Inadequate

Norfolk and Suffolk NHS Foundation Trust

Quality Report

Hellesdon Hospital
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Core services inspected	CQC registered location	CQC location ID
Acute and psychiatric intensive care units	Carlton Court	RMY13
Acute and psychiatric intensive care units	Northgate Hospital	RMY03
Acute and psychiatric intensive care units	Woodlands	RMYX1
Acute and psychiatric intensive care units	Wedgewood House	RMYX5
Acute and psychiatric intensive care units	Hellesdon Hospital	RMY01
Acute and psychiatric intensive care units	Fermoy Unit	RMYXX
CAMHs inpatient services	Lothingland	RMYX2
CAMHs community services	Trust Headquarters	RMY01
Eating disorder	Trust Headquarters	RMY01
Forensic inpatient services	Norvic Clinic	RMY04
Forensic inpatient services	Hellesdon Hospital	RMY01
Forensic inpatient services	Highlands	RMY27
Forensic inpatient services	St Clements	RMYX3

Summary of findings

Forensic community services	Trust Headquarters	RMY01
Adult community services	Trust Headquarters	RMY01
Learning disability inpatient services	Walker Close	RMYX4
Learning disability inpatient services	Lothingland	RMYX2
Learning disability community services	Trust Headquarters	RMY01
Older peoples' inpatient services	Julian Hospital	RMY02
Older peoples' inpatient services	Woodlands	RMYX1
Older peoples' inpatient services	Carlton court	RMY13
Older peoples' inpatient services	Wedgewood House	RMYX5
Older peoples' community services	Trust Headquarters	RMY01
Crisis services and health based places of safety	Trust Headquarters	RMY01

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 mental health services at this provider	**Inadequate** 
Are mental health services safe?	**Inadequate** 
Are mental health services effective?	**Requires Improvement** 
Are mental health services caring?	**Good** 
Are mental health services responsive?	**Requires Improvement** 
Are mental health 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 findings

Overall summary

When aggregating ratings, our inspection teams follow a set of principles to ensure consistent decisions. The principles will normally apply but will be balanced by inspection teams using their discretion and professional judgement in the light of all of the available evidence.

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

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

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

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

- We found that there was not a safe, effective or responsive service at this trust and the board needs to take urgent action to address areas of inadequacy.
- While the board and senior management had a vision with strategic objectives in place staff did not feel fully 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 had been involved in a number of initiatives to engage with staff. However, staff told us that leadership from above ward level was not visible or accessible to them**.** Staff told us that they did not feel engaged in the improvement agenda.
- Despite the trust collecting data there was little evidence of this being used 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 found that while performance improvement tools and governance structures were in place these had not always facilitated effective learning or brought about improvement to practices.
- Throughout this inspection we heard from service users, carers and local user groups who felt that they had not been effectively engaged by the trust in planning and improvement processes.
- We had a number of concerns about the safety of this trust. These included unsafe environments that did not promote the dignity of patients; insufficient staffing levels to safely meet patient's needs; inadequate arrangements for medication management; concerns regarding seclusion and restraint practice.
- We were also concerned that while the trust had systems in place to report incidents, improvement was needed to ensure learning or action.
- A large number of staff had not received their mandatory training and 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 may have been moved, discharged early or managed within an inappropriate service.

However:

- Overall we saw good multidisciplinary working and generally people's needs, including physical health needs, were assessed and care and treatment was planned to meet them.
- We observed some positive examples of staff providing emotional support to people, despite the challenges of staffing levels and some poor ward environments.

It is our view that the trust needs to take significant steps to improve the quality of their services and we find that they are currently in breach of regulations.

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 intended to take to address our concerns.

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 this domain because:

- We were concerned that staffing levels were not sufficient or safe at a number of inpatient wards and community teams across the trust.
- We found a number of environmental safety concerns. While some work was being planned or underway to remove potential ligature risks, we are concerned that planned actions would not adequately address all issues. We also found that the layout of some wards did not facilitate the necessary observation of patients. We were concerned about the design of seclusion facilities across the trust.
- The trust had policies and processes in place to report and investigate any safeguarding or whistleblowing concerns. Most staff told us that they were able to raise any concerns that they had but not all were clear that any improvement would occur as a result of their concern. The trust had systems in place to report incidents however we found a number of incidents across the trust that had not resulted in learning or action.
- Arrangements were not adequate for the safe and effective administration, management and storage of medication across the trust.
- We have a number of concerns about incidents of restraint and seclusion at the trust. We found that there was a high level of prone restraint and that the policies and procedures did not meet guidance. We found practices such as safe holding that were not set out in the trust policies. We were told that seclusion was used in a punitive manner.

Are services effective?

Requires Improvement

We rated Norfolk and Suffolk NHS Foundation Trust as requiring improvement overall for this domain because:

- Staff told us that they did not always feel supported or valued by the trust. Not all staff had received their mandatory training and many staff had not received regular supervision and appraisal. The trust acknowledged that this was their major area of risk but did not have a sufficient plan to address this.

Summary of findings

- The trust had a number of different records systems across the trust. This meant that it was difficult to follow information and that the trust could not ensure that people's records were accurate, complete and up to date.
- People's needs, including physical health needs, were assessed and care and treatment was planned to meet them. Overall we saw good multidisciplinary working. Usually care plans and risk assessment were in place and updated were people's needs changed however people's involvement in their care plans varied across the services.
- Systems were in place to ensure that the service complied with the Mental Health Act (MHA) and adhered to the guiding principles of the MHA Code of Practice. However, we found that staff did not always recognise and manage people's restraint or seclusion within the safeguards set out in the MHA Code of Practice.

However:

- 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 (NICE) or other relevant national guidelines. The trust had also participated in a wide range of audit and research and had attained accreditation for a number of services.

Are services caring?

Good

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

- Staff showed us that they wanted to provide high quality care, despite the challenges of staffing levels and some poor ward environments. We observed some very positive examples of staff providing emotional support to people. We did hear from individual service users and their carers that they had experienced a poor and uncaring response from some staff. This particularly related to community teams and where people had been in crisis.
- 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 saw some very good examples of care plans being person centred however not all care plans indicated the involvement of the service user.
- 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.

Summary of findings

- The trust has a user engagement strategy and carer's strategy which set out the trust's commitment to working in partnership with service users and carers. The trust told us about a number of initiatives to engage more effectively with users and carers. However throughout this inspection we heard from service users, carers, local user groups and staff who felt that they had not been effectively engaged by the trust is its transformation programme.

Are services responsive to people's needs?

Requires Improvement

We rated Norfolk and Suffolk NHS Foundation Trust as requiring improvement overall for this domain because:

- Throughout this inspection we were consistently told that there was a shortage of beds across the trust and that this had impaired patient safety and treatment. Staff worked with other services in the trust to make arrangements to transfer or discharge patients. However, a lack of available beds meant that people may have been moved, discharged early or managed within an inappropriate service.
- We found that access to the crisis service across the trust was generally good during the day. However there was not an out of hours service available to children and adolescents, or in some areas for people over the age of 65 with dementia in crisis. Some patients and their relatives told us that they had not been able to get hold of someone in a crisis.
- We found that the environment in a number of units did not reflect good practice guidance and had an impact on people's safety, dignity or treatment. At a number of units we found that there was not appropriate single sex accommodation to protect the privacy and dignity of patients.
- Most units that we visited had access to grounds or outside spaces and generally had environments that promoted recovery and activities. However we found that some older people's wards were cramped and cluttered.
- Generally we found that patients did not have restricted freedom and that informal patients understood their status. However we were concerned about the potential restriction of informal patients at the PICUs.
- 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. However we found that the trust did not have facilities to make information available in an easy read format.

However:

Summary of findings

- The trust is making improvements to the complaints process to address a rise in complaints. We found that patients knew how to make a complaint and many were positive about the response they received.

Are services well-led?

Inadequate

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

- The trust board had some significant changes over the past year. A recent independent review highlighted that the trust had made progress in its organisational development but there remained the need for significant change in the governance structure.
- 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.
- The trust stated that staff engagement was a key priority. We were unable to find evidence for action around this and there appeared to be considerable drift in work to engage staff in improving the service.
- A large number of staff we spoke with told us that morale was very poor. Some staff told us that they had no confidence in senior management and felt they had been let down.

Summary of findings

Our inspection team

Our inspection team was led by:

Chair: Joe Rafferty, Chief Executive Officer, Merseycare NHS Trust

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

Inspection Manager: Lyn Critchley, Inspection Manager, CQC

The team included CQC managers, inspection managers, inspectors and support staff and a variety of specialist and experts by experience that 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

To get to the heart of people who use services' experience of care, we always ask the following five questions of every service and trust:

- 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 21 October and 23 October 2014.Unannounced inspections were also carried out on the late evening of 06 November 2014.

During the visit the team:

- Held service user focus groups and met with local user forums
- Held focus groups with different staff groups.
- Talked with patients, carers, family members and staff.
- Looked at the personal care or treatment records of a sample of patients.
- Observed how staff were caring for people.
- Interviewed staff members.
- Reviewed information we had asked the trust to provide.
- Attended multi-disciplinary team meetings.
- Met with local stakeholders and user groups.
- Collected feedback using comment cards.

We visited all of the trust's hospital locations and sampled a number of community mental health services. We inspected all wards across the trust including adult acute services, psychiatric intensive care units (PICUs), secure wards, older people's wards, and specialist wards for people with learning disabilities and children and adolescents. We looked at six places of safety under section 136 of the Mental Health Act. We inspected community services including all of the trust's crisis services, integrated delivery teams and older peoples' teams, and a sample of teams for people with a learning disability, children and adolescents and eating disorders.

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

Summary of findings

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 on1 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 and community based support, in partnership with other agencies, to those whose needs relate to drug or alcohol dependency in Norfolk.

The trust serves a population of approximately 1.5 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 £216 million for the period of April 2013 to March 2014. In 2012/13, the trust staff saw over 14,000 individuals.

Norfolk and Suffolk NHS Foundation Trust has a total of 15 locations registered with CQC and has been inspected 14 times since registration in April 2010. At the time of our visit there were a number of compliance actions in place from the findings of our previous inspections. These were:

- Hellesdon Hospital – we had last visited this location in December 2013 and it was found to be non-compliant in two areas. These were: respecting and involving people who use services and care and welfare.
- Lothingland - we had last visited this location in October 2013 and it was found to be non-compliant in two areas. These were: respecting and involving people who use services and staffing levels
- Wedgewood House - we had last visited this location in November 2013 and it was found to be non-compliant in two areas. These were: staffing levels and skill mix and record keeping.
- Woodlands - we had last visited this location in October 2013 and it was found to be non-compliant in record keeping processes.

During this inspection we reviewed all of these areas of previous non-compliance.

The trust board had undertaken some significant changes prior to our inspection. There was a relatively new chair who had been in post for just over a year. The chief executive had been appointed for four months and the director of nursing also had only been in post just over a year. The medical director had announced his intention to step down after 14 years. The finance director had resumed his position after a year in post as interim chief executive. There were also fairly newly appointed non-executive directors in post.

Since 2013 the trust has been undergoing a programme of service transformation which has led to some service closures, mergers and reorganisation.

What people who use the provider's services say

The Care Quality Commission community mental health survey 2014 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 where people receiving community care or treatment between September and November 2013. There were a total of 256 responses, which was a response rate of 30%. Overall, the trust was performing about the same as other trusts across most areas. However respondents stated that the trust was performing worse than other trusts in relation to reviewing care, continuity of care and crisis care. This specifically related to questions about whether people felt involved in their care, consistency of workers and the response people received in a crisis.

Summary of findings

A review of people's comments placed on the 'patient opinion' and 'NHS choices' websites was conducted ahead of the inspection. 36 comments were noted of which 81% were partly of wholly negative. Issues raised were about access and response in a crisis, staff attitude, and support for carers.

The trust launched the Friends and Family Test in April 2014. The Friends and Family Test seeks to find out whether people who have used the service would recommend their care to friends and family. There has been limited response to this as yet however all submissions to date have been positive about the trust services.

Prior to the inspection we met with services users and their carers across the trust. This included a focus group facilitated by an independent user led local organisation and attendance at user and carer groups linked to the trust. During these sessions we heard both positive and negative comments about the trust services. Generally people stated that staff were caring however a number of people stated that access to services, particularly in a crisis, was difficult. People told us of a shortage of beds and that people were often sent a long way from home if they needed inpatient care.

During our inspection we received comment cards completed by service users or carers. We also received a large number of phone calls and emails directly to CQC from service users, carers and voluntary agencies supporting service users. Throughout the inspection we spoke with a large number of people using inpatient services and some people in receipt of community treatment.

People who use inpatient services generally felt safe and supported. However at some units people told us that staff shortages could impinge on the availability of activities and access to leave. People also told us that access to inpatient care close to home was not always possible, with people receiving care from out of area services.

Most people who use community services told us that staff were good and supportive. A number told us that there had been significant changes within the teams and that this had caused uncertainty and poor communication. Some people told us that they did not always know what to do in a crisis and others reported a poor response from crisis teams.

Good practice

- In adult community services staff at one location had set up "pop up" group sessions as an alternative to secondary care. The sessions were aimed for people new to the service and linked them with local support groups who might be able to support their current needs.
- We found that having approved mental health professionals (AMHP) situated in the main Norfolk police control room had benefitted had benefitted people in crisis.
- The dementia and intensive support team (DIST) had introduced an innovative helpline to assist carers and care homes with support and advice.
- The dementia and complexity in later life team (DCLL) had integrated its collaborative working with GPs and social workers to increase outcomes for patients.
- We found examples of innovative multi-disciplinary team working within child and adolescent community teams and with local agencies to meet young people's needs.
- The trust has developed services such as the Compass Centre (a therapeutic and education service) and intensive support team (IST) and evidenced this had reduced the number of admissions of young people to hospital.
- Forensic services had developed a buddying system were buddies were remunerated for their work at Whitlingham ward and was promoting self-medication on the low secure wards.

Summary of findings

Areas for improvement

Action the provider MUST or SHOULD take to improve

- The trust must have an effective system to share learning from incidents in order to make changes to patients care and reduce the potential for harm to 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 that action is taken so that the environment does not increase the risks to patients' safety.
- The trust must ensure that action is taken to remove identified ligature risks and to mitigate where there are poor lines of sight.
- The trust must ensure there are enough personal alarms for staff and visitors and carry out and document regular checks of emergency equipment.
- The trust must ensure that all mixed sex accommodation meets 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 there are sufficient staff at all times to provide care to meet patients' needs.
- The trust must ensure that there are robust policies and procedures that keep staff and patients safe in the community.
- 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 giving them access to 24 hour crisis teams.
- The trust must review the unallocated cases in community services and ensure that there is an allocated care coordinator
- The trust must ensure that a 'standard operating procedure' is introduced to manage effectively the interface between the various community services provided.
- The trust must ensure that all risk assessments and care plans are updated consistently in line with multi-disciplinary reviews.
- The trust must carry out assessments of capacity and record these in the care records
- The trust should ensure all staff including bank and agency staff have completed statutory, mandatory and where relevant specialist training
- The trust must ensure all staff receive regular supervision and annual appraisals.
- The trust must ensure that they provide people with the right information about services and that this is in the right format for the individual.
- The trust must ensure that proper procedures are followed for detention under the Mental Health Act and that the required records relating to patient's detention are in order.
- The trust must ensure that arrangements for patients taking section 17 leave are clear for their safety and that of others.
- The trust must ensure that patients who are detained under the Mental Health Act have information on how to contact the CQC.
- The trust must review the delivery of their vision and values to ensure they are understood and owned by all staff.
- The trust must ensure that there are systems in place to monitor quality and performance of the teams.
- The trust must review its procedures for maintaining records, storage and accessibility including out of hours provision.

Norfolk and Suffolk NHS Foundation Trust

Detailed findings

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 for this domain because:

- We were concerned that staffing levels were not sufficient or safe at a number of inpatient wards and community teams across the trust.
- We found a number of environmental safety concerns. While some work was being planned or underway to remove potential ligature risks, we are concerned that planned actions would not adequately address all issues. We also found that the layout of some wards did not facilitate the necessary observation of patients. We were concerned about the design of seclusion facilities across the trust.
- The trust had policies and processes in place to report and investigate any safeguarding or whistleblowing concerns. Most staff told us that they were able to raise any concerns that they had but not all were clear that any improvement would occur as a result of their concern. The trust had systems in place to report incidents however we found a number of incidents across the trust that had not resulted in learning or action.
- Arrangements were not adequate for the safe and effective administration, management and storage of medication across the trust.
- We have a number of concerns about incidents of restraint and seclusion at the trust. We found that there was a high level of prone restraint and that the policies and procedures did not meet guidance. We found practices such as safe holding that were not set out in the trust policies. We were told that seclusion was used in a punitive manner.

Inadequate

Are services safe?

Our findings

Safe and clean ward environment

The trust undertakes an annual programme of environmental health and safety checks. Ligature risk assessments are reviewed as part of this programme. In July 2014 the assessments highlighted that there had been different approaches across the trust and that some ligature risks existed that had not been flagged. This was highlighted to the board and placed on the risk register. At the time of our visit plans were being drawn up to address some risks and some immediate work undertaken. However we were concerned that risks at the Norvic Clinic, Walker Close, Lark and Rollesby PICUs and acute wards at Hellesdon, Carlton Court and Wedgewood Unit were not being adequately addressed. At some units such as the Norvic Clinic, Walker Close, Lark PICU, and acute units at Hellesdon and Carlton Court we also found that lines of sight were not clear meaning staff could not always observe patients.

We were told that regular trust-wide cleanliness audits are undertaken. The latest audit resulted in a score of 77% against a target of 95% compliance. Most services we visited were clean and well maintained. However we found that the standard of cleanliness was not sufficient at the Norvic Clinic and essential maintenance to people's bathrooms had not been carried out in a timely way.

We noted that when a significant environmental risk had been identified at the Suffolk access and assessment service, this had been added to the local risk register and escalated appropriately by local managers. However no action had been taken to resolve the issues.

At Walker Close the emergency alarm system only worked in one bungalow meaning a member of staff would have to use the non-portable telephone to summon assistance from the other bungalows.

Most units that we visited had a clinic room available and were equipped for the physical examination of patients. The trust had audited the availability and condition of resuscitation equipment in April 2014 and found a number issues. The recommendations from this report were highlighted for action by the board in June 2014. However, we found that emergency resuscitation equipment was not always readily available, maintained or fit for purpose at a number of locations including Walker Close and Great Yarmouth and Waveney community teams.

The seclusion facilities at the Norvic clinic were located away from wards which meant that people needing seclusion had to be moved down stairs and along corridors to reach the seclusion area. This represented a risk to people and staff. We were also concerned that the seclusion areas in the Norvic Clinic, Southgate and Foxhall Ward did not have en-suite facilitates and people secluded would need to leave the seclusion room to use the toilet and shower facilities. This could present a risk to staff and people. Patients who could not be allowed out to use the toilet and washing facilities were given a urine bottle or a bedpan when in seclusion. This is an unacceptable situation.

The seclusion suite at Southgate ward did not meet guidance or the MHA Code of Practice as there was no communication system in place to allow patients to communicate with staff whilst in the bedroom area.

On some units there were not clear arrangements for ensuring that there was single sex accommodation in adherence to guidance from the Department of Health and the MHA Code of Practice, to protect the safety of patients.

Safe staffing

As part of a trust wide service strategy, in 2013 the trust reviewed and set staffing levels for all teams. Since June 2014 the trust has published both the planned and actual staffing levels on their website. This indicated that during September 2014 there had been a number of times when actual staffing fell below the required level, with 13% of shifts unfilled. Other information supplied by the trust stated that 169 incident forms were submitted in September 2014 as a result of inappropriate staffing levels causing potential risk. The trust confirmed that they have a vacancy rate of over 11% and that staff turnover stood at over 17% in September 2014. Nursing vacancies were particularly high, with over 65% of vacancies covered by bank or agency staff.

The trust told us that processes to request additional staff had been streamlined to aid easier requests and to allow improved monitoring of the use of bank and agency staff. Ward and team managers confirmed that processes were in place to request additional staff where required.

Inadequate

Are services safe?

However we found that staffing levels were not always sufficient in the community teams, particularly the adult and older people's teams. This meant that staff were managing very high caseloads and there were some delays in treatment. At the community and home treatment team based at Carlton Court at the time of our visit limited staff meant there was no capacity to undertake assessments and people in need of assessment were not able to access the service they needed.

At some inpatient units we found that temporary staff were not used and staffing was insufficient. This meant that staff were unable to take breaks, worked additional hours or were unable to complete necessary tasks. We found that in forensic services and acute services there were at times insufficient staff. This meant that patients' leave and activities programmes could be affected. We were particularly concerned that we found at the learning disability inpatient service that agency staff were managing a very challenging patient who was segregated. The agency staff were not registered nurses and were largely unsupervised, and were able to take few breaks. In some units, temporary bank and agency staff were regularly used to achieve the required levels of staff. Some patients told us of the impact this had on their care and treatment. Patients often told us that staff did their best but were under significant pressure.

Medical cover was generally acceptable, except for Rollesby PICU and some community teams. We were told that out of hours medical cover could be an issue in some areas. Some older people's community teams had limited or no dedicated medical cover.

Assessing and managing risk to patients and staff

We looked at the quality of individual risk assessments across all the services we inspected. Generally these were in place and addressed people's risks. However we found that risk assessments were not always being updated for people following incidents of concern or changes to an individual's needs. At Walker Close we found that there was no formal risk assessment in place. Not all risk assessments had included information indicating the person's involvement in the process.

The trust has an observation policy in place and generally staff were aware of the procedures. Ward managers indicated that they were able to request additional staff to undertake observations however that on occasions agency staff were not available. This meant that the wards could be left short of staff to manage the general population.

In February 2014 the Health and Safety Executive issued a report setting out material breaches for standards of risk management and training for managing violence and aggression at the Norvic Clinic. The trust had developed an action plan to reach compliance by May 2014. However we found that not all staff had received mandatory physical intervention training.

The use of restraint and seclusion were defined as reportable incidents at the trust and arrangements were in place to monitor such incidents. Incidents were recorded on a database and would be discussed and monitored at patient safety meetings.

Prior to the visit we asked the trust for restraint and seclusion figures. We were concerned to note that there had been a high level of face down (prone) restraints. These amounted to 32% of all recorded restraints. A report had recently been submitted to the trust's service governance committee outlining the trust's response to the Department of Health's recently published 'Positive and Proactive Care: reducing the need for restrictive interventions'. The trust told us that the director of nursing had been appointed as lead for this work and a working group had recently been set up to look at restraint practice and training. However the trust was yet to comply with all requirements of the Department of Health's guidance by the target date of September 2014 as it was yet to formalise a reduction strategy or decide on future training options. This was acknowledged by the trust.

We reviewed existing policies regarding management of aggression and physical intervention. These did not reference the safe management of patients in a prone position or address specialist needs of people with a learning disability, autism or a physical condition in line with existing or the new guidance. The guidance also requires all staff to have an understanding of the Mental Capacity Act. We found that only 80% of staff had received this training by September 2014.

We found that 'safe holding' was being used in children's services. We could not find any information about safe holding within the trust polices relating to physical intervention or management of aggression. This meant

that staff had no clear guidance regarding whether contact was therapeutic holding or physical intervention and therefore the necessary safeguards and recording process to follow.

At the Norvic clinic we found that there were policies and procedures for observation in place to reduce the level of violence and self-harm. However, we were concerned that the use of seclusion may be punitive. Whilst on the unit we saw that people who became violent were restrained and removed to the seclusion ward. Five people told us that they had been restrained and secluded following refusal to follow staff instructions. One person told us that if you do not sit correctly on the chairs you could end up being restrained and secluded. During our visit to the clinic one seclusion room was in use. We were told that it was not a seclusion episode but that the person was segregated due to risk. Staff we spoke with did not understand the difference between seclusion and segregation and used the term indiscriminately. Staff also informed us that on the previous day both a female and male patient had been secluded in the adjacent rooms. Staff showed they were concerned for the patients' privacy and dignity but stated they had no other option open to them.

At the PICUs we looked at the seclusion records for three patients. One patient had recently been cared for continuously in seclusion for sixteen days. Another patient had been in seclusion for twenty three days. Seclusion observations and reviews were recorded. However there were no specific care plans and risk assessments and accompanying reviews on the use of seclusion for this length of time. It was not clear that seclusion had been used for the minimum time possible or that patients' knew what to do for seclusion to be ended. This does not meet the MHA Code of Practice.

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 their 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.

Systems were in place to maintain staff safety in the community. The trust had lone working policies and arrangements and most staff in community teams told us that they felt safe in the delivery of their role. However staff in one older person's home treatment team told us that there were not safe working practices in place.

Medicines management

At eight inpatient units and seven community teams we found that there were not appropriate procedures in place for the administration, management, storage and audit of medications. On additional inpatient units and at community teams we found that temperature checks necessary for ensuring the integrity of medications had not been undertaken.

We found that:

- Fridge temperatures were not routinely checked or recorded, or where issues were found these had not resulted in the medication being removed. At additional units we found that clinic room temperatures were very high and may have damaged the integrity of medications.
- At some units and adult teams we found that there was no recording system for the receipt or management of stock medicines and there was no evidence of auditing of medication related paperwork.
- At some units medicines were found to be out of date and open bottles of liquid medication had no dates on them. This meant that the ward could not ensure they were disposed of within the recommended timescale.
- At five integrated delivery teams (IDT) medications were not being disposed off in line with trust policy.
- At Walker Close there were a number of gaps in the recording of whether medication had been administered to the patient. We found that one person had not been given six doses of their medication during a two day period.
- At Waveney ward we found that medicines were in an unlocked trolley, that the medicines cupboard was not fixed to the walls, that a medicine fridge was unlocked, gaps in the dispensing of medication, and that dates that creams and liquid medicines had been opened were not recorded.
- At other acute units, we found gaps in prescribing and dispensing and delays in medication being given.
- At the Fermoy unit, medications were stored in an unsecured trolley.

Inadequate

Are services safe?

- At the Norvic Clinic, staff were unsure of the process for rapid tranquilisation and supporting policies did not clarify the agreed process.

Reporting incidents and learning from when things go wrong

Prior to the inspection we reviewed all information available to us about the trust including information regarding incidents.

A serious incident known as a 'never event' is where it is so serious that it should never happen. The trust had not reported any 'never events' since September 2013. We did not find any 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 them to report all death or severe harm incidents to the CQC via the NRLS. There were 182 serious incidents reported by the trust between September 2013 and March 2014. This was within the expected range for a trust of this type and size. Overall, the trust had improved its reporting rates and been a good reporter of incidents during 2013/14 when compared to trusts of a similar size.

Arrangements for reporting safety incidents and allegations of abuse were in place. However the trust told us that they had been aware that the investigation of incidents was not robust. Therefore work had been undertaken in previous months to ensure better investigation of incidents and to address the dissemination of learning. We were told that all serious incidents will be reviewed by the patient safety lead, the executive team and the board.

Staff we spoke with were able to describe their role in the reporting process and said that they were encouraged to report incidents and near misses. Most staff confirmed they had received mandatory safety training and most felt supported by their manager following any incidents or near misses. Some staff told us that the trust encouraged openness and there was clear guidance on incident reporting. We saw that staff had access to an online electronic system to report and record incidents and near misses.

Where serious incidents had happened we saw that investigations were usually carried out. Some teams confirmed clinical and other incidents were reviewed and monitored monthly and discussed by the management team and shared with front line staff. However, we found very few examples of staff feeling that learning from past incidents was informing planning of services or service provision. Most staff felt that they did not get feedback following incidents and almost no staff thought that they received feedback from incidents that had occurred in another part of the trust.

We found a number of concerns regarding the management of incidents at the trust which meant incidents were recurring and risks remained unaddressed. At Waveney Acute service we found that following two serious incidents a relevant risk assessment had not been put in place. At Lark ward we found that there had been multiple incidents of aggression by one patient on other patients and staff. It was unclear what action had been taken to prevent further incidents.

Every six months the Ministry of Justice publishes a summary of Schedule 5 recommendations (previously rule 43) which had been made by coroners with the intention of learning lessons from the cause of death and preventing further deaths. In the latest report covering the period from October 2012 to March 2013 there were no concerns regarding the trust raised by the coroner.

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.

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 requiring improvement for this domain because:

- Staff told us that they did not always feel supported or valued by the trust. Not all staff had received their mandatory training and many staff had not received regular supervision and appraisal. The trust acknowledged that this was their major area of risk but did not have a sufficient plan to address this.
- The trust had a number of different records systems across the trust. This meant that it was difficult to follow information and that the trust could not ensure that people's records were accurate, complete and up to date.
- People's needs, including physical health needs, were assessed and care and treatment was planned to meet them. Overall we saw good multidisciplinary working. Usually care plans and risk assessment were in place and updated were people's needs changed however people's involvement in their care plans varied across the services.
- Systems were in place to ensure that the service complied with the Mental Health Act (MHA) and adhered to the guiding principles of the MHA Code of Practice. However, we found that staff did not always recognise and manage people's restraint or seclusion within the safeguards set out in the MHA Code of Practice.

However:

- 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 (NICE) or other relevant national guidelines. The trust had also participated in a wide range of audit and research and had attained accreditation for a number of services.

Our findings

Assessment of needs and planning of care

The Care Quality Commission community mental health survey 2014 found that overall the trust was performing worse than other trusts in the areas of involving people in care planning and care reviews and information about crisis care. 7 out of 10 respondents stated that they had been involved in their care plan, while 7 out of 10 said they had received a review of their care in the last 12 months. 7 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.

Services used a number of different IT care records systems. The community teams and some inpatient services also used both computerised and paper copies for the recording of care documents. This made it difficult to follow information and meant that the trust could not ensure that people's records were accurate, complete and up to date. Senior staff said this would be addressed with the implementation of the trust's new computerised system, however this would not be in place until summer 2015.

The trust told us that it was a priority that service users have clinical assessments which identify their treatment, care, and physical health needs. The trust had established a system of regular local audits of the care record. Performance data provided by the trust had indicated that there had been some improvement in staff completing records following significant events and service users receiving a care review.The trust was also meeting the target regarding follow up of discharged inpatients in 99% of cases.

In most inpatient services we found that people's care needs and risks were fully assessed and care plans had been put in place. Most care plans viewed included reference to physical health needs. However in acute services some care plans had not been fully completed or updated following changes to people's needs, and risk assessments had not always been updated. At community

teams some care plans lacked clear information for staff who may be unfamiliar with the person, meaning people may not always receive appropriate care. At some services we found that there were no crisis contingency plans in place. Not all care plans indicated the involvement of the service user. At the learning disability inpatient services we found that some care plans included the views of patients however the care plans were not available in a format that most patients could understand.

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 (NICE) 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 Score (HoNOS). However within the learning disability services we found limited awareness of evidence based guidance from NICE or the use of outcome measures.

The trust's physical health project group had identified the Commissioning for Quality and Innovation's (CQUIN) framework for 2014/15 and introduced the "Rethink Mental Illness" scheme which was outlined in the NICE guidelines (Rethink:2003). We were told that the trust was introducing a physical health booklet alongside people's assessments to enable them to capture people's individual health needs.

The records of community team service users' showed us that people's physical healthcare needs were usually assessed and addressed in partnership with the person's GP.

At inpatient units we found that generally people's physical health needs were assessed. Physical health examinations and assessments were usually documented by medical staff following the patient's admission to the ward. Nurses were usually completing baseline physical health checks on patients. However at the Norvic clinic there were difficulties with access to GPs. At Sandringham ward we were particularly concerned that the physical health care needs of a patient were not being met and had to flag these to senior management for immediate action during our visit.

At community teams, we observed that they used Health of the Nation Outcome Scale (HoNOS) during the referral process. HoNOS 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 participated in a number of the Royal College of Psychiatrists' quality improvement programmes. The service at Norvic participated in the forensic network audit. Services that were accredited included the ECT suite and most acute wards. However we were told at the Fermoy unit that due to staff shortages the accreditation programme had been put on hold. We looked at the accreditation reports for the services. Usually the recommendations from these were considered however we noted the report from the review of the Norvic Clinic in February 2014 had highlighted issues with the toilet facilities in the seclusion area and ligature points in the wards that had not been addressed.

During 2014 the trust has participated in a range of clinical research and developed a research strategy. The trust also undertook a wide range of clinical effectiveness and quality audits. These include compliance with NICE guidance, suicide prevention, medication, clinical outcomes, care planning, Mental Health Act administration and patient satisfaction. During 2013-14 the trust also participated in a number of national clinical audits and national confidential enquiries including: National audit of psychological therapies (NAPT), National audit of schizophrenia (NAS), Mental health clinical outcome review programme: National Confidential Inquiry into Suicide and Homicide for people with Mental Illness (NCISH).

The trust told us that there had not yet been a trust-wide audit using the Green Light Toolkit. This audit aims to assess whether services are appropriate for people with a learning disability. The board had, therefore, asked for a plan to be developed to improve the trust's approach to providing universal quality care. At the time of the inspection a working group had been meeting but there had been limited action regarding this programme.

Skilled staff to deliver care

In the 2013 NHS Staff Survey, the trust scored within the worst 20% of mental health trusts for 21 key findings. These related to staff feeling satisfied with the quality of work they

are able to deliver, staff feeling work pressure, recommending the trust as a place to work or receive treatment, risks around managerial communication, believing patient care was not the trust's top priority, believing the trust provides equal opportunities and staff experiencing discrimination.

The trust had recognised the need for improvement to ensure staff felt valued and fully supported, and so had undertaken a number of initiatives to address this. Data from the staff element of the Friends and Family Test from April 2014 indicated that there had been an increased level of staff satisfaction. Sickness absence rates had fallen slightly since the staff survey was completed however remained above target at 5.3%, with very high rates for absence due to stress at 26% of these.

Most staff we met told us that they had completed necessary mandatory training. However, prior to the inspection the trust supplied us with details of their set mandatory training requirements and regarding the uptake and this showed that not all regular staff had received mandatory training. At September 2014 only 57% of all required training had been completed. There was particularly low uptake for training in clinical risk assessment (61%), suicide prevention (64%) physical intervention (74%), immediate life support training (53%), medicines management (54%) fire safety (53%) health record keeping (47%) infection control (29%) and rapid tranquilisation (33%). Staff received an induction on commencing employment at the trust. Most staff had undertaken basic safeguarding training. However only 37% of relevant staff had undertaken advanced safeguarding training.

We also found that staff at the adult and older people's community teams had not received training in the application of the assessment tools that they work with. Staff within learning disability services had not been able to access specialist training to meet the needs of their client group. Issues of travel and time were stated as barriers to accessing some training, as face to face training occurred at sites in the trust which were difficult for some staff to access. The trust recognised training as a major area of non-compliance and supplied an action plan setting out how they would address these issues.

At September 2014 supervision rates were 45% and appraisal rates were 58.8%. Staff told us that supervision was used to manage performance issues and development however a number of staff told us that lack of staffing and service pressures meant that they did not regularly receive supervision and therefore performance feedback.

Multi-disciplinary and inter-agency team work

On the wards we visited we usually saw good multi-disciplinary working, including ward meetings and regular multi-disciplinary meetings to discuss patient care and treatment. At most units we saw input from occupational therapists, psychologists, pharmacy and the independent advocacy services. However in learning disability services we were told that there was no access to occupational therapy. Medical cover was generally acceptable, except for Rollesby PICU and some community teams.

At most wards there were effective handovers with the ward team at the beginning of each shift. These helped to ensure that people's care and treatment was co-ordinated and the expected outcomes were achieved.

In Norfolk social workers had returned to the employ of the county council from the trust. Staff reported that this was yet to have an impact on patient care.

We noted that the relationship between different services could be confusing for people who required crisis care. We found that whilst the access and assessment teams were identified as the single point of admission to services, a number of other trust services such as liaison psychiatry were also involved in the gatekeeping of services. There was no trust wide 'standard operating procedure' for the interface between the varying community services.

We saw that community teams usually attended discharge planning meetings and patients told us this was really 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. Staff also worked well with other professionals, using the care programme approach process. Some staff in older people's teams reported that there were difficulties with effective working across teams and external agencies.

Adherence to the MHA and the MHA Code of Practice

A mental health managers group was in place which has 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. The hospital managers meeting exercises a number of key functions, including monitoring aspects of MHA performance, receiving MHA reviewer reports, and raising issues of concern for resolution.

We were told that the hospital managers have a rolling programme of training that ensures that they have the knowledge and skills to undertake the role effectively. This training programme covers issues of clinical relevance, policy, and legal aspects. Individual members also have a targeted personal development plan which is reviewed and updated on an annual basis through the appraisal programme. We were told that this was working well however we were not shown any evidence regarding training or appraisals at the time of the visit.

Staff training in the MHA was not good. We found that only 63% of registered a staff and 46% of relevant non-registered staff had received mandatory MHA training.

We visited all of the wards at the trust where detained patients were being treated. We also reviewed the records of people subject to community treatment and people who had been assessed under section 136 of the MHA. We also looked at procedures for the assessment of people under the MHA.

We reviewed a range of files within the MHA administration office covering a variety of sections of the MHA and a range of locations for detention. We found there was a clear process for scrutinising and checking the receipt of documentation. This system aims to identify any mistakes or inaccuracies in the MHA documentation, and so is an important component in avoiding unlawful detentions. However not all of the files examined were fully scrutinised. This may lead to an unnecessary risk of unlawful detention going unrecognised. The files were otherwise comprehensive and well-organised.

At the inpatient units systems were in place to ensure compliance with the MHA and adherence to the guiding principles of the MHA Code of Practice. We reviewed a large number of records for patients who were detained under the MHA. All legal paperwork was in place and appeared in order. Treatment appeared to have been given under an appropriate legal authority. In most units we saw good evidence of regular testing of capacity to consent for treatment, however not all patients in acute services had their capacity recorded.

At the MHA office we found that files did not routinely include details about whether a person had been provided with their rights under the MHA. Where this was identified we requested this information from the relevant wards but found that in some cases this was also missing from ward files. However we found in most cases that people spoken with at the wards had regularly been explained their rights. Advocates, including independent mental health advocates, were available to people, and in most cases their use was actively promoted. A standardised system was in place for authorising and recording section 17 leave of absence.

We reviewed care and treatment records for people subject to community treatment. These showed us that where required, legal documentation was being completed appropriately by staff.

However, we found that a person who had been detained under the MHA for some months had for a period been moved to a hostel without either a community treatment order in place or authorised leave under section 17 of the MHA. We were concerned that a hostel is not an appropriate place for detention under the MHA and further that this facility was not staffed at all times. We raised this concern with the trust at the time of our inspection.

Seclusion was practiced at a number of the services we visited. Generally seclusion paperwork was completed and indicated that the safeguards required within the Mental Health Act Code of Practice had been adhered to. However at the Norvic clinic we found staff's understanding about the practice of seclusion to be lacking and that the terminology seclusion and segregation were used interchangeably. We also found that seclusion was being used in a punitive manner. At the PICUs we found that seclusion may not always have been used for the minimum time possible. Within the child and adolescent services we found that safe-holding was being used. There were no policies available for this practice and it therefore was not subject to necessary recording.

We reviewed practice under section 136 of the MHA in detail. We found some good practice in relation to having approved mental health professionals (AMHPs) situated in

the police control room which had benefitted both services. We were told that this had brought about a reduction in the use of Section 136 of the Act. We were told that funding had also been agreed in order to appoint a number of nurses to provide permanent staff to the section 136 suites at Hellesdon Hospital and the Fermoy unit and to employ two nurses to accompany police officers in a triage car in Suffolk. However we noted some delays in the assessment of some people who were admitted under section 136 of the Act and noted that all of these units could only accommodate one person at a time. This could mean the need for people to be transported long distances to an alternative health-based place of safety.

Staff at the section 136 units appeared to be knowledgeable about the Mental Health Act and the code of practice. They were aware of their responsibilities around the practical application of the Act and we found that the relevant legal documentation was completed appropriately in those records reviewed. We noted all of the section 136 units visited had patient information readily available for and everyone was given a leaflet about the powers and responsibilities of Section 136 of the Act.

The accurate recording of all episodes of the use of section 136 is essential to enable the trust to plan their service provision effectively but we found that the procedures and practice varied from unit to unit.

Good practice in applying the MCA

Training rates for staff in the Mental Capacity Act were not good with just 69% of registered nurses and 52% of unregistered staff trained at the end of September 2014. However, most staff spoken with 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 if applicable. However we found that not all patients had clearly had their mental capacity recorded within acute units.

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 for this domain because:

- Staff showed us that they wanted to provide high quality care, despite the challenges of staffing levels and some poor ward environments. We observed some very positive examples of staff providing emotional support to people. We did hear from individual service users and their carers that they had experienced a poor and uncaring response from some staff. This particularly related to community teams and where people had been in crisis.
- 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 saw some very good examples of care plans being person centred however not all care plans indicated the involvement of the service user.
- 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 has a user engagement strategy and carer's strategy which set out the trust's commitment to working in partnership with service users and carers. The trust told us about a number of initiatives to engage more effectively with users and carers. However throughout this inspection we heard from service users, carers, local user groups and staff who felt that they had not been effectively engaged by the trust is its transformation programme.

Our findings

Kindness, dignity, respect and support

Overall, we saw that staff were kind, caring and responsive to people and were skilled in the delivery of care. Generally staff were knowledgeable about the history, possible risks and support needs of the people they cared for. We observed many instances of staff treating patients with respect and communicating effectively with them. Staff showed us that they wanted to provide high quality care, often despite the challenges of staffing levels and some poor ward environments.

Throughout our inspection we observed some positive examples of staff providing emotional support to people. Generally people told us that staff were very kind and supportive, and that they were treated with respect. People were usually informed about their care and treatment. People we spoke with on the wards were mainly positive about the staff and felt they made a positive impact on their experience on the ward. However, some people were concerned at the lack of time staff had to spend with them. Other people were concerned about the welfare of staff who they perceived as overworked.

We did hear from individual service users and their carers that they had experienced a poor and uncaring response from some staff. This particularly related to community teams and where people had been in crisis.

We were told that staff respected people's personal, cultural and religious needs. In most units we found a space had been allocated for prayer and reflection. Food was available at all units to meet people's personal or cultural dietary needs.

The involvement of people in the care they receive

The Care Quality Commission community mental health survey 2014 found that overall the trust was performing worse than other trusts in the areas of involving people in care planning and care reviews and information about crisis care. 7 out of 10 respondents stated that they had been involved in their care plan, while 7 out of 10 said they had received a review of their care in the last 12 months. 7 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.

The trust told us that it was a key priority that service users have effective care plans which identify their treatment, care, and physical health needs was a key priority. The trust

Good

Are services caring?

had established a system of local regular local audits of the care record. Performance data provided by the trust indicated that there had been improvement in in the quality of care plans and people's involvement in these.

In most inpatient services we found that people's care needs were reflected in care plans. However some care plans had not been fully completed or updated following changes to people's needs. At the adult community teams some care plans lacked clear information for staff who may be unfamiliar with the person, meaning people may not always receive appropriate care. At adult community teams we found that some people there were no crisis contingency plans in place.

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. Most people said that they were aware of their care plans and were able to take part in the regular reviews of their care. We saw some very good examples of care plans being person centred. However not all care plans indicated the involvement of the service user. At the learning disability inpatient services we found that some care plans included the views of patients however the care plans were not available in a format that most patients could understand.

On a number of wards we found welcome packs that included detailed information about the ward and a range of medication information leaflets. Most patients we spoke with told us that they were given good information when they were admitted to the wards. Some community service users told us that they had found arrangements for teams confusing and had been given limited information. Others added that lack of continuity of workers and changes to teams had added to this issue.

Patients had access to advocacy including an independent mental health advocate (IMHA) and there was information on the notice boards at most wards on how to access this service.

The trust has very recently implemented the friends and family test (FFT) to measure patient and carer feedback. Questionnaires were given to patients and their carers on discharge. There has been limited response to date however the trust is optimistic that the findings are positive.

Some patients we spoke with told us they also felt able to raise any concerns in the community meetings and that they 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.

The trust has a user engagement strategy and carer's strategy which set out the trust's commitment to working in partnership with service users and carers. The trust told us about a number of initiatives to engage more effectively with users and carers. These included the employment of peer workers and the development of both local and trust-wide engagement groups. We found that community meetings occurred at the majority of inpatient services that we visited across the trust. 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 some dedicated workers had taken up post and work had begun on training, policies, information and an updated strategy.

Throughout this inspection we heard from service users, carers, local user groups and staff who felt that they had not been effectively engaged by the trust is its transformation programme.

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 requiring improvement for this domain because:

- Throughout this inspection we were consistently told that there was a shortage of beds across the trust and that this had impaired patient safety and treatment. Staff worked with other services in the trust to make arrangements to transfer or discharge patients. However, a lack of available beds meant that people may have been moved, discharged early or managed within an inappropriate service.
- We found that access to the crisis service across the trust was generally good during the day. However there was not an out of hours service available to children and adolescents, or in some areas for people over the age of 65 with dementia in crisis. Some patients and their relatives told us that they had not been able to get hold of someone in a crisis.
- We found that the environment in a number of units did not reflect good practice guidance and had an impact on people's safety, dignity or treatment. At a number of units we found that there was not appropriate single sex accommodation to protect the privacy and dignity of patients.
- Most units that we visited had access to grounds or outside spaces and generally had environments that promoted recovery and activities. However we found that some older people's wards were cramped and cluttered.
- Generally we found that patients did not have restricted freedom and that informal patients understood their status. However we were concerned about the potential restriction of informal patients at the PICUs.
- 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. However we found that the trust did not have facilities to make information available in an easy read format.

However:

- The trust is making improvements to the complaints process to address a rise in complaints. We found that patients knew how to make a complaint and many were positive about the response they received.

Our findings

Access, discharge and bed management

The trust has undertaken a programme of transformation to refocus services to providing community care and minimising lengths of stay in hospital. This has meant ward closures and rationalisation. Throughout this inspection we were consistently told that there was a shortage of beds across the trust and that this had impaired patient safety and treatment. The trust told us that the average length of stay had decreased to just 15 days on acute wards.

The trust monitors both bed occupancy rates and delayed transfers of care. At the time of the inspection the number of delayed transfers of care was 5.1% against a target of 7.5%. At March 2014 bed occupancy rates at the trust stood at 83% across all services which is below the England average. We looked at the latest data for delayed transfers of care and found that for the Suffolk East locality this figure was actually over 12%. We also analysed the data for bed occupancy between January and June 2014 and found that acute service figures were between an average of 100 and 116%.

During the inspection we found some adult and older people's services where bed occupancy was far in excess of 100%. At an unannounced visit to Waveney Acute Service we were concerned to find that the ward which is allocated for 15 patients was full with a further five patients on short term leave. This meant there was no bed for these patients to return to should this be required. We also found that the ward was supporting an additional seven patients who had been placed out of area.

During our inspection we found patients were long distances away from their home area due to bed availability and this impacted on the care provided and the potential for families to visit. The trust told us that they are

trying to reduce the out of area admissions and this was flagged as a risk on the risk register. Staff and patients also reported concerns about the high level of out of area admissions. This also usually meant that patients were subsequently transferred or repatriated, which was sometimes disruptive to the continuity of their care.

Community and intensive team members told us that they spent a lot of time trying to find appropriate inpatient beds for people. Ward staff told us that sometimes they had to admit people in beds where the patient was on leave. Staff reported that sometimes patients were transferred from PICUs to acute beds too early due to the pressure on beds. Staff worked with other services in the trust to make arrangements to transfer or discharge patients. However staff told us that bed availability in the intensive care units meant that there had been delays on occasion in transferring a patient who needed intensive care.

We found that access to the crisis service across the trust was generally good during the day and, where necessary, urgent assessments could be arranged within four hours. Quality assurance information reflected that the teams were generally keeping within this target. A 24 hour service was provided by the adult teams. However there was not an out of hours service available to children and adolescents, or in some areas for people over the age of 65 with dementia in crisis. Some patients and their relatives told us that they had not been able to get hold of someone in a crisis as phones were frequently unanswered.

We found that generally there was evidence of different groups working together effectively to ensure that patients' needs continued to be met when they moved between services.

The trust provided data regarding the seven day post discharge follow up target. At the time of our inspection this had raised to 99% compliance. 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 and many people told us that they were fully involved in their discharge planning.

The ward environment optimises recovery, comfort and dignity

The trust told us that during 2013 'Patient-Led Assessments of the Care Environment' (PLACE) visits had taken place to acute services. This is a self-assessment process undertaken by teams including service users and representatives of Healthwatch. The results indicated that the trust scored above the national average for the category of privacy, dignity and wellbeing. We found some good examples of staff protecting people's privacy and promoting dignity. However we found a numbers of concerns across the trust were people's privacy and dignity had not been maintained.

The trust had declared itself compliant to the Department of Health standards for eliminating mixed sex accommodation. However on a number of units we found arrangements that did not promote people's dignity or adequately protect people's safety. These included:

- At the Fermoy Unit we found that male patients were using bathroom facilities meant for female patients due to unresolved maintenance issues.
- At Waveney Acute Services there were three rooms designated as 'swing beds' for use by either gender dependent on need. Locking arrangements were in place. However at the time of our visit a towel had been placed to stop the access door closing meaning male patients could enter the area that at the time was designated to very vulnerable female patients.
- There were no female only lounges on either of the wards at the Woodlands unit.
- The seclusion room on Southgate ward had to be accessed via the female wing of the ward. This meant that male patients would need to be moved through this area. We also noted that the entrance to this suite was not fully obscured from the exterior of the building.
- At the Woodlands unit there were rooms designated as 'swing beds' for use by either gender dependent on need. On the day of our inspection the beds on Southgate ward were locked during the day due to staffing shortages. This meant that patients could not access their bedrooms when they wished.
- There was a bedroom in Sandringham ward that did not meet the guidelines for single sex accommodation, but the room was not in use at the time.
- At the Norvic clinic the seclusion facility had two rooms that could be used for either gender. We were made aware of occasions when both male and female patients had been accommodated together.

Requires Improvement

Are services responsive to people's needs?

Most units that we visited 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. However we found that the garden area at the Wedgewood unit was overgrown and may present a risk to patient observation. Adult and forensic services generally had environments that promoted recovery and activities, with space for quiet and to meet visitors. However we found that some older people's wards were cramped and cluttered. We found that they lacked a choice of rooms for visitors, and for quiet times. This meant that some wards were not dementia friendly. At Walker Close we found that the former activities bungalow was being used for the segregation of a patient. We had concerns about the appropriateness of this environment as well as the effect this had on activity, quiet and visitor space for existing patients.

Most wards we visited had a telephone available for patient use in a private area. However at Yare ward we found that the phone had been broken and not replaced.

The majority of patients we spoke with were happy with the choice and quality of food available to them. However some patients at Walker Close did not like the cook-chill system in operation. Staff told us that they buy takeaways to supplement this food.

Ward policies and procedures minimise restrictions

Generally we found that staff did not restrict peatient's freedom and that informal patients understood their status and knew how to, and were assisted, to leave the wards. However some patients in forensic services told us that some staff were punitive in their approach and there were unnecessary rules. At Lark PICU we heard that in the previous 11 months there had been 12 patients admitted to the ward who were informal patients. We were further concerned that there was no policy or procedures for staff to follow when informal patients are cared for within a PICU. At Walker Close and the Woodlands unit we found there was restricted access to drinks and snacks.

Meeting the needs of all people who use the service

We found a range of information available for service users regarding their care and treatment. Many of the leaflets were available in other languages however we were told that the trust did not have facilities to make these available in an easy read format. We did not see any information in an easy-read format during our inspection of Walker Close.

Staff told us that interpreters were available via a central request line and had been used previously to assist in assessing patients' needs and explaining their care and treatment. However during our inspection at one ward we encountered a patient whose interpretation needs were difficult to meet, due to their particular dialect. We saw that staff were working hard to try to resolve this.

At most inpatient services we saw that multi-faith rooms were available for patients to use and that spiritual care and chaplaincy was provided when requested. We saw there was a range of choices provided in the menu that catered for patients dietary, religious and cultural needs.

Listening to and learning from concerns and complaints

A number of community service users and former patients told us that the trust did not always investigate their complaints. Some people suggested that the trust did not respond to their complaints.

At the inpatient services most patients 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 (PALS). Information about the complaints process was usually displayed at the wards.

The trust provided details of all complaints and contacts received between August 2013 and July 2014. There had been 586 formal complaints. The analysis of this highlighted key themes as staff attitudes, access to services, continuity of care and communication. The trust informed us that during the period 16% of complaints had been upheld and 26% were partially upheld. 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.

The complaints lead told us that they recognised that the level of complaints had increased and was high. The trust has reviewed the complaints process and made some changes. This has included additional dedicated staff, a centralised recording process, clearer guidance and training for staff and chief executive and governor oversight. The lead explained that all complaints are now triaged to ensure any safeguarding matters raised by complaints are appropriately managed. We were told that

Requires Improvement

Are services responsive to people's needs?

more complaints are being upheld and that formal analysis of the complaints is planned. Complaints were discussed at local governance meetings and at the trust-wide service governance committee. Information about the levels of complaints is included in the patient safety report and quality dashboard that is provided to the board.

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. At some units we saw actions that had occurred as the result of complaints. However at other units' staff we spoke with did not have any 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 for this domain because:

- The trust board had some significant changes over the past year. A recent independent review highlighted that the trust had made progress in its organisational development but there remained the need for significant change in the governance structure.
- 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.
- The trust stated that staff engagement was a key priority. We were unable to find evidence for action around this and there appeared to be considerable drift in work to engage staff in improving the service.
- A large number of staff we spoke with told us that morale was very poor. Some staff told us that they had no confidence in senior management and felt they had been let down.

Our findings

Vision and values

The trust board and senior management team had developed a vision statement and values for the trust in 2014. We were told that this was following detailed engagement with service users, employees and commissioners. The vision was stated as: 'To provide safe, sustainable services achieving positive patient outcomes, innovation and learning'. The values were stated as: "We care, we listen, we deliver' -

- deliver safe, effective services which meet local needs
- work together to achieve the best possible outcome for you
- keep our promises, with each of us accountable for what we do."

The trust gave us a copy of their strategic objectives for 2014 to 2016. The objectives were set out against the CQC domains and key objectives included a range of measures to improve staffing resources, staff engagement and workforce development. Senior management were aware of the strengths and improvement needs of the trust. They recognised that staff engagement was a key priority.

The trust board members we spoke with told us that this strategy had been developed by the board and it was their intention to cascade this to all staff. However we noted that the date on the vision statement was August and little had been done to achieve these aims. Additionally, when we asked senior staff to describe how far they had got, they were unable to show where the trust had made progress.

During this inspection we met with a large number of trust employees. Many were not aware of the trust's vision and values and strategic objectives. Others were aware of them but said they had not been involved in the development of these or did not see how they could be applied to their roles. We found some evidence of the vision and values on display within inpatient services and this was also available to staff on the trust intranet.

We found that staff were committed to ensuring that they provided a good and effective service for people who used the services, but did not always feel able to influence change within the organisation. Generally, most staff told us they knew their immediate management team well and most felt they had a good working relationship with them. Most staff were aware of and felt supported by the trust's local management structures however many staff were unclear about who the senior management team were at the trust. Most staff stated that they had not met with or seen senior managers at their service. Some staff told us

that they were very demoralised and felt let down by the senior management team. While we saw evidence of the senior team visiting specific services, most staff told us that the senior team was not visible within their service.

Good governance

The trust has a board of directors who are accountable for the delivery of services and seek assurance through its governance structure for the quality and safety of the trust. Reporting to this are committees for workforce development, communications, audit and risk and the mental health act managers. The trust told us that since 2013 they manage all quality governance through the service governance committee which also reports to the board. Reporting to this are sub-committees for clinical effectiveness and policy, health and safety, infection control, information governance, mental health legislation, equality and diversity, medical advice, research, and drugs and therapies. These committees had terms of reference, defined membership and decision making powers.

The service governance committee, which is chaired by a non-executive director of the trust, takes oversight of patient safety and quality. We saw that local governance groups were in place in all the localities and services, which also fed in to the service governance committee.

We noted that there were a large number of committees and we were concerned that the line of sight from the board to the point of care was overly extended. It was difficult to see how the decisions made at the board are executed and monitored.

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.

A mental health managers group 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.

The trust supplied us with a copy of an independent review, undertaken in October 2014. This highlighted that the trust had made progress in its organisational development but there remained the need for significant change in the governance structure. The trust acknowledged this and told us that they had begun to make plans to address this.

Leadership, morale and staff engagement

The board had some significant changes over the past year. There was a relatively new chair who had been in post just over a year. The chief executive was appointed four months prior too our inspection and the director of nursing also had only been in post just over a year. There had also been some other internal movements to provide more leadership to the Norfolk area. The medical director had announced his intention to step down after 14 years. The finance director had resumed his position after a year in post as interim chief executive. There were also fairly newly appointed non-executive directors in post.

Since 2013 the trust has been undergoing a programme of service transformation which has led to some service closures, mergers and reorganisation. The trust told us that this strategy had been developed in partnership with staff, patients and other stakeholders following detailed consultation. At a presentation from the trust prior to this inspection they stated that staff engagement was a key priority.

Ahead of the inspection we were aware that staff and patients at the trust had not all been welcoming of the changes and some had been campaigning to stop service closures. Some staff, patients and stakeholders told us that the programme has been designed around cost saving rather than quality improvement, and had compromised patient safety.

We heard from board members that out of area placements were reducing, but we saw little evidence that this was a sustained reduction. Bed occupancy was very high and this bore out staff fears about the quality of the service that could be provided.

Some staff told us that they had no confidence in senior management and felt they had been let down. Others told us that they had been worried about speaking openly with us for fear of victimisation. We had sight of a letter from a senior manager that instructed staff to only give

information to CQC that was requested. The urgent need for a workforce and operational development plan to deal with the issues of low staff morale was not prioritised or backed up with actions.

In the 2013 NHS Staff Survey, the trust scored within the worst 20% of mental health trusts for 21 key findings. These related to staff not feeling satisfied with the quality of work they are able to deliver, staff feeling work pressure, recommending the trust as a place to work or receive treatment, risks around managerial communication, believing patient care was not the trust's top priority, believing the trust provides equal opportunities and staff experiencing discrimination. This is the second year running that the results had been poor, with this year showing a worsening in morale. There had been little action to address the staff survey results.

The trust told us they had recognised the need for improvement to ensure staff felt valued and fully supported, and so had undertaken a number of initiatives to address this. The trust told us that data from the staff element of the Friends and Family Test from April 2014 indicated that there had been an increased level of staff satisfaction. We looked at the results from this and noted that the response rate was very low at 5%. Staff fed back to the trust that they felt that the survey was not confidential as they had to input an assignment number.

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. However we found that some staff had been raising safety issues of concern with their managers without any action being taken.

We found very few examples of staff feeling that learning from past incidents was informing planning of services or service provision. Despite requests for information we saw little evidence that the trust could provide such assurance. Information was held in different places and was not easily accessible, even to the governance staff.

We looked at data available about staffing. Sickness absence rates had fallen slightly since the staff survey was completed however remained above target at 5.3%, with very high rates for absence due to stress at 26% of these.

The trust confirmed that they have a vacancy rate of over 11% and that staff turnover stood at over 17% in September 2014. Nursing vacancies were particularly high with over 65% covered by bank or agency staff.

We were concerned that there were low energy and action levels at board level. We heard no evidence to suggest that staff felt inspired by their leaders and saw no evidence that this was on the workforce agenda. We did recognise, however, that there were new board members and that there was will from the board to engage with staff.

Commitment to quality improvement and innovation

The trust told us about the challenges and improvements they needed to make. Throughout our inspection we identified both similar and additional concerns as those identified by the trust. The trust had risk registers in place held at different levels of the organisation which were reviewed at locality meetings and the board. We reviewed the overarching risk register sent to us prior to the inspection and noted that while some of the concerns we found had been highlighted others, such as ligature and environmental risks, restrictive practice and medication management issues, had not been flagged.

The trust told us that improvements in quality and safety were their highest priority. The trust has a quality account that set out arrangements for performance improvement. The director of nursing oversees the work programme for this agenda. Progress against the objectives is reviewed by the board and the service governance committee on a monthly basis via a business performance report. The key objectives for 2014/15 are: quick access to services, learning from mistakes, out of hours' access, carers' needs and continuity of care. We reviewed the performance reports for this and the previous year's targets. We noted that while some progress had been made some targets for 2013/14 had not been fully met such as access to physical healthcare, robust crisis plans and 7 day ward activity programmes. The fourth target for last year regarding information for service users about their medication had yet to be reviewed however we noted that the results of the 2014 community service user survey indicate that the trust performed below average for this target.

This business performance report also acts as a performance report against key indicators and an early warning system for identifying risks to the quality of services and includes measures of organisational delivery,

Inadequate

Are services well-led?

workforce effectiveness and quality and safety. These include: serious incidents, 7 day post discharge follow up, delayed transfers of care, access to crisis teams, and CPA and waiting times, bed occupancy, average length of stay, as well as staffing measures such as vacancies, sickness, turnover and training rates. At September 2014 key risks were flagged as 18 week waiting time targets, data quality, access to psychological therapy (IAPT), staff sickness, vacancy, turnover and training rates.

The board also receives a monthly patient safety report from the director of nursing. This provides an overview of service user safety indicators, including serious incidents, medication incidents, harm free care and assaults, service user and carer experience indicators including complaints and the Friends and Family Test, clinical assurance, including audit and external reports, safe staffing report and quality dashboard.

Throughout the inspection we reviewed incident information and looked at whether this had resulted in any learning. While we found some positive examples of learning and changes to practice at a local level we were concerned that some serious incidents had not led to positive learning and action at the trust level. We are also concerned that despite a governance structure in place to provide oversight to quality and safety our findings indicate that that there is room for improvement in the trust to ensure that lessons are learned from quality and safety information and imbedded in to practice.

During 2014 the trust has participated in a range of clinical research and developed a research strategy. The trust also undertakes a wide range of clinical effectiveness and quality audits. These include suicide prevention, medication, clinical outcomes, care planning, Mental Health Act administration and patient satisfaction. During 2013-14 the trust also participated in a number of national clinical audits and national confidential enquiries including: National audit of psychological therapies (NAPT), National audit of schizophrenia (NAS), Mental health clinical outcome review programme: National Confidential Inquiry into Suicide and Homicide for people with Mental Illness (NCISH).

The trust participates in a number of accreditation schemes and service networks. All acute services have been accredited under the AIMS (Royal College of Psychiatrist's accreditation for inpatient services) programme. The ECT services are accredited with ECTAS (Royal College of Psychiatrist's accreditation for ECT). The secure services are part of the quality network for forensic services.

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.