpatients across the trust detained under the Mental Health Act. A further 129 patients were subject to a community treatment order.

Mental Health Act administrators audited statutory detention forms every month. Ward staff carried out weekly checks of Mental Health Act processes, such as providing patients with information about their rights and recording section 17 leave of absence. The trust produced a bi-monthly Mental Health Act heat map. Information from the Mental Health Act heat map identified trends and areas of concern about the application of the Act across the trust.

Mental Health Act training was mandatory. Overall 75% of staff had been trained at 31 March 2017. This was 15% below the trust target of 90%. In some community adult and forensic services compliance rates were particularly low.

Nursing staff and on-call managers had training to enable them to receive and carry out initial checks of statutory forms. The Mental Health Act administration team scrutinised detention documents for accuracy and completeness. The team did not keep a log of rectifiable errors but completed incident forms and informed the ward of any documents found to be invalid.

There was a system in place to remind clinicians of the date that an authority for detention was due to expire. However, we found two occasions where this was not effective and the patients' section 2 lapsed despite the responsible clinician's intention to regrade the patient to a section 3.

Consent to treatment and capacity requirements were mainly adhered to. However, in some services copies of consent to treatment forms were not always attached to medication charts. For five patients across acute and older peoples wards certificates of consent to treatment were inaccurate and did not include all medication prescribed.

In some services the Mental Health Act status of patients was not included on any medication charts, so staff unfamiliar with the patients had no way of knowing the status without checking elsewhere.

We reviewed 89 sets of community treatment order documents across the trust. We found one set of documents contained an error. The trust later confirmed it was a fundamental error and invalidated the patient's community treatment order.

Certificates authorising treatment for patients subject to a community treatment order were either missing or were completed after the due date for 17 patients. Community staff did not keep copies of the certificates with the medication charts for 20 of the 89 patients' whose records we reviewed in the community.

Mental Capacity Act and Deprivation of Liberty Safeguards

When we last inspected the trust we had specific concerns about procedures under the Mental Capacity Act and Deprivation of Liberty Safeguards, particularly in older people's and learning disability services. The trust told us that they had set up a group to undertake and review the trust procedures, review training and develop practice based learning. The trust had also undertaken audit.

The Mental Capacity Act lead was employed by a local clinical commissioning group and was hosted by the trust three days a week. A mental health law forum had overall responsibility for the application of the Mental Capacity Act. The forum reported to the quality governance committee.

Training rates for staff in the Mental Capacity Act had improved since our last inspection at 80**%** of staff trained at the end of March 2016. 82% of staff had trained in the Deprivation of Liberty Safeguards.

Generally, staff had an awareness of the Mental Capacity Act and the Deprivation of Liberty Safeguards. We saw some units where recent mental capacity assessments and best interest decisions had been carried out where applicable. However, we found that 16 patient files (of 89) within community adult teams had no reference to the patient's mental capacity recorded.

The trust had carried out an audit of capacity to consent to treatment. The service compliance for recording capacity when prescribing medication within seven days of admission was 69%.

When we last inspected we were concerned that a number of patients had been given covert medication without the correct documentation in place. There was a policy for covert administration and the trust had carried out an audit in April 2017 which showed 50% compliance regarding care plans describing which medications can be given, 57% compliance regarding care plans describing the method of administering covert medications and 57% compliance regarding care plans describing planned review date. However, at this inspection we found that person centred plans were in place for the patients we reviewed who were receiving medication covertly.

Between 1 April 2016 and 31 March 2017, 119 Deprivation of Liberty Safeguards applications were made; 33 of the 119 were authorised and one application was not approved.

Staff had made 112 Deprivation of Liberty Safeguards applications for a number of patients across the wards in older people's inpatient services. On patient records checked, all but two had not been authorised by the local authority. On six wards, the urgent authorisation had expired and there was no evidence that staff had applied for an extension. One patient on Abbeygate had been secluded twice without a Deprivation of Liberty Safeguards authorisation in place. The manager on Abbeygate had sought further guidance from the local authority. The local authority had advised that they continued to treat the patient in their best interests until they completed assessments. However, we were concerned that the trust had not addressed this issue with the local authorities in other cases. Trust records did not always capture how the patient's capacity to give consent to their treatment and care was managed in the interim.

Inadequate

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

Summary of findings

We rated Norfolk and Suffolk NHS Foundation Trust as inadequate overall for safe because:

- We found a number of environmental safety concerns. Not all potential ligature risks had been removed or managed effectively. The layout of some wards did not facilitate the necessary observation of patients.
- The breaches of regulation identified at our previous inspections had not been resolved.
- Seclusion rooms were not fit for purpose and did not meet guidance laid down to ensure safe seclusion practice. Seclusion was not always managed and recorded in line with the safeguards of the Mental Health Act Code of Practice.
- The trust had not fully eliminated mixed sex accommodation.
- Some acute services continued to have shared dormitories.
- Staffing levels, including medical staff and other healthcare professionals, were not sufficient at a number of inpatient wards and community teams across the trust. The trust was consistently not meeting their planned fill rate for qualified nurses.
- The trust had not ensured that all staff had sufficient mandatory training in all key courses. Of particular concern were levels of training in suicide prevention and life support.
- The trust had not ensured that all risk assessments were in place, updated consistently in line with changes to patients' needs or risks, or reflected patient's views on their care.
- Restrictive practices, particularly seclusion, long term segregation and rapid tranquilisation particularly in acute services must be reduced.
- Physical health checks required following rapid tranquilisation had not been undertaken as required.
- Not all services had access to a defibrillator. Staff were unclear about alternative arrangements for life support in the event of an emergency.
- The numbers of serious incidents at the trust remain high.

However:

- The trust was meeting its obligations under Duty of Candour regulations.
- The trust had contingency plans in place in the event of an emergency.

Our findings

Safe and clean care environments

The trust told us there was a detailed programme to modernise environments and reduce risk. The trust undertook an annual programme of environmental health and safety checks. All services had received an environmental risk assessment in the previous twelve months.

The trust's overall patient led assessments of the care environment (PLACE) score for condition, appearance and maintenance of the environment for 2016 was 97%, against a national average of 95%. Generally, buildings were well maintained and staff told us new maintenance issues were dealt with in a timely manner.

Since 2014, there had been an inconsistent approach to ligature point management at the trust. The trust had placed this on their risk register and began a programme to address these risks. The trust stated they had implemented a trust-wide ligature removal programme and ligature risk action plans for all inpatient areas. The trust had also

commissioned an independent audit of ligature management. However, we found confusion in many services about where responsibility was held for ongoing ligature audits and mitigation or removal plans.

The trust had taken some actions since our last inspection to reduce environmental risks. Some environmental improvements had been undertaken. Wards had developed 'heat maps' for staff to identify higher risk areas for greater observation. All wards had received a more detailed and consistent ligature point audit. However, at a number of services across forensic, acute, PICU and rehabilitation wards, some ligature risks remained. Assessments detailed ligature points but some referenced 'local management' for low and high risk points without a clear rationale behind this. Not all planned actions to remove or replace the identified risks had been undertaken. In forensic and rehabilitation services ligature audits recorded what actions were required to be taken to reduce the risk for patients, but no timeframes had been set for the work to be carried out. Board and committee papers showed that there was a belief that this work had been finalised in many areas.

In some wards, we found our concerns were heightened due to difficult layouts impeding the ability of staff to observe patients. While the trust had installed CCTV and observation mirrors in some areas and closed some rooms off to address this we remain concerned about the mitigations put in place in some acute, forensic and rehabilitation services.

We remain concerned about Churchill Ward, an acute ward in King's Lynn, where the design and layout made it very difficult for staff to manage these risks. The trust had recently taken ligature risks off their locality risk register due to some work that had been undertaken but we found that ligature risks remained. We note that the trust has a business case to re-provide this service by December 2018 however we remained concerned about safety in the interim.

Ligature audits in some community teams in the adult, children and adolescent and older people's services were either incomplete or not present. In older people's community bases we found ligature points in most patient toilets. These were not included in the trust's environmental ligature risk audit. Two team managers told us the trust had informed them that ligature audits were not a priority for community settings.

Soundproofing of interview rooms and offices was poor in some community team bases. which could be used as a weapon. In community child and adolescent services there was a small reception area for both children and adults visiting Thurlow House. This was a potential safeguarding risk for children and young people. This was partially rectified during the inspection period by risk assessing patients and seeing some people elsewhere if deemed necessary.

There were environmental risks in the interview rooms at the crisis team at the Fermoy Unit in Kings Lynn. These risks were identified in our last inspection. The rooms had ligature risks, such as blinds with pulls and window handles. The furniture was not fixed down and there was only one door in and out. This door could be barricaded as the door opened inwards.

When we inspected previously, we raised concerns about arrangements to eliminate mixed gender accommodation. These ward arrangements did not meet guidance set by the Department of Health or within the Mental Health Act code of practice. The trust had acted on the majority of these concerns, however, they reported 30 occasions between April 2016 and March 2017 where they were unable to fully meet guidance. Seventeen breaches were in Avocet and Poppy Wards, which were within the acute wards.

Waveney, Glaven and Churchill wards in acute services had some shared double bedrooms with curtain partitions. This did not respect patients' dignity and privacy and is not conducive to recovery.

Since 2014, we had concerns about the environment of and access arrangements to seclusion rooms. The trust had addressed some of these matters, but issues remain about some seclusion facilities:

- Staff in acute services at Wedgwood House, Yarmouth Acute, Northgate and Churchill wards had to seclude patients at the health-based place of safety suite on occasion. Male patients requiring seclusion from either Northgate or Southgate ward had to walk through the female bedroom corridor on Southgate ward. The trust was building a new seclusion room for Southgate, which was due for completion in August 2017.
- A second designated seclusion room in the PICU Rollesby ward did not meet standards. A mirror was

positioned to give staff greater vision but the vision panel was smeared and there was no CCTV or intercom. The room was in a communal ward area and did not have a toilet, which could affect patients' dignity.

- In older people's wards the seclusion room on Abbeygate did not comply with guidance. The bathroom was located in the low stimulus area outside the seclusion room; there was no staff observation area and the room was located on the main corridor of the ward. Other wards in older people's services would sometimes seclude patients in their bedrooms.
- In forensic services, seclusion rooms at the Norvic Clinic and Hellesdon Hospital did not meet the required standard. The seclusion room on Yare Ward was not in use due to being damaged. In the interim, the ward had converted a bedroom as a temporary seclusion room. Whitlingham ward seclusion room was not in use at the time of the inspection due to a flood. Eaton ward patients only had access to seclusion down a flight of stairs or the use of the 'safe room', which did not meet the required standard. The seclusion rooms in Earlham ward and Foxhall house met the required standard.

In 2016, we found environmental health and safety in some health-based places of safety that did not meet the requirements of the Royal College of Psychiatrists' national standards. Some improvements had been made since our last inspection, particularly at Northgate Hospital and the Fermoy unit. However, the suite at Wedgwood House in Bury St Edmunds had no toilet or washing facilities in the room, although there was a bathroom next door. The suite at Woodlands in Ipswich met the standards, except doors opened inwards and there was a blind spot when the shower room door was open. CCTV was in use at Fermoy but there was no sign or information to inform patients of this. This was rectified during the time of the inspection.

We remained concerned about the safety of the environments at some acute hospitals, managed by other trusts, from which the psychiatric liaison services operated, particularly the assessment room used at Queen Elizabeth hospital in King's Lynn. The environmental risks were not on the trust register at the time of our last inspection and were still not on the risk register at the time of this inspection. We were not assured the trust were aware of, or addressing, the potential risks to staff assessing patients within this facility.

This long list of outstanding safety issues is unacceptable and shows that the trust does not have a thread of safety running through the organisation to protect patients from harm. The board has not ensured within a reasonable timeframe that the environments and practices promote safe care and treatment.

We were told that regular trust-wide cleanliness audits were undertaken. The overall patient-led assessments of the care environment (PLACE) score for the trust for cleanliness of the environment for 2016 were 99%, against a national average of 98%. We found that all wards and community team bases were clean during this inspection.

The trust did not have an infection control doctor. This was included in the trust risk register and the trust had made arrangements with another trust for specialist advice. In clinical areas 84% of staff had undertaken infection control training by April 2017. The trust had effective infection control practices, which included Legionella assessments and processes. Staff had access to protective personal equipment, such as gloves and aprons. Wards undertook regular infection control audits, which indicated good compliance. There were adequate hand washing facilities and gel available for staff to adhere to infection control principles in wards and community team bases. Handwashing posters were on display.

Generally, staff ensured that equipment was well maintained and clean. Clinic rooms were clean and usually well equipped to carry out basic physical examinations and monitoring. Most wards had fully equipped clinic rooms with accessible resuscitation equipment and emergency drugs that were accessible to all staff. Generally, staff checked these regularly to ensure medication was fully stocked, in date and equipment was working effectively. However, in community adult teams concerns were identified with all clinic rooms. These included out of date equipment. Some equipment was not calibrated or safety checked.

When we inspected the trust previously we had some concerns about a lack of personal alarms at some services. At this inspection we found most ward staff carried personal alarms. However, we observed that staff at St Catherine's did not use the alarms and there was no system in place for signing alarms in and out. Most community teams had personal safety alarms and alarms were usually fitted in interview rooms. However, the crisis team at King's Lynn had no alarm system and staff used personal attack

alarms when seeing patients. Staff told us they would not know the location of the alarm if it was activated. In community adult teams safety alarms for staff did not work at the Great Yarmouth and West Norfolk sites. Treatment rooms were not fitted with alarms and staff were not using personal alarms in community child and adolescent services at Thurlow House.

In most wards there were call systems in patients' bedrooms for patients to call for help if needed. However, there was no nurse call system at St Catherine's. In addition, at some community adult teams alarm pull cords in some accessible toilets were not working and staff did not appear to know how to respond if these were pulled.

Safe staffing

At previous inspections we had significant concerns about staffing levels at the trust.

Recruitment and retention had been key issues for the trust and had been placed on the risk register. The recruitment of registered nurses was particularly difficult. The trust had revised their recruitment and retention strategy and undertaken considerable work to attract new staff. New roles had been introduced to support nurses, including assistant practitioners who in some areas were undertaking a flexible nursing programme to become a qualified nurse.

Processes to request additional staff had been streamlined to enable easier requests and to improve monitoring of the use of bank and agency staff. Ward and team managers confirmed that they had the authority to request additional staffing based on clinical need.

The trust confirmed that they had an overall vacancy rate of over 11% and that staff turnover stood at 15% in May 2017. The overall vacancy rate was the same as in previous inspections, but below the national average of 13%. The overall vacancy rate for qualified nurses was higher at 18%. Some services had a high vacancy rate. For example, vacancy rates of 32% for nurses in community children's and adolescent services, 22% for nurses and 21% for healthcare assistants in learning disability wards and 30% for nurses in acute services.

Sickness absence rates had risen slightly since our last inspection to 5%. Sickness rates for absence due to stress remained very high at 29% of those on sickness absence.

The trust had set safer staffing levels in 2013. Since June 2014, the trust had published both the planned and actual staffing levels on their website. The trust had also introduced an escalation procedure for when staffing levels fell below a safe level. The board reviewed overall staffing levels on a monthly basis as part of the performance board report.

Figures published for January to March 2017 indicated that staffing as a whole had exceeded planned staffing levels. However, the overall numbers of qualified nurses deployed against the required number for the shifts varied between 88 and 90% on days and 88 and 89% on nights during this period. During the period, nine wards had limited numbers of qualified nurses deployed and fell below 70% of the monthly planned shifts. On nine wards the planned monthly staff hours in March 2017 for combined qualified and non-qualified staff had not been met.

Between April 2016 and March 2017, the trust had 4,524 qualified nursing shifts filled by bank staff and 14,005 shifts filled by agency staff. This equated to 21%. There were 2,057 qualified nursing shifts not filled by either bank or agency staff during this time across the trust. This equated to 2%. The trust had 22,349 nursing assistant shifts filled by bank staff and 2,120 shifts filled by agency staff. This equated to 24%. There were 3,061 nursing assistant shifts not filled by either bank or agency staff across the trust. This equated to 3%.

Acute services had the most shifts filled by bank staff during this time with 8,898 (40% of all nursing assistant bank shifts). They also had the most filled by agency staff with 1,163 (55% of all nursing assistant agency shifts). Acute services had the most shifts not filled by either bank or agency staff with 1,182 (39% of all nursing assistant shifts not filled).

Staffing was sufficient on some but not all wards at the time of our inspection in July 2017. We found that staffing did not always meet the trust's target within the acute, PICU and some forensic and older people's wards. In addition, some wards, particularly in the forensic and acute services, were using very high levels of bank and agency staff to meet their staffing targets.

The trust stated that there had been no reports of harm occurring to patients due to low staffing levels in the past year but acknowledged that staffing may have had an impact on lengths of stay and staff stress levels.

However, 406 incidents reported by staff were attributed to low staffing levels in acute services from April to June 2017.

Are services safe?

These included 263 incidents of 'insufficient regular nursing staff'; 115 incidents of 'low staffing levels'; six incidents of 'no or lack of trained/supervisor staff'; two incidents of staff not having breaks; four incidents where there were no male staff available to provide care to men. Northgate staff recorded an occasion where a medical physical examination of a patient in seclusion could not take place as there were insufficient staff numbers available for restraint of the patient. Poppy ward staff had reported four incidents when there was insufficient staffing to restrain patients. Thirty-three staff in the acute wards told us staff shortages impacted on the service.

The trust told us that community teams had safe staffing levels and where necessary agency nurses had been employed on a long term basis. However, we found that staffing levels were not always sufficient in the community teams, particularly the crisis teams at night, older people's teams, and some adult teams. This meant that staff were managing very high caseloads and there were some delays in treatment. Caseloads in some instances were above the Royal College of Psychiatrists' recommended levels. In some older people's teams core staffing levels had not been reviewed by the trust since 2014 despite the concerns of front line staff. Caseloads were an average of 60-70, with an average of 90 referrals a month. In adult community teams there was delay in allocating a care co-ordinator. Approximately 473 patients on waiting lists did not have an allocated care coordinator. Other community teams were better staffed through the use of bank and agency staff.

We remained concerned about staffing arrangements for some of the health-based place of safety suites. These were managed in different ways across the trust. Specifically allocated staff managed some units. Staff from the acute ward staffed the suite at Northgate Hospital when a patient was admitted. This reduced the staffing numbers on the acute service when they were needed to staff an admission to the suite. At the suite at the Fermoy Unit, staff were not available to take responsibility for patients detained under section 136 so this was undertaken by police.

The trust confirmed that wherever possible regular bank and agency staff were used to provide continuity of care. Agency staff were provided with a local induction and some supervision from regular staff.

The medical director told us that medical cover was sufficient at the trust, however, acknowledged there were 15 vacancies with 12 locum doctors working at the time of the inspection. The majority of the locums were in West Norfolk.

The trust had made improvements in the amount of medical staffing input in crisis services since the last inspection. However, some services were short of medical cover. In older people's wards medical input was below the established level. This meant that consultants did not review patients as often as needed. Consultant psychiatrists in the West Norfolk older people's teams only saw the most complex cases. Psychiatrists mostly reviewed the GP scan results to form a diagnosis and would then prescribe medication without a face to face consultation. At acute wards there were stated to be sufficient doctors but not all doctors were permanent staff. However, trust incident data from April to June 2017 showed six occasions when doctors did not attend the ward. Four Suffolk doctors said there were challenges with the senior house officer out of hour's rota as it was issued at short notice. One consultant in Great Yarmouth was responsible for an acute ward, a rehabilitation service and the crisis team.

The last inspection identified that the trust must ensure staff receive mandatory training in accordance with the trust policy. The trust required staff to attend a variety of mandatory training courses. The trust had set a target to reach 90% training compliance. Information provided by the trust on mandatory training requirements and uptake showed that 86% of regular staff had received mandatory training.

The data showed that seven training courses were below the 75% CQC training compliance target; Fire Training (72%), Suicide Prevention (72%), BLS (Basic Life Support – 70%), Information Governance (70%), Intermediate Life Support (70%), Medical Mandatory Training Days (59%) and Manual Handling – Clinical (54%).

We looked at local training data at all services we visited. Generally, this indicated that staff had completed most mandatory training. However, we were concerned about training compliance in the forensic service where 17 mandatory courses had not met the trust target of 90%. Ten training courses were below 75%. These included Mental Capacity Act, Mental Health Act, suicide prevention, basic life support and manual handling. Crisis services overall training compliance was 83%. There were 29

training courses classed as mandatory; 19 out of the 29 courses were below target; 12 courses were below 75% compliance, including Personal Safety (69%), Physical Intervention (69%), Fire Training (63%), Basic Life Support (58%), Intermediate Life Support (63%) and Suicide Prevention (63%).

The average length of time taken from advertisement to a person commencing work was dropping. There had been very recent moves to shorten this. Since March 2017 the trust had exceeded their target of 75 days and had reduced the time to hire from 82.8 days to 69 days in June. However the fruits of this were still to be seen across the trust.

Assessing and managing risk to patients and staff

In most services individual risk assessments were in place and addressed people's risks. However, in community adult services we found that from 89 patient records reviewed, 25 records had out of date risk assessments or risk assessments that did not link effectively with the needs identified in the patients' care plans. In acute services, we found six examples where these were not updated after concerning incidents. In addition, patients' crisis and contingency plans varied in quality and 10 were not completed. In community children and adolescent services 15 core assessments and risk assessments were not completed for patients. In older people's services, 11 risk assessments of those reviewed had not been reviewed or updated by staff. The risk identification recorded did not appear relevant to the patient in 12 of the records reviewed. Eight patient records at East Suffolk DIST contained generic risk assessments and were not personalised.

Staff were aware of the procedures in the trust observation policy. Training on observation practice was included within the clinical risk assessment mandatory training. Ward managers indicated that they were able to request additional staff to undertake observations.

The trust had clear policies in place relating to safeguarding and whistleblowing procedures. Additional safeguarding guidance was available to staff via the trust's intranet. We found that most staff had received mandatory safeguarding training and knew about the relevant trust-wide policies relating to safeguarding. Most staff we spoke with were able to describe situations that would constitute abuse and could demonstrate how to report concerns. We saw examples of safeguarding documents in records which were completed accurately. A governance process was in place that looked at safeguarding issues at both trust and directorate levels on a regular basis.

Restrictive practice, seclusion and restraint

The director of nursing was executive lead for restrictive practice. Restrictive interventions had been monitored via the patient safety group meeting and reported to the board on a quarterly basis. The trust had also recently appointed a professional lead to take forward their agenda to reduce restrictive intervention by 25% by 2020. A working group had been set up and a reduction strategy was being developed.

The use of restraint and seclusion were defined as reportable incidents at the trust. The trust told us that overall rates of restraint had reduced and that there had been a reduction in prone restraint, in line with the trust's target for a 10% reduction in 2016/17. However, between April and June 2017 the trust was above its target at 23 restraints per thousand bed days and five prone restraints per thousand bed days. Seclusion episodes were on target at four per thousand bed days.

In 2016 the prevention and management of aggression (PMA) training was reviewed and the trust decided to deliver this training in-house. PMA trainers had been aligned to clinical areas and positive practice champions recruited to support staff in managing complex presentations. Other initiatives were underway to support the reduction of restrictive interventions. These included the implementation of 'safe-wards', the use of positive behaviour support plans and more rigorous monitoring of restrictive interventions.

The trust data showed that 77% of staff had received training in restrictive interventions. Staff confirmed they were working towards reducing the use of restraint and focussing more on de-escalation as recommended in best practice guidelines. Staff told us that they would avoid prone restraint and if a patient was in the prone position they would try to turn them over at the earliest opportunity. We observed a number of examples of staff managing patients' aggressive behaviour effectively with an emphasis on de-escalation techniques.

Trust figures for restraint, seclusion and rapid tranquilisation showed that restraint was used on 2,350 occasions in the 12 months to March 2017. Of these, face

down (prone) restraint was used on 538 occasions. This equated to almost 23% of all restraints, which was a 4% reduction since the last inspection but prone restraint remained high in acute services. The majority of all restraints had occurred on the acute wards, which together with the PICUs had used restraint on 1,227 occasions equating to 52% of all restraints. These wards also had the majority of prone restraints at 407 incidents, equating to 76% of all prone restraints.

The trust reported that seclusion was used on 612 occasions during the same period. There had been a small reduction in the use of seclusion since our last inspection but the use of long term segregation had increased slightly at 34 uses. The majority of episodes of seclusion had occurred in acute wards where seclusion had been used on 452 occasions, equating to 74% of all seclusion episodes. Long term segregation had occurred 21 times on the acute wards.

Rapid tranquilisation had been used on 564 occasions at the trust during the same period; 438 of these were in acute wards and 90 were in older people's wards. This was a significant increase since the last inspection. We were concerned about physical health monitoring following rapid tranquilisation.

Since 2014, we have had serious concerns about seclusion practice at the trust. During this inspection we reviewed seclusion practice across all services. We judged that a number of seclusion facilities were not safe and did not meet guidance laid down to promote safety.

The trust was auditing the seclusion process and records. The trust had produced seclusion 'heat maps' following audits of seclusion records. Audits showed from 01 May to 02 July 2017 that wards were not meeting the standard for staff recording and monitoring of patients in seclusion with an 'amber' rating (50-90%). We carried out a review of seclusion practices prior to our main site visit. We reviewed 50 sets of records relating to periods of seclusion and long term segregation that took place between March 2017 and June 2017. We found that records did not always meet the recommendations set out in the Mental Health Act Code of Practice:

- Staff records and checks of patients in seclusion were not always completed. For example, four records did not have a review by a doctor in one hour. Eleven records did not have reviews by two nurses every two hours. Nine records did not have an independent multi-disciplinary team review after eight or 12 hours.
- Thirteen records did not have a plan as to how patients' needs were to be met.
- Nutrition and hydration of patients in seclusion was not monitored in all cases.
- Records of two patients in long term segregation did not detail carers' views.
- One long term segregation record had gaps for daily medical reviews for 10 days and did not have hourly nursing records or nursing reviews. We were unable to find records of full MDT reviews or evidence of an Independent Mental Health Advocate referral. A nursing record was not updated to include a patient's seclusion episode.
- On Northgate ward, a record of the staff rationale for a patient's seclusion in July 2017 was that they were threatening self-harm, which is contrary to the Mental Health code of practice requirements.
- On Abbeygate ward one patient had been secluded twice since April 2017 without a Deprivation of Liberty Safeguards authorisation in place. Staff had not completed seclusion records for this patient in line with trust policy. Observations had not been recorded; there was no seclusion care plan for one episode and the name of the practitioner who authorised the second seclusion had not been recorded.

Generally, patients were not subject to blanket restrictions. Most ward entrances were locked with entry and exit controlled by staff, but there were signs displayed on the doors providing information on their right to leave for informal patients. We observed patients being able to leave the wards where appropriate. However, on Churchill ward there were two occasions where staff had recorded that informal patients could not have leave. Seniors managers were taking action to investigate this further.

Medicines management

The trust provided a medicines optimisation service during office hours. The dispensing and supply function of the pharmacy service operated from Hellesdon Hospital, Norwich. The pharmacy team provided a stock top up service to inpatient wards; other services could order from

the pharmacy. There was no out of hours service for supply or clinical advice, but ward staff had access to emergency medicines cupboards and there were arrangements in place for them to dispense medicines for patients who were discharged when the pharmacy was closed.

There was a ward-based clinical pharmacy service to inpatient wards. Ward staff told us that the contribution made by the pharmacy team was valuable. We saw that pharmacists reviewed prescriptions, attended ward rounds and meetings to advise doctors on safe prescribing and supported ward staff to administer medicines safely. Pharmacy staff were available to speak to inpatients and their carers. The trust subscribed to an internet service which provided medicines information leaflets in a range of languages and formats.

The service was funded to support inpatients only. The support available to community based teams was limited. Staff in the rehabilitation service told us that they were not able to obtain medicines in suitable packaging for patients to administer their own medicines in preparation for discharge, and protocols were not in place to support the process. Each service had a designated member of the pharmacy team they could contact for advice.

Medicines were stored and transported securely; however, they were not always stored within the appropriate temperature range. Since our last inspection the trust had installed air conditioning in clinic rooms and introduced a centrally operated environmental monitoring system to record temperatures in medicine fridges and storage areas. We saw the monitoring equipment had been installed, but we were told it was not in use yet as it hadn't been fully implemented and the policy had not been updated. During the recent warm weather records showed that some areas exceeded the maximum recommended temperature. The policy stated that ward staff should contact the pharmacy for advice on how the stock should be managed, for example by reducing the expiry date. We saw this in operation in some areas. However, there were wards where no action had been taken when the temperature of the medicines fridge or the storage area exceeded the maximum recommended temperature. We also saw wards where the temperatures of storage areas were not recorded regularly.

Committees were in place to manage medicines optimisation, including a drug and therapeutics committee and a medicines safety group. The medicines safety officer reviewed medicines incidents, identified trends and ensured that action was taken to reduce the risk of incidents reoccurring. Safety alerts, drug safety updates and National Institute for Health and Care Excellence (NICE) guidance were reviewed and discussed; for example, the guidance published in April 2017 on prescribing valproate in women of childbearing age.

A series of audits were carried out to identify areas for improvement, including a monthly audit which ward staff carried out to monitor the use of medicines. We saw that changes had been made as a result of these audits. For example, on Poppy ward a junior doctor reviewed the treatment charts every morning to check that any discontinued medicines were correctly recorded to prevent patients being given medicines that were no longer necessary. However, the issues around maintaining suitable storage temperatures for medicines had not been addressed in all areas.

An up to date policy covering rapid tranquilisation, based on the current NICE guidance was available. The policy provided guidance on how to manage episodes of agitation when other calming or distraction techniques failed to work. We saw that patients were offered oral medicines before intramuscular injection was used. However, the policy required staff to carry out and record physical health observations every hour after rapid tranquilisation, or every 15 minutes if the patient was at higher risk. We saw that these observations were not always recorded. Internal audits showed an improvement in recording observations from 29% in February 2017 to 40% in May 2017. The trust had participated in a recently published national audit which showed that the observations were recorded at least once in the hour after rapid tranquilisation in 30 – 40% of cases. This was better than the national result, which was less than 30%. However, the trust was not meeting the national guidelines. We saw that the subject was on the agenda for discussion at the next drug and therapeutics committee meeting.

Track record on safety

Since 2014, we identified that improvement was needed by the trust to ensure there was learning and action taken from reported incidents.

We reviewed all information available to us about the trust, including information regarding incidents prior to the inspection. A serious incident known as a 'never event' is where it is so serious that it should never happen. The trust

had reported no never events through STEIS (Strategic Executive Information System) between 01 April 2016 and 31 March 2017. We did not find any other incidents that should have been classified as never events during our inspection.

Since 2004, trusts have been encouraged to report all patient safety incidents to the National Reporting and Learning System (NRLS). Since 2010, it has been mandatory for trusts to report all death or severe harm incidents to the CQC via the NRLS. Between 1 April 2016 and 31 March 2017the trust had reported 9,414 incidents to the NRLS.

There were 48 incidents categorised as death during the period and a further six had resulted in severe harm. When benchmarked, the trust was in the highest 25% of reported incidents when compared with similar trusts. The NRLS considers trusts that report more incidents than average and have a higher proportion of reported incidents that are no or low harm to have a maturing safety culture. Also, the trust reported 78% of no harm incidents which was above the national average.

Between 01 April 2016 and 31 March 2017 trust data showed there were 242 serious incidents which required further investigation. The majority of these were 'unexpected or avoidable death' at 184 incidents. The majority of deaths had occurred in community adult services at 74. A further 22 had occurred in crisis services. The majority of inpatient deaths had occurred in older people's wards at 17 incidents. 191 incidents related to 'apparent/actual/suspected self-inflicted harm'.

During our inspection the trust confirmed that there had been 27 deaths between 01 April 2017 and 31 May 2017. These were under investigation.

Overall, the trust had improved its reporting rates and had been a good reporter of incidents during 2016/17 when compared to trusts of a similar size. It was noted that the overall rates of severe and moderate incidents decreased during the reporting period.

In 2016, the trust commissioned an external company, Verita, to undertake an independent review of unexpected deaths at the trust between April 2012 and December 2015. The report made 13 recommendations including that there needed to be more detailed and informed discussion at board meetings about unexpected deaths and more cohesive governance structures to ensure that learning was being applied across the trust.

Following this review the trust developed a mortality review group and an action plan to address these issues. The trust developed a suicide reduction strategy with partners in the local authorities and third sector. The trust told us this work had included changes to the investigation process including clearer terms of reference, better tools, improved training for investigators and staff, audit and quality review of investigations, more openness and transparency with families following incidents. The trust was aiming for a zero tolerance of suicide and had instigated a programme of work to reduce suicide.

The trust had undertaken some service level and geographical reviews to understand the causality and common learning from clusters of deaths. The trust also commissioned an independent mortality review from Mazars. This review provided statistical analyses of all deaths from 2011 to 2015 and aimed to benchmark against other trusts. The Mazars report found that broadly the overall rate of unexpected deaths did not differ from the England average.

The trust had also undertaken an internal clinical review of deaths considered to be due to suicide or as a consequence of self-harm between 2012 and March 2016. The internal report found that the majority of people were under the care of a community or crisis services at the time of or just prior to their death. Around a fifth of people were awaiting assessment or treatment. A fifth of people had been discharged from a ward for less than six months. The majority had a history of previous attempts, many within three months of their death. However, in some cases there was no risk assessment or care coordinator in place. Approximately half did not have a crisis plan in place. During this inspection we looked in detail at these reviews and the actions the trust had taken. We found that work had begun on all required actions, but further work was needed to ensure that there were not missed opportunities.

The National Safety Thermometer is a national prevalence audit which allows the trust to establish a baseline against which they can track improvement. The trust participates in this initiative within older adult services. The harms that are relevant for the trust include rates for falls resulting in harm, new pressure ulcers and new cases of catheter and urinary tract infections, acquired whilst under the trust's care. The target for compliance is 95%. At May 2017, the trust had scored 93%.

Inadequate

Are services safe?

The Ministry of Justice publishes all Schedule 5 recommendations which had been made by the local coroners with the intention of learning lessons from the cause of death and preventing deaths. One concern had been raised about the trust since April 2016.

Reporting incidents and learning from when things go wrong

The staff survey 2016 had indicated that incident reporting was below average at the trust. It also indicated that staff did not always feel they would be supported following a report or thought that procedures were fair and effective. We noted that this had improved since the last survey.

Arrangements for reporting safety incidents and allegations of abuse were in place. We saw that staff had access to an online electronic system to report and record incidents and near misses. Most staff confirmed they had received mandatory safety training and that there was clear guidance on incident reporting. Most staff told us that the trust encouraged openness. Most felt supported by their manager following incidents or near misses.

Where serious incidents had happened we saw that investigations were usually carried out, but this needed to be improved to include all serious incidents.

The trust had developed a range of initiatives to encourage learning from incidents. These included 'five key learning points' posters and 'patient safety first safety together' newsletters to share information with staff from incidents across all services. The managers handbook had been revised to include top tips for patient safety and 'human factors' champions had been trained from within teams. Teams generally confirmed clinical and other incidents were reviewed and monitored monthly and discussed by the management team and shared with front line staff.

Duty of Candour

In November 2014, a CQC regulation was introduced requiring NHS trusts to be open and transparent with people who use services and other 'relevant persons' in relation to care and treatment and particularly when things go wrong.

The trust had taken a number of actions to meet this requirement. The trust had provided briefings to staff and managers. A policy and guidance document was in place. Incident systems had been amended to capture duty of candour considerations; the patient safety team take an overview of action taken to meet this duty. Duty of candour consideration had been included in trust induction training and training for incident investigators. The board were sighted each month via the patient safety report on any concerns where duty of candour considerations had been included.

We examined case records where patients had experienced a notifiable event to check that staff had been open and honest in their dealings with patients and carers. We found evidence within records that the trust was meeting its duty of candour responsibilities. Staff we spoke with in services were aware of the duty of candour requirements in relation to their role.

Anticipation and planning of risk

Systems were in place to maintain staff safety in the community. The trust had lone working policies and arrangements. Most staff in community teams told us that they felt safe in the delivery of their role.

The trust had necessary emergency and service continuity plans in place and most staff we spoke with were aware of the trust's emergency and contingency procedures. Staff told us that they knew what to do in an emergency within their specific service.

Emergency resuscitation equipment was available and regularly checked in most inpatient services. Equipment, including resuscitators, was well-maintained, clean and checked regularly.

However, in a number of community adult and integrated delivery team (IDT) bases automated external defibrillators were not available. Bury North IDT had a defibrillator but this was not calibrated. Some teams did not have emergency equipment such as oxygen and adrenaline in place, yet administered depot injections. The trust informed us subsequently that automated external defibrillators were in place and available to community staff at co-located inpatient services. Community staff were not aware that they could access these if needed.

We were concerned that not all staff had received life support training. At March 2017 overall trust compliance was 70% for both basic life support and intermediate life support. However, at some acute and forensic wards training compliance was lower at below 50%.

Requires improvement

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.

Summary of findings

We rated Norfolk and Suffolk NHS Foundation Trust as requires improvement overall for effective because:

- While access to a single record had been addressed by the application of the electronic system, we remain concerned about the performance of this system and the impact this had on staff.
- Care plans were not always in place or updated when people's needs changed in crisis, child and adolescent and adult community teams and acute services. People's involvement in their care plans varied across the services.
- Not all staff had received appraisal or supervision. The system for recording levels of supervision was not effective.
- We found continued concerns about the application of the Deprivation of Liberty Safeguards and the Mental Health Act.
- Staff did not always complete or record physical healthcare checks in acute wards, and adult and children and adolescent community teams

However:

- Generally, people received care based on a comprehensive assessment of individual need and services used evidence based models of treatment.
- The trust had participated in a range of patient outcome audits.

Our findings

Assessment of needs and planning of care

When we last inspected the trust in July 2016 they had introduced a new electronic records system. We were very concerned about the performance of this system. Since then the trust had undertaken various improvement initiatives and some progress had been made. However, at this inspection we observed that it remained difficult to establish a contemporaneous record of patient care in some services. We also observed that technical problems with the system, particularly in community services, meant staff could not always access records. We acknowledge the trust had attempted to resolve these issues but we remained concerned about the risks to safe patient care.

The Care Quality Commission community mental health survey 2016 was sent to people who received community mental health services from the trust to find out about their experiences of care and treatment. Six out of 10 agreed with someone at the trust what care and services they will receive. Seven out of 10 respondents stated that they had been involved in their care plan and had received a review of their care in the last 12 months. Seven out of 10 people had said they had a plan covering what to do if they had a crisis while only 5 out 10 felt supported in a crisis. There was a slight deterioration in the results against the previous community mental health survey.

The trust undertakes an audit of the care plan approach twice a year. During the first quarter of 2017, 76 clinical teams participated with 491 patient records being audited. The trust found that there was evidence that 95% of patients had care plans and for 87% of patients these were in date. This was a slight improvement on previous audits.

In May 2017, the trust had not met its target for patients on the care programme approach having a formal review within 12 months. The trust had scored 91% against a target of 95%. The trust told us they had undertaken detailed work to improve care planning processes. As a result a further 500 patients had been placed on care programme approach. They aimed to be compliant by the end of the financial year.

In some services we found that the care plans were detailed, individualised to the patient's needs and showed the patient's involvement in the care planning process. In the majority of mental health services, people's care needs and risks were assessed and care plans had been put in place. However, in crisis, child and adolescent and adult community teams we found 37 patients (of 160) that did not have a care plan in place. In the majority of services,

care plans had been reviewed following changes to people's needs, and risk assessments had been updated but care plans had not always been reviewed in acute and community adult services. In addition, in acute wards and a number of community teams the quality of care plans varied, some were generic and some lacked sufficient detail or were incorrect. Those patients could not be guaranteed that their needs would be properly understood.

Best practice in treatment and care

In the services we inspected, most teams were using evidence based models of treatment and made reference to National Institute for Health and Care Excellence guidelines. We saw that people in the community generally received care based on a comprehensive assessment of individual need and that outcome measures were considered using the Health of the Nation Outcome Scale.

At community teams, we observed that they used Health of the Nation Outcome Scale during the referral process. Health of the Nation Outcome Scale is a measurement tool which identifies a person's mental health, well-being and social functioning and is rated by clinicians at known points in the care pathway for example; admission, review and discharge. By comparing records at these points, the impact, or clinical outcome, of the care and treatment provided for an individual patient can be measured.

The trust had a lead for physical health and a physical health strategy group. The trust told us that the key objectives were to embed physical health monitoring and health promotion in to care planning processes. Guidance and monitoring tools were in place to support this work. Some services had employed physical healthcare nurses to promote this.

Within most services patients' physical health needs were usually identified. Patients had a physical healthcare check completed by the doctor on admission and their physical healthcare needs were being met. Physical health examinations and assessments were usually documented by medical staff following the patients' admission to the ward. Ongoing monitoring of physical health problems was taking place. However, we were also concerned that staff did not always complete or record physical healthcare checks in acute wards, and adult and children and adolescent community teams. At these services we found that 48 patient records (of 158) contained no physical healthcare information. We have additional concerns about physical health monitoring following rapid tranquilisation as set out in the safe domain.

The trust undertook a wide range of clinical effectiveness and quality audits. These included suicide prevention, medication, clinical outcomes, care planning, records completion, Mental Health Act and Mental Capacity Act administration, the application of National Institute for Health and Care Excellence guidance, physical healthcare and patient satisfaction. We found that most teams had some involvement with audit.

All trusts must comply with the NHS England 'accessible information standards' in regard to access to healthcare for people with a learning disability. The trust had a strategy in place and undertook regular audit to assess whether services were appropriate for people with a learning disability. At the most recent audit the trust was above the national average on 25 of the 27 standards.

Skilled staff to deliver care

We have been concerned about supervision and appraisal rates at the trust since 2014.

The trust had a response rate of 58%, in the 2016 NHS Staff Survey, which was above average for mental health trusts in England. This compared with a response rate of 52% for this trust in the 2015 survey. The trust scored worse than average for appraisal quality and frequency. This score was a slight improvement on the previous survey.

The trust could not supply data about the levels of clinical and management supervision undertaken prior to the inspection. The trust said that they no longer kept central data on clinical supervision, leaving this to individual practitioners to maintain their own records as expected by their professional bodies. In April 2017 the trust introduced a new electronic system for recording management supervision. We found that this had not been implemented fully and some staff had experienced difficulty inputting data.

Some managers had developed their own mechanisms for monitoring management and clinical supervision and were able to share their data with us. However, other services visited were not able to demonstrate their supervision rates and we observed some gaps in supervision folders

sampled. The trust could not be assured that staff received regular supervision, that performance issues were robustly monitored and addressed and that staff were following best practice.

At May 2017, trust wide appraisal rates were 62% for medical staff and 66% for other clinical staff. The trust target is 89%. The trust could not be sure that performance issues, training needs and developmental opportunities were identified and addressed with staff.

Staff were usually able to access specialist training. Most support workers were undertaking the care certificate as appropriate. Staff in older people's services gave us examples of additional training completed, such as courses on dementia awareness, Alzheimer's, communications, leg ulcers and wound care. Staff in some services told us that specialist therapy training such as in cognitive behavioural therapy and dialectical behaviour therapy, were more readily available than previously. However, a number of staff across services told us there was no training for staff on how to best support patients with a personality disorder. The trust confirmed that they were looking to provide this training in the next financial year.

Multi-disciplinary and inter-agency team work

On the wards we visited we usually saw good multidisciplinary working, including ward meetings and regular multi-disciplinary meetings to discuss patient care and treatment.

At most teams we saw input from occupational therapists, psychologists, pharmacy and the independent advocacy services. Some teams had peer support workers who assisted with ensuring patient involvement in planning meetings and activities. However, in some adult, older people's and learning disability community teams we were told that there was no access to psychologists and occupational therapy. In older people's and learning disability services there was a lack of access to a speech and language therapist which meant specialist assessments were delayed. Some community children and adolescent teams did not have access to play therapists.

We found some services were short of medical cover which could affect multidisciplinary working. In the West Norfolk older people's teams' consultant psychiatrists only saw the most complex cases. Psychiatrists mostly reviewed the GP scan results to form a diagnosis and would then prescribe medication without a face to face consultation. This meant the service was not following best practice and this could lead to potential diagnostic and prescribing errors.

There were effective handovers with the ward team at the beginning of each shift on most wards. These helped to ensure that people's care and treatment was co-ordinated and the expected outcomes were achieved. However, we found that at Churchill ward the handover was unstructured with staff relying on memory rather than referring to records to pass on information. This could pose a risk to staff and patients' safety. The SBAR tool was introduced during the inspection to improve the handover.

In Suffolk, teams had integrated social workers under a section 75 agreement. In Norfolk, whilst social workers had returned to the employ of the county council from the trust some years ago, most community teams had social workers co-located within the team base. Staff in some services in Norfolk told us that access to social workers could be difficult.

Generally, staff worked well with other professionals, using the care programme approach process. We saw that community teams usually attended discharge planning meetings and patients told us this was beneficial to them, making the process of leaving the wards feel safer. Generally, we saw that the community teams worked well with inpatient teams to meet people's needs.

Adherence to the Mental Health Act and the Mental Health Act Code of Practice

The trust had governance arrangements to monitor and review the way that functions under the Mental Health Act were exercised on its behalf. The mental health law forum had oversight of the application of the Act within the trust. The forum, which met bi-monthly, had responsibility for reviewing and ensuring compliance with the legal and statutory requirements of the Mental Health Act. The mental health law forum reported to the quality governance committee, which in turn reported to the board of directors.

The trust had 40 associate hospital managers, approximately half of whom were recent recruits. They told us the latest recruitment campaign was organised in an effort to attract a diverse group of applicants and induction training was good. The trust chair, chaired the managers'

quarterly committee meetings. The associate managers had an escalation route for concerns. The Board of Directors approved the re-appointment of associate hospital managers.

There was a Mental Health Act administration manager with Mental Health Act administrators at most of the inpatient locations. Staff across the trust told us they knew who to go to for advice and support about the Mental Health Act.

The team carried out a daily ward check of the number of detained patients, admissions, discharges and transfers. As at 11 July 2017, there were 100 inpatients across the trust detained under the Mental Health Act. A further 129 patients were subject to a community treatment order.

Mental Health Act administrators audited statutory detention forms every month. Ward staff carried out weekly checks of Mental Health Act processes, such as providing patients with information about their rights and recording section 17 leave of absence. The trust produced a bi-monthly Mental Health Act heat map. Information from the Mental Health Act heat map identified trends and areas of concern about the application of the Act across the trust.

Mental Health Act training was mandatory. Overall 75% of staff had been trained at 31 March 2017. This was 15% below the trust target of 90%. In some community adult and forensic services compliance rates were particularly low.

Nursing staff and on-call managers had training to enable them to receive and carry out initial checks of statutory forms. The Mental Health Act administration team scrutinised detention documents for accuracy and completeness. The team did not keep a log of rectifiable errors but completed incident forms and informed the ward of any documents found to be invalid.

There was a system in place to remind clinicians of the date that an authority for detention was due to expire. However, we found two occasions where this was not effective and the patients' section 2 lapsed despite the responsible clinician's intention to regrade the patient to a section 3.

Consent to treatment and capacity requirements were mainly adhered to. However, in some services copies of consent to treatment forms were not always attached to medication charts. For five patients across acute and older peoples wards certificates of consent to treatment were inaccurate and did not include all medication prescribed.

In some services the Mental Health Act status of patients was not included on any medication charts, so staff unfamiliar with the patients had no way of knowing the status without checking elsewhere.

We reviewed 89 sets of community treatment order documents across the trust. We found one set of documents contained an error. The trust later confirmed it was a fundamental error and invalidated the patient's community treatment order.

Certificates authorising treatment for patients subject to a community treatment order were either missing or were completed after the due date for 17 patients. Community staff did not keep copies of the certificates with the medication charts for 20 of the 89 patients' whose records we reviewed in the community.

Good practice in applying the Mental Capacity Act

When we last inspected the trust we had specific concerns about procedures under the Mental Capacity Act and Deprivation of Liberty Safeguards, particularly in older people's and learning disability services. The trust told us that they had set up a group to undertake and review the trust procedures, review training and develop practice based learning. The trust had also undertaken audit.

The Mental Capacity Act lead was employed by a local clinical commissioning group and was hosted by the trust three days a week. A mental health law forum had overall responsibility for the application of the Mental Capacity Act. The forum reported to the quality governance committee.

Training rates for staff in the Mental Capacity Act had improved since our last inspection at 80**%** of staff trained at the end of March 2016. 82% of staff had trained in the Deprivation of Liberty Safeguards.

Generally, staff had an awareness of the Mental Capacity Act and the Deprivation of Liberty Safeguards. We saw some units where recent mental capacity assessments and best interest decisions had been carried out where applicable. However, we found that 16 patient files (of 89) within community adult teams had no reference to the patient's mental capacity recorded.

Requires improvement

Are services effective?

The trust had carried out an audit of capacity to consent to treatment. The service compliance for recording capacity when prescribing medication within seven days of admission was 69%.

When we last inspected we were concerned that a number of patients had been given covert medication without the correct documentation in place. There was a policy for covert administration and the trust had carried out an audit in April 2017 which showed 50% compliance regarding care plans describing which medications can be given, 57% compliance regarding care plans describing the method of administering covert medications and 57% compliance regarding care plans describing planned review date. However, at this inspection we found that person centred plans were in place for the patients we reviewed who were receiving medication covertly.

Between 1 April 2016 and 31 March 2017, 119 Deprivation of Liberty Safeguards applications were made; 33 of the 119 were authorised and one application was not approved.

Staff had made 112 Deprivation of Liberty Safeguards applications for a number of patients across the wards in older people's inpatient services. On patient records checked, all but two had not been authorised by the local authority. On six wards, the urgent authorisation had expired and there was no evidence that staff had applied for an extension. One patient on Abbeygate had been secluded twice without a Deprivation of Liberty Safeguards authorisation in place. The manager on Abbeygate had sought further guidance from the local authority. The local authority had advised that they continued to treat the patient in their best interests until they completed assessments. However, we were concerned that the trust had not addressed this issue with the local authorities in other cases. Trust records did not always capture how the patient's capacity to give consent to their treatment and care was managed in the interim.

Good

Are services caring?

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

Summary of findings

We rated Norfolk and Suffolk NHS Foundation Trust as good overall for caring because:

- Staff showed us that they wanted to provide high quality care. We observed some very positive examples of staff providing emotional support to people.
- Most people we spoke with told us they were involved in decisions about their care and treatment and that they and their relatives received the support that they needed.
- We heard that patients were well supported during admission to wards and found a range of information available for service users regarding their care and treatment.
- The trust had an involvement policy which set out the trust's commitment to working in partnership with service users. The trust told us about a number of initiatives to engage more effectively with users and carers.

However:

- 21 out of 76 care plans on acute wards did not demonstrate patient involvement.

Our findings

Kindness, dignity, respect and support

Staff showed us that they wanted to provide high quality care, despite the challenges of staffing levels in some services. We observed some very positive examples of staff providing emotional support to people across all services visited. We saw staff that were kind, caring and compassionate in their response to patients and their carers. We observed many instances of staff treating patients with respect and communicating effectively with them. We saw staff working with patients to reduce their anxiety and behavioural disturbance.

Staff demonstrated that they wanted to provide high quality care and were knowledgeable about the history, possible risks and support needs of the people they cared for.

Almost all of the patients and relatives we spoke with told us that staff were kind and supportive, and that they or their loved ones were treated with respect. We received particularly positive comments in older people's, community learning disability services and wards for children and adolescents.

We were impressed with the care provided by staff at the child and adolescent ward, the Dragonfly unit. We observed a strong patient centred culture, patients were treated with exceptional care and respect and staff were passionate about the service.

Whilst some patients and their carers said there could be delays in accessing services most felt staff interactions were responsive and timely to patient's requests and needs.

We were told that staff respected people's personal, cultural and religious needs. We saw some very good examples of the trust attempting to deliver services in line with peoples' cultural needs. Generally, people's privacy and dignity were being protected in services however we had some concerns at Northgate and Southgate wards in the acute service.

Confidentiality was understood by staff and maintained at all times. Staff maintained privacy with people, who were asked if they would like their information shared with their relatives or whether they wanted their relatives present during assessments. Information was stored securely, both in paper and electronic format.

The involvement of people in the care they receive

In 2016, we saw some very good examples of care plans being person centred. However, not all care plans indicated the involvement of the service user.

The Care Quality Commission community mental health survey 2016 was sent to people who received community mental health services from the trust to find out about their experiences of care and treatment. Overall, the trust was performing about the same as other trusts across all areas. 6 out of 10 agreed with someone at the trust what care and

services they will receive. 7 out of 10 respondents stated that they had been involved in their care plan and had received a review of their care in the last 12 months. 7 out of 10 felt they were involved as much as they wanted to be in decisions about the medicines they received. There was a slight deterioration in the results against the previous community mental health survey.

The trust told us that one of their key priorities was to improve service user experience as measured by the community service user survey - planning care element, to above average by 2019. The trust told us that they were updating the CPA (care programme approach) policy to include co-produced care and recovery plans and ensuring recovery training for all staff.

The trust undertakes an audit of the care plan approach twice a year. During the first quarter of 2017, 76 clinical teams participated with 491 patient records being audited. The trust found that there was evidence that 72% of patients were involved in their care plan and 71% of patients had been involved with the development of their risk assessment. 61 % of patients had received a copy of their care plan. 61% of appropriate family/carers were involved in the care plan. This was a slight improvement on previous audits.

We saw some very good examples of care plans being person centred and demonstrating patient involvement. Care plans were particularly inclusive in children's inpatient and forensic services. However, at acute wards 21 out of 76 care plans did not demonstrate patient involvement.

In all services we found that there was an opportunity for patients to attend care planning meetings.

In the first quarter of 2017, Healthwatch Norfolk carried out a survey of the response to people in a mental health crisis. This looked at a range of services including those of the trust. The survey found that half of the respondents who were known to the trust did not have a crisis care plan in place.

At crisis services patients told us they were involved in their care and treatment and were aware of their care plans. Records showed most patients had been involved in planning their care and had either received or refused a copy of their care plan.

We found a number of examples of relatives being involved in care planning where this was appropriate. We observed that when a patient was unable to be actively involved in the planning of their care, or when they wanted additional support, staff involved family members with the patient's consent.

Inpatient services orientated people to the ward on admission. At most services we found welcome packs that included detailed information about the ward philosophy, the staff present on the ward, ward activities, Mental Health Act information and how to complain. Notice boards on the wards held a variety of information for patients and carers. A range of information leaflets about the services were available. We saw that there was information available throughout the trust and via its website about how to provide feedback on the specific services received by people.

Almost all patients we spoke with told us that they were given good information when they were admitted to the wards. Some patients told us that staff had taken time to clearly explain ward procedures when they had been unclear or confused. Most detained patients told us that staff had explained their rights under the Mental Health Act.

Patients had access to advocacy including an independent mental health advocate (IMHA) or independent mental capacity advocate (IMCA). There was information on the notice boards at most wards on how to access these services. Most patients were aware of advocacy but not all had used the service. Posters containing advocacy information and contact details were visible on wards.

Patients told us that they had opportunities and were encouraged to keep in contact with their family where appropriate. Visiting hours were in operation within inpatient services. We found at most services there was a sufficient amount of dedicated space for patients to see their visitors. At most services there were specific children's visiting areas.

The trust had a combined service user and carers' involvement policy 'improving services together' which was being updated. This set out a commitment for working in partnership with service users, carers and wider stakeholders. This work was overseen by a trust wide service user and carer partnership.

The trust had a number of user and carers' forums and inpatient services had community meetings to engage patients in the planning of the service and to capture feedback. In most services this meeting was chaired by

Good

Are services caring?

patients and was attended by relevant ward staff. Minutes were usually taken and we saw evidence of actions that were raised being completed. Patients told us they felt able to raise concerns in the community meetings and that they usually felt listened to.

The trust had implemented the 'triangle of care' toolkit which provides an accredited framework to develop carer involvement within local services. This was developed by carers and mental health staff to improve carer engagement in acute inpatient and home treatment services and was being rolled out across additional services.

The trust had used the friends and families test (FFT). At November 2015 the results indicated that 87% of patient respondents were likely or extremely likely to recommend the trust services. The response to the test demonstrated a fluctuating picture of satisfaction during the 6 months prior to this at between 84 and 90%. This was an improvement since we last inspected the trust in 2016 and about average with other mental health trusts.

During this inspection we heard from service users, carers and local user and carer groups about their experience of care. Some people were unhappy with the service they or their loved one had received and did not feel involved. However, the majority of people we met were positive about their care and treatment and the service they had received. Most felt involved in their care planning.

Requires improvement

Are services responsive to people's needs?

By responsive, we mean that services are organised so that they meet people's needs.

Summary of findings

We rated Norfolk and Suffolk NHS Foundation Trust as requires improvement overall for responsive because:

- Bed occupancy rates at the trust were high, particularly in acute services leading to a large number of patients had been treated outside the trust, moved, discharged early or managed within an inappropriate service.
- Community and crisis teams did not always meet targets for urgent and routine assessments following referral.
- Access to the crisis service out of hours for people over the age of 65 with dementia was not commissioned in some areas. Some patients and their relatives told us that they had not been able to get hold of someone in a crisis.
- The trust continued to have no overarching operating procedure for crisis services that clearly defined key performance indicators and targets for the services.

However:

- Most units had access to grounds or outside spaces and generally had environments that promoted recovery and activities.
- The trust had an effective complaints process. We found that patients knew how to make a complaint and many were positive about the response they received.
- We found a range of information available for service users regarding their care and treatment and many of the leaflets were available in other languages and an accessible format.

Our findings

Service planning

The trust works with seven CCGs and two local authorities across two counties. The trust told us that they were committed to integration and alliance across health and social care through sustainability and transformation plans (STPs). They aimed to play a significant role in this and to champion parity for mental health in terms of funding and access to services.

The trust told us that they had good and improving working relationships with commissioners and other stakeholders. The trust gave examples of recent support they had received from commissioners and partners. These included: the development of crisis cafes, alternative step down beds with the third sector, and a clinical variation project with primary care. Other joint work included a project with the CCGs looking at joined up physical and mental health care and a team working with police in the control room. The trust had also recently set up a Veterans mental health service with the Walnut Trust.

The trust had recently appointed a single director for mental health with the Suffolk local authority, to ensure a more integrated delivery of health and social services across Suffolk.

The trust told us that they had been successful in National bids for £8m funding for a regional mother and baby unit and the development of Chatterton House to replace the Fermoy unit in Kings Lynn.

When we inspected previously, we found that there was a shortage of beds across the trust. This meant that people may have been moved, discharged early or managed within an inappropriate service. The trust told us that they did not believe that they had insufficient beds. They had commissioned a review from an independent organisation to consider bed availability. This identified a range of variance across Norfolk and Suffolk in service models, in referral and admission rates and in the operation of community teams. An action plan was developed in response which included a dedicated team to review out of trust placements.

Requires improvement

Are services responsive to people's needs?

The trust provided details of a range of actions they had taken to attempt to resolve delays with their partners. Acute Discharge teams had been introduced by the trust to facilitate a smooth discharge and reduce any delays occurring. The ward teams told us that they worked closely with both crisis services and community teams to ensure continuity of care when patients were discharged from hospital. At most wards we found that arrangements for discharge were discussed and planned with the care co-ordinators and other involved care providers. Many patients told us that they were fully involved in their discharge planning.

Access and discharge

The trust managed access to services via two separate teams one covering Norfolk and one covering Suffolk. The teams provided advice, guidance and a triage which prioritised referrals according to risk and identified need. Staff in the crisis services gate kept all inpatient beds. At the time of our inspection the trust was meeting the national target at 99% of admissions to acute wards being gate-kept by crisis teams. They were also involved in discharge planning from inpatient wards and considered whether home treatment was an appropriate option.

When we inspected the trust in 2016, we found that access to the crisis service was generally good during the day but there was not an out of hours' service in some areas for people over the age of 65 with dementia. The trust told us that they were not commissioned for this service. This meant that that after 8pm emergency support would need to be accessed by calling 111 or 999.

We judged that there was insufficient capacity to manage crisis at night. The response to crisis calls out of hours was inconsistent. In Norwich crisis calls were diverted to a mobile after nine o'clock at night when the staff member was out. The staff member was unable to answer the call when they were with a patient so the call diverted to voicemail. After midnight in Great Yarmouth one member of staff had to respond to telephone calls on the crisis line, make gatekeeping assessments for admission to the inpatient wards and undertake assessments in the emergency department of the acute hospital. At times during the night in Kings Lynn, crisis staff also had to work on the inpatient ward due to the ward's shortage of staff whilst providing a crisis service.

The trust continued to have no overarching operating procedure for crisis services that clearly defined key performance indicators and targets for the services. We reviewed the operational policies for the crisis teams and found that there was no specific KPI included in the operational policy for the crisis team based at Hellesdon in Norwich or the teams in Suffolk. This was a requirement notice from the last inspection.

The trust's target for seeing people in an emergency was 4 hours and 72 hours to see those with urgent needs. Crisis services were not consistently meeting the trust target for response to emergency assessments. There were also discrepancies between the trust's definition of an assessment following an emergency referral and practice. It was, therefore, unclear how the trust accurately monitored or assured itself that staff prioritised face to face assessments over telephone contact. This was a requirement notice from the last inspection.

Those patients known to crisis services had access to a crisis phone number. However, if a member of the public was not known to the trust and they needed help they were unable to access the crisis teams. MIND were commissioned to provide a crisis line for people not open to mental health services. Information related to this line was not easily located on the trust website or internet, meaning people might not easily locate the contact number when needed. People told us that their only option in a crisis had been to either telephone 111, wait to see their GP or attend Accident and Emergency departments.

There were five health-based places of safety across Norfolk and Suffolk. Data provided by the trust from April 2016 to March 2017 showed thirteen occasions when a patient was not able to access the health based place of safety because it was already in use. Between 13 June and 17 July 2017, data showed the trust had closed the facilities in Suffolk on three occasions due to shortage of staff. When this occurred patients were diverted elsewhere in the trust. An alternative place of safety could either involve lengthy travel away from the patient's home area or mean the place of safety would have to be in an emergency department in an acute hospital or in a police station.

The trust provided data to show waiting times for a Mental Health Act assessment in a health based place of safety. The average length of time from admission to commencement of an assessment was 5.4 hours. Our review of 23 records of patients assessed in the place of

Requires improvement

Are services responsive to people's needs?

safety also showed the Approved Mental Health Practitioner and doctor did not always attend within the three hours target set in the interagency protocol for section 136 of the Mental Health Act.

Community teams had targets for urgent and routine assessments following referral. Generally, these were being met. However, in older people's teams' referral to assessment times varied across the service. The West Suffolk DIST team was not meeting the four hour response time due to staff shortages. The East Suffolk DIST was not meeting the local target set at 28 days.

Referral to treatment targets differed across service type and locality. Trust data provided showed that most services met their targets for referral to treatment times. However, in some teams, particularly in older people's, adults and child and adolescent services, patients had been assessed but had a further wait for allocation to a care coordinator. In community adult teams there were waiting lists of approximately 473 patients who did not have an allocated care coordinator. In community child and adolescent teams there were waiting lists ranging from three weeks to eight months for care co-ordinators in some pathways and a seven-month waiting list for psychology.

Most teams were flexible in arranging appointments with people at times that were best for them and mostly visited people in their own home. Appointments were rarely cancelled and when they were people were usually contacted with an explanation and the appointment rearranged.

Most teams had procedures for when a person did not attend an appointment. Managers told us that they actively tried to engage with people who were reluctant to engage with services. People who did not attend an appointment were contacted again by phone or letter and efforts were made to rearrange. However, in community adult teams we were concerned to find examples of where staff had not followed the trust's 'non-access visits and missed/ cancelled appointments' policy.

The trust monitored bed occupancy rates. Between April 2016 and March 2017 average bed occupancy rates at the trust stood at 92% across all services. It is generally accepted that when occupancy rates rise above 85%, the quality of care provided to patients is affected. Four out of the six inpatient core services had bed occupancies of 85% and above; Wards for older people (98%), Acute (94%), Child and adolescent wards (92%) and Forensic (86%). Five wards had over 100% bed occupancy; acute wards Glaven and Waveney Ward and older people's wards Rose, Reed and Sandringham.

Between April 2016 to July 2017, 472 patients had been cared for on more than two separate wards during a single admission episode. Several patients had a significant number of ward transfers during their admission and we considered this was not conducive to their recovery. For example, a Glaven patient was transferred between five wards in seven weeks, including out of area, as there had been no psychiatric intensive care beds available. Since their admission 17 out of 20 Northgate and Southgate patients had transferred wards. This included a patient having three admissions within a week in June including to an out of area bed. A Thurne patient was admitted to seven different wards since June 2016, another patient was admitted 10 times since January 2016. Between April 2016 and March 2017, 92 patients had moved wards during the night.

Locality managers told us they had weekly telephone calls to assess and monitor bed availability and risks. A discharge screening tool was used with patients to identify their needs to help identify high risk patients. Staff said that discharge planning started on admission. Yarmouth acute ward had community in-reach workers supporting patients with discharge. Crisis team staff and discharge facilitators attended the ward for meetings to check when patients could be discharged or were ready to go on leave.

Community and crisis team members told us that there remained difficulty in arranging hospital admission for people whose mental health had deteriorated and that there were insufficient beds. Ward staff told us that sometimes they had to admit people in beds where the patient was on leave. During our night visit to Northgate hospital we observed that 26 patients had been allocated to a 20 bedded ward. An additional patient was using the place of safety and was subsequently moved to a rehabilitation service. At St Catherine's, a rehabilitation service, we found that a patient had been admitted in crisis as there was no acute bed available.

When we last inspected the trust they told us that they had decreased their out of area placements significantly in the previous year. They had reduced their expenditure on this by a third, saving £1million. However, between April 2016 and March 2017, there have been 387 out of trust

placements. 85% of these had been for patients requiring an acute or PICU bed. This was a significant rise since our last inspection when there had been just 81 over a six month period. The trust acknowledged that this was too high. They told us that they had negotiated contracts with local independent providers to reduce the impact on patients being long distances from home.

The trust monitored situation where discharges and transfers of care were delayed. Between April 2016 and March 2017 there were a total of 102 patients whose discharge had been delayed. 82% of these were in acute and older people's wards. Between March 2016 and February 2017, there were a total of 207 delayed transfers of care for patients and 6,264 delayed days. NHS England data showed that the reasons for the majority of the delays were: 55% were due to awaiting residential home placement or availability, 11% were due to patient or family choice.

Following discharge there was a system in place in acute services to contact patients to assess their welfare. The ward staff telephoned the patient 48 hours after discharge and either the crisis resolution and home treatment team or community teams would visit within 7 days of discharge from the ward. The trust provided data regarding the seven day post discharge follow up target. At the time of our inspection the trust had met this target at 95% compliance.

Between April 2016 and March 2017 there had been 315 readmissions within 28 days of discharge across 21 wards. Acute wards accounted for 81% of all readmissions within 28 days. Of the overall readmissions, 28 (11%) of patients were readmitted back to a ward less than 24 hours after being discharged. Four of the 28 patients were readmitted within less than two hours.

The facilities promote recovery, comfort, dignity and confidentiality

Assessments undertaken under the patient-led assessment of the care environment (PLACE) reviews in 2016 identified that the trust scored about average at 90% for the privacy, dignity and well-being element of the assessment. Five of the nine inpatient units scored worse than the England average. Three inpatient services, the Fermoy Unit, St Clements Hospital and Northgate Hospital, scored below 85%.

Patients had personalised their bedrooms where appropriate on most wards. Lockable storage was available to patients at all areas. However, we found that the acute wards, Waveney, Glaven and Churchill, had some shared double bedrooms with curtain partitions which adversely affected patient's dignity and privacy. We found some examples of staff protecting people's privacy and promoting dignity. However, we had some concerns regarding mixed sex accommodation that are set out above under the safe domain.

Most units had a clinic room available and were equipped for the physical examination of patients. We found that most services had access to grounds or outside spaces. Services generally had environments that promoted recovery and activities. Wards usually had rooms for visitors and for quiet times.

Assessments were undertaken at four units under the patient-led assessment of the care environment (PLACE) reviews in 2016 identified that the trust scored about average at 90% for the dementia friendly element of the assessment. The trust had scored 94% against an England average of 83%. At this inspection, we found that, where relevant, ward environments had been improved to be more dementia friendly. Facilities promoted recovery and comfort.

Patients had access to drinks and snacks 24 hours a day. At older people's wards we saw that patients were supported to eat and drink.

At most services patients were offered appropriate activities. Most patients told us that staff supported them to maintain independence and provided meaningful activities.

All wards we visited had a telephone available for patient use in a private area.

Generally community teams had a range of rooms for patients to use, including group and individual rooms. However, community child and adolescent teams and some adult teams did not have dedicated interview rooms to see patients. The ad hoc room booking system left patients waiting for some considerable time while staff found a suitable room.

Meeting the needs of all people who use the service

The trust told us that they were committed to equality and diversity and pro-active about engaging with underrepresented groups. Access to information for all

patients had been a key piece of work. The trust had adopted a policy regarding accessible information and had developed a range of leaflets, letters and tools in easy read formats. Staff had been recruited as greenlight toolkit champions, had been trained in Makaton and in assessing for reasonable adjustments.

We found a range of information available for service users regarding their care and treatment. Many of the leaflets were available in other languages and accessible formats. Where these were not available staff told us they were able to access translated versions for patients.

At most inpatient services we saw that multi-faith rooms were available for patients to use. Spiritual care and chaplaincy was provided when requested. A spirituality practice guide and transgender guidance leaflet were available for staff to support the diverse needs of patients.

Interpreters were available via a central request line and had been used to assist in assessing patients' needs and explaining their care and treatment.

Assessments undertaken under the patient-led assessment of the care environment (PLACE) reviews in 2015 identified that the trust scored better than average at 98% for the overall food element of the assessment against an England average of 91%. Five hospital sites scored 100% and no units scored lower than the national average for food. At the majority of services we saw that there was a range of choices provided in the menu that catered for patients' dietary, religious and cultural needs.

The majority of patients we spoke with were happy with the choice and quality of food available to them. However, at the forensic wards, patients reported that the food was bland and tasteless. They did not enjoy the food and some chose to request halal food as it was tastier.

Inpatient and community services were mainly provided from facilities that were equipped for disability access. In environments where this was not possible arrangements were in place to ensure alternative access to the service. However, two patients at Thurne ward in acute services raised concerns about wheelchair accessibility. We requested information from the trust and they stated they did not carry out regular disabled access assessments.

Listening to and learning from concerns and complaints

Patients on wards told us that they were given information about how to complain about the service. This was usually contained within the ward information booklet and included information about how to contact the patients' advice and liaison service. Information about the complaints process was usually displayed at the wards.

The head of patient safety led on complaints work to ensure an integrated approach to patient experience information. The trust had a dedicated staff team, a centralised recording process, clear guidance and training for staff and governance oversight. The lead explained that all complaints are triaged to ensure any safeguarding matters raised by complaints are appropriately managed.

Complaints were discussed at local governance meetings and at the trust-wide quality governance committee. The chief executive signed off all complaint responses. Information about the levels of complaints was presented to the board on a quarterly basis.

The trust provided details of all complaints and contacts received between April 2016 and March 2017. There had been 661 formal complaints. The analysis of this highlighted key themes as all aspects of clinical care, clinical treatment and attitude of staff. The trust informed us that during the period 15% of complaints had been upheld and 34% were partially upheld. The majority of complaints were about adult community services at 30%. 28% of these complaints were upheld.

We were told that the level of complaints had risen by 12% compared to the previous year. Levels of complaints that were upheld had reduced by approximately 10%. A total of 82 complaints have been re-opened in this reporting year. 25 complaints were re-opened when the complainant expressed their disagreement with the investigation findings and supplied further evidence or information in support of their position. Five complaints had been referred to the ombudsman during this time. Two of these were upheld by the ombudsman. During the same period the trust received 465 compliments.

The trust used an online survey to analyse complainants experience following the conclusion of a complaint

Requires improvement

Are services responsive to people's needs?

investigation. For 2016/17, there were 65 responses. 50% of complainants advised they had difficulty finding out how to complain. 57% felt they were not adequately kept informed of progress and would have liked more contact.

The trust also provided information about the complaint issues and the actions they had taken as a result of the findings. We reviewed this information and saw some good examples of learning from complaints.

Complaints information was also looked at some of the services we visited. Reports usually detailed the nature of complaints and a summary of actions taken in response. Generally, complaints had been appropriately investigated and included recommendations for learning. Staff told us they received feedback about complaints and at some units we saw actions that had occurred as the result of complaints. Staff we spoke with had awareness of the themes of complaints received about the ward or other inpatient units within the trust.

Inadequate

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.

Summary of findings

We rated Norfolk and Suffolk NHS Foundation Trust as inadequate overall for well led because:

- The board needed to take further and more timely action to address areas of improvement and to demonstrate leadership in ensuring safety for patients. The service was not yet fully safe, effective or responsive at all services. The breaches of regulation identified at our previous inspections had not been resolved. Patients do not benefit from safe services in all areas.
- The trust leadership did not demonstrate a safety narrative running through the organisation.
- Information was not always robust. The board needed to ensure that their decisions were implemented and brought about positive improvement. Data was not effectively captured and showed a lack of rigour.
- Performance improvement tools and governance structures did not facilitate effective learning and did not bring about improvement to practices in all areas.
- Work was required to ensure that all risks were fully captured and understood by the board and that actions were taken in a timely way to address these.

However:

- Morale was found to be good across the trust. This was supported by the staff survey and the staff element of the Friends and Family Test.
- The trust had improved arrangements to engage service users and staff in the planning and development of the trust.

Our findings

Vision, values and strategy

The trust's vision and values were updated in October 2015 following an engagement exercise known as the 'putting people first project'. The trust had undertaken 2000 hours of listening exercises and had met with 1300 staff, service users and carers. The vision was stated as: "Be a champion for positive mental health, by providing safe, effective, trusted services together with our partners". The values were stated as: "working together for better mental health: positively – respectfully – together".

The trust had delivered training to managers to imbed the values and behaviours, revised the appraisal system to be a values based approach, and adopted values based recruitment processes. Managers confirmed that values based recruitment had improved the recruitment process and set out expectations that staff employed upheld the values of the trust. The trust told us that that their values were well embedded. 900 staff had participated in the equality survey in 2016: 99% of respondents stated they were aware of the trust's values.

Staff had completed awareness training relating to the trust's values. Some teams had developed a service statement based around the values. Almost all staff were aware of the trust's vision and values and could describe them. Most staff agreed they shared the trust's values. We saw staff putting the values into action in the ways in which they interacted with patients.

Most staff across services told us that, since the last CQC inspection, communication and engagement with staff about the planning and delivery of trust services had improved

The trust strategy for 2016 to 2021 included three key strategic priorities. These were:

1. improving quality and achieving financial viability
2. working as one trust
3. focussing on prevention, early intervention and promoting recovery

The strategy was underpinned by clinical, workforce and organisational development, service user and carer, recovery, staff wellbeing, leadership, technology and estates strategies, and an operational plan. Together these set out more detailed objectives to meet this plan, as well as arrangements to monitor progress. The trust confirmed

that the 'putting people first programme' had helped to inform the development of the strategies, and particularly the workforce and organisational development and clinical strategies.

The trust's quality priorities for 2016/17 were to provide staff with the tools to manage people who self-harm better, improve service user feedback and compliance with capacity recording. The trust had also set a five year target for suicide reduction.

Under priority 1 within the operational plan, the trust had key objectives to deliver trusted, effective, quality driven services' and to 'deliver their 2016/17 financial plans and stay within budget'. The trust stated they were ahead of their financial plan while investing heavily in better environments, additional staff, leadership development and engagement. In 2016/17 and reduced their deficit to £3.3 million. The financial turnaround was marked and had taken pressure off this aspect of trust performance.

The trust board, executive team and quality governance committee reviewed performance against the strategy on a monthly basis via the quality improvement, business performance and quality account reports. These included a dashboard and heat maps that indicated where possible risks may be. Performance against annual objectives was also published within the quality account.

Good governance

The trust had a board of directors who were accountable for the safe delivery of services. The trust had an integrated board assurance framework and risk register which was reviewed monthly by the audit committee and the board. Risk registers were held at different levels of the organisation which were reviewed at directorate and locality meetings.

Reporting to this were committees for operational development and workforce, audit and risk and the Mental Health Act managers. Quality was managed through the quality governance committee which also reported to the board. Reporting to this were sub-committees for clinical effectiveness and policy, health and safety, infection control, safeguarding, suicide prevention, physical health, mental health legislation, equality and diversity, research, and drugs and therapies. The service user and carer partnership reported directly to the board and information governance was accountable to the audit and risk committee. These committees had terms of reference, defined membership and decision making powers.

The quality improvement report acted as a performance report against key indicators and an early warning system for identifying risks to the quality of services. The performance report included a number of measures such as: targets for clinical outcomes, patient experience, access and waiting time targets, bed occupancy, as well as staffing measures such as vacancies, sickness, turnover and training rates. The report also included an update against all quality improvement plans (QIP). The quality dashboard was further updated in September 2016 to include a balanced scorecard.

A mental health managers committee had overall responsibility for the application of the Mental Health Act and the Mental Capacity Act, and performs the role of the 'hospital managers' as required by the Mental Health Act. We met with the hospital managers and found that they provide a regular annual report to the board, to inform the executive of performance in this area. The board also receive further information and assurance through the board committee structure.

Local governance groups were in place in all the localities and services, which also fed in to the quality governance committee. Staff demonstrated they were aware of their responsibilities in relation to governance. Most staff told us that they were aware of the governance structure and had access to performance information and meeting minutes. Most staff told us that they would escalate any risks they were aware of. Team managers confirmed that they were involved in governance groups and that they were able to raise issues through the risk register and operational groups.

When we inspected the trust in 2014 we found that, despite the trust collecting data, there was little evidence of the use of intelligence and data to inform performance. The board could not assure us that it knew how the trust was performing and how decisions were implemented or impacted on quality. We were concerned that the board had limited oversight of the point of care. It was difficult to see how the decisions made at the board were executed and monitored.

Inadequate

Are services well-led?

When we re-inspected in 2016, the trust told us that improvements in quality and safety were their highest priority and they had worked hard to address these issues and to develop better systems to capture and address risk. We found that the board had begun to address areas of concern. Most key risks that had been highlighted following our first inspection were reflected within the risk registers including ligature risks, seclusion environments, staffing levels. Key risks flagged within the board assurance framework were poor IT performance, continued low staff morale, not exiting special measures, not achieving financial sustainability and weak accountability.

During the inspection in 2016, we found that the trust had addressed some of the specific concerns that we raised in 2014, or had plans in place to address these in the near future. We found that trust had undertaken work to engage with staff and their stakeholders and involved them in their plans. This had led to improved staff morale and performance. Patient satisfaction had also improved. The trust had reduced the use of agency staff, reduced out of area placements, and invested in additional staffing. Community team caseloads had also been reduced. Overall incident levels had fallen and there were a range of initiatives to encourage learning from incidents. The trust had a clearer vision and strategy, improved governance systems and performance indicators.

However, at this inspection of 2017 we have found that not all issues that were highlighted in 2016, and some issues that we first raised in 2014, had been addressed. We continue to have concerns about some practices and resources including:

- The robustness of the arrangements in relation to assessing, mitigating and managing the risks of ligature points in the patient care areas. Whilst more comprehensive ligature risk assessments and action plans were in place, they did not address all ligature risks and a number of ligature risks remained on the wards. Not all identified risks had been set a timescale in which they would be addressed.
- A large number of arrangements on wards to eliminate mixed gender accommodation. The trust had acted on the majority of these concerns and had begun to declare breaches of this guidance. However, some concerns remained, particularly in acute services where there had been 30 breaches in the previous year.
- Seclusion practice and the environmental arrangements in seclusion rooms. Whilst work had been undertaken on some seclusion facilities seclusion environments were still not compliant with guidance or legislation. We were also concerned that seclusion continues to be undertaken in facilities that were not designated for seclusion including places of safety and bedrooms. Seclusion recording and safeguarding practice were found to be poor.
- Staffing levels at the trust were low. While there had been some improvement we were concerned that the trust was not meeting its own set staffing levels, particularly for qualified staff. There was also a lack of access to doctors and wider healthcare professionals in some services.
- Supervision and appraisal rates. At this inspection, data available at a trust level indicated poor compliance with these.The trust had stopped monitoring clinical supervision at a trust level. Not all teams had information available at the local level. A system was introduced to record management supervision but this was yet to imbed. It was concerning that senior management did not have access to reliable data to understand their compliance with these requirements.
- Some key individual mandatory training remained below accepted compliance levels. Some services, particularly acute and crisis services were significantly below requirements.
- Restrictive practice, particularly seclusion, long term segregation and rapid tranquilisation particularly in acute services. The trust had undertaken work to meet the Department of Health's 'Positive and Proactive Care' agenda. This had led to a planned reduction of prone restraint.
- Monitoring of patients physical healthcare following rapid tranquilisation.
- Clinical risk assessments, care plans and crisis plans were not in place or up to date for all patients.
- The performance of the electronic records system and the impact this had on staff and patient care.
- The levels of serious incidents at the trust remain high.

Inadequate

Are services well-led?

- Unreliable data and multi- stranded routes for data collection provided little or no assurance to the board or executive.
- Lack of availability of beds meant that people did not always receive the right care at the right time and sometimes people had been moved, discharged early or managed within an inappropriate service.
- Some community and crisis services were not meeting their targets for assessing and treating patients.

During this inspection period we found that the information given to the board differed to that returned as part of the provider information return sent to us prior to the inspection or information requested during and after the inspection period. There were several attempts to cleanse this data but on every occasion was in various formats and offering differing conclusions. This showed that the data that the board relied on to assure itself about the trust's performance was flawed and therefore unreliable.

Data is not being turned into information and then used to inform practices and policies and there remains room for improvement to ensure that lessons were learned from quality and safety information and that these were fully imbedded in to practice. We reviewed the risk registers for the trust and directorates and saw that some but not all risks that we identified through this inspection had been included in the risk register. A number of risks had been considered as addressed and closed on the risk register when the risks still existed and had not been fully resolved. We found some examples of learning from improvements that had not always been applied to other areas of the trust. This showed that further work was required to ensure that all risks were fully captured and understood by the board. We were concerned that while the trust's own governance system had highlighted some of these issues, the trust was yet to fully address these across all services.

We judged that there was a lack of grip around some serious issues that had been identified over the past two inspections. These include the risks posed by ligatures, the environmental deficiencies in seclusion rooms and the poor understanding of and use of data. We were particularly concerned that the information and learning from deaths within the trust had not been given adequate focus. Despite several reports there was a lack of traction within the trust to affect change in practices based on findings from the learning following these serious incidents. The pace of change had been slow and patients were left at risk as a consequence.

Throughout, and immediately following our inspection, we raised our concerns with the trust. The trust senior management team informed us of a number of immediate actions they had taken to address our concerns.

Fit and proper persons test

In November 2014, a CQC regulation was introduced requiring NHS trusts to ensure that all directors were fit and proper persons. As a consequence of this the trust had checked that all senior staff met the necessary requirements. The trust had ensured that relevant policies and procedures included the requirement to check all future senior staff had the met this standard. They had also developed guidance and an annual fit and proper persons test checklist to be signed off as part of performance appraisal. During the inspection the trust provided us with details of all the checks they had undertaken to meet this regulation.

Leadership and culture

We had inspected the trust in October 2014 under CQC's comprehensive inspection programme. We found that, while the board and senior management had a vision with strategic objectives in place, staff did not feel engaged in the improvement agenda of the trust. Morale was found to be very poor across the trust and staff told us that they felt let down by management. The trust was rated inadequate overall and was placed in special measures by Monitor following recommendation by CQC.

When we re-inspected the trust in 2016 we found that for the first nine months the board had failed to make sufficient progress; there was little traction and the pace of the change was very slow. Following new additions to the board membership, the breadth of understanding of the issues involved improved markedly and with it the pace of change. We saw that the board was in a much more mature phase and had worked to ensure that it could offer challenge within the board and to staff throughout the trust in order to drive improvement. We found a revitalised energy at board level with a spirit of stronger leadership. A number of initiatives had been taken to improve leadership at all levels of the trust. Staff morale had improved markedly. However, this was at the beginning of the transformation and needed further work.

Are services well-led?

Since then, work had been undertaken to complete the programme to simplify and standardise the operational leadership model. All localities had implemented a triumvirate management model incorporating a locality manager, a modern matron and clinical lead. These were supported by deputy matrons, and a HR and governance business partner allocated to each locality.

The trust was brought out of special measures following the inspection in July 2016, with the expectation that they would need additional support at board level to improve. Despite a support package that was delivered via NHS I, it is disappointing that by this inspection, in July 2017, the improvements had slowed and major safety issues had remained unresolved. We found that the board did not have the drive to effect change at a pace and with sufficient traction to bring about improvements needed to resolve the failings in safety and to sustain an improvement cycle.

At January 2017, the percentage of staff who would recommend the trust as a place to receive care was worse than the England average – 78% compared to 80%. The percentage of staff who would not recommend the trust as a place to receive care is better the England average – 3% compared to the England average of 6%. The response rate was very low at 63 individuals.

We met with a large number of staff at this inspection. We found that staff remained committed to ensuring that they provided a good and effective service for people who used the services. Most felt engaged by the trust and able to influence change within the organisation. Generally staff felt that morale continued to improve and there had been an improvement with communication from board to ward level. Staff we spoke with appeared happy in their roles and proud of the service they worked in.

Staff told us they knew their immediate management team well and felt supported by them. Most felt they had a good working relationship with their immediate managers. Most staff were aware of, and felt supported by, the trust's local management structures. Most staff were clear about who the senior management team were at the trust. Many staff stated that they had met with or seen senior managers at their service.

There had been very few allegations of bullying or harassment at the trust. Staff were aware of their role in monitoring concerns and assessing risks. They knew how to report concerns to their line manager and most felt they would be supported if they did. Generally, staff felt that learning from past incidents had improved and was informing planning of services or service provision. Between April 2016 and March 2017 there had been four were whistleblowing reports to CQC. The trust had piloted having a 'putting people first guardian' since September 2016. The role was to provide independent and confidential advice and support to staff who raise a concern while escalating cases to the right level so that they can be resolved efficiently. The guardian told us that there had been 24 contacts since the role began. For most people it had been about supporting them to get things straight for themselves to then take their own action. There had been no consistent themes to date.

The trust has an 'equality, diversity and inclusion' policy which was published in March 2017. This covers the responsibilities and duties of all levels of staff, methods of implementation of the policy, equality monitoring, education and raising concerns.

During this inspection we also looked at the trust application of the Workforce Race Equality Standard (WRES). This requires all NHS organisations to demonstrate progress against nine indicators of workforce equality. The trust had implemented the workforce race equality standard (WRES) metrics, along with an action plan to address the differences in measures for black minority and ethnic staff (BME). The trusts grading against the outcomes showed that 12 out of 18 outcomes were 'developing'. Four had moved from 'undeveloped' to developing' and there was one outcome which was graded as 'achieving': Flexible working options are available to all staff consistent with the needs of the service and the way people lead their lives.

The trust undertook a second benchmarking exercise in April 2017. The early findings from this are that: 11% of BME applicants were successful at interview compared to 18% of white applicants; BME staff were twice as likely as white colleagues to be the subject of disciplinary action; BME staff consistently reported much less favourable experiences at work than white staff. Overall the trust provided a less positive experience for all staff compared to the national averages scores for mental health trusts. The metrics also considered findings from the NHS staff survey. These findings included staff experiencing harassment, bullying or abuse from patients, relatives or the public in

the last 12 months, of which 50% of BME staff at the trust experienced and staff experiencing harassment, bullying or abuse from staff in the last 12 months, of which 31% of BME staff experienced.

The trust produced an annual equality report, which included workforce data and examples of equality work, providing evidence of compliance against the three main headings of the general duty. The board had discussed these and reviewed the action plan throughout the year. We noted that there had been good progress in recruiting WRES leads and delivering equality and diversity training but considerable work was needed to develop service level equality assessments and action plans. The trust had created a specific work stream, working with the BME employee network group, to identify and implement ways of improving the employment issues.

There were five active staff network groups for: BME, LGBT, spirituality and wellbeing, mental health and disability.

Engagement with the public and with people who use services

The trust had a combined service user and carers' involvement policy 'improving services together' which was being updated. The trust had also developed a recovery strategy. This had been co-produced with service users and carers. Together these set out a commitment for working in partnership with service users, carers and wider stakeholders. This work was overseen by a trust wide service user and carer partnership. A patient and carer report was presented to the board on a quarterly basis.

The trust had a developed a dedicated team to support the engagement strategy, and had recruited staff within services to champion user and carer involvement. The lead for patient involvement told us that the trust had rationalised the engagement process by creating a hub and spoke model for stakeholder groups. There was a trust wide service user and carer partnership: reporting to this were area hubs. A range of local user, carer and stakeholder groups fed in to the area hubs.

Work undertaken on this agenda had included increased partnerships with voluntary and community groups, involvement in developing the vision, values, strategies and clinical priorities, and involvement in the complaints procedure review and suicide strategy. Service users delivered staff training, were involved in recruitment and had delivered patient stories at board. The trust was piloting 'pop up' meetings in the community to gain wider public views of the service.

Other initiatives developed by the trust included the use of the 'triangle of care' toolkit which provides an accredited framework to develop carer involvement within local services.

The trust told us that they were committed to equality and diversity and pro-active about engaging with underrepresented groups. Access to information for all patients had been a key piece of work undertaken. The trust put in place a policy regarding accessible information and had developed a range of leaflets, letters and tools in easy read formats. Staff had been recruited as greenlight toolkit champions and had been trained in Makaton and assessing for reasonable adjustments.

The trust had employed 40 peer support workers to work in services across the trust. Peer support workers we met were very positive about the support they received from the trust to undertake their roles.

The trust had a number of user and carers' forums and inpatient services had community meetings to engage patients in the planning of the service and to capture feedback. Minutes were usually taken and in most cases we saw evidence of actions that were raised being completed. Patients told us they felt able to raise concerns in the community meetings and that they usually felt listened to.

We saw that there was information available throughout the trust and via its website about how to provide feedback on the specific services received by people.

Since 2013, 'Patient-Led Assessments of the Care Environment' (PLACE) visits had taken place to most inpatient services. This was a self-assessment process undertaken by teams including service users and representatives of Healthwatch.

The Care Quality Commission community mental health survey 2015 was sent to people who received community mental health services from the trust to find out about their experiences of care and treatment. Those who were eligible for the survey were people receiving community care or treatment between September and November 2015. There were a total of 239 responses, which was a response rate of

28%. Overall the trust scored 'about the same' as other mental health trusts in five of the ten areas of the survey. There were seven sub-areas where patient experience declined from 2015 to 2016, this included:

- Having been told who is in charge of organising care
- Involved in agreeing care to be received
- Involved in discussing how care is working
- Overall experience
- Staff checked how they were getting on with new medication
- Staff understood impact of mental health on other areas of life
- Given help or advice with finding support for finding or keeping work.

The trust had used the friends and families test (FFT). At November 2015 the results indicated that 87% of patient respondents were likely or extremely likely to recommend the trust services. The response to the test demonstrated a fluctuating picture of satisfaction during the 6 months prior to this at between 84 and 90%. This was an improvement since we last inspected the trust in 2016 and about average with other mental health trusts.

During this inspection we met with the council of governors. The trust had elected members and appointed individuals who were patients, service users, staff or other stakeholders who represent members and other stakeholder organisations. Some governors told us that they had seen much improvement at the trust over the previous two years. They felt that they are now able to hold the trust to account via the non–executive directors on key issues and were confident that the response they received was timely, open and transparent. They reported they were able to call individual directors to the meetings should this be required. However, some governors were less positive and did not feel engaged in the improvement of the trust.

During this inspection we heard from many service users, carers and local user groups about their experience of care. Some people were unhappy with the service they or their loved one had received. However, the majority of people we met were positive about their care and treatment and the service they had received.

Quality improvement, innovation and sustainability

The trust undertook a wide range of clinical effectiveness and quality audits. These include suicide prevention, medication, clinical outcomes, care planning, records completion, infection prevention, Mental Health Act and Mental Capacity Act administration, application of National Institute of Health and Care Excellence guidance, physical healthcare and patient satisfaction.

During 2016/16 the trust had participated in five national clinical audits. These included POMH - UK national audit of rapid tranquilisation, monitoring of patients prescribed lithium, prescribing high-dose and combination antipsychotics on adult acute, intensive care and forensic wards, and prescribing antipsychotic medication for people with dementia.

The trust participated in two national enquiries: the National Confidential Inquiry into Suicide, Homicide and Unexplained Death, by People with Mental Illness and the National Confidential Enquiry into Patient Outcome and Death – Young People's Mental Health Study.

The trust had participated in three accreditation schemes; the ECT Accreditation Service (ECTS), the Quality Network for Inpatient CAMHS (QNIC) and the Quality Network for forensic Mental Health Services.

We found a number of innovative practices:

- At the Dragonfly unit we saw sensitive handling of difficult issues. Staff understood individual needs of patients. We saw staff show exceptional care and respect for a patient who was distressed. We saw a parent who was upset and staff sensitively routed other people away to allow privacy.
- At the Dragonfly unit staff offered a range of therapeutic interventions in line with National Institute for Health and Care Excellence guidelines. One patient told us they had asked for another therapy session between school and suppertime and staff immediately arranged an additional therapy session. Another patient told us there was lots of therapy.
- At the Dragonfly unit we heard how staff regularly presented to other units and encouraged improvements across children's and young people's services.
- The trust actively participated in the Green Light Toolkit which was a yearly audit to check how well mental

health services were meeting the needs of people with learning disabilities and autism. The trust had recruited and trained 128 champions to deliver this agenda. The trust was rated above average for 24 of the 27 standards.

- The peer support worker role was imbedded into community teams. A new 'peer support navigator' role was being trialled in adult community teams. This offered patients up to six sessions with the staff member to prepare for discharge and aid reintegration into their local community. This role offered patients the opportunity to work with a staff member with lived experience of being discharged from services, and offered great insight and understanding of the anxieties patients could be experiencing at this time of change.
- One of the clinical team leaders for community adults was taking a lead role for developing services and support for pregnant patients and patients with children.This project and associated changes and development of policies and procedures was linked to the lessons learnt and analysis of serious incidents within the trust.
- The service manager for Coastal IDT had designed and implemented an intranet page only accessible to their service staff. This contained links to policies, local community resources and minutes from meetings. Designed to support staff to keep abreast of information and service development without overloading them with multiple emails.
- In child and adolescent teams one staff member in conjunction with other members of their team was undertaking a research project about the impact and management of multiple traumas. The objective of the research was to influence future service development around management of waiting lists across the trust.
- The trust had continued to develop 'The Compass' centre. This centre provided a therapeutic education service for young people who might otherwise be placed in schools out of area. The compass centre was a partnership between Norfolk County Council children's services and Norfolk and Suffolk NHS Foundation trust.
- There was a parent and infant mental health attachment project at Mary Chapman house in Norwich. This service offered attachment based therapy and mental health support to parents and infants where the local authority had identified high safeguarding concerns.
- The psychologist from the older people's services visited local schools to deliver a workshop about dementia, helping to raise awareness of the effects of this illness amongst the wider population.
- The staff from the psychiatric intensive care unit, Lark ward, had shared their research with national journal publications in 2017 such as the journal of psychiatric intensive care brief report 'can amount of and duration of seclusion be reduced in psychiatric intensive care units by agreeing SMART goals with patients' and the British Journal of Healthcare Management 'Can mental health clusters be replaced by patient typing.'

This section is primarily information for the provider

Requirement notices

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.

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Treatment of disease, disorder or injury	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment • The trust had not taken action to remove all identified ligature anchor points and had not done all that is reasonably practicable to mitigate any such risks. The trust had not addressed all risks in relation to poor lines of sight. • The trust had not ensured that all mixed sex accommodation met Department of Health and Mental Health Act code of practice and promoted safety and dignity. • The trust had not ensured that seclusion facilities were safe and appropriate and that seclusion and restrictive practice were managed within the safeguards of national guidance and the Mental Health Act Code of Practice. • The trust had not fully implement guidance in relation to restrictive practices or reduced the number of restrictive interventions • The trust used bed bays in the acute wards. • The trust had not ensured that all services had access to a defibrillator or that staff were aware of arrangements for life support in the event of an emergency • The trust had not ensured there are enough personal alarms for staff and that patients had a means to summon assistance when required. • The trust had not ensured that people received the right care at the right time by placing them in suitable placements that met their needs or gave them access to 24 hour crisis services. • The trust had not ensured that patient disruption was minimised during their episode of care or ensured that discharge arrangements were fully effective

This section is primarily information for the provider

Requirement notices

- The trust had not ensured that all risk assessments, crisis plans and care plans were in place, updated consistently in line with changes to patients' needs or risks, or reflected patient's views on their care.
- The trust had not ensured that the prescribing, administration and monitoring of vital signs of patients was completed as detailed in the NICE guidelines [NG10] on violence and aggression: short-term management in mental health, health and community settings.
- The trust had not ensured that there was full and clear physical healthcare information and that patients physical healthcare needs were met
- The trust had not ensured that the temperature of medicines storage areas were maintained within a suitable range, and that the impact on medicines subject to temperatures outside the recommended range was assessed and acted on.

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Treatment of disease, disorder or injury	Regulation 18 HSCA (RA) Regulations 2014 Staffing • The trust had not ensured that there were sufficient staff at all times, including medical staff and other healthcare professionals, to provide care to meet patients' needs. • The trust had not ensured all relevant staff had completed statutory, mandatory and where relevant specialist training, particularly in suicide prevention and life support. • The trust had not ensured that all staff receive regular supervision and annual appraisals, and that the system for recording levels of supervision was effective and provided full assurance to the trust board

Regulated activity	Regulation

This section is primarily information for the provider

Requirement notices

Assessment or medical treatment for persons detained under the Mental Health Act 1983

Treatment of disease, disorder or injury

Regulation 13 HSCA (RA) Regulations 2014 Safeguarding service users from abuse and improper treatment

- The trust had not ensured that patients were only restricted within appropriate legal frameworks.

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.

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Treatment of disease, disorder or injury	Section 29A HSCA Warning notice: quality of health care During our inspection in July 2017 we found failings with: 1. Systems and processes that did not operate effectively to ensure that the risks to patients were assessed, monitored, mitigated and the quality of healthcare improved in relation to: 2. Systems to monitor and learn for quality and performance information 3. Ligature point management and environmental risks 4. Seclusion environments and seclusion practice 5. Accommodation for men and women 6. Staffing levels 7. Management oversight and governance to ensure staff had regular supervision, appraisal and training 8. Access to services 9. Risk assessment and care planning 10. Clinical records 11. Access to alarms and emergency equipment