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

Summary of findings

Wards for people with learning disabilities	Walker Close	RMYMW
Wards for people with learning disabilities	Lothingland	RMYX2
Community mental health services for people with learning disabilities and autism	Trust Headquarters - Hellesdon Hospital	RMY01
Wards for older people with mental health problems	Julian Hospital	RMY02
Wards for older people with mental health problems	Carlton Court	RMY13
Wards for older people with mental health problems	Woodlands	RMYX1
Wards for older people with mental health problems	Wedgwood House	RMYX5
Community-based mental health services for older people	Trust Headquarters - Hellesdon Hospital	RMY01
Community-based mental health services for adults of working age	Trust Headquarters - Hellesdon Hospital	RMY01
Mental health crisis services and health-based places of safety	Trust Headquarters - Hellesdon Hospital	RMY01
Mental health crisis services and health-based places of safety	Fermoy Unit	RMYXX
Mental health crisis services and health-based places of safety	Northgate Hospital	RMY03
Mental health crisis services and health-based places of safety	Woodlands	RMYX1
Mental health crisis services and health-based places of safety	Wedgwood House	RMYX5
Substance misuse services	Trust Headquarters - Hellesdon Hospital	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 services at this Provider	Requires improvement 
Are services safe?	**Inadequate** 
Are services effective?	**Requires improvement** 
Are services caring?	**Good** 
Are services responsive?	**Requires improvement** 
Are services well-led?	**Requires improvement** 

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.

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Overall summary

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

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

- We found that whilst there had been considerable progress since 2014, the service was not yet safe in all areas, fully effective or responsive at this trust. The board needed to take further and more immediate action to address areas of inadequacy.
- The trust had reorganised its governance processes and began to use quality information to inform performance. However, the board needed to ensure that their decisions were implemented and brought about positive improvement.
- We found that whilst performance improvement tools and governance structures were in place these had not always facilitated effective learning or brought about improvement to practices.
- We had a number of concerns about the safety of some services at this trust. These included unsafe environments that did not promote the dignity of patients; insufficient staffing levels to safely meet patients' needs; inadequate arrangements for medication management; concerns regarding seclusion and restraint practice.
- The trust did not have effective systems to record whether staff had received their mandatory training. Many staff had not received regular supervision and appraisal.
- A lack of availability of beds meant that people did not always receive the right care at the right time and sometimes people had been moved, discharged early or managed within an inappropriate service.
- Whilst access to a single record had been addressed by the application of a single electronic system, we were very concerned about the performance of this system and the impact this had on staff and patient care.

However:

- The board and senior management had developed a vision with strategic objectives in partnership with staff and patients and had assumed a leadership role and style that was making a difference.
- Morale was found to have significantly improved across the trust. This was evidenced by the staff element of the Friends and Family Test which indicated that there had been an increasing level of staff satisfaction since 2014.
- The trust had undertaken improvement to the environment at some services.
- The trust had improved systems for recording and learning from incidents.
- 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.

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 safe because:

- We found a number of environmental safety concerns. Whilst some work was being planned or underway to remove potential ligature risks, we were 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.
- The trust had not ensured that all mixed sex accommodation met guidance and promoted safety. Some seclusion rooms and dormitory areas did not promote privacy and dignity.
- We were concerned about the design of seclusion and place of safety facilities across the trust and that seclusion was not managed within the safeguards of the Mental Health Act Code of Practice.
- We were concerned that staffing levels, including medical staff, were not sufficient at a number of inpatient wards and community teams across the trust.
- The trust had not ensured that all staff had sufficient mandatory training. Of particular concern were levels of training in restrictive intervention and life support.
- The trust had not ensured that all risk assessments were in place, updated consistently in line with changes to patients' needs or risks, or reflected patient's views on their care.
- There had been significant work carried out to reduce restrictive intervention and overall rates had reduced. However, data provided by the trust showed that restraint remained above average and levels of prone restraint remained high in acute and learning disability services.
- 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. The trust had identified that there had been a high number of deaths of community patients and had commissioned an independent review to look in to this. The trust was addressing the issues that were highlighted through this work however we are concerned that overall rates of death remain high at the trust.
- Arrangements were not adequate for the safe and effective administration, management and storage of medication across the trust. The trust was not compliant with Controlled Drug

Summary of findings

legislation when ordering controlled drug medication from another trust. The trust had not consistently maintained medication at correct temperatures in all areas or ensured action was taken if it was found to be outside correct range.

However:

- Generally we found that patients did not have restricted freedom and that informal patients understood their status.
- The trust had policies and processes in place to report and investigate any safeguarding or whistleblowing concerns.
- Services were clean, with good infection control practices.
- Incidents were reported and investigated. The trust was meetings its obligations under Duty of Candour regulations.
- The trust had contingency plans in place in the event of an emergency.

Are services effective?

Requires improvement

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

- While access to a single record had been addressed by the application of the electronic system, we were very concerned about the performance of this system and the impact this had on staff.
- Care plans were not always in place or updated when people's needs changed in community adults, rehabilitation and older people's services. People's involvement in their care plans varied across the services.
- Not all staff had received appraisal or supervision. Systems for recording levels of supervision and appraisal were also not effective.
- There were poor levels of training and procedures were not always followed in the application of the Mental Capacity Act.
- Training in the Mental Health Act was also insufficient.

However:

- People's needs, including physical health needs, were usually assessed and care and treatment was delivered to meet them.
- Generally, people received care based on a comprehensive assessment of individual need and services used evidence based models of treatment.
- The trust had participated in a range of patient outcome audits.
- Generally, we saw good multidisciplinary working.
- Overall, systems were in place to ensure compliance with the Mental Health Act (MHA) and the guiding principles of the Mental Health Act MHA Code of Practice.

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Are services caring?

Good

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

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

However:

- In learning disability, CAMHs and older people's services patients had not always been involved in developing or reviewing their care plans.

Are services responsive to people's needs?

Requires improvement

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

- There remained a shortage of beds across the trust and that this had impaired patient safety and treatment at times. 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. However, an out of hours service was not commissioned in some areas for people over the age of 65 with dementia. 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 impacted on people's dignity.

However:

- Most units that we visited had access to grounds or outside spaces and generally had environments that promoted recovery and activities.

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- The trust had an effective complaints process. We found that patients knew how to make a complaint and many were positive about the response they received.
- We found a range of information available for service users regarding their care and treatment and many of the leaflets were available in other languages and an easy read format.

Are services well-led?

Requires improvement

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

- We found that whilst there had been some progress since 2014, the service was not yet safe, fully effective or responsive at this trust. The board needed to take further and more immediate action to address areas of inadequacy.
- The trust had reorganised its governance processes and begun to use quality information to inform performance. However, the board needed to ensure that their decisions were implemented and brought about positive improvement.
- Leadership was not yet fully embedded or effective at all levels. There was a gap in leadership and oversight at service level (triumvirate level).
- We found that whilst performance improvement tools and governance structures were in place these had not always facilitated effective learning or brought about improvement to practices.
- 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. A number of these had not been fully addressed since our last inspection in 2014.
- We reviewed the risk registers for the trust and directorates and saw that some, but not all, risks that we identified through this inspection had been included in the risk register. This showed that further work was required to ensure that all risks were fully captured and understood by the board.

However:

- At the time of the last inspection, there was a relatively new chair, chief executive and director of nursing. Since then the board had been strengthened by new appointments to the medical director and finance director roles and some non-

executive roles. At this inspection the board told us that they were 'a different organisation – positive about the future, willing to learn, and continuing to improve'. We found a revitalised energy at board level with a spirit of stronger leadership.

- The board had raised their visibility through a programme of executive and non-executive visits to services, and engagement initiatives. Work had also been undertaken to simplify and standardise the operational leadership model. All localities had implemented a triumvirate management model incorporating a locality manager, a modern matron and clinical lead. These were supported by deputy matrons, and a HR and governance business partner allocated to each locality.
- The trust 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 'putting people first' programme had been the key vehicle to engage with staff. Morale was found to have significantly improved across the trust. This was evidenced by the staff element of the Friends and Family Test which indicated that there had been an increasing level of staff satisfaction since 2014.
- The board and senior management had developed a vision with strategic objectives in partnership with staff and patients.
- The trust had undertaken improvement to the environment at some services.
- The trust had improved systems for recording and learning from incidents.
- The trust had improved arrangements to engage service users and staff in the planning and development of the trust.

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Our inspection team

Our inspection team was led by:

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

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

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

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

Why we carried out this inspection

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

How we carried out this inspection

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

• Is it safe?

• Is it effective?

• Is it caring?

• Is it responsive to people's needs?

• Is it well-led?

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

We carried out an announced visit between 13 and 22 July 2016. Unannounced inspections were also carried out between 27 July and 4 August 2016.

Prior to and during the visit the team:

- Held patient focus groups and met with local user forums.
- Asked a range of other organisations that the trust worked in partnership with for feedback. These included NHS England, local clinical commissioning groups, Monitor, Healthwatch, local authorities overview and scrutiny committees, Health Education England, and other professional bodies.
- Met with local stakeholders and user groups.
- Held focus groups with 32 different groups of staff, including administration staff, both qualified and non-qualified nursing staff, doctors, allied health professionals, the trust's governors, non-executive directors and union representatives.
- Visited 31 wards and 50 community locations.
- Talked with more than 220 patients and 90 carers and family members.
- Collected feedback using comment cards.
- Observed how staff were caring for people.
- Attended 35 community treatment appointments.
- Attended 20 multi-disciplinary team meetings.
- Looked at the personal care or treatment records of more than 400 patients.
- Looked at 50 patients' legal documentation including the records of people subject to community treatment under the Mental Health Act.
- Interviewed more than 500 staff members and 90 team managers.
- Interviewed senior and middle managers.

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

Following the announced inspection:

- We made unannounced inspections to three crisis teams, three community child and adolescent teams and older people's wards.
- A number of data requests were also met by the trust.
- We received an update from the trust regarding the immediate actions taken as a result of the high level feedback provided at the end of the inspection.

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

We also visited three locations where community substance misuse services are provided.

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

Information about the provider

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

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

Norfolk and Suffolk NHS Foundation Trust provides services for adults and children with mental health needs across Norfolk and Suffolk. Services to people with a learning disability are provided in Suffolk. They also provide secure mental health services across the East of England and work with the criminal justice system. A number of specialist services are also delivered including a community based eating disorder service and community based support, in partnership with other agencies, to those whose needs relate to drug or alcohol dependency in Norfolk.

The trust is the seventh largest mental health trust in the UK. The trust has more than 400 beds and runs over 70 community services from more than 50 sites and GP practices across an area of 3,500 square miles. The trust serves a population of approximately 1.6 million and employs just under 4,000 staff including nursing, medical, psychology, occupational therapy, social care, administrative and management staff. It had a revenue income of £212 million for the period of April 2015 to March 2016. In 2015/16, the trust staff saw over 55,000 individual patients.

Norfolk and Suffolk NHS Foundation Trust has a total of 13 locations registered with CQC and has been inspected 15 times since registration in April 2010.

We last inspected the trust in October 2014 under CQC's comprehensive inspection programme. The trust was rated inadequate overall and was placed in special measures by Monitor following recommendation by CQC. Monitor appointed an improvement director who has been working with the trust over the past year and a half.

We were particularly concerned about the safety, responsiveness and leadership at the trust. We found that while the board and senior management had a vision with strategic objectives in place neither the board nor the staff were fully engaged with these. Staff were not involved in the improvement agenda of the trust. Morale was found to be very poor across the trust. We found that whilst performance improvement tools and governance structures were loosely in place these had not always facilitated effective learning or brought about improvement to practices. We had a number of concerns about the safety of this trust. These included unsafe environments that did

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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.

Since 2014, we have monitored the trust on a monthly basis as part of a multi-agency stakeholder assurance meeting chaired by the improvement director and attended by NHS England, commissioners and other stakeholders. The trust was slow to engage with the necessary improvements, but once fully committed the progress has gained traction.

During this inspection we reviewed the five CQC domains of safe, effective, caring, responsive and well led. We also considered all areas of previous non-compliance.

Good practice

- The 'care farm' initiative and recovery college were examples of improvement and innovation.
- One clinical psychologist in an integrated delivery team had been given a day per week funded to promote a 'research friendly' environment within the trust. The same psychologist ran 15 minute 'mindfulness' groups for staff each morning in an effort to reduce staff stress.
- An example of improving and developing the service was given regarding the safer care pathways, 'closing the gap in patient safety' for dementia wards implemented at Julian Hospital and Carlton Court. At Julian Hospital, carers were involved in the redesign of an information booklet aiming to improve communication to reduce patient distress and a patient centred admission process. Staff away days were planned with staff. A new occupational therapy model of care was developed to increase therapeutic interventions to reduce incident rates for example for falls and violence and aggression. As of March 2016 a reduction of incidents was identified.
- Doctors said they had links with Cambridge University, for example regarding research for Lewy body dementia and learning from innovative practice.
- In the older people's community teams, we saw an example of good practice at Wymondham, where the team had developed an additional cognitive stimulation therapy group for younger people with dementia, which met in a pub, in an effort to reduce stigma.
- Service team leaders demonstrated innovation in practice, and delivered on ideas to improve patient care and overcome challenges within their services. Managers involved their staff in making decisions for service improvement.
- In the crisis teams, a pilot scheme was in place to improve service provision at Mariner House to evaluate 'delays in patient pathways'. Although led by the core team leader, the staff contributed, and we saw flow charts of the scheme, and actions arising from the work.
- At the home treatment teams in Woodlands, we saw individual folders for patients, which contained risk assessments and care plans. This meant information about patients was easily accessible to staff prior to going out to see them.
- The AFI team at Northgate hospital used innovative ways to manage the needs of their patients. The core team leader was involved in multi-agency working groups and had led the team to be able to deliver treatment in different ways to conventional home visits. An example of this is the 'early help hub' where patient's needs were discussed and multiple agencies could be involved. The core team leader made suggestions of how each agency could assist in the holistic treatment of the patient.
- Members of the CAMHs teams attended the child and family research meetings held every two months to support the development of research within the service.
- The CAMHs inpatient ward was a member of the quality network for inpatient CAMHS, QNIC, which is a national quality improvement programme.

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- The Norfolk recovery partnership facilitated a pregnancy liaison partnership protocol for pregnant clients across Norfolk. This ensured that any pregnant clients who needed support for substance abuse were supported by a dedicated team of a substance misuse NRP nurse, a midwife, neonatal intensive care nurse, their GP and a health visitor.
- NRP Unthank Road was taking part in a fingerprints study with King's College London. The study investigated whether fingerprints could be used to screen for drug use as a less invasive way of drug testing. Clients who were willing to take part in the study were offered a £5 food voucher on completion of a sample collection.

Areas for improvement

Action the provider MUST take to improve

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

Summary of findings

- The trust must ensure that governance processes capture and learn from adverse incidents.

Action the provider SHOULD take to improve

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

Norfolk and Suffolk NHS Foundation Trust

Detailed findings

Mental Health Act responsibilities

A mental health law forum had overall responsibility for the application of the Mental Health Act (MHA) and the Mental Capacity Act (MCA). The forum reported to the quality governance committee. The Trust conducted a bi-monthly MHA administration heat map which identified trends and highlighted areas of concern. The trust collated MHA activity and ethnicity quarterly. The hospital managers provided an 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.

We met with the hospital managers and were informed that they link with the MHA manager. We were told that the hospital managers met quarterly and received training relevant to their role. This training programme covered issues of clinical importance, policy and procedures, and legal aspects including the MHA Code of Practice.

We looked at procedures for the assessment of people under the MHA. 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.

Mental Health Act records were generally in good order. There was a clear process and system in place for the administration of detention paperwork however some issues had not been identified by the provider but were addressed promptly when we raised them.

Overall MHA training compliance was below the trust target at 69%.

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.

Seclusion and long term segregation was practiced at a number of the services we visited. At the Norvic Clinic and Hellesdon Hospital the seclusion rooms did not meet the required standards as set out by the Code of Practice. Seclusion paperwork was inconsistent. We found incomplete paperwork across the trust. It was not always clear when seclusion became long-term segregation.

We reviewed practice under section 136 of the MHA in detail. Staff at the health based places of safety appeared to be knowledgeable about the MHA and 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 in those records reviewed. However, we found that patients were not always given their rights under section 132.

People detained under Section 136 were rarely conveyed to the health based places of safety by the ambulance service. In most cases people were transported by the police. This did not adhere to the MHA Code of Practice, which states that police should convey in exceptional circumstances only.

The provider did not have robust systems in place to assess and record people's mental capacity to make decisions. There was no MCA audit process in place within the trust. The MCA lead was employed by a local CCG and was hosted by the trust three days a week. There was a lack of

clarity around the interface between the MHA and MCA. We found several examples where people had their MHA section rescinded and were then placed onto the MCA with no clear rationale as to why.

Mental Capacity Act and Deprivation of Liberty Safeguards

A mental health law forum had overall responsibility for the application of the Mental Capacity Act (MCA). The forum reported to the quality governance committee.

The trust had compliance with capacity recording as one of its quality priorities for 2016/17. The trust told us that they had recognised that this area worked required improvement. At May 2016, there was a key risk flagged to the board of not meeting the target for recording of patient's capacity.

Training rates for staff in the Mental Capacity Act were not good with just 73% of staff trained at the end of March 2016.

Generally, staff had an awareness of the Mental Capacity Act and the deprivation of liberty safeguards. However, some staff in the learning disability teams were not confident in carrying out decision specific mental capacity assessments, and where they identified this need, deferred the assessment to psychologist and consultant psychiatrist colleagues. We saw some units where recent mental capacity assessments and best interest decisions had been carried out where applicable. However we found that not all patients had had their mental capacity recorded within community adult teams, crisis services and older people's units.

We had specific concerns within older people's services about procedures under the MCA. We found that patients were being taken off the Mental Health Act and a deprivation of liberty authorisation applied for. Assessments by the local authority were delayed and trust records did not always capture how the patient's capacity to give consent to their treatment and care was assessed or managed in the interim. Staff's assessment and recording of 'do not attempt resuscitation' decisions was also inconsistent on Rose and Sandringham wards.

86 Deprivation of Liberty Safeguards applications were made between October 2015 and March 2016. Of these 28 were authorised. It was noted that not all of these had been notified to CQC as required under regulation. Rose ward made the highest number of applications however Reed Ward had the most applications authorised.

Inadequate

Are services safe?

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

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

Summary of findings

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

- We found a number of environmental safety concerns. Whilst some work was being planned or underway to remove potential ligature risks, we were 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.
- The trust had not ensured that all mixed sex accommodation met guidance and promoted safety. Some seclusion rooms and dormitory areas did not promote privacy and dignity.
- We were concerned about the design of seclusion and place of safety facilities across the trust and that seclusion was not managed within the safeguards of the Mental Health Act Code of Practice.
- We were concerned that staffing levels, including medical staff, were not sufficient at a number of inpatient wards and community teams across the trust.
- The trust had not ensured that all staff had sufficient mandatory training. Of particular concern were levels of training in restrictive intervention and life support.
- The trust had not ensured that all risk assessments were in place, updated consistently in line with changes to patients' needs or risks, or reflected patient's views on their care.
- There had been significant work carried out to reduce restrictive intervention and overall rates had reduced. However, data provided by the trust showed that restraint remained above average and levels of prone restraint remained high in acute and learning disability services.
- 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. The trust had identified that there had been a high number of deaths of community patients and had commissioned an independent review to look in to this. The trust was addressing the issues that were highlighted through this work however we are concerned that overall rates of death remain high at the trust.
- Arrangements were not adequate for the safe and effective administration, management and storage of medication across the trust. The trust was not compliant with Controlled Drug legislation when ordering controlled drug medication from another trust. The trust had not consistently maintained medication at correct temperatures in all areas or ensured action was taken if it was found to be outside correct range.

However:

- Generally we found that patients did not have restricted freedom and that informal patients understood their status.
- The trust had policies and processes in place to report and investigate any safeguarding or whistleblowing concerns.
- Services were clean, with good infection control practices.
- Incidents were reported and investigated. The trust was meetings its obligations under Duty of Candour regulations.
- The trust had contingency plans in place in the event of an emergency.

Our findings

Safe and clean care environments

Inadequate

Are services safe?

We were told that regular trust-wide cleanliness audits were undertaken. The overall patient led assessments of the care environment (PLACE) score for the trust for cleanliness of the environment for 2015 was 99% against a national average of 97%. This had improved greatly since our inspection of October 2014. We found, bar some minor exceptions in seclusion rooms and places of safety, that wards and community team bases were clean.

The trust had an estates strategy. This programme of work was overseen by an estates manager reporting to the director of finance. The board monitored this work via the estates, workforce and technology transformation programme reports. The trust told us that there was a detailed programme to modernise environments and reduce risk. There was stated to be some flexibility built in to the programme to address urgent pieces of work. The trust undertook an annual programme of environmental health and safety checks. All services had received an environmental risk assessment in the previous twelve months.

Generally, buildings were well maintained. Staff stated that new maintenance issues were dealt with in a timely manner.

When we inspected the trust in 2014 we were concerned that there had been an inconsistent approach to ligature point management. Some ligature risks existed that had not been identified or addressed. The trust placed this on their risk register and began a programme to address these risks. Ligature point risk assessments were reviewed as part of this programme. The trust stated they had implemented a trustwide ligature removal programme and ligature risk action plans for all inpatient areas. Since then, all services had received a more detailed and consistent ligature point audit. The trust had undertaken improvement in some wards to remove, manage or mitigate the risks.

However, at a number of services across forensic, acute, PICU and older people's wards, some planned actions to remove or replace the identified risks had not been undertaken. In some cases this was six months after the risks had been highlighted. Some fixtures identified for removal had no set timeframe for this work. On some wards we were also provided with additional risk assessments undertaken by ward staff. It was noted that these were not all consistent and some risks had not been included on both assessments. We also found additional risks at forensic and acute services that had not been picked up through the audits. For many identified risks the action point to address this was stated as staff vigilance which was not always an appropriate mitigation on its own.

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

We were particularly concerned about Churchill Ward, an acute ward in King's Lynn, where the design and layout made it very difficult for staff to manage these risks. The plans to manage these risks depended on high staff vigilance. However, as this ward was very busy with very unwell patients, it was easy to foresee occasions where staff may be required to respond to other incidents on the ward and not be able to carry out the level of observation required to manage this risk.

When we inspected in 2014, we raised concerns about a large number of wards' arrangements to eliminate mixed gender accommodation. These wards did not meet guidance set by the Department of Health or within the Mental Health Act code of practice. The trust had acted on the majority of these concerns. However, some concerns still remain.

Within older people's wards we found that the majority of wards did not meet all aspects of the Department of Health or Mental Health Act code of practice guidance. The two seclusion rooms at the Norvic Clinic were located on Earlham ward. Staff used this ward for patients who required long-term segregation. This meant that male and female patients had been secluded or nursed in the same area. This did not promote privacy and dignity due to the positioning of seclusion rooms. The seclusion room on Southgate Ward had to be accessed by male patients via the female wing of the ward. This meant that male patients would need to be moved through this area. The trust had put in place a protocol to manage this procedure however this did not fully protect patients dignity. When the seclusion facility at Lark Ward was in use women were unable to access the female only lounge or their bathroom.

Inadequate

Are services safe?

When we inspected in 2014 we had a number of concerns about the environment of and access arrangements to seclusion rooms. We remain concerned during this inspection about some seclusion facilities:

- We were concerned about the access to the seclusion suite at the Wedgwood Unit as patients needed to be moved down a staircase to access this.
- We were concerned that the seclusion areas at a number of services did not have ensuite facilities. This meant that people secluded would need to leave the seclusion room to use the toilet and shower facilities or be given a urine bottle or a bedpan when in seclusion. This had not yet been addressed at Yare Ward, Rollesby Ward, Abbeygate Ward and Avocet Ward, although plans were underway to address this at the Norvic Clinic and Whitlingham Ward.
- In 2014, we found that the seclusion suite at Southgate Ward did not meet guidance or the Mental Health Act code of practice as there was no communication system in place to allow patients to communicate with staff while in the bedroom area. At this inspection we found that there were no intercom systems in any of the seclusion rooms in forensic services and at Rollesby Ward. At Poppy, Avocet and Lark wards we found there was a telephone with a cord used to communicate with patients in the seclusion room. When the patient is stepping down from seclusion, the patient may access the wider suite area. Therefore, the cord posed a risk to patient safety as it could be used as a ligature. At Lark Ward staff were aware of this risk and had asked for the phone to be removed and an alternative two way communication system to be installed.
- We had concerns that staff used the section 136 health-based places of safety suites in the Fermoy and Wedgwood units for seclusion. At Great Yarmouth and Waveney Acute Service, the Willows and Whitlingham Ward we found that patients had been secluded in de-escalation rooms or bedrooms. These facilities did not meet the environmental requirements of the Mental Health Act code of practice.
- At Abbeygate Ward and Avocet Ward there was no clock, the Mental Health Act code of practice requires one to be within the patient's view. Patients in seclusion had to access these in the low stimulus area outside the seclusion room.
- At Rollesby ward, the second seclusion room did not have a mattress. This was due to a misunderstanding of the trust's policy but was resolved by the end of the inspection.

In 2014, we found concerns with environmental health and safety in some health-based places of safety that did not meet the requirements of the Royal College of Psychiatrists' national standards. These included furniture that was light and portable and not secured to the floor which could be used as a potential weapon and doors that opened inwards and could be barricaded against staff. In addition, at a number of units, entrances and windows were not obscured so patients were visible to members of the public. At this inspection we found that some improvements had been made at the suites however at Hellesdon, Woodlands, Northgate and Fermoy the furniture had not been replaced or fixed to the floor. In addition we found that the suite at Northgate hospital was dirty and the ligature environment risk assessment did not identify risks found by inspectors.

We were also concerned about the safety of the environment at some acute hospitals, managed by other trusts, from which the psychiatric liaison services operated.

We found that some learning disability and older people's community teams had insufficient office space for their staff to work from.

Generally, staff ensured that equipment was well maintained and clean. Clinic rooms were clean and usually well equipped to carry out basic physical examinations and monitoring. Most wards had fully equipped clinic rooms with accessible resuscitation equipment and emergency drugs that were accessible to all staff. Generally, staff checked these regularly to ensure medication was fully stocked, in date and equipment was working effectively. However, at Abbeygate and Foxglove wards we found gaps in recording checks of the automated external defibrillator and emergency response bags. At the crisis team in Northgate Hospital the electrocardiogram (ECG) machine had not been calibrated. We informed senior staff of our concern however, when we returned to the unit one week later, we found staff had still not recalibrated the machine. Generally, fridge temperatures were checked and any issues addressed, however, a number of the clinics across

services had recorded temperatures above 25 degrees, which could affect the efficacy of the medication stored within the clinics. These had not all been addressed by staff.

Staff had access to infection control training. However, in clinical areas only 68% of staff had undertaken this by April 2016. However, the trust had effective infection control practices which included Legionella assessments and processes. Staff had access to protective personal equipment, such as gloves and aprons. Wards undertook regular infection control audits. In wards and community team bases there were adequate hand washing facilities and gel available for staff to adhere to infection control principles. Handwashing posters were on display.

We had been concerned about a lack of personal alarms at wards in 2014. At this inspection at all wards staff carried personal alarms, which they used to summon help in an emergency. Most community teams had personal safety alarms and alarms were usually fitted in interview rooms. However, the crisis teams had variable access to personal alarms when on duty.

In most wards there were call systems in patients' bedrooms for patients to call for help if needed. However, in acute services most wards did not have call bells in the bedrooms. Poppy ward had two rooms with call bells but staff had turned them off. Staff told us that they only turned them on if there was a need or a patient with mobility difficulties was on the ward.

Safe staffing

In 2014 we had significant concerns about staffing levels at the trust.

The trust acknowledged that recruitment and retention had been key issues for the trust. This had been placed on the risk register. The recruitment of registered nurses was particularly difficult. The trust had since revised their recruitment and retention strategy and undertaken considerable work to attract new staff. New roles had been introduced to support nurses including assistant practitioners who in some areas were undertaking a flexible nursing programme to become a qualified nurse. The trust told us that there had been a 50% increase in recruitment activity in June 2016, largely attributable to more proactive recruitment activity in central Norfolk. They acknowledged however that there had been a high number of internal appointments. They confirmed the strategy would focus on increasing external appointments.

The trust confirmed that they have an overall vacancy rate of over 11% and that staff turnover stood at 10% in May 2016. The overall vacancy rate was the same as in 2014 but below the national average of 13%. The vacancy rate for qualified nurses was higher at 14%. The turnover rate had reduced significantly from 17% in 2014. However, some services had a high vacancy rate. For example, older people's wards had a vacancy rate of 20% for nurses and 13% for healthcare assistants. Fernwood had the highest rate for qualified nurse vacancies at 28%.

The trust had set safer staffing levels in 2013. Since June 2014, the trust had published both the planned and actual staffing levels on their website. The trust told us that this was reviewed in 2015 when staffing levels were raised on some wards. This was further reviewed in May 2016. The trust had also introduced an escalation procedure for when staffing levels fall below a safe level. The board reviewed overall staffing levels on a monthly basis as part of the performance board report.

Figures published for November 2015 to March 2016 indicated that staffing as a whole had exceeded planned staffing levels. However, the overall numbers of qualified nurses deployed against the required number for the shifts varied between 80 and 89% on days and 84 and 91% on nights during this period. In June 2016, eight wards had limited numbers of qualified nurses deployed and fell below 70% of the monthly planned shifts. During this time there were only 39% of nursing shifts filled on nights at Whitlingham Ward. On eight wards combined qualified and non-qualified staff had not met the planned monthly staff hours. Of particular concern was Glaven Ward where just 74% of planned hours were filled.

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

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 they had the authority to request additional staffing based on clinical need. The trust had implemented

an electronic staff rostering system during 2015. We received mixed feedback from staff about this across wards. Some stated there was flexibility to make requests and ensure cover and others disagreed. The trust acknowledged that this system had not been well received by all staff but had led to a fairer and more efficient staff planning system.

At the time of our inspection in July 2016, staffing was sufficient on some but not all wards. We found that staffing did not always meet the trust's target within the acute, PICU and some forensic and older people's wards. In addition, some wards, particularly in the forensic and acute services, were using very high levels of bank and agency staff to meet their staffing targets. In the last quarter, 3710 shifts had been filled in acute services by bank or agency staff. This meant that staff were not always able to complete necessary tasks. This also meant that patients' leave and activities programmes could be affected. Some patients told us of the negative impact this had on the continuity of their care and treatment.

The trust told us that community teams had safe staffing levels and where necessary agency nurses had been employed on a long term basis. However, we found that staffing levels were not always sufficient in the community teams, particularly the crisis, CAMHS, and learning disability teams. This meant that staff were managing very high caseloads and there were some delays in treatment. Caseloads in some instances were above the Royal College of Psychiatrists' recommended levels. Of particular concern was the CAMHs caseloads which varied hugely across the service. One lead care professional was allocated 95 patients. In some older peoples and learning disability teams there was delay in allocating a care co-ordinator. At the crisis and home treatment teams based at King's Lynn and Northgate Hospital limited staff meant there was limited capacity to undertake assessments and people in need of assessment were not always able to access the service they needed in a timely way. Other community teams were better staffed through the use of bank and agency staff.

We were concerned about staffing arrangements for the health based place of safety suites. These were managed in different ways across the trust. Specifically allocated staff managed some units and staff from acute wards staffed other suites when a patient was admitted. This reduced the staffing numbers on the acute service when they were needed to staff an admission to the suite. Support workers staffed the suite at Hellesdon Hospital and there was limited registered nurse cover. Funding had been approved by the Clinical Commissioning Group (CCG) for registered nurse posts, but due to problems with appointment, support workers were working in the service. At the suite at the Fermoy Unit, staff were not available to take responsibility for patients detained under section 136 so this was undertaken by police.

The trust confirmed that wherever possible regular bank and agency staff were used to provide continuity of care. Agency staff were provided with a local induction and some supervision from regular staff. However, we were concerned that agency staff in some acute services did not receive the same restrictive intervention training to trust staff. This was particularly noted at the Fermoy unit where on occasions two out of four staff were agency nurses.

Sickness absence rates had fallen slightly since our last inspection to 4.7%. Sickness rates for absence due to stress remained high at 26% of these.

The medical director told us that medical cover was sufficient at the trust, however acknowledged there were about 15 locum doctors working at any time. The majority of the locums were in West Norfolk, where seven out of nine consultants were locums. The central Norfolk location was also considered to be stretched because of the distance between the hospital sites.

We found some services that were short of medical cover. In the rehabilitation service the consultant worked for two sessions per week and there was no junior doctor cover.

In the acute services in Norfolk the doctors covered a wide geographical area out of hours. Staff told us they were able to contact doctors for advice and guidance but they could not always attend the site in a timely way. There was a waiting list at Ipswich Coastal integrated delivery team for people to see a psychiatrist for routine appointments and clinics had to be cancelled due to insufficient numbers of doctors. In the Suffolk dementia intensive support teams (DISTs), there were no psychiatrists in the team which could cause a significant delay in arranging quick access to a doctor where this was not deemed to be an emergency. There was limited medical cover for the home treatment team at Wedgwood House. This meant there were delays in the doctor conducting medical reviews. In older people's services, Fernwood and Foxglove wards did not have easy

access to an on-site doctor due to recruitment difficulties and instead relied on sharing a consultant with the community team. Some Abbeygate staff said there was not much continuity as doctors covered other wards.

The trust required staff to attend a variety of mandatory training courses. The trust had set a target to reach 90% training compliance by September 2016. Prior to the inspection the trust supplied us with details of their set mandatory training requirements and the uptake. This showed that not all regular staff had received mandatory training. At April 2016, only 77% of all required training had been completed. The trust explained that they had difficulties with their training recording system as there was a lag between local data and the trustwide database. Just prior to the inspection the trust told us overall training levels had increased to 84%.

In April 2016, the trust figures showed there was particularly low uptake for training in immediate life support (37%), manual handling (43%), physical interventions (50%), rapid tranquilisation (50%), basic life support (51%), personal safety, fire training, medicines management (all 61%), Mental Health Act (63%), infection control (68%) and suicide prevention (69%).

We looked at local training data at all services we visited. Generally, this indicated that staff had completed most mandatory training but this had not been captured by the trust's systems. However, we were concerned about training compliance at the acute units and PICUs, where overall compliance was 68%, CAMHS community services at 71% and CAMHs inpatient services at 73%. We were very concerned about compliance at the PICU Lark Ward where only 2.5% of staff had undertaken immediate life support and 68% physical intervention training.

Assessing and managing risk to patients and staff

We looked at the quality of individual risk assessments across all the services we inspected. In most services these were in place and addressed people's risks. Within forensic and older people's wards these had improved greatly since our previous inspection. However, we found that risk assessments were not always updated for people following incidents of concern or changes to an individual's needs within acute services. At Northgate Hospital we found that there was no formal risk assessment in place for people within the place of safety. We were concerned that in the CAMHs service risk assessments were not completed following the first face to face assessment of young people in a timely manner. Within learning disability services patients' risk assessment for fluids and nutrition lacked detail. In older people's community teams many risk assessments lacked detail.

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

The trust had clear policies in place relating to safeguarding and whistleblowing procedures. Additional safeguarding guidance was available to staff via the trust's intranet. We found that most staff had received 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 and could demonstrate how to report concerns. We saw examples of safeguarding documents in records which were completed accurately. A governance process was in place that looked at safeguarding issues at both a trust and at directorate levels on a regular basis.

Restrictive practice, seclusion and restraint

The deputy director of nursing was executive lead for restrictive practice. In 2014 a working group had been set up to oversee a work programme to meet the Department of Health's 'Positive and Proactive Care: reducing the need for restrictive interventions'. Since then, this programme had considered the six key reduction strategies. Work undertaken had included a review of all relevant policies and training delivery, benchmarking against other services, development of supportive behaviour plans, and involvement in the safe wards initiative. Restrictive interventions have been monitored via the patient safety group meeting and reported to the board on a quarterly basis.

As part of this programme, the prevention and management of aggression (PMA) training was reviewed and the trust decided to deliver this training in house. Training had been developed to ensure that supine (face up) interventions were taught as the safest way to intervene on the floor and prone restraint was only used as a last resort. A team was set up to deliver this training from

Are services safe?

January 2016. Accreditation had also been gained for this training. PMA trainers had been aligned to clinical areas and positive practice champions recruited to support staff in managing complex presentations. Other initiatives were underway to support the reduction of restrictive interventions. These included the implementation of 'safe-wards', the use of positive behaviour support plans and more rigorous monitoring of restrictive interventions.

Ahead of this inspection data supplied by the trust suggested that only 50% of staff had received restrictive intervention training. However, at inspection the trust clarified this figure was incorrect and nearer 75% of staff had been trained. The trust confirmed they were working on recording relating to training. We looked at local training records for staff at all services we visited. Generally, these confirmed that relevant staff had undertaken the training. At services, staff confirmed they were working towards reducing the use of restraint and focussing more on de-escalation as recommended in best practice guidelines. Staff told us that they would avoid prone restraint and if a patient was in the prone position they would try to turn them over at the earliest opportunity. We observed a number of examples of staff managing patients' aggressive behaviour effectively with an emphasis on de-escalation techniques.

Policies and procedures were in place and had been updated covering the management of aggression, physical intervention, seclusion and segregation. The trust told us that they had updated these policies and they had been reviewed to reflect latest guidance regarding the safe management of patients in a prone position and addressed the specialist needs of children or people with a learning disability, autism or a physical condition. The seclusion and segregation policies had been reviewed to reflect the updated Mental Health Act Code of Practice.

The use of restraint and seclusion were defined as reportable incidents at the trust. The trust told us that overall rates of restraint had reduced and that there had been a reduction in prone restraint, in line with the trust's target for a 10% reduction in 2015/16. During the period there had been 61 prone restraints per month, compared to 76 incidents per month in 2014/15. However, the trust acknowledged that the overall incidents of physical restraint reported in 2015/16 had increased slightly and remained above the national average at 224 per month. The physical intervention lead told us that this was due to the trust having improved its overall reporting of all incidents, including restrictive practice. Further work was underway to help staff identify differing levels of interventions and so to ensure more refined recording and reporting of the types of interventions used.

Prior to the visit we asked the trust for detailed restraint, seclusion and rapid tranquilisation figures. Restraint was used on 1345 occasions in the six months to March 2016. Of these, face down (prone) restraint was used on 394 occasions. This equated to almost 27% of all restraints, which was an improvement since the last inspection but remained high in acute and learning disability services. The majority of all restraints had occurred at the acute wards which together with the PICUs had used restraint on 766 occasions equating to 57% of all restraints. These wards also had the majority of prone restraints at 286 incidents equating to 21% of all prone restraints.

The data indicated that 184 of prone restraints (47% overall) had resulted in rapid tranquilisation. However, we found that staff on Abbeygate ward did not always complete incident forms after giving rapid tranquilisation injections.

We were also concerned that staff on Abbeygate ward and in acute services. had not always undertaken the physical health observations required following rapid tranquilisation

The trust reported that seclusion was used on 347 occasions during the same period. The trust stated that there had also been 14 uses of long term segregation. The majority of episodes of seclusion had occurred in acute wards where seclusion had been used on 252 occasions equating to 73%. The trust told us that the number of recorded seclusion events averaged 52 per month in 2015/16, which was a 15% reduction on 2014-2015.

In 2014, we had serious concerns about seclusion practice at the trust. During this inspection we reviewed seclusion practice across all services. We found concerns about the safety of a number of seclusion facilities as outlined above under environment. Generally, we saw improved seclusion practice and found that the trust was auditing the seclusion process and records against policy. However, some concerns remain:

- We found poorly documented seclusion records in forensic, older people's, acute and PICU wards. The electronic record system did not support seamless

records and it was difficult to navigate the system. Staff were unable to find information, and spent a disproportionate length of time trying to ascertain if the patient received appropriate care in seclusion. We noted that doctors did not always write entries, there were missing times of when seclusion ended, and terminology such as 'open' seclusion was used on occasion. It was also not always clear when seclusion became long-term segregation.

- It was not possible to confirm if staff regularly offered food and fluids to patients during seclusion, as staff did not routinely record this.
- In acute services there were standardised care plans in place regarding the use of least restrictive practice and no personal views were reflected. On Waveney ward, three care plans included a seclusion plan or consideration for transfer to a PICU when this was not clinically indicated. Those care plans were inaccurate.
- Some ward managers in acute services explained that seclusion reviews were not consistently taking place within the Mental Health Act and trust policy timeframe due to inadequate out of hours medical cover being available to respond immediately.
- In older people's services Willow Ward had no designated seclusion area and staff told us the low stimulus room was not used to seclude patients. However, trust information from October 2015 to March 2016 showed that seclusion had occurred on 10 occasions. For one patient on Abbeygate who had been secluded there was no doctor's review documented despite staff saying they had contacted one.

Patients were not subject to blanket restrictions. Most ward entrances were locked with entry and exit controlled by staff. However, there were signs displayed on the doors providing information on their right to leave for informal patients. We observed patients being able to leave the wards where appropriate.

Medicines management

When we inspected in 2014 we found that at eight inpatient units and seven community teams there were not appropriate procedures in place for the administration, management, storage and audit of medications. In addition, we found that temperature checks necessary for ensuring the integrity of medications had not always been undertaken. At this inspection, we found that there had been some improvement to the administration, management, storage and audit of medications however concerns remain about the temperature checks necessary for ensuring the integrity of medications.

In response to the NHS England and MHRA patient safety alert: Improving medication error incident reporting and learning (March 2014) the trust had appointed a Medicine Safety Officer (MSO) who had the responsibility to oversee medication error incident reporting.

Pharmacists and pharmacist technicians visited wards to check patients' prescription charts and ensure medicines were available. They were involved in patients' medicine requirements from the point of admission through to discharge. This included undertaking a check of patients' medicines on admission to check what current medicines the patient was prescribed.

Checks were also made to ensure that any known allergies or sensitivities to medicines were recorded accurately on patients' prescription charts. Clinical pharmacists were regularly involved in inpatient multidisciplinary team meetings to discuss patients' medicine requirements. However, there was no medicines management input within the community teams. This could have resulted in an increased risk of incorrect safe and secure handling of medicines and unsafe practice in relation to the administration and prescribing of medicines.

Arrangements were in place to check that medicines in inpatient areas were stored securely and within safe temperature ranges using a regular audit tool. We found that medicines were stored securely with access restricted to authorised staff. Temperature records of inpatient medication clinic rooms were recorded daily and had further regular checks to ensure this was done. However, although we found that the temperature in the rooms containing medication on some of the inpatient wards was recorded as above 25 degrees, no action was taken. In addition, arrangements were not in place to check that medicines were within safe temperature ranges at the crisis team based at Hellesdon hospital, as the room containing medication was not monitored. In acute wards we found that on one ward the fridge temperature monitoring was not always carried out as per trust policy. Appropriate action regarding temperatures outside correct range was not undertaken on three wards.

Inadequate

Are services safe?

The trust was non-compliant with Controlled Drug legislation, when ordering and administering controlled drug at wards based at Wedgwood House, Northgate Hospital and Thurne Ward.

An up to date policy covering rapid tranquilisation, which was based on the current NICE guidance NG10 dated May 2015, was available. It advised on how to treat patients in order to manage episodes of agitation, when other calming or distraction techniques had failed to work. We found the prescribing at the trust to be in line with the policy and NICE guidelines. However, we saw that rapid tranquilisation was not always reported, using the incident reporting system, as stated in the trust's policy. The trust used this data to monitor its' use of rapid tranquilisation as it did not carry out a specific audit. This would result in an under reporting of its use. In addition, we found that the monitoring of patients vital signs post rapid tranquilisation, as recommended by NICE guidelines NG10, was not always documented in the patient records.

We saw appropriate arrangements were in place for recording the administration of medicines. These records were clear and fully completed, except at the Woodlands Unit and Lark Ward, where we found a number of missed medication doses. One patient on Lark Ward had 19 gaps in the medication record. These records were then unable to show that patients were getting their medicines when they needed them.

In substance misuse services staff at Hellesdon Hospital were not logging the prescription numbers of prescriptions stored within boxes. Staff did not carry out any audits with regard to unopened boxes held in the storage area, meaning that they would not know if any prescriptions went missing.

Documentation for the administration of covert medicines was not always up to date.

Track record on safety

When we inspected in 2014 we were concerned that while the trust had systems in place to report incidents, improvement was needed to ensure learning or action.

We reviewed all information available to us about the trust including information regarding incidents prior to the inspection. A serious incident known as a 'never event' is where it is so serious that it should never happen. The trust had reported no 'never events' between May 2015 and May 2016 through STEIS (Strategic Executive Information System). We did not find any other incidents that should have been classified as never events during our inspection.

Since 2004, trusts have been encouraged to report all patient safety incidents to the National Reporting and Learning System (NRLS). Since 2010, it has been mandatory for trusts to report all death or severe harm incidents to the CQC via the NRLS. Between April 2015 and September 2015 the trust had reported 8,803 incidents to the NRLS.

There were 31 incidents categorised as death during the period and a further 8 had resulted in severe harm. When benchmarked, the trust was in the highest 25% of reporters of incidents when compared with similar trusts. The NRLS considers trusts that report more incidents than average and have a higher proportion of reported incidents that are no or low harm to have a maturing safety culture. Also, the trust reported 77% of no harm incidents compared to the national average of 62%.

Between 15 January 2015 and 12 March 2016 there were 215 serious incidents which required further investigation. The majority of these were 'unexpected or avoidable death' at 152 incidents. The majority of deaths had occurred in community adult services at 61. The majority of inpatient deaths had occurred in acute services at six incidents. During our inspection the trust confirmed that there had been 55 deaths since April 2016 which were under investigation.

Overall, the trust had improved its reporting rates and had been a good reporter of incidents during 2015/16 when compared to trusts of a similar size. It was noted that the overall rates of severe and moderate incidents decreased during the reporting period.

In February 2016, the trust commissioned an external company, Verita, to undertake an independent review of unexpected deaths at the trust between April 2012 and December 2015. During this period there had been 686 deaths of which 405 of these incidents were investigated as serious incidents, as they were not due to natural causes. 620 of these deaths had occurred in the community while 51 deaths had occurred in inpatient units. 14 people had been detained at the time of their death. Overall, it was found that the trust's root cause analysis investigation process met national requirements but improvements were needed to procedures following a death and the

actions taken following the investigation. The review did not highlight themes in relation to patient factors and service level issues from the incidents but found that the majority of the investigation reports reviewed featured recommendations that were not 'SMART'. There were additional concerns about the trust's process for engaging and supporting families after a death, although the report found there had been some improvement in later investigations. The report made 13 recommendations including that there needed to be more detailed and informed discussion at board meetings about unexpected deaths and more cohesive governance structures to ensure that learning is being applied across the trust.

Following this review the trust developed an action plan to address these issues. The trust told us that key work to meet this challenge would include changes to the investigation process including clearer terms of reference and tools, improved training for investigators, audit and quality review of investigations, more openness and transparency with families following incidents. The trust told us they were aiming for a zero tolerance of suicide. At the time of the inspection the trust was delivering public consultation events on its renewed suicide prevention strategy, with an aim to publish this in September 2016. Events had included staff and services users. The trust was bringing together the two suicide working groups that existed in Norfolk and Suffolk and more detailed reporting was being developed for the board. During this inspection we looked at these actions in some detail. We found that work had begun on all required actions but further work was needed.

The National Safety Thermometer is a national prevalence audit which allows the trust to establish a baseline against which they can track improvement. The trust participates in this initiative within older adult services. The harms that are relevant for the trust include rates for falls resulting in harm, and new pressure ulcers and new cases of catheter and urinary tract infections, acquired whilst under the trust's care. The target for compliance is 95%. At May 2016 the trust had scored 91%.

The Ministry of Justice publishes all Schedule 5 recommendations which had been made by the local coroners with the intention of learning lessons from the cause of death and preventing deaths. Six concerns had been raised about the trust since July 2014.

Reporting incidents and learning from when things go wrong

The staff survey 2015 had indicated that incident reporting was below average at the trust. It also indicated that staff did not always feel they would be supported following a report or thought that procedures were fair and effective.

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

Where serious incidents had happened we saw that investigations were usually carried out. However, in acute and older people's wards we found that not all incidents found in continuous notes were recorded on the incident reporting system.

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

Duty of Candour

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

The independent review of unexpected deaths at the trust in February 2016 (Verita Report), highlighted concerns about the trust's process for engaging and supporting families after a death although the report found there had been some improvement in later investigations. The trust told us that they were working hard to address this issue.

The trust had taken a number of actions to meet this requirement. In 2014, the trust provided briefings to staff and managers. Since, a policy and guidance document had

been signed off by the board in November 2015. Incident systems had been amended to capture duty of candour considerations; the patient safety team take an overview of action taken to meet this duty. Duty of candour consideration had been included in trust induction training and training for incident investigators. The board were sighted each month via the patient safety report on any concerns were duty of candour considerations have been included.

We examined case records where patients had experienced a notifiable event to check that staff had been open and honest in their dealings with patients and carers. We found

within records evidence that the trust was meeting its duty of candour responsibilities. Staff we spoke with in services were aware of the duty of candour requirements in relation to their role. However, we spoke with some relatives who did not believe the trust was meeting their obligations under the Duty Of Candour following incidents involving their loved ones.

Anticipation and planning of risk

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 learning disability community teams and some crisis teams told us that there were not safe working practices in place.

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

Emergency resuscitation equipment was available and regularly checked in most inpatient services. Equipment, including resuscitators, were well-maintained, clean and checked regularly. However, this was not the case in Abbeygate and Foxglove wards ward where the defibrillator and emergency bags were not always checked. We were concerned that not all staff had received life support training.

Requires improvement

Are services effective?

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

Summary of findings

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

- While access to a single record had been addressed by the application of the electronic system, we were very concerned about the performance of this system and the impact this had on staff.
- Care plans were not always in place or updated when people's needs changed in community adults, rehabilitation and older people's services. People's involvement in their care plans varied across the services.
- Not all staff had received appraisal or supervision. Systems for recording levels of supervision and appraisal were also not effective.
- There were poor levels of training and procedures were not always followed in the application of the Mental Capacity Act.
- Training in the Mental Health Act was also insufficient.

However:

- People's needs, including physical health needs, were usually assessed and care and treatment was delivered to meet them.
- Generally, people received care based on a comprehensive assessment of individual need and services used evidence based models of treatment.
- The trust had participated in a range of patient outcome audits.
- Generally, we saw good multidisciplinary working.
- Overall, systems were in place to ensure compliance with the Mental Health Act (MHA) and the guiding principles of the Mental Health Act MHA Code of Practice.

Our findings

Assessment of needs and planning of care

In 2014, the trust had a number of different records systems. 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. Since then, the trust had introduced a new electronic records system which was rolled out across the whole trust so that there was only one system that all staff would use to record all patient information. While access to a single record had been addressed by the application of the system, we are very concerned about the performance of this system and the impact this had on staff. We heard that the roll out of this system had not been well managed. We observed that it was difficult to establish a contemporaneous record of patient care. We also observed technical problems with the system that staff could not always access records. We acknowledge the trust's attempt to resolve these issues but remain concerned about the risks this had on safe patient care.

The Care Quality Commission community mental health survey 2015 was sent to people who received community mental health services from the trust to find out about their experiences of care and treatment. Overall, the trust was performing about the same as other trusts across in all areas. 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. This was slightly improved results against the previous community mental health survey.

Generally we found the care plans were detailed, individualised to the patients' needs and showed the patients' involvement in the care planning process. In the majority of mental health services, people's care needs and risks were assessed and care plans had been put in place. However, this was not the case at some of the in acute, learning disability and child and adolescent services. In addition, at acute and older peoples services the quality of

care plans varied and some lacked sufficient detail. In the majority of services, care plans had been reviewed following changes to people's needs, and risk assessments had been updated. However, care plans had not always been reviewed in acute services. Most care plans indicated the involvement of the patient. This was not the case within acute, children's inpatient, and older people's community services. However, we did find that patients were generally knowledgeable about their care.

Within services patients' physical health needs were usually identified. Patients had a physical healthcare check completed by the doctor on admission and their physical healthcare needs were being met. Physical health examinations and assessments were usually documented by medical staff following the patients' admission to the ward. Ongoing monitoring of physical health problems was taking place. However, we were also concerned that staff did not complete or record physical healthcare checks in 19 care records for those admitted to the health based place of safety suite at Northgate Hospital.

In May 2016, the trust had not met its target for CPA patients having a formal review within 12 months. The trust had scored 86% against a target of 95%. The trust acknowledged this and said they were working hard to address this. In community adult services, we found that documentation relating to care programme approach (CPA) reviews was lacking in some records. There was no evidence that a face to face, fully attended formal CPA review had taken place in some cases. This meant that we could not be certain that all patients had received a full formal CPA Review as required.

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).

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

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. Staff recorded in care notes if patients refused to have their physical health monitored. Staff repeatedly encouraged patients to engage with them.

During 2015/16 the trust 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 suicide prevention, medication, clinical outcomes, care planning, Mental Health Act and Mental Capacity Act administration, application of NICE guidance, physical healthcare and patient satisfaction. We found that most teams had some involvement with audit. One psychologist in an integrated delivery team had been given a day per week funded to promote a 'research friendly' environment within the trust.

All trusts must comply with the NHS England 'accessible information standards' by 31 July 2016 in regard to access to healthcare for people with a learning disability. The trust had undertaken a trust-wide audit using the Green Light Toolkit. This audit aims to assess whether services are appropriate for people with a learning disability. Since the trust had recruited 76 greenlight champions, communication packs for people with learning disability or autism had been developed and information had been made more accessible through the availability of easy read

versions. The trust recognised that the electronic record system created some challenges to full compliance due to the requirement of easy read care plans and risk assessments.

Skilled staff to deliver care

In the 2015 NHS Staff Survey, the trust had a response rate of 52%, which is above average for mental health trusts in England and compares with a response rate of 36% for this trust in the 2014 survey. The trust scored worse than average for appraisal quality and frequency.

Staff were usually able to access specialist training. However, within learning disability and older people's community teams we were told that staff did not have access to client group specific training. Support workers were undertaking the care certificate as appropriate.

In 2014, we were concerned about supervision and appraisal rates. At this inspection, data available at a trust level indicated poor compliance with these. The trust explained that they had difficulties with their recording systems for supervision and appraisal as there was a lag between local data and the trustwide database. While local records confirmed better compliance, it is concerning that senior management did not have access to reliable data to understand their compliance with these requirements. It was noted that levels of clinical supervision were previously recorded on the trust risk register but this risk was closed in March 2016.

At June 2016 trust level supervision rates were 59% and appraisal rates were 63%. 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. The trust told us they were working hard to address this and aimed to be compliant with the 90% target by September 2016. In July 2016, the Deputy Director of Nursing convened a focus group with a view to reviewing the clinical supervision policy to ensure a more realistic understanding of clinical supervision. The trust was also improving data collection processes for supervision.

Multi-disciplinary and inter-agency team work

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

At most teams we saw input from occupational therapists, psychologists, pharmacy and the independent advocacy services. Some teams had peer support workers which assisted with ensuring patient involvement in planning meetings. However, in learning disability services we were told that there was no access to psychologists and occupational therapy. In older people's services there was a lack of access to a speech and language therapist which meant specialist assessments were delayed. We found some services were short of medical cover which could affect multidisciplinary working.

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 however, most community teams had social workers co-located within the team base. In Suffolk, section 75 agreements were in place which meant that teams had integrated social workers.

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 Mental Health Act and the Mental Health Act Code of Practice

A mental health law forum had overall responsibility for the application of the Mental Health Act (MHA) and the Mental Capacity Act (MCA). The forum reported to the quality governance committee. The Trust conducted a bi-monthly MHA administration heat map which identified trends and highlighted areas of concern. The trust collated MHA activity and ethnicity quarterly. The hospital managers

provided an 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.

We met with the hospital managers and were informed that they link with the MHA manager. We were told that the hospital managers met quarterly and received training relevant to their role. This training programme covered issues of clinical importance, policy and procedures, and legal aspects including the MHA Code of Practice.

We looked at procedures for the assessment of people under the MHA. 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.

Mental Health Act records were generally in good order. There was a clear process and system in place for the administration of detention paperwork however some issues had not been identified by the provider but were addressed promptly when we raised them.

Overall MHA training compliance was below the trust target at 69%.

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.

Seclusion and long term segregation was practiced at a number of the services we visited. At the Norvic Clinic and Hellesdon Hospital the seclusion rooms did not meet the required standards as set out by the Code of Practice. Seclusion paperwork was inconsistent. We found incomplete paperwork across the trust. It was not always clear when seclusion became long-term segregation.

We reviewed practice under section 136 of the MHA in detail. Staff at the health based places of safety appeared to be knowledgeable about the MHA and 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 in those records reviewed. However, we found that patients were not always given their rights under section 132.

People detained under Section 136 were rarely conveyed to the health based places of safety by the ambulance service. In most cases people were transported by the police. This did not adhere to the MHA Code of Practice, which states that police should convey in exceptional circumstances only.

The provider did not have robust systems in place to assess and record people's mental capacity to make decisions. There was no MCA audit process in place within the trust. The MCA lead was employed by a local CCG and was hosted by the trust three days a week. There was a lack of clarity around the interface between the MHA and MCA. We found several examples where people had their MHA section rescinded and were then placed onto the MCA with no clear rationale as to why.

Good practice in applying the Mental Capacity Act

A mental health law forum had overall responsibility for the application of the Mental Capacity Act (MCA). The forum reported to the quality governance committee.

The trust had compliance with capacity recording as one of its quality priorities for 2016/17. The trust told us that they had recognised that this area worked required improvement. At May 2016, there was a key risk flagged to the board of not meeting the target for recording of patient's capacity.

Training rates for staff in the Mental Capacity Act were not good with just 73% of staff trained at the end of March 2016.

Generally, staff had an awareness of the Mental Capacity Act and the deprivation of liberty safeguards. However, some staff in the learning disability teams were not confident in carrying out decision specific mental capacity assessments, and where they identified this need, deferred the assessment to psychologist and consultant psychiatrist colleagues. We saw some units where recent mental capacity assessments and best interest decisions had been carried out where applicable. However we found that not all patients had had their mental capacity recorded within community adult teams, crisis services and older people's units.

We had specific concerns within older people's services about procedures under the MCA. We found that patients were being taken off the Mental Health Act and a deprivation of liberty authorisation applied for.

Requires improvement

Are services effective?

Assessments by the local authority were delayed and trust records did not always capture how the patient's capacity to give consent to their treatment and care was assessed or managed in the interim. Staff's assessment and recording of 'do not attempt resuscitation' decisions was also inconsistent on Rose and Sandringham wards.

86 Deprivation of Liberty Safeguards applications were made between October 2015 and March 2016. Of these 28 were authorised. It was noted that not all of these had been notified to CQC as required under regulation. Rose ward made the highest number of applications however Reed Ward had the most applications authorised.

Good

Are services caring?

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

Summary of findings

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

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

However:

- In learning disability, CAMHs and older people's services patients had not always been involved in developing or reviewing their care plans.

Our findings

Kindness, dignity, respect and support

We observed some very positive examples of staff providing emotional support to people across all services visited. We saw that staff were kind, caring and compassionate in their response to people. We observed many instances of staff treating patients with respect and communicating effectively with them. We saw staff working with patients to reduce their anxiety and behavioural disturbance. Staff demonstrated that they wanted to provide high quality care and were knowledgeable about the history, possible risks and support needs of the people they cared for.

When we inspected the trust in 2014, we had concerns about the punitive attitude of some staff at the Norvic Clinic. At this inspection, we found that staff interacted with patients in a caring and respectful manner and remained interested when engaging patients in meaningful activities. Patients reported they felt safe on their wards. The majority of staff were supportive of them and their individual needs, even during restraint and seclusion.

We were impressed with the care provided by staff in the crisis teams. We observed face-to-face interactions and telephone conversations with patients in distress where staff showed care, empathy and knew their patients well. Staff demonstrated commitment to and passion for their role.

Staff interactions were usually responsive and timely to patient's requests and needs. However, we had some concerns about people's privacy and dignity being protected in the learning disability service.

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

We were told that staff respected people's personal, cultural and religious needs. We saw some very good examples of the trust attempting to deliver services in line with peoples' cultural needs.

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

The involvement of people in the care they receive

Good

Are services caring?

In 2014, we saw some very good examples of care plans being person centred. However, not all care plans indicated the involvement of the service user.

The trust told us that patient involvement in their care was a key quality priority for 2016/17. They had set a target at 90% for patients reporting that had been involved in their care though the user survey.

The Care Quality Commission community mental health survey 2015 was sent to people who received community mental health services from the trust to find out about their experiences of care and treatment. Overall, the trust was performing about the same as other trusts across in all areas. 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. 7 out of 10 felt they were involved as much as they wanted to be in decisions about the medicines they received. This was slightly improved results against the previous community mental health survey.

In the final quarter of 2015, Healthwatch Suffolk and Suffolk User Forum (SUF) carried out a survey of the trust's patients and their carers. The survey received 119 responses. Key recommendations from this included the need for improved information between assessments and a renewed effort to allow all service users to be a part of their care planning.

In July 2015, the trust had audited involvement of patients in decisions about prescribed medicines. Although small scale, audit results shows that adherence to standards were generally poor overall, no wards fully met required standards. 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. This was however not always the case in acute and older people's wards.

We saw some very good examples of care plans being person centred. However, at acute and older people's wards not all care plans indicated the involvement of the service user. In all services we found that there was an opportunity for patients to attend care planning meetings.

When we inspected the trust in 2014, we found that patients at the Norvic Clinic had not been involved in developing their care plans. At this inspection, we found that patients were actively involved in the writing of their care plans and risk assessments, and attended weekly ward rounds and care programme approach meetings.

We found a number of examples of relatives being involved in care planning where this was appropriate. We observed that where a patient was unable to be actively involved in the planning of their care, or where they wanted additional support, staff involved family members with the patients' consent. At the CAMHs ward we saw that with consent from the young person, families and carers had appropriate involvement in the young person's care, this included being invited to care programme approach meetings. However, at the CAMHs community teams this was not always the case.

Inpatient services orientated people to the ward on admission. At most services we found welcome packs that included detailed information about the ward philosophy, the staff present on the ward, ward activities, Mental Health Act information and how to complain. Notice boards on the wards held a variety of information for patients and carers. A range of information leaflets about the services were available. Almost all patients we spoke with told us that they were given good information when they were admitted to the wards. Some patients told us that staff had taken time to clearly explain ward procedures when they had been unclear or confused. Most detained patients told us that staff had explained their rights under the Mental Health Act.

Patients had access to advocacy including an independent mental health advocate (IMHA). There was information on the notice boards at most wards on how to access these services. Arrangements were also in place to access independent mental capacity advocates (IMCA) and we saw examples of where this was actively promoted. Most patients were aware of advocacy but not all had used the service. Posters containing advocacy information and contact details were visible on wards.

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

Good

Are services caring?

their visitors. At most services there were specific children's visiting areas. Older people's wards had recently implemented flexible visiting times to encourage carer involvement.

The trust had a combined service user and carers' involvement policy. This with the clinical strategy priorities 2016/2017 set out a commitment for working in partnership with service users, carers and wider stakeholders. This work was overseen by a trust wide service user and carer partnership. The trust had a number of carers' forums and inpatient services had community meetings to engage patients in the planning of the service and to capture feedback. In most services this meeting was chaired by patients and was attended by relevant ward staff. Minutes were usually taken and we saw evidence of actions that were raised being completed. Patients told us they felt able to raise concerns in the community meetings and that they usually felt listened to.

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 had implemented the 'triangle of care' toolkit which provides an accredited framework to develop carer involvement within local services. This was developed by carers and mental health staff to improve carer engagement in acute inpatient and home treatment services. The trust had undertaken 13 carer events and all teams had recruited a carers' champion. This programme was evaluated in 2015 and was awarded a gold star for positive performance.

At the Learning Disability Service (CAMHS) Waveney, a group aimed at supporting patients siblings had been developed and implemented. Patients were encouraged to develop and maintain independence, whilst patients' families were appropriately included and involved in the care and treatment of their relatives.

The trust had used the Friends and Families Test (FFT) since 2014. At November 2015 the results indicated that 77% of patient respondents were likely or extremely likely to recommend the trust services. The response to the test demonstrated a fluctuating picture of satisfaction during the 12 months before our inspection at between 77 and 98%. However, all months were higher than the trust's own target of 71%. There had been a good participation rate by former inpatients at between 45 and 63%. However, there was poor response from former community patients at between 7 and 16% during the period.

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

Requires improvement

Are services responsive to people's needs?

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

Summary of findings

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

- There remained a shortage of beds across the trust and that this had impaired patient safety and treatment at times. 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. However, an out of hours service was not commissioned in some areas for people over the age of 65 with dementia. 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 impacted on people's dignity.

However:

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

Our findings

Access and discharge

When we inspected in 2014, we found that access to the crisis service across the trust was generally good during the day but there was not an out of hours' service commissioned for children and adolescents or in some areas for people over the age of 65 with dementia in crisis.

The trust managed access to services via three separate teams. The access and focused intervention team in Great Yarmouth, and the access and assessment teams in Norfolk and Suffolk. The teams provided advice, guidance and a triage which prioritised referrals according to risk and identified need.

The trust's target for seeing people in an emergency was 4 hours and 72 hours to see those with urgent needs. However, staff were not clear if they needed to make contact with patients referred to them by telephone or face-to-face to meet these targets. The trust was not meeting targets for emergency referrals between January 2016 and June 2016. Crisis teams in Suffolk had 43 cases (7%) that did not meet this target. Crisis teams in Norfolk had 535 cases (93%) that did not meet this target. The access and assessment team in Suffolk did not meet this target in four cases (17%). The access and assessment team in Suffolk also did not meet the target for urgent referrals in 32% of cases over the three months prior to our inspection. In Suffolk, Clinical Commissioning Groups (CCGs) had implemented a remedial action plan to address failings in meeting targets. At the time of our inspection the trust had not met the national target at 95% of admissions to acute wards being gate-kept by crisis teams.

At psychiatric liaison services there have been 109 breaches of the A&E 4 hour waiting standard between October 2015 and March 2016. However, when we inspected we found the teams were responsive to targets set for responding to patients attending A&E services with a mental health crisis. Of those who attended A&E 99% of patients were seen within one hour and discharged within four hours. No patients stayed for longer than eight hours.

We found that crisis services were available to young people but access arrangements to services for older people in a crisis remained complicated. The trust told us that emergency and urgent referrals were responded to within timescales set by the trust and managers told us

there were no waiting lists for routine assessments. In central Norfolk and Waveney, the dementia intensive support team provided emergency and crisis support until nine pm. However, the Suffolk intensive support services did not provide out of hours crisis support. People with dementia in crisis would seek support from out of hours' GP services or emergency services. In King's Lynn there was a crisis team but they did not work with people with dementia.

Those patients known to crisis services had access to a crisis line. At night, in one crisis service the telephone was re-directed to the acute ward if staff from the crisis team were out of the office with a patient or travelling to an appointment. This meant a patient might not speak to someone who knew him or her well. In other services, staff carried a mobile phone and, when they were unavailable, patients could leave a message. Staff told us they always contacted patients as soon as they were able. However, if a member of the public was not known to crisis services and they needed help for a mental health crisis they had to telephone 111, wait to see their GP or attend A&E.

Substance misuse services facilitated a 24/7 emergency phone line for clients, which was managed by recovery staff. Staff did not feel that the service was being utilised by clients effectively and felt they were insufficiently trained to manage the calls they received.

The crisis teams also worked with people until they could be handed over to community teams. Staff reported they had difficulty discharging patients to the care of community mental health teams. Crisis teams were reluctant to discharge patients from their caseloads until patients had been allocated permanent care co-ordinators. The trust provided us with data that four patients at the crisis and home treatment team at Hellesdon had a delayed discharge due to a permanent care co-ordinator not being allocated. There was no mechanism to record or retrieve data to monitor discharges from home treatment and crisis teams to community teams where a permanent care co-ordinator was allocated. As a result, the trust was not able to measure the responsiveness of its provision.

In 2014, the trust had obtained funding to pilot a scheme where nurses accompany police officers in a triage car with the aim of reducing the use of Section 136 detention at the Woodlands unit in Suffolk. The trust had fully implemented this in Suffolk, in co-operation with the police service.

There were five health-based places of safety across Norfolk and Suffolk. There were delays in an approved mental health professional (AMHP) attending health based places of safety out of hours. 38% of cases had an AMHP arrive after a four hour period. The longest wait for an AMHP to arrive was 16.5 hours at Woodlands. Data also showed that in most cases, police vehicles were used to transport patients to the health based place of safety. Only 32% of patients admitted to the health based place of safety were brought by ambulance as required by the Mental Health Act code of practice. The trust had recently contracted a secure transport provider with a two hour response rate to reduce these delays.

Community teams had targets for urgent and routine assessments following referral. Generally, these were being met but in older people's teams referral to assessment times varied across the service. Teams in Norfolk were meeting these targets however, teams in Suffolk were not. Referral to treatment targets differed across service type and locality. Trust data provided showed that most services were meeting their targets for referral to treatment times. However, in some teams, particularly in older people's, learning disability and child and adolescent services, patients had been assessed but were awaiting allocation to a care coordinator.

Most teams were flexible in arranging appointments with people at times that were best for them and mostly visited people in their own home. However in community child and adolescent teams we saw many appointments were offered during school hours. Appointments were rarely cancelled and when they were people were usually contacted with an explanation and the appointment rearranged. However, in the Coastal integrated team at Ipswich clinics were cancelled on a regular basis. Most teams had procedures for when a person did not attend an appointment. Managers told us that they actively tried to engage with people who were reluctant to engage with services. People who did not attend an appointment were contacted again by phone or letter and efforts were made to rearrange.

When we inspected in 2014, we found that there was a shortage of beds across the trust. This meant that people may have been moved, discharged early or managed within an inappropriate service.

The trust monitored bed occupancy rates. Between October 2015 and March 2016 average bed occupancy rates

Requires improvement

Are services responsive to people's needs?

at the trust stood at 89% across all services. It is generally accepted that when occupancy rates rise above 85%, it can start to affect the quality of care provided to patients. Between October 2015 and March 2016, 25 of 36 wards had averaged over 85%. Three wards had over 100% bed occupancy, acute wards Churchill (113%) and Waveney Ward (108%) and older people's ward Rose (102%). It was noted that the PICU in Norfolk had occupancy rates of 95% while the PICU in Suffolk had 67%.

Between October 2015 and March 2016, 321 patients had been cared for on more than two separate wards during a single admission episode. This had not included transfers from a PICU to another ward.

The trust had increased the overall numbers of acute beds. During this inspection, there were beds available on five acute wards however staff acknowledged this was unusual. Locality managers told us they had weekly telephone calls regarding bed availability in their area to assess and monitor bed availability and risks. Community and crisis team members told us that there remained difficulty in arranging hospital admission for people whose mental health had deteriorated and that there were insufficient beds. They said that on several occasions when Mental Health Act assessments of people were delayed because there were no beds available to admit people to. 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. At Rollesby PICU occupancy was high and acute ward managers and crisis teams told us that there were occasions when they had not been able to access a bed.

Bed occupancy for the child and adolescent ward between October 2015 and March 2016 was 98%.There was not a waiting list for child and adolescent beds at the time of the inspection. However staff in the community youth teams told us that young people were placed out of area on occasions, particularly if they had complex needs or were male. The trust was intending to re-provide this unit later in 2016 to address these issues.

Since our last inspection in 2014, the trust had reviewed the provision of inpatient beds for older patients with mental health needs. Managers reported that greater emphasis was placed on providing community care for patients with dementia.

Overall, the trust's specific older patients' bed capacity had decreased by nine. However, all acute inpatient units had become 'age inclusive' so patients could also be admitted to these wards. Bed occupancy exceeded 100% at times. Sandringham ward had the highest bed occupancy in May and June 2016 at 101%. Trust waiting list data showed that 12 patients, mostly women were waiting for admission to hospital at the time of our inspection.

The trust told us that they had decreased their out of area placements significantly in the previous year. They had reduced their expenditure on this by a third, saving £1million. The trust had negotiated specific contracts with local independent healthcare providers to avoid out of area placements. Between October 2015 and March 2016, there have been 81 out of area placements. 72 of these had been for patients requiring an acute or PICU bed.

At the time of the inspection, within acute services there were two patients placed outside of the trust and 13 placed within the trust but not local to their home. Trust information from April to June 2016, showed 15 out of area treatment beds arranged for older patients. Some placements were a long distance away such as Somerset. At the time of our inspection there were 11 young people in out of area placements. This meant that young people were placed away from home.

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 monitored delayed transfers of care. Between October 2015 and March 2016, there were 60 delayed discharges across the trust. The ward with the highest numbers of delayed discharges was Willow Ward. Acute and older people's wards were responsible for 82% of the cases. NHS England data (April 2015 - March 2016) showed that the reasons for the majority of the delays were: 52% were due to awaiting residential home placement or availability, 11% were due to awaiting nursing home placement and 7% were due to public funding. The trust provided details of a range of actions they are taking to attempt to resolve delays with their partners.

Acute Discharge teams had been introduced by the trust to facilitate a smooth discharge and reduce any delays occurring. The ward teams told us that they worked closely with both crisis services and community teams to ensure

Requires improvement

Are services responsive to people's needs?

continuity of care when patients were discharged from hospital. At most wards we found that arrangements for discharge were discussed and planned with the care co-ordinators and other involved care providers. Many patients told us that they were fully involved in their discharge planning.

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

Between October 2015 and March 2016, there had been 196 readmissions within 90 days of discharge. The wards with the highest number of readmissions were Great Yarmouth and Waveney Acute Service at 35, Southgate Ward with 33 and Thurne Ward with 24. All of these wards are acute wards for adults. These accounted for 92% of all readmissions within 90 days.

In June 2016, Healthwatch Norfolk conducting a survey of GP practices regarding their experiences of accessing mental health services at the trust. 46 practices responded. The survey found that most practices felt communication with mental health services was poor, with slow response rates.

The facilities promote recovery, comfort, dignity and confidentiality

Assessments undertaken under the patient-led assessment of the care environment (PLACE) reviews in 2015 identified that the trust scored better than average at 92% for the privacy, dignity and well-being element of the assessment against an England average of 86%. Two inpatient services, the Fermoy Unit and St Clements Hospital, scored just below the average at 85%. However, all other inpatient services scored above the average, with the Norvic Clinic, Northgate Hospital and Woodlands scoring above 94%.

We found some good examples of staff protecting people's privacy and promoting dignity. However, we had a number of concerns regarding mixed sex accommodation, which are set out above under the safe domain. We also found a number of concerns across the trust where people's privacy and dignity had not been promoted or maintained. These included:

- Interview rooms at the older people's community teams in Stowmarket were not soundproofed and we could hear conversations in the room next door.
- In some acute and PICU wards patients did not have access to private lockable storage.
- In older people's wards we found door vision panels were left open across most wards.
- One patient at Fernwood Ward had two out of four bedroom windows covered with privacy film which meant patients could still see into the other two windows from the garden.
- In 2014 we raised concerns about the availability of female only lounges at older people's services. At this inspection we found on Fernwood Ward there was no separate female lounge. Laurel had a female quiet area but this was in the communal area of the ward and easily accessible by male patients.
- At Abbeygate Ward we saw a woman walk into the male sleeping area without staff intervening. At Maple ward the female corridor was open both times we visited, which meant male patients could access this.
- During our visit on Rose ward, we saw that staff pushed a female patient in a wheelchair in their nightdress down a corridor.
- In the acute service three wards still had shared bedrooms. On one ward, 20 patients had to share one toilet and one bathroom for several weeks during a period of refurbishment. This was insufficient to meet demand. A second toilet refurbishment was completed during inspection.
- The entrance to the place of safety at Woodlands was open to view by the public. This compromised patients' privacy and dignity.

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. Services generally had environments that promoted recovery and activities. Wards usually had rooms for visitors, and for quiet times.

Requires improvement

Are services responsive to people's needs?

In 2014, we identified that some older people's wards were cramped and cluttered, and not dementia friendly. At this inspection, we found that, where relevant, ward environments had been improved to be more dementia friendly. Facilities promoted recovery and comfort.

At most wards patients had personalised their bedrooms were appropriate. However, at Walker Close we saw patients' bedrooms were untidy, not personalised and did not reflect patient's needs. The manager told us patients only stayed for a short period and did not need to personalise their bedrooms.

At most services patients were offered appropriate activities. Most patients told us that staff supported them to maintain independence and provided meaningful activities. However, at Walker Close there were no structured therapeutic activities taking place. Staff told us there were no planned activities and they had no occupational therapy staff for the ward. We saw from a patient's activity log that patients were offered some activities, but opportunities were limited.

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

At wards patients had access to drinks and snacks 24 hours a day. At older people's wards we saw that patients were supported to eat and drink. However, at Walker Close we observed that some staff did not provide appropriate practical support to a patient to drink.

Generally community teams had a range of rooms for patients to use, including group and individual rooms. However, the home treatment team in Suffolk did not have dedicated interview rooms to see patients. In psychiatric liaison services at Ipswich hospital there was no dedicated room for staff to see patients.

Meeting the needs of all people who use the service

The trust told us that they were committed to equality and diversity and pro-active about engaging with underrepresented groups. The trust was a finalist in the national 'Positive Practice' awards for its project (Open Mind) focussed on improving mental health services for BME communities. Work had also been undertaken on the Inspiring Progress Project. This culminated in a conference in October 2015 aimed at sharing the learning with communities and wider public.

We found a range of information available for service users regarding their care and treatment. Many of the leaflets were available in other languages. When we inspected in 2014, we were told that the trust did not have facilities to make these available in an easy read format. This had been addressed and we saw information in an easy-read format across the trust. However, there were limited leaflets available in either other languages or easy read in the community learning disability services.

At most inpatient services we saw that multi-faith rooms were available for patients to use. Spiritual care and chaplaincy was provided when requested. A Spirituality practice guide and transgender guidance leaflet had been put in place for staff to better support the diverse needs of patients. Staff told us that interpreters were available via a central request line and had been used to assist in assessing patients' needs and explaining their care and treatment.

Assessments undertaken under the patient-led assessment of the care environment (PLACE) reviews in 2015 identified that the trust scored better than average at 93% for the overall food element of the assessment against an England average of 88%. St Clements Hospital and Woodlands scored lower than the national average for food. At the majority of services we saw that there was a range of choices provided in the menu that catered for patients dietary, religious and cultural needs. However, patients at the forensic and rehabilitation services at St Clements told us that while the Halal food was good and the menu changed weekly, there was limited choice of other food to meet the dietary requirements of other religious and ethnic groups.

The majority of patients we spoke with were happy with the choice and quality of food available to them. However, at the forensic wards at St Clements, which had a score for ward food of 79%, which was below the national average, patients reported being unhappy with the quality of food. There was a lack of choice and the food was not freshly cooked.

Inpatient and community services were mainly provided from facilities that were equipped for disability access. In environments where this was not possible arrangements were in place to ensure alternative access to the service. However, at the crisis team in Hellesdon Hospital a toilet had been designated as a disabled toilet that had no disabled facilities.

Requires improvement

Are services responsive to people's needs?

Listening to and learning from concerns and 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. However, in older people's wards not all carers were sure about the complaints procedure.

The trust provided details of all complaints and contacts received between April 2015 and March 2016. There had been 592 formal complaints. The analysis of this highlighted key themes as all aspects of clinical treatment, attitude of staff and communication. The trust informed us that during the period 15% of complaints had been upheld and 32% were partially upheld. The majority of complaints were about adult community services at 56%. 50% of these complaints were 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. 56% related to adult community services. 50% of these complaints were upheld. Five complaints had been referred to the ombudsman during this time. One was upheld by the ombudsman regarding the policy following when people didn't attend appointments. During the same period the trust received 229 compliments.

The head of patient safety led on complaints work to ensure an integrated approach to patient experience information. In 2014, the trust reviewed the complaints process and made some changes. This included additional dedicated staff, a centralised recording process, clearer guidance and training for staff and governance oversight. The lead explained that all complaints are triaged to ensure any safeguarding matters raised by complaints are appropriately managed. We were told that the level of complaints had been fairly consistent since 2014 however more complaints were being upheld. Complaints were discussed at local governance meetings and at the trust-wide quality governance committee. The chief executive signs off all complaint responses. Information about the levels of complaints was presented to the board on a quarterly basis.

The trust used an online survey to analyse complainants experience following the conclusion of a complaint investigation. For 2015/16, there were 57 responses. Most people felt that the complaints process was clear and accessible. However, 25 people felt they were not adequately kept informed of the progress of their complaint.

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

Requires improvement

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 requires improvement overall for well led because:

- We found that whilst there had been some progress since 2014, the service was not yet safe, fully effective or responsive at this trust. The board needed to take further and more immediate action to address areas of inadequacy.
- The trust had reorganised its governance processes and begun to use quality information to inform performance. However, the board needed to ensure that their decisions were implemented and brought about positive improvement.
- Leadership was not yet fully embedded or effective at all levels. There was a gap in leadership and oversight at service level (triumvirate level).
- We found that whilst performance improvement tools and governance structures were in place these had not always facilitated effective learning or brought about improvement to practices.
- 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. A number of these had not been fully addressed since our last inspection in 2014.
- We reviewed the risk registers for the trust and directorates and saw that some, but not all, risks that we identified through this inspection had been included in the risk register. This showed that further work was required to ensure that all risks were fully captured and understood by the board.

However:

- At the time of the last inspection, there was a relatively new chair, chief executive and director of nursing. Since then the board had been strengthened by new appointments to the medical director and finance director roles and some non-executive roles. At this inspection the board told us that they were 'a different organisation – positive about the future, willing to learn, and continuing to improve'. We found a revitalised energy at board level with a spirit of stronger leadership.
- The board had raised their visibility through a programme of executive and non-executive visits to services, and engagement initiatives. Work had also been undertaken to simplify and standardise the operational leadership model. All localities had implemented a triumvirate management model incorporating a locality manager, a modern matron and clinical lead. These were supported by deputy matrons, and a HR and governance business partner allocated to each locality.
- The trust 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 'putting people first' programme had been the key vehicle to engage with staff. Morale was found to have significantly improved across the trust. This was evidenced by the staff element of the Friends and Family Test which indicated that there had been an increasing level of staff satisfaction since 2014.
- The board and senior management had developed a vision with strategic objectives in partnership with staff and patients.
- The trust had undertaken improvement to the environment at some services.
- The trust had improved systems for recording and learning from incidents.
- The trust had improved arrangements to engage service users and staff in the planning and development of the trust.

Our findings

Vision, values and strategy

Requires improvement

Are services well-led?

When we inspected the trust in October 2014 we found that the trust had a vision and values statement but senior staff were not able to demonstrate where the trust had made progress against these. The trust had also failed to ensure that the values were well embedded or owned by all staff.

The trust's vision and values were updated in October 2015 following an engagement exercise known as the 'putting people first project'. The trust had undertaken 2000 hours of listening exercises and had met with 1300 staff, service users and carers.

The vision was stated as: "Be a champion for positive mental health, by providing safe, effective, trusted services together with our partners". The values were stated as: "working together for better mental health: positively – respectfully – together".

To imbed further the values and behaviours the trust had delivered training to managers, revised the appraisal system to be a value based approach, and adopted values based recruitment processes. At the time of this inspection, the trust told us that they were continuing the putting people first programme and were planning to conduct further engagement in September 2016.

The trust gave us a copy of their strategy for 2016 to 2021. This included three key strategic priorities. These were:

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

The strategy was underpinned by refreshed clinical, workforce and organisational development, service user and carer, staff wellbeing, leadership, technology and estates strategies, and an operational plan. Together these set out more detailed objectives to meet this plan, as well as arrangements to monitor progress. The trust confirmed that the 'putting people first programme' had helped to inform the development of the strategies, and particularly the workforce and organisational development and clinical strategies.

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

Under priority 1 within the operational plan, the trust had key objectives to deliver trusted, effective, quality driven services' and to 'deliver their 2016/17 financial plans and stay within budget'. This was also reflected in the board assurance framework and risk register. The trust told us that they had implemented a programme management office (PMO) to help drive cost-savings and efficiency measures without compromising quality of care. The trust had met their financial plan in 2015/16 and reduced there deficit by £1.5 million. For this year, the cost improvement plans (CIPs) amounted to £10 million with a target to reduce the deficit to £4.8m. At July 2016, the trust stated they were ahead of this plan while investing heavily in better environments, additional staff, leadership development and engagement.

Most staff across services told us that since the last CQC inspection trust communication and engagement with staff for the planning and delivery of trust services had improved. Almost all staff were aware of the trust's vision and values and could describe them. Posters describing the trust's vision were on display in services. Some staff told us that they had been involved in the 'putting people first' sessions from which the values were developed. Managers showed us invitation lists for staff involvement and engagement. Some staff had recently completed awareness training relating to the trust's values. Other staff had been involved in team discussions about the values. Managers told us how values based recruitment was taking place to ensure staff were selected to uphold these values.

Some teams had developed a service statement based around the values. Most staff agreed they shared the trust's values. However, within learning disability services, possibly due to the pending organisational changes, staff were not in agreement with the trust values.

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

Good governance

When we inspected the trust in 2014 we found that, despite the trust collecting data, there was little evidence of the use of intelligence and data to inform performance. The board

could not assure us that it knew how the trust was performing and how decisions were implemented or impacted on quality. We were concerned that the board had limited oversight of the point of care. It was difficult to see how the decisions made at the board were executed and monitored. At this inspection, the trust told us that improvements in quality and safety were their highest priority and they had worked hard to address these issues and to develop better systems to capture and address risk.

The trust had an integrated board assurance framework and risk register which was reviewed monthly by the audit committee and the board. Risk registers were also in place, held at different levels of the organisation which were reviewed at directorate and locality meetings. Most key risks that had been highlighted following our last inspection were reflected within the risk registers including ligature risks, seclusion environments, staffing levels. At May 2016, key risks flagged within the board assurance framework were poor IT performance, continued low staff morale, not exiting special measures, not achieving financial sustainability and weak accountability.

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

During 2015, the chair of the trust became the chair of the quality governance committee, to ensure clearer board oversight. We saw that local governance groups were in place in all the localities and services, which also fed in to the quality governance committee.

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

At June 2016, the QIP highlighted key performance risks such as supervision and appraisal compliance, review of inpatient bed requirements and the management of section 17 leave. Key performance indicators that were below target included: sickness and vacancy rates, appraisal targets, numbers of CPA patients having formal review within 12 months, admissions to inpatient services who had access to crisis teams, data completeness, the patient safety thermometer, and waiting times.

The board also received a monthly update of performance against the quality priorities. At May 2016, good progress was noted against two of these targets. However, there was a key risk flagged of not meeting the target for recording of patient's capacity.

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

Staff demonstrated they were aware of their responsibilities in relation to governance. Most staff told us that they were aware of the governance structure and had access to performance information and meeting minutes. Most staff told us that they would escalate any risks they were aware of. Team managers confirmed that they were involved in governance groups and that they were able to raise issues through the risk register and operational groups.

During this inspection, we found that the trust had addressed a number of the specific concerns that we raised in 2014, or had plans in place to address these in the near future. We found that trust had undertaken significant work

Requires improvement

Are services well-led?

to engage with staff and their stakeholders and involve them in their plans. This had led to improved staff morale and performance. Patient satisfaction had also improved. The trust had reduced the use of agency staff, reduced out of are placements, and invested in additional staffing. Community team caseloads had also been reduced. Overall incident levels had fallen and there were a range of initiatives to encourage learning from incidents. The trust had a clearer vision and strategy, improved governance systems and performance indicators. Mental Health Act compliance had improved.

However, we found that not all issues that were highlighted in 2014 had been addressed fully and that the learning from some of these improvements had not always been applied to other areas of the trust. We continue to have concerns about some practices and resources including:

- We had some concerns about the robustness of the arrangements in relation to assessing, mitigating and managing the risks of ligature points in the patient care areas. Whilst more comprehensive ligature risk assessments and action plans were in place, they did not address all ligature risks and a number of ligature risks remained on the wards. Not all identified risks had been set a timescale in which they would be addressed.
- In 2014, we raised concerns about a large number of arrangements on wards to eliminate mixed gender accommodation. The trust had acted on the majority of these concerns however some concerns still remained, particularly in older people's services.
- We had a number of concerns about seclusion practice and the environmental arrangements in seclusion rooms. Whilst work had been undertaken on some seclusion facilities we remain concerned about some facilities and have found further concerns regarding seclusion recording practice. We were also concerned that seclusion was being undertaken in facilities that were not designated for seclusion including places of safety and bedrooms.
- In 2014, we found concerns with environmental health and safety in some health-based places of safety that did not meet the requirements of the Royal College of Psychiatrists' national standards. At this inspection we found that some improvements had been made, however some suites continued to not meet the guidance.
- We had significant concerns about staffing levels at the trust. While there had been some improvement we were concerned that the trust was not meeting its own set staffing levels, particularly for qualified staff. There were also some additional issues found at this inspection regarding access to doctors.
- In 2014, we were concerned about training, supervision and appraisal rates. At this inspection, data available at a trust level indicated poor compliance with these.The trust explained that they had difficulties with their recording systems for training, supervision and appraisal as there was a lag between local data and the trustwide database. While local records confirmed better compliance, it was concerning that senior management did not have access to reliable data to understand their compliance with these requirements.
- Since 2014, the trust had undertaken significant work to meet the Department of Health's 'Positive and Proactive Care' agenda. This had led to a planned reduction of prone restraint. However, further work was required to reduce overall restrictive practice.
- Medicine management issues raised in 2014, had largely been addressed. However, we found additional concerns at this inspection and particularly about the procedures for controlled drugs management.
- In 2014, 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. Whilst access to a single record had been addressed by the application of the electronic record system, we were very concerned about the performance of this system and the impact this had on staff.We heard that the roll out of this system had not been well managed. We observed that it was difficult to establish a contemporaneous record of patient care. We acknowledge the trust's attempt to resolve these issues but remain concerned about the risks this had on safe patient care.
- When we inspected in 2014, we were concerned that while the trust had systems in place to report incidents, improvement was needed to ensure learning or action. The trust had developed a range of initiatives to encourage learning from incidents. Staff felt they received more support and feedback following

incidents. The trust recognised they were a high reporter of unexpected deaths in England between April 2012 and September 2015, and had commissioned an independent review to better understand this. The trust is addressing the issues that were highlighted through this work however we are concerned that overall rates of death remain high at the trust.

While performance improvement tools and governance structures had been put in place, our findings indicate that there remains room for improvement to ensure that lessons are learned from quality and safety information and these are fully imbedded in to practice. We reviewed the risk registers for the trust and directorates and saw that some but not all risks that we identified through this inspection had been included in the risk register. This showed that further work was required to ensure that all risks were fully captured and understood by the board. We were concerned that while the trust's own governance system had highlighted some of these issues, the trust was yet to fully address these across all services.

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

Fit and proper persons test

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

Leadership and culture

When we inspected in 2014 we found that, while the board and senior management had a vision with strategic objectives in place, staff did not feel engaged in the improvement agenda of the trust. Moreover, at that time, some board members were unable to describe the vision to us and were unable to talk us through progress. Morale was found to be very poor across the trust and staff told us that they felt let down by management. The trust had recognised that staff engagement was a key priority but we were unable to find evidence for action to address this.

The trust was placed into special measures by Monitor in February 2015 following the last inspection and on recommendation from CQC. Monitor appointed an improvement director to oversee and guide the trust. Since that time there have been regular monthly meetings between stakeholders and the trust to monitor progress against the action plan formulated by the trust. This was an extensive piece of work. Initially the board failed to make sufficient progress; there was little traction and the pace of the change was very slow. There was a lack of grip in many areas. Following the new additions to the board membership and increased grip on the leadership issues the report highlighted, the breadth of understanding of the issues involved improved markedly and with it the pace of change. At this inspection we saw that the board was in a much more mature phase and had worked to ensure that it could offer challenge within the board and to staff throughout the trust in order to drive improvement. We found a board that was energised by the tasks ahead.

Since 2013, the trust has been undergoing a programme of service transformation which led to some service closures, mergers and reorganisation. Staff and patients 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 was designed around cost saving rather than quality improvement, and had compromised patient safety. Others told us that they had been worried about speaking openly with us for fear of victimisation. 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.

At the time of the last inspection, there was a relatively new chair, chief executive and director of nursing. Since then the board had been strengthened by new appointments to the medical director and finance director roles and some non-executive roles. At this inspection the board told us that they were 'a different organisation – positive about the future, willing to learn, and continuing to improve'. We found a revitalised energy at board level with a spirit of stronger leadership.

Requires improvement

Are services well-led?

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 'putting people first' programme had been the key vehicle to engage with staff. This had led to co-production of the values and behaviours as well as key strategies. The workforce and organisational development strategy had been refreshed and value based appraisal, supervision and team meeting structures had been introduced. Staff awards and recognition schemes had been developed. Leadership training and a well-being strategy had been implemented. A newly qualified academy had been set up.

The board had raised their visibility through a programme of executive and non-executive visits to services, opportunities for staff to shadow executive team members and managers, senior management engagement forums and 'board bulletins'. The chief executive had begun a weekly bulletin called 'Michael's Monday Message' and the 'Ask Michael' mailbox had been set up. The chief executive also began to open all staff inductions.

Work had also been undertaken to simplify and standardise the operational leadership model. All localities had implemented a triumvirate management model incorporating a locality manager, a modern matron and clinical lead. These were supported by deputy matrons, and a HR and governance business partner allocated to each locality. Leadership had improved across the trust however this was not yet fully embedded or effective.

In the 2015 NHS Staff Survey, the trust had a response rate of 52%, which is above average for mental health trusts in England and compares with a response rate of 36% for this trust in the 2014 survey. The trust scored worse than average for 12 key findings. These related to staff not feeling engaged, staff feeling work pressure, recommending the trust as a place to work or receive treatment, risks around managerial communication, appraisal quality and frequency, believing the trust provides equal opportunities and staff experiencing discrimination or harassment. The trust had improved in seven key areas across motivation, quality issues and working with service users.

We looked at data available about staffing. Sickness absence rates had fallen slightly since 2014 to 4.7% however remained slightly above the target of 4.5%. There remained very high rates for absence due to stress at 26% of these.

The trust confirmed that they have an overall vacancy rate of over 11% and that staff turnover stood at 10% in May 2016. The overall vacancy rate was the same as in 2014 but below the national average of 13%. The vacancy rate for qualified nurses was higher at 14%. The turnover rate had reduced significantly from 17% in 2014. However, some services had a high vacancy rate. For example, older people's wards had a vacancy rate of 20% for nurses and 13% for healthcare assistants. Fernwood had the highest rate for qualified nurse vacancies at 28%.

At June 2016, the staff element of the Friends and Family Test indicated that there had been an increasing level of staff satisfaction since 2014. The response rate had increased from 5% in 2014, to 46%. 58% of staff who responded were likely to recommend the trust to friends and family for care or treatment, compared to 44% the previous year. 48% of respondents were likely to recommend NSFT to friends and family as a place to work, compared to 32% the previous year. 67% of respondents felt able to contribute to improvements at work and 64% felt motivated at work.

We met with a large number of staff at this inspection. We found that staff were committed to ensuring that they provided a good and effective service for people who used the services. Most felt engaged by the trust and able to influence change within the organisation. Some staff reported there had been many changes within the trust over the previous two years, some had been painful and morale had been very low. However, they felt that it was improving and there had been an improvement with communication from board to ward level. Staff we spoke with appeared happy in their roles and proud of the service they worked in. Morale had improved significantly in the majority of services.

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. Most staff were clear about who the senior management team were at the trust. Many staff stated that they had met with or seen senior managers at their service.

Requires improvement

Are services well-led?

There had been very few allegations of bullying or harassment at the trust. Staff were aware of their role in monitoring concerns and assessing risks. They knew how to report concerns to their line manager and most felt they would be supported if they did. Generally, staff felt that learning from past incidents had improved and was informing planning of services or service provision.

During this inspection we also looked at the trust application of the Workforce Race Equality Standard (WRES). This requires all NHS organisations to demonstrate progress against a number of indicators of workforce equality. The trust produced an annual equality report, which included workforce data and examples of equality work, providing evidence of compliance against the three main headings of the general duty. The trust had implemented the workforce race equality standard (WRES) metrics, along with an action plan to address the differences in measures for black minority and ethnic staff (BME). The trust undertook a benchmarking exercise in April 2016. Overall the trust was performing better than most other mental health trusts in the region but identified four areas that required further work. The board have discussed these and reviewed the action plan throughout the year. We noted that most of the trust's action plan had been achieved.

The trust told us about a number of positive achievements regarding equality and diversity. The trust was a finalist in the national Positive Practice awards for its project (Open Mind) focussed on improving mental health services for BME communities. The trust was awarded, by NHS Employers, for its participation/ achievement, for being a partner on the Equality, Diversity and Inclusion programme. The trust launched a new Employee Network Group and is inclusive of BME, LGBT, Mental health, Disability and Faith and belief.

Engagement with the public and with people who use services

The trust had a combined service user and carers' involvement policy. This with the clinical strategy priorities 2016/2017 set out a commitment for engagement and working in partnership with service users, carers and wider stakeholders.

This work was overseen by a trust wide service user and carer partnership. Work undertaken on this agenda had included increased partnerships with voluntary and community groups, involvement in developing the vision, values, strategies and clinical priorities, and involvement in the complaints procedure review and suicide strategy. Service users had begun delivering staff training on the Mental Health Act, were involved in recruitment and had delivered patient stories at board. 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 had a developed a dedicated team to support the engagement strategy, and had recruited staff within services to champion user and carer involvement. The trust had recently appointed a head of recovery to oversee this agenda.

The service user and carer involvement strategy commits to equality and diversity and pro-active engagement with underrepresented groups. The trust was a finalist in the national 'Positive Practice' awards for its project (Open Mind) focussed on improving mental health services for BME communities. Work had also been undertaken on the Inspiring Progress Project. This culminated in a conference in October 2015 aimed at sharing the learning with communities and wider public. A Spirituality practice guide and transgender guidance leaflet was put in place for staff to support service users better.

The trust had set up a recovery college in October 2013. The recovery college provided a range of courses and workshops to service users, carers and members of staff to develop their skills, understand mental health, identify goals and support their access to opportunities. This was reviewed in November 2015 and received very positive feedback from participants. The trust had during 2015 employed 40 peer support workers to work in services across the trust. Peer support workers we met were very positive about the support they received from the trust to undertake their roles.

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

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

Requires improvement

Are services well-led?

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

The Care Quality Commission community mental health survey 2015 was sent to people who received community mental health services from the trust to find out about their experiences of care and treatment. Those who were eligible for the survey where people receiving community care or treatment between September and November 2014. 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 in all areas. This was an improvement against the previous community mental health survey.

In the final quarter of 2015, Healthwatch Suffolk and Suffolk User Forum (SUF) carried out a survey of the trust's patients and their carers. The survey received 119 responses. Key recommendations from this were: the need for improved continuity of care co-ordinators, information and record keeping between assessments, more comprehensive medicines reviews and a renewed effort to allow all service users to be a part of their care planning.

The trust used the friends and family test (FFT) to measure patient and carer feedback. At June 2016, the results indicated that 81% of patient respondents were likely or extremely likely to recommend the trust services. There was however a very low participation rate by patients at roughly 180 people per month (0.01% response rate).

During this inspection we met with the council of governors. The trust had 22 elected members and appointed individuals who were patients, service users, staff or other stakeholders who represent members and other stakeholder organisations. The council included two youth governors who were representatives of the trust's wider youth forums. The governors told us that they had seen much improvement at the trust over the previous two years. They felt that they are now able to hold the trust to account via the non–executive directors on key issues and were confident that the response they received was timely, open and transparent. They reported they were able to call individual directors to the meetings should this be required.

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

Quality improvement, innovation and sustainability

During 2015/16 the trust 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 suicide prevention, medication, clinical outcomes, care planning, Mental Health Act and Mental Capacity Act administration, application of NICE guidance, physical healthcare and patient satisfaction.

During 2015/16 the trust was not eligible to participate in any national clinical audits or national confidential enquiries.

Prior to our inspection in 2014, the trust had participated in a number of accreditation schemes. Following the imposition of special measures in February 2015, the Royal College of Psychiatrist's had suspended the trust's accreditation. However, the trust had recently received accreditation for the psychiatric liaison service in West Suffolk. The Tier 4 child and adolescent service in Lothingland was a member of the QNIC (Quality Network for Inpatient CAMHS) scheme. Secure services also participated in relevant peer reviews via the quality network for forensic services. In July 2016, the trust renewed its accreditation for the ECT service with ECTAS (Royal College of Psychiatrist's accreditation for ECT).

We found a number of innovative practices:

- The 'care farm' initiative and recovery college were examples of improvement and innovation.
- One psychologist in an integrated delivery team had been given a day per week funded to promote a 'research friendly' environment within the trust.The same psychologist ran 15 minute 'mindfulness' groups for staff each morning in an effort to reduce staff stress.
- An example of improving and developing the service was given regarding the safer care pathways, 'closing the gap in patient safety' for dementia wards implemented at Julian Hospital and Carlton Court. At Julian Hospital, carers were involved in the redesign of an information booklet aiming to improve communication to reduce patient distress and a patient centred admission process. Staff away days were planned with staff. A new

occupational therapy model of care was developed to increase therapeutic interventions to reduce incident rates for example for falls and violence and aggression. As of March 2016 a reduction of incidents was identified.

- Doctors said they had links with Cambridge University, for example regarding research for Lewy body dementia and learning from innovative practice.
- In the older people's community teams, we saw an example of good practice at Wymondham, where the team had developed an additional cognitive stimulation therapy group for younger people with dementia, which met in a pub, in an effort to reduce stigma.
- Core team leaders demonstrated innovation in practice, and delivered on ideas to improve patient care and overcome challenges within their services. Managers involved their staff in making decisions for service improvement.
- In the crisis teams, a pilot scheme was in place to improve service provision at Mariner House to evaluate 'delays in patient pathways'. While led by the core team leader, the staff contributed, and we saw flow charts of the scheme, and actions arising from the work.
- At the home treatment teams in Woodlands, we saw individual folders for patients, which contained risk assessments and care plans. This meant information about patients was easily accessible to staff prior to going out to see them.
- The AFI team at Northgate hospital used innovative ways to manage the needs of their patients. The core team leader was involved in multi-agency working groups and had led the team to be able to deliver treatment in different ways to conventional home visits. An example of this is the 'early help hub' where patient's needs were discussed and multiple agencies could be involved. The core team leader made suggestions of how each agency could assist in the holistic treatment of the patient.
- Members of the team attended the child and family research meetings held every two months to support the development of research within the service.
- The CAMHs inpatient ward was a member of the quality network for inpatient CAMHS QNIC, which is a national quality improvement programme.
- The Norfolk recovery partnership facilitated a pregnancy liaison partnership protocol for pregnant clients across Norfolk. This ensured that any pregnant clients who needed support for substance abuse were supported by a dedicated team of a substance misuse NRP nurse, a midwife, neonatal intensive care nurse, their GP and a health visitor.
- NRP Unthank Road was taking part in a fingerprints study with King's College London. The study investigated whether fingerprints could be used to screen for drug use as a less invasive way of drug testing. Clients who were willing to take part in the study were offered a £5 food voucher on completion of a sample collection.

This section is primarily information for the provider

Requirement notices

Action we have told the provider to take

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

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Treatment of disease, disorder or injury	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment • The trust had not ensured that all risk assessments and care plans were in place, updated consistently in line with changes to patients' needs or risks, or reflected patient's views on their care. • The trust had not ensured that people received the right care at the right time by placing them in suitable placements that met their needs and giving them access to 24 hour crisis teams. • The trust had not ensured that all ligature risks were identified on the ligature risk audit and had not done all that is reasonably practicable to mitigate any such risks. • The trust had not ensured that all mixed sex accommodation met guidance and promoted safety and dignity. • The trust had not ensured that seclusion facilities are safe and appropriate and that seclusion is managed within the safeguards of the Mental Health Act Code of Practice • The trust had not ensured that the environment did not increase the risks to patients' safety. • The trust had not ensured effective systems for the management, storage or administration of medication, including controlled drugs. • The trust had not ensured there were enough personal alarms for staff and that patients had a means to summon assistance where required. This was a breach of regulation 12

Regulated activity	Regulation

This section is primarily information for the provider

Requirement notices

Assessment or medical treatment for persons detained under the Mental Health Act 1983 Treatment of disease, disorder or injury	Regulation 11 HSCA (RA) Regulations 2014 Need for consent • The trust had not carried out assessments of capacity and recorded these in the care records • The trust had not ensured that procedures and safeguards required under the Mental Health Act Code of Practice were adhered to. This was a breach of regulation 11

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Treatment of disease, disorder or injury	Regulation 18 HSCA (RA) Regulations 2014 Staffing • The trust did not always deploy sufficient numbers of suitable qualified, competent, skilled and experienced staff to ensure they could meet people's care and treatment needs. • The trust did not ensure that all staff had sufficient training. • The trust did not ensure that all staff received appraisal and supervision. This was in breach of regulation18

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Treatment of disease, disorder or injury	Regulation 17 HSCA (RA) Regulations 2014 Good governance • The systems to assess, monitor and mitigate the risks relating to the health, safety and welfare of patients who may be at risk and systems to assess, monitor and improve the quality and safety of the services provided were not operating effectively. • The trust had not ensured that there were systems in place to monitor quality and performance and that governance processes led to required and sustained improvement.

This section is primarily information for the provider

Requirement notices

- The trust had not ensured that learning and improvements to practice are made following incidents and adverse events.
- The trust had not ensured that clinical information systems were robust. There was not a clear and accurate contemporaneous record of patient care.

This was a breach of regulation 17