Norfolk and Suffolk NHS Foundation Trust

Inspection report

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Date of inspection visit: 13, 14, 15, 20, 21, 22 September 2022, 1, 2, 15 ,16, 17, 21, 23, 24 November 2022
Date of publication: 24/02/2023

Ratings

Overall trust quality rating	Requires Improvement
Are services safe?	**Requires Improvement**
Are services effective?	**Requires Improvement**
Are services caring?	**Good**
Are services responsive?	**Requires Improvement**
Are services well-led?	**Requires Improvement**

Our findings

Our reports

We plan our next inspections based on everything we know about services, including whether they appear to be getting better or worse. Each report explains the reason for the inspection.

This report describes our judgement of the quality of care provided by this trust. We based it on a combination of what we found when we inspected and other information available to us. It included information given to us from people who use the service, the public and other organisations.

We rated well-led (leadership) from our inspection of trust management, taking into account what we found about leadership in individual services. We rated other key questions by combining the service ratings and using our professional judgement.

Overall summary

What we found

Overall trust

We inspected Norfolk and Suffolk NHS Foundation Trust because at our last inspection we rated the trust inadequate overall and took enforcement action.

We carried out an unannounced comprehensive inspection of 2 core services – child and adolescent mental health wards and community-based mental health services for adults of working age; and unannounced focussed inspections of 4 core services which were - acute wards for adults of working age and psychiatric intensive care units, long stay or rehabilitation mental health wards for working age adults, mental health crisis services and health-based places of safety and wards for older people with mental health problems. We also inspected the well-led key question for the trust overall.

We chose these 6 core services to see if they had complied with the warning notice we issued and if there had been improvements since our last inspection in November and December 2021.

The trust provides the following mental health services, which we did not inspect this time:

- Wards for people with a learning disability or autism.
- Specialist community mental health services for children and young people.
- Community based services for older people
- Forensic inpatient or secure wards
- Community mental health services for people with a learning disability or autism

Our rating of services improved. We rated them as requires improvement because:

Our findings

- We rated safe, effective, responsive and well-led as requires improvement, and caring as good.
- Three of the core services we inspected had improved. The child and adolescent mental health ward had improved from a rating of inadequate to a new rating of good. The acute wards for adults of a working age and the community-based mental health services for working age adults had both improved from a rating of inadequate to a new rating of requires improvement. One core service, mental health crisis services had remained requires improvement overall. The other 2 services, rehabilitation ward and wards for older people with mental health problems could not be rated as we only inspected a few of the key questions. Our overall rating took into account the current ratings of the 5 core services we did not inspect at this time.
- Across the 6 core services we rated 24 domains associated with the key questions. Four domains had improved by 2 ratings from inadequate to good; 10 had improved by 1 rating; 9 had stayed the same and 1 had seen a reduction in the rating.
- The most concerning ratings were the inadequate ratings for the safe domain for acute wards for adults of a working age and wards for older people with mental health problems. For these services we found that improvements required at the last inspection as stated in the warning notice had not been achieved consistently across the wards. For example, on a few wards ligature reduction work had not yet taken place (although was planned); some wards did not have enough staff who had completed the mandatory training; a few staff were not carrying out restrictive interventions appropriately such as restraint or seclusion. There were still a small number of wards where standards of care needed to significantly improve. This demonstrated that the positive changes focusing on patient safety introduced at pace by the trust since the last inspection needed some further refinement and embedding to improve the consistency of care. The trust recognised that there were still challenges, but the Care Quality Commission had confidence that the trust had leaders with the commitment and experience to continue to take this forward at pace as demonstrated by services with improved ratings.
- Whilst the rating of the trust had improved the Care Quality Commission chief inspector of hospitals has recommended to NHS England and NHS Improvement that the trust remains in the Recovery Support Programme at the current level to ensure it receives ongoing relevant support to continue to make the changes required.

Our inspection identified the following areas where further improvement was needed:

- The trust had access to a wide range of data including staffing, incidents, complaints, safeguarding, whistleblowing, feedback from quality and safety review visits but this was not always brought together effectively. This meant that services which were struggling might not be identified at an early stage to ensure they had the necessary ‘wrap around’ support package to improve in a timely manner.
- There are examples of where essential environmental improvements had not happened fast enough to address patient safety concerns and whilst systems were in place to request this work, further input was needed to ensure repairs took place in a timely manner.
- We observed a range of ability and confidence in ward and team managers and in middle management in the care groups. Managers were not always escalating concerns quickly enough to get the help they needed. The services where we had the most concerns on this inspection were also where managers appeared to lack experience or motivation. Whilst the trust had leadership development opportunities in place both for groups and individuals, these needed to be further developed to support people to perform to a consistently high standard. The trust had secured funding to increase their leadership development team with plans to develop a talent management programme, but this had not yet come into effect.
- Clinical leadership needed to develop and embed further. For nurses there was a well-developed nurse leadership structure reflecting the geography of the trust and the patient safety priorities for the chief nurse. Allied health professionals were line managed by the chief nurse. Each care group was led by a clinical director (mostly medics), a

lead nurse, a service director and people participation lead. Despite these leadership roles the consultant psychiatrists did not feel they were fully engaged in decision making relating to the trust and there was an acknowledgement that this could improve. The chief medical officer planned to actively involve the medics in looking at future models of care which was welcomed by the consultant psychiatrists. He was developing plans to improve their leadership development. He was also reviewing the engagement of junior doctors. It was also acknowledged by the trust that the psychologists should either be managed by the chief medical officer or chief nurse rather than the current arrangement of management by the deputy chief executive.

- The trust had considerable further work to undertake in terms of their digital transformation. The current contract for the patient record system will expire in April 2025 and they were deciding which system would be best meet their needs going forward. This decision making was been operationally led by the chief operating officer. In the meantime, access to live data was limited to identify areas for improvement and inform managerial decision making. Some data was available through Power BI, but many staff did not have the skills to access and make use of this. However, at a trust wide level for key governance committees, data was felt to be largely accurate, well presented and appropriately analysed.

Our inspection identified a number of areas where improvements had taken place:

- The trust was moving from a position of being reactive in response to external stakeholders including the Care Quality Commission to being proactive. There was a clear and realistic plan in place to deliver phased improvement. The inspection found evidence of the work being done to address the basics. There were many examples of this including mandatory training compliance at 90%, appraisal completion rates at 95%, improved systems and training for conducting therapeutic observations of patients and improvements to medicine management. The Care Quality Commission inspection found an example of where a restraint had been carried out in an unacceptable manner, however systemic improvements were taking place which should reduce the likelihood of this happening in the future. This included the rolling out of accredited training for the prevention and management of violence and aggression where most staff had been trained or their training was booked and the strengthening of a trust wide team supporting wards to reduce the use of physical interventions and where needed ensure this is done appropriately.
- Since the last inspection the executive leadership team had strengthened. The 3 appointments had come with considerable experience, the deputy chief executive and chief people officer, chief medical officer and chief operating officer. The executive leadership team had clear leadership roles for delivering the strategic priorities and were actively working on translating this into practice. For example, the chief operating officer was leading work to deliver timely access to services. This included ensuring there was an understanding of the reasons for waiting lists, improving the quality of the data, reviewing the models of services and reducing unwarranted variations between similar teams. Our inspections of adult community mental health teams found that whilst there were waiting lists, the people on them were being monitored and receiving access to some therapeutic input. The chief operating officer recognised the complexity of this work and the need to engage with external stakeholders such as NHSE and join programmes to learn from other providers.
- Since the last inspection the governance processes had been strengthened. The number of sub-committees of the Board had been reduced to streamline the systems for gaining assurance. External stakeholders had become active participants in the governance processes through membership of committees. We found examples of where assurance processes had been strengthened. The trust had developed an evidence assurance group to ensure the data being used to monitor progress with the Care Quality Commission action plan was accurate and corroborated to ensure the improvements were really happening in practice. The trust had strengthened a team which visited wards and teams to carry out quality and safety reviews. This team had carried out over 100 visits between March to October 2022 and these included patient representatives and external stakeholders. This had identified areas for improvement both for individual service. and trust wide. This had led to changes such as an improved staff induction process. The trust had just introduced a new method of completing clinical audits which were done online with the

results submitted electronically. These audits reflected the areas identified at the last inspection where improvements were needed. The chief operating officer had strengthened assurance through the quality performance meetings where the care groups were held to account for the services they managed. These were now taking place monthly, made better use of data and set clearer expectations in terms of improvements. Finally, the number of visits of executives and non-executive directors to services had increased. Twenty-nine visits had taken place since late spring by the chair and non-executive directors to services. Following our inspection there was a recognition that assurance could be strengthened further – particularly the review of incidents through viewing CCTV. This had been taking place, but the quantity and quality of this review was being developed.

- There was a full recognition by the trust of the need to improve the culture of the organisation. Many of the staff we met during the inspection talked about the improvements in the culture, but it was clear that there were still some teams where staff were experiencing discrimination and had poor morale. Since the last inspection work had taken place to start improving the culture although there was a recognition that it would take time to see significant changes in measures such as the staff survey results although the trust were hopeful of seeing a few green shoots. The trust leaders recognised the importance of role modelling the appropriate behaviours which was very evident throughout the well led review. They were clear of the need to avoid a blame culture and create one where staff felt supported to learn and improve. They had introduced a leadership and management behaviour framework. Executive leaders were holding weekly online 'hear to listen' events where any staff could join and ask any question anonymously if they wished. The calls were recorded for colleagues who could not join at the time and were being attended by 200-300 staff. The trust had launched a trust wide piece of work to listen to staff and turn this into action and about 30% of the trust staff had chosen to complete the initial survey. These results were available at the time of the inspection and were enabling the trust to start understanding the scale and nature of the issues. The process will support further work with teams to listen and promote improvements. The trust was working to improve opportunities for staff to speak up and had just started to use an external speak up guardian arrangement to ensure greater independence from the trust. The trust was supporting the staff networks, which each had an executive sponsor, and had been provided with extra resources to develop further.
- The trust had recognised that it needed to bring forward the work to refresh the trust strategy to align with the plans in the wider health and social care economy across the 2 system geographies. The aim was to have a new strategy by April 2023 and use the ongoing staff engagement work to consult as needed. The refreshed strategy would be clinically led and clinically informed by the work which had been started by the chief medical officer to look at future models of care. There were plans to also refresh the workforce, estates and digital supporting strategies later in the year. At the time of the inspection the trust strategy was displayed across the services, was available on the intranet, used to align governance papers but not widely referred to by members of staff.
- The trust was actively involved in the work across both care systems in Norfolk and Suffolk. The chief executive was a member of both Integrated Care Boards. The trust leaders understood that there needed to be effective system working to meet the mental health needs of the population. They also recognised that the focus should not be on growing the trust, but rather to identify the areas they could do well as a secondary healthcare provider and where other providers including those in the third sector were better placed to meet people's needs. Since the last inspection there had been the addition of an Improvement Board as a sub-committee of the Board to support partner engagement and monitor trust progress. There were positive examples of collaborative working. This included mental health nurses working in primary care across both systems. In West Suffolk the trust was working with Mind to support people with long term mental health conditions. Mind were able to offer people up to 3 interventions a week such as help with accessing fitness activities to improve their overall health. The trust recognised that there was scope to significantly grow this collaborative working.

Our findings

- Patient participation had embedded further across the trust over the last year. There were 8 people participation leads aligned to the care groups and 8 people participation co-ordinators. People participation was embedded across the trust with people with lived experiences actively involved in governance committees, quality assurance work, staff recruitment and training, research and quality improvement work. The trust also employed peer support workers across a range of services.

How we carried out the inspection

Before the inspection visit, we reviewed information that we held about each of the core services.

During the inspection visits, we:

- Visited 19 wards and 12 teams
- Spoke to 139 staff performing a wide range of roles
- Spoke to 96 patients and 24 relatives or carers
- Looked at 135 individual patient records
- Looked at over 100 medication records
- Attended 12 meetings including staff handovers, multidisciplinary meetings and patient community meetings
- Looked at a number of records involved in the day to day operation of the services.

You can find further information about how we carry out our inspections on our website: www.cqc.org.uk/what-we-do/how-we-do-our-job/what-we-do-inspection.

What people who use the service say

In the services we inspected, feedback from patients and carers was largely positive. On the child and adolescent mental health ward, patients said they felt safe and well cared for. Patients felt the staff were supportive of their needs and were friendly and approachable, staff had the skills to meet their needs and helped them through crisis and in difficult situations. Patients said the ward was calm and that there were enough staff to meet their needs and go out on activities and leave. On the acute wards for adults of working age and psychiatric intensive care units, patients were mostly happy with the care they received, thought there were enough staff to deliver care, felt safe on the wards and said that staff looked after their physical health. Patients told us they were involved in their care decisions. Overall patients thought that wards were clean and that they could give feedback about their care. On the long stay/rehabilitation mental health ward for working age adults, all patients said they felt safe on the ward and staff were kind, they felt listened to, and staff helped them when they needed it. On the wards for older people with mental health problems, patients told us they felt the staff treated them like human beings, and the atmosphere in the wards was relaxed and safe. Patients told us staff were always around and getting staff attention wasn't a problem. They felt involved in their care planning and decision-making and were able to be supported by their family members in the care planning process. Patients told us they were able to go to their weekly ward round to ask questions about their care.

In the community-based mental health services for adults of working age, most service users and carers we spoke to were very positive about the service. They told us staff were good at communicating with them and had a caring approach. All patient felt listened to, and said they were fully involved in their care. Feedback from carers was positive about the care and treatment family members received. Relatives told us that staff were supportive and they kept them

Our findings

involved in their loved one's care. In the mental health crisis services and health-based places of safety, most patients and carers we spoke with said they were seen within the timeframe the staff told them when they initially called them, and they were seen regularly, which changed frequency dependant on their level of need. All patients and carers we spoke with told us patients received their medicines on time.

There were however some areas for improvement identified by people who used the service. On the acute wards for adults of working age and psychiatric intensive care units, 2 patients gave us examples where staff had not always been kind and polite and a further 4 said night staff were not always responsive to them, 1 patient had specific concerns about their care which we followed up with ward staff. Several patients told us they did not have a copy of their care plan or had not been given enough information about the medicines they were prescribed or the about ward when they were first admitted. In the mental health crisis services and health-based places of safety, 3 patients said they had no care plan and were not given a copy. Four carers said their relative had no care plan and 5 carers said they had not been given a copy. One patient told us they had no advice regarding their medicines.

Outstanding practice

We found the following outstanding practice in community based mental health services for adults of working age:

- The service in Bury were piloting a programme of support and treatment for patients based on national guidance for cognitive behavioural therapy. The programme planned care around 3 areas of need: unusual experiences, low mood and personality disorder. The unusual experiences programme for patients who were hearing voices or experiencing hallucinations. It involved support groups, one-to-one psychology and medication. The low-mood programme aims to stabilise patients' mood. The personality disorder programme provided support and therapy. Packages were delivered by nurses. The service had developed a workbook for each programme to provide a clear structure to each intervention.

Areas for improvement

Action the trust MUST take is necessary to comply with its legal obligations. Action a trust SHOULD take is because it was not doing something required by a regulation but it would be disproportionate to find a breach of the regulation overall, to prevent it failing to comply with legal requirements in future, or to improve services.

Action the trust MUST take to improve:

Trust wide

- The trust must ensure that the governance systems are further refined to enable the early identification of wards or teams which were struggling so the necessary support can be put into place. (Regulation 17(1)).

Long stay/rehabilitation mental health wards for working age adults

- The trust must ensure that ensure staff keep up to date with their mandatory training. (Regulation 18(1)).

Acute mental health wards for adults of working age and psychiatric intensive care unit

Our findings

- The trust must ensure that safety hazards are resolved in the Southgate ward seclusion room and that any seclusions that take place in a patients' bedroom follow processes to make the environment as safe as possible for patients. (Regulation 12(1)).
- The trust must ensure that environmental repairs are dealt with promptly so that patients can make full use of the ward and facilities on Great Yarmouth and Waveney Acute service. (Regulation 17(1)).
- The trust must make sure that patient's alarm call buttons are always switched on so that these can be used by patients. (Regulation 12(1)).
- The trust must ensure any actions in relation to fire risk assessments are completed. (Regulation 12(1)).
- The trust must continue its program to ensure there are enough staff available and suitably trained across all the wards to carry out physical interventions safely. (Regulation 18(1)).
- The trust must continue its program to ensure the completion of staff mandatory training across all wards. (Regulation 18(2)).
- The trust must ensure staff always carry out appropriate physical health observations following rapid tranquillisation. (Regulation 12(1)).
- The trust must continue its training to ensure that staff consistently follow trust policy and best practice guidance when they undertake and record enhanced observations. (Regulation 12(1)).
- The trust must ensure that they record the reasons for the use of 'as and when' medicines to ensure patient's behaviour is not controlled by excessive and inappropriate use of medicines. (Regulation 12(1)).
- The trust must ensure that staff follow guidance for the administration of all medicines, including recording were a depot has been administered. (Regulation 12(1)).
- The trust must continue its work to ensure that staff respond to all patient's' physical health needs, including planning of care, completing physical health observations and taking action in response to these when required. (Regulation 12(1)).
- The trust must ensure staff are kind and responsive to all patients and respect patients' dignity and privacy when providing care. (Regulation 10(1)).
- The trust must continue its work to ensure that there are governance processes in place so that it has sufficient oversight and assurance to ensure consistently high standards of care and treatment across all the wards. (Regulation 17(1)).

Mental health crisis services and health-based places of safety

- The trust must ensure there are enough staff to meet the needs of the service including assessing emergency referrals within the 4-hour target. (Regulation 18(1)).
- The trust must ensure staff complete and are up to date with mandatory training. (Regulation 18(2)).
- The trust must continue their work to ensure patients have a physical health assessment and enough information in their care plan to enable staff to respond to physical healthcare needs. (Regulation 12(1)).
- The trust must ensure that data relating to crisis services is accurate and timely to ensure they can be appropriately monitored. (Regulation 17(1)).
- The trust must ensure all the teams have appropriate telephone arrangements so that patients can access teams in a timely manner including out of hours. (Regulation 12(1)).

Our findings

Community based mental health services for adults of working age

- The trust must ensure that mandatory training across all teams meets the trust target. This includes personal safety and safeguarding training. (Regulation 12(1)).
- The trust must ensure that updates to patients' risk assessments are recorded consistently so that they can be easily located and used by members of the team. (Regulation 12(1)).
- The provider must ensure that patients do not have wait for long periods of time before receiving treatment from a psychologist. (Regulation 9(1)).
- The trust must continue its work, in partnership with other stakeholders, to look at models of service for adult community mental health services to meet the needs of the local population in a timely manner. (Regulation 17(1)).
- The trust must ensure that patients on the waiting list are contacted in line with trust policy. (Regulation 12(1)).
- The trust must ensure that data relating to services is available in a consistent format so that teams who are outliers can be identified and supported. (Regulation 17(1)).

Mental health wards for older people

- The trust must ensure that the planned works to address ligatures on Blickling and Sandringham wards are addressed. (Regulation 12(1)).
- The trust must ensure that patients who are identified as a risk of suicide or self harm, are unable to access rooms continuing high risk items such as electric beds. (Regulation 12(1)).
- The trust must ensure that when conducting patient observations, staff ensure that patients are safe. (Regulation 12(1)).
- The trust must ensure that staff attend to incidents in a timely way and in line with trust systems and processes. (Regulation 12(1)).

Action the trust SHOULD take to improve:

Trust wide

- The trust should ensure that the work is progressed to ensure timely resolution of environmental repairs with the prioritisation of work which impacts on patient safety.
- The trust should consider how it reviews CCTV footage to strengthen assurance processes.
- The trust should ensure work continues to improve clinical engagement across the trust with a focus on work to develop new models of care.
- The trust should ensure work continues to develop competent and motivated staff leading clinical services, especially at a ward or team and care group level of the organisation.
- The trust should prioritise the digital transformation program.

Long stay/rehabilitation mental health wards for working age adults

- The trust should ensure it completes the work to reduce ligature points in communal parts of the ward.

Acute mental health wards for adults of working age and psychiatric intensive care unit

Our findings

- The trust should ensure that staff wear any PPE required in response to the Covid 19 pandemic in line with trust policy and public health guidance.
- The trust should continue its work to recruit and retain staff to provide improved consistency of care in wards with high use of temporary staff.
- The trust should ensure it provides all patient's with information about their medicines including alternative medicines and potential side effects.
- The trust should continue its work to ensure that bank and agency staff can access essential care record information on all wards.
- The trust should continue its work to ensure staff follow trust policies and procedures to search patients or their rooms and that searching does not constitute a blanket restriction.
- The trust should continue its work to ensure all staff are supervised, appraised and inducted into their role.
- The trust should ensure staff can attend regular team meetings where actions are completed.
- The trust should continue its work to ensure patients receive all the information they require when they are admitted to the ward.
- The trust should continue its work to ensure all patients receive a copy of their care plan.
- The trust should ensure that decisions for patients not to be able to make their own hot drinks is regularly reviewed.

Child and adolescent mental health ward

- The trust should continue its work to ensure that the recruitment of a substantive specialist CAMHS consultant to act as RC takes place
- The trust should continue its work to ensure the recruitment of a substantive senior psychologist takes place
- The trust should consider the impact of increasing the capacity of patient beds on current staffing levels and care provided.

Mental health crisis services and health-based places of safety

- The trust should continue to support patients to have a copy of their care plan.
- The trust should consider future models for crisis services to offer consistently high-quality care and treatment and avoid unwarranted variations. This includes the tools used by the teams to triage patients and monitor clinical outcomes.
- The trust should continue its work to improve the flow of patients accessing inpatient services to ensure that the Health Based Place of Safety bed is not used as an overspill facility for the acute ward.

Community based mental health services for adults of working age

- The trust should ensure that patients do not face long waits for routine medical reviews.

Is this organisation well-led?

Our rating of well-led improved. We rated it as requires improvement.

Our findings

Leadership

Since our previous inspection in November and December 2021, significant changes had taken place to enhance the capacity and capability of the Board. The executive leadership team had strengthened. The trust had appointed a chief operating officer, chief people officer and an interim chief medical officer. The chief finance officer of 5 years was serving a full notice prior to leaving and plans were in place to secure a replacement. There were also changes to the non-executive directors with the appointment of a new chair. Two new non-executive directors had been appointed and were coming into post after the inspection bringing clinical experience. The chair recognised that there was more to do to improve the diversity of the Board and was actively addressing this as part of the future appointments of non-executive directors.

The people appointed to positions of senior leadership had the appropriate skills, knowledge and experience to perform their roles. The members of the executive leadership team had clearly defined roles as leads for delivering the strategic improvement priorities and were actively working on translating this into practice. Members of the executive leadership team spoke about this work with confidence. For example, the chief operating officer was leading work to deliver timely access to services. This included ensuring there was an understanding of the reasons for waiting lists, improving data quality, reviewing the models of services and reducing unwarranted variations between similar teams. Our inspections of adult community mental health teams found that whilst there were waiting lists, the people on them were being monitored and receiving access to some therapeutic input. The chief operating officer recognised the complexity of this work and the need to engage with external stakeholders such as NHS England and joined programmes to learn from other providers.

The non-executive directors had well defined areas of responsibility and brought a wide range of skills, experience and connections with external bodies. They were able to describe their roles with clarity. The non-executive directors worked together attending more than just their main sub-committee of the Board to ensure issues that extended across more than 1 committee were considered in a joined-up manner. There were regular facilitated Board development sessions taking place supporting the strategic work of the trust.

Across the trust new leaders had been brought in to drive improvement in areas such as medicines management and the acute wards. At the last inspection, pharmacy staff told us the senior leadership team within the pharmacy department were not visible or approachable. At this inspection, staff told us visibility improved since the new chief pharmacist had been in post. They had good insight into the trust and were in the process of analysing all clinical areas to review where the risks were and how the pharmacy service could be improved.

Since our previous inspection the trust had introduced a leadership and management behaviour framework launched in August 2022. This had provided clarity on standards of practice and behaviours which aligned closely to the trust's refreshed accountability and performance framework. This reflected the trust's values and made it easier for the senior leadership team to hold people to account. The trust were in the process of developing a new leadership competency framework which was due to be launched in 2023.

Fit and proper person checks were in place. These were refreshed on an annual basis or if there were any changes in individual circumstances. The non-executive directors only had standard disclosure and barring checks in place, rather than the expected enhanced checks for people visiting services and meeting patients. This was due to the disclosure and barring service and not something the trust could control. This was a national issue which the trust had flagged with NHS England. To manage this risk, non-executive directors did not undertake visits to patient areas unsupervised.

Our findings

The trust leadership team had a comprehensive knowledge of current priorities and challenges and took action to address them. We found the trust had moved at pace to make changes to deliver the improvements we told the trust they must make following the previous inspection. Many of the wards and teams had improved. However, we still found examples of poor care practice on some wards delivering treatment to people with an acute mental illness and older people. The trust leadership team were aware that further work was needed to further extend and embed improvements – particularly relating to patient safety. They demonstrated the drive and commitment to carry on with this challenging work. It was positive to see that the trust leadership team also recognised their limitations. They were open to asking for assistance and learning from good practice demonstrated by other providers. They were also bringing in external support to create 4 interim directors of operations to assist with complex pieces of work – for example a review of services with a focus on improving access and performance.

Clinical leadership needed to develop and embed further. For nurses, there was a well-developed nurse leadership structure reflecting the geography of the trust and patient safety priorities for the chief nurse. Allied health professionals were line managed by the chief nurse. Each care group was led by a clinical director, a lead nurse, a service director and a people participation lead. Despite these leadership roles, the consultant psychiatrists did not feel they were fully engaged in decision making relating to the trust and there was an acknowledgement that this could improve. The chief medical officer planned to actively involve the medics in looking at future models of care and this was welcomed by the consultant psychiatrists. They were developing plans to improve their leadership development. They were also reviewing the engagement of junior doctors. The trust acknowledged that their existing management structures were not meeting the specialist needs of staff.

Leadership development opportunities were available. Members of the executive leadership team had access to mentoring, coaching and buddying opportunities. They described how these were very supportive of their individual development. Non-executive directors had buddying arrangements in place with non-executive directors from other trusts.

The inspection found a variation in the skills, experience and motivation of ward and team leaders and more senior leaders at a care group level. Whilst there were a number of leadership development opportunities in place there was more to do and the trust had plans to extend this further in 2023. Since 2021 the trust had provided a ‘leading confidently’ programme for staff in bands 4-7. At the time of the inspection 400 staff had completed this training. The trust had plans in 2023 to review the care groups and restructure operations teams; commission a senior leadership programme aligned to the leadership competency framework; increase the leadership development team capacity linked to a proposed talent management programme with a focus on supporting staff from a black and minority ethnic background to progress in their careers.

Vision and Strategy

After the last inspection, the trust recognised the need to make changes at pace to address the enforcement action taken by the Care Quality Commission. They understood that they needed to prioritise and develop a realistic programme of change. They developed a phased improvement approach. The focus of phase 1 which was up to August 2022 had been to ‘address the basics’. This included understanding the root causes of challenges, completing tasks with an immediate impact particularly in improving patient safety and focusing on having good data and internal assurance. At the time of this inspection the trust was moving into phase 2 which was about sustaining improvement. We could see that everyone we interviewed understood about this phased approach and the importance of addressing the basics. The approach was realistic and achievable.

Our findings

The trust had a vision and set of values with quality and sustainability as the top priorities. Since our previous inspection the trust refreshed their vision statement with the new members of the Board. The refreshed vision was to 'be an outstanding mental health service provider noted for excellence in safety, quality and service user and staff experience'.

The current strategy had 5 outcomes it was trying to achieve. These had been translated into 5 improvement priorities each with an executive director lead. These were making your voice count which was translating into work to transform the culture of the organisation; changing services to meet people's needs which was translating into work to transform models of care in partnership with people who use services and system partners; improving governance and leadership; safety for all which was translating into work to improve patient safety; and timely access which was translating into work to ensure there were staff and services in the right place.

The trust recognised it needed to bring forward the work to refresh the trust strategy to align with the plans in the wider health and social care economy across the 2 system geographies. The aim was to have a new strategy by April 2023 and use the ongoing staff engagement work to consult as needed. The refreshed strategy would be clinically led and clinically informed by the work which had been started by the chief medical officer to look at future models of care. There were plans to also refresh the workforce, estates and digital supporting strategies later in the year. These strategies needed to include the outcome measures so that progress could be monitored. At the time of the inspection the trust strategy was displayed across the services, available on the trust intranet, used to align governance papers including the Board Assurance Framework. Although the strategy was embedded from a governance perspective, it was not widely referred to by members of staff. However, the ward staff were aware of the vision and strategy.

Staff, patients, carers, and external partners had the opportunity to contribute to discussions about the strategy, especially where there were plans to change services. The trust had invested in patient participation leads as part of their model of leadership in the care groups. Participation leads were people with experience of using the services. Staff we spoke with confirmed the patient participation leads' involvement in strategy discussions.

The trust did not have a medicines optimisation strategy. We found this at our previous inspection. However, the provider told us this was due to be developed in early 2023.

Since the last inspection the trust had strengthened its work with system partners. This was reflected in the positive feedback from external stakeholders. An Improvement Board had been set up to monitor progress with the trust's improvement plan with an evidence assurance group. This forum brought together staff from the trust with system partners including regulators, members of Integrated Care Boards and other external partners.

The trust was working across 2 systems. The trust Board completely understood the importance of aligning their strategy to the plans for the wider health and social care economy. There was an active desire to work with social care and the third sector. Trust leaders recognised that for some of the services they were delivering that they might not be the best provider and that other organisations might be better placed to do this work. They were committed to becoming an expert secondary mental health service and understood that in the future this might mean that they would become a smaller more specialist organisation.

An example of partnership working was the trusts' active participation in the Suffolk mental health collaborative and Norfolk and Waveney Mental Health Partnership Board. The trust was also a member of the East of England provider collaborative for specialist mental health. The trust shared responsibility for the commissioning and provision of specialist services in the region with neighbouring trusts. The East of England provider collaborative was running a pilot

for children and adolescent mental health services (CAMHS) looking at alternatives to a hospital admission. The trust were also working with the provider collaborative on the community forensics transformation pilot with local voluntary, community and social enterprise partners. The trust also actively participated in system meetings such as Urgent and Emergency Care and Mental Health Transformation Boards.

Culture

The trust recognised that they had to improve the culture of the organisation. The Board meeting in September 2022 included a paper which clearly articulated the challenges they faced. There was a recognition that there were pockets of discriminatory and marginalising behaviour across the trust. Many of the staff we met during the inspection talked about improvements in the trust culture, but it was clear that there were still teams with poor morale.

The Board had taken steps to revisit their own culture and behaviours. Several key Board appointments, including the chair, appeared to have significantly improved their energy and commitment to transform the organisation. We observed respect and courtesy between all the staff we met and a confidence between Board members to ask advice and where needed, challenge. We heard acceptance that the trust had exhibited some defensive behaviours in the past and were committed to ensure this improved.

We observed that trust executive leader's role modelling appropriate behaviours which was evident throughout the well-led review. They were clear of the need to avoid a blame culture and create one where staff felt supported to learn and improve. We heard about engagement activities already taking place including 'hear to listen' an online regular conversation open to all staff with executive leaders where staff can raise any issues anonymously if they wish or send emails directly to executive leaders. These were being attended regularly by around 300 staff and many more watched the recordings.

We also heard how Board members including non-executive directors, had arrangements in place to visit services each week and meet patients and staff. They all described how this enabled them to gain insights and identify areas for improvement.

A sub-committee of the Board had been established – the Culture and Remuneration Committee to oversee work to improve culture and ensure actions are delivered. This was supported by a culture dashboard bringing together key data including annual staff surveys; monthly pulse surveys; workforce data measuring staff retention and sickness; monthly freedom to speak up reports and staff wellbeing data.

To support the cultural transformation the trust had employed an external provider used successfully by other NHS providers. This organisation supported work to ensure the staff voice was heard and to close the feedback loop by ensuring the listening turns into action. At the time of the inspection this work had been launched and about 30% of the trust staff had chosen to complete the initial survey. These results were available at the time of the inspection and were enabling the trust to start understanding the scale and nature of the issues. Themes from the results were available at the time of the well led review and included feedback about ongoing discrimination, inequality, harassment and accountability.

The trust had an equality, diversity and inclusion strategy and with the support of an external expert progress could already be seen from the workforce race equality standards measured as part of the NHS staff survey. This included a reduction in reports of harassment from ethnic minority groups for the third consecutive year, a reduction of over 20% from 2018. There was also a sustained improvement in the relative likelihood of appointment from shortlisting for

applicants from ethnic minorities. Plans were in place to make further improvements including a review of recruitment processes to further reduce bias and training in cultural competency. The trust had recruited to a new role; equality diversity and inclusion practitioner, whose role was to support the development and delivery of equality diversity and inclusion within clinical services.

Staff networks were in place promoting the diversity of staff. Each staff network had an executive sponsor and had been provided with extra resources to develop further. The trust had several employee networks including LGBT+; BME International Staff; Carers; Ability; Autism; Faith, Spirituality and Belief; Women's; Lived Experience and Mental Health. Events had taken place including events for LGBT History Month and Black History Month where staff voices from under-represented groups had been given a platform.

The trust recognised staff success by staff awards. The trust had launched STAR awards to recognise staff, including a new equality, diversion and inclusion award.

The trust was working to improve opportunities and confidence for staff to speak up and had just started to use an external freedom to speak up guardian arrangement to ensure greater independence from the trust. The trust had 60 internal culture champions across services.

Arrangements for the trust to have a guardian of safe working hours were in place. This role was carried out by a consultant psychiatrist, the current incumbent had been in post since September 2022. The guardian of safe working hours reported quarterly to the Board. According to the November 2022 Board report, between July and September 2022, 12 exception reports had been received, of which 11 were due to additional hours worked. There was 1 exception report raised due to immediate safety concern.

Recruitment and retention of staff was an ongoing challenge for the trust as reflected across the NHS. Data reported to the Board in November 2022 showed that vacancy rates were 9.73% across the trust. There were variations between different staff groups. Clinical support worker vacancy rates were reducing and were projected to reach 3% by January 2023. Registered nurse vacancies continued to cause the greatest concern at 18.82%. Data reported to the Board in November 2022 showed that staff turnover across the trust was currently at 16.1%. Turnover rates had decreased slightly in November but remained above the trust target and this figure had increased over the year. However, the trust were still managing a sustained increase in staff numbers overall, despite significant turnover and vacancy rates. They were using values-based recruitment and had introduced a refreshed induction programme.

Data reported to the Board in November 2022 showed that the number of staff leaving the trust having not completed 2 years of service was significantly above the trust target with an average of 41%. The trust had increased scrutiny to understand the reasons for this, particularly in low performing areas, and follow up on feedback from staff attending the recently refreshed induction programme. The trust had introduced a more refined way of making sure all leavers were able to discuss their reasons for leaving and capturing this through more updated exit interviews.

Data reported to the Board in November 2022 showed that staff sickness rates across the trust were all above the trust target. The staff sickness rate for the rolling 12-month period was 6.07%. Sickness rates for November across the trust averaged 5.51%. Overall, in month sickness absence levels had reduced since a peak in May 2022 but continue to remain above the trusts target.

Staff appraisal completion rates had improved significantly from the last inspection and were at 95%.

Our findings

Pharmacy staff told us they felt more supported by pharmacy leaders than in previous years. Departmental culture was on the trust risk register, and there was an action plan to address this including forums where staff could provide feedback. Culture around medicines safety required ongoing improvement but work was ongoing.

Governance

The trust had structures, systems and processes in place to support the delivery of its strategy including sub-board committees, care group and team governance meetings. Leaders regularly reviewed these structures. Since the last inspection governance processes had been strengthened. The number of sub-committees of the Board had been reduced to streamline systems for gaining assurance. Workplans had been refreshed for these committees. Also following a quality governance review there had been the creation of 2 new operational committees to focus on patient experience and clinical effectiveness.

Papers for Board meetings and other committees were of a reasonable standard and contained appropriate information. We found improvements from the simplified governance processes showing a clearer link from wards to Board. Staff at different levels of the organisation understood and were able to articulate how governance processes worked. An example of this was the refreshed Medicines Optimisation Committee which fed into the Quality Assurance committee. The clinical pharmacy service model had been modified so smaller clinical teams, each with a lead, had responsibility for their clinical areas. Staff told us this had helped increase oversight of their areas, as they could analyse medicines incidents and issues in their area and escalate this as appropriate.

A new accountability framework set out the structure of team, care group and senior trust governance meetings. Managers used meetings to share essential information such as learning from incidents and complaints and to take action as needed. The trust had access to a wide range of data including staffing, incidents, complaints, safeguarding, whistleblowing, feedback from quality and safety review visits but this was not always brought together effectively. This meant that services which were struggling might not be identified at an early stage to ensure they had the necessary support to improve in a timely manner.

The trust had become much more open and transparent in its work. The trust had established a Multi-Agency Improvement Board to support partnership working to identify risks and find solutions. Issues could be escalated to the oversight and assurance group chaired by NHS England. External stakeholders were active participants in the governance processes through attending key committees.

Since the last inspection the trust had strengthened their assurance processes. The chief operating officer had strengthened the quality performance meetings where the care groups were held to account for the services they managed. These were now taking place monthly, made better use of data and set clearer expectations in terms of improvements. Reviews were taking place to further improve governance at a care group level.

There were robust arrangements in place to ensure that the trust discharged its powers and duties under the provisions of the Mental Health Act 1983 (MHA) and Mental Capacity Act 2005 (MCA). The trust held a network of internal and external oversight meetings to assess compliance with the Mental Health Act. Prior to October 2022, the governance structure included the Mental Health Act Committee, the purpose of which was to gain assurance of the effective implementation of the trusts obligations under the Mental Health Act, Mental Capacity Act and relevant legislation, to monitor the effective administration and use of the law and to provide assurance that the trust has discharged its legal responsibilities. Since October 2022, and as a result of streamlining of the governance processes within the trust, the work of the Mental Health Act committee was now overseen by the Quality Assurance Committee, to ensure integrated quality and safety conversations in relation to mental health law compliance.

Our findings

Prior to October 2022, the Mental Health Law Monitoring Group reported to the Mental Health Act committee. As part of the streamlining of the Governance structure, Care Group monitoring, compliance and assurance responsibilities had been devolved to Care Groups. Mental health law compliance had been added to each of the monthly governance meetings. The Mental health law assurance and governance lead attended each meeting to report on, monitoring and support compliance, and reported directly to the Quality Committee. The legal aspects of the role of the Mental Health Law Monitoring Group transferred to the Mental Health Law Forum. This included policy development and review, horizon scanning, audit and assurance work. The Mental Health Law Forum reported directly to the Quality Committee.

An annual Mental Health Act report was provided to the Board to discuss and review.

The trust had strengthened a team which visited wards and services to carry out quality and safety reviews. These reviews had a programme of areas to visit but were also carried out based on emerging risk. The team carried out holistic quality and safety reviews. The team carried out over 100 visits between March and October 2022 and team members included patient representatives and external stakeholders. These visits identified areas for improvement both for individual services and trust wide. This led to changes such as an improved staff induction process.

The trust recently introduced a new method of completing an appropriate range of clinical audits online with the results submitted electronically. These audits reflected the areas identified at the last inspection where improvements were needed such a seclusion; rapid tranquilisation; medicines management; therapeutic observations; and care planning. We found a growing confidence in the auditing process and better outcomes from audits leading to better patient safety.

The number of visits of executives and non-executive directors to services had increased. Twenty-nine visits to services had taken place since late spring by the chair and non-executive directors.

Following our core service inspection there was a recognition that assurance could be strengthened further, particularly the review of incidents through viewing CCTV. This had been taking place, but the quantity and quality of this review needed further development.

Management of risk, issues and performance

The trust had a risk strategy, framework and policy in place. This outlined the trusts approach to risk at a strategic, corporate and operational level.

Since the last inspection a new Board Assurance Framework had been introduced. This clearly identified strategic risk and how these were being addressed. During the well led review members of the Board spoke with insight about the pressures faced by the trust including; staffing, demand and changing at pace. The trust recognised they had challenges which included recruitment and retention of staff, culture, inconsistent models of care and referral practices. The Board Assurance Framework made it clear which executive director was leading on the area of risk and the progress being made.

Our inspections of services found that staff had access to the risk register either at a team or care group level and were able to effectively escalate concerns as needed. Staff concerns matched those on the risk register. These were brought together in a corporate risk register. We found risks were escalated in a timely manner and these were put onto the relevant risk register, such as bed capacity and medical engagement.

Our findings

Our inspection looked at several areas of risk mostly associated with patient safety which had formed the main content of the warning notice issued at the last inspection. This found that the trust had moved at pace to make the necessary changes and that significant improvements could be seen at all levels of the trust. However, there was more work to do to ensure these improvements were implemented consistently, that they are embedded and that where services are struggling that this is identified quickly, and they are given the support needed.

Improvements had taken place to ensure that physical interventions such as restraint were only used when needed and carried out safely. This included the completion of accredited training for the prevention and management of violence and aggression, which most staff had been trained or their training had been booked. The trust had strengthened a trust wide team who supported wards to reduce the use of physical interventions and where needed ensure they were carried out appropriately. There had been some notable success such as Lark ward (a psychiatric intensive care unit) where there had been a 50% reduction in violent incidents through ward initiatives such as encouraging staff to respond quickly to patients requests for assistance. However, we still found an incident on a ward for older people where a restraint did not appear to be undertaken appropriately or safely. We also found 1 acute ward where seclusion in a patients' bedroom was not being recognised so the appropriate safeguards could be put into place.

The trust had carried out a lot of work on the improved systems and training for conducting therapeutic observations of patients. The chief nurse actively engaged with national work on observations and therapeutic engagement through the national nurse director forum. The trust policy been refreshed and the induction training for conducting therapeutic observations of patients was delivered with patients. Staff also had to complete a competency check list and records of observations were checked by matrons. A web-based app had been introduced to conduct and record observations. This also enabled the therapeutic observations to be audited. This process included asking patients about their experience and checking CCTV. However, we found 1 example where an older person had been left too long after having a fall as the observations had not happened in a timely manner.

The trust had improved its work to ensure safer staffing levels. This had included defining safer staffing numbers which could be flexed based on the needs of the patients; introducing local and trust wide daily safety huddles to review staffing levels; using an e-rostering system which also included the training details of staff. The trust had protocols in place to review the time it took staff to respond to incidents if required. For example, in at the Wedgwood unit in Bury St Edmunds there were 3 wards; Northgate, Southgate and Abbeygate wards. The longest response time between the wards was 11 seconds running response from Northgate to Abbeygate ward, all other responses were below this time. The trust told us this system had been in place for many years and ensured the wards remained safe and functional and not depleted during an incident. We reviewed this information for October 2022 and confirmed a team had been available at all times.

The trust had increased their focus and oversight of mandatory training. Although we found mandatory training figures in the services we inspected did not always meet trust targets, they had improved since our previous inspection. For example, as of November 2022, overall compliance in the trusts physical intervention training was 80%, that had increased from 43% at our previous inspection. The trust had added in 42% more training sessions for personal safety training and an additional 45% training sessions for physical intervention since our previous inspection. This included additional training put on at weekends to capture staff. Where staff were booked onto training the trust now recorded predicted training figures to see where their compliance would be once staff had then completed their training. This provided better oversight of training compliance.

The trust had carried out a range of work to reduce ligature points across the wards and improve the assessment and mitigation of ligature risks. We saw the trust had a works programme for ligature reduction work in place with a phased approach which had been risk assessed with work underway. We did inspect a rehabilitation ward with obvious ligature

risks but a programme of environmental improvements costing £1.1m was underway by the end of the inspection. A clinical safety specialist had joined the health and safety team to support ligature reviews aimed at strengthening the accuracy and consistency of these. Ligature incidents were reviewed daily by the risk team and clinical safety specialist with alerts sent out internally as required. The trust had recently implemented an online tool for ligature risk assessments. This included monthly reminders to ward managers to update the ligature risk assessment which allowed the health and safety team to remotely monitor the content and required actions. Ward managers completed monthly ligature walk arounds with the estates team lead and matron. Progress with work on ligatures were monitored through the trust governance processes.

We found many examples of where the quality of individual risk assessments had improved. The trust audited compliance with risk assessments being reviewed and at the time of the inspection this was at 95%. However, there were still a few areas where individual patient risk needed to be managed better and where the recording of risk assessments needed to be kept up to date and recorded in the same place in the care records.

The trust had made progress to improve how it met the physical healthcare needs of patients. This included an extensive programme to improve the physical health outcomes of patients. This work was led by a consultant psychiatrist and deputy director of nursing. Ward managers completed physical healthcare audits. Audits reviewed the physical health assessments patients had on admission, ongoing physical health screening, ongoing physical health observations and the patients' physical health needs being reflected in their care plan. At the time of the well led review the completion rate was 91% across inpatient services. Rates were lower in the community, but the trust were working with commissioners to arrange additional resources to do this work. Suffolk, which was better resourced, was in the top 10% of the country for completion of this work. The trust developed physical health training for clinicians which 64% of staff had completed at the time of our inspection. This was competency-based training for staff and included access to boxes of essential equipment so staff could practice their techniques. Staff also had online access to bitesize training on specific key topic areas. Our inspections showed that whilst there had been significant progress further work was needed to consistently apply and embed this work.

Since the last inspection the management of serious incidents had improved. The trust had remained good at reporting incidents. The trust had effective processes in place to manage the investigation of serious incidents. Serious incidents were reported and the patient safety team reviewed these daily. The trust was an early adopter of the new national patient safety incident response framework which sets out the NHS's approach to developing and maintaining effective systems and processes for responding to patient safety incidents for the purpose of learning and improving patient safety. There was a robust incident decision making process following this framework and the type of investigation or response to take following any incident. The safety incident reviews the Care Quality Commission reviewed were of good quality.

The trust had worked hard to reduce the number of overdue incidents that needed investigating. This had reduced almost 90% from 1300 in November 2021. Since April 2022 they had maintained an average of 100 open incidents. Learning from incidents was ongoing. Patient safety alerts had been issued detailing newly identified risks following learning from incidents. There had also been a number of learning summits looking at areas like the oversight given to people on waiting lists; a review of missed appointments; improving the pathway for young people with ADHD. We saw and multiple examples of these during our core service inspection. The trust also held daily and weekly huddles in which learning is shared from incidents. The trust was an accredited member of the Royal College of Psychiatrists serious incident accreditation network for meeting standards including the involvement of staff, patients and families in investigations.

Our findings

The trust had recruited health and safety champions on each ward and updated training had been rolled out to all managers. The trust had implemented new health and safety inspection software which collected data for actioning. This data was monitored at weekly risk team huddles.

The trust was working across several sites where the estate was out of date which added to the challenge of delivering safe care that supported patient's privacy and dignity. Estates and maintenance teams had monthly meetings to look at clinical risk priorities. Estates and maintenance prioritised urgent requests through collaborative working with the risk team and clinical safety specialist. There was a task and finish group underway to monitor outstanding work. The trust Board had sight of the most significant risks and mitigating actions were clear. Risks were on the local risk register and site-specific risk assessments were in place on how they would manage this. We found some examples of where repairs had not taken place in a timely manner impacting on patients using those services and recognise that the improvements need to embed.

At the previous inspection we saw that the pharmacy team did not have enough oversight of medicines optimisation across the trust. At this inspection, we saw the pharmacy department were in the early phases of developing a regular programme of audit to monitor medicines in clinical areas. However, during our inspection, we found some examples of where this needed to embed further. This included ensuring physical health monitoring takes place appropriately following rapid tranquilisation; ensuring the reasons for the use of 'as and when' medication is recorded; and how covert medication should be administered is clearly recorded.

The Performance and Finance Committee provided comprehensive updates to the Board about the trusts financial position. The trust was confident about breaking even in the current year due to the use of non-recurrent funds. They were concerned about the financial outlook for the following year. They had invested in additional leadership capacity to support the improvement of the trust.

Whilst there were cost improvement plans in place – these did not impact directly on clinical services. The main financial pressures related to the use of temporary staff and out of area placements where they had block booked some acute mental health beds in the independent sector so they can treat patients locally.

Information Management

Since the last inspection the trust had progressed work to improve the availability, quality and presentation of data. The performance function was being strengthened and had been moved from the finance to the operations team. The trust had worked with NHS England to refresh the use of statistical process control to present data so it clearly showed trends over time for the Integrated Quality and Performance Board report and other Board papers; and to strengthen the dashboards used for care groups. Two hundred trust staff had attended training on how to interpret data and narrate governance assurance reports with further training planned. The trust was also working to incorporate model hospital benchmarking data to allow comparisons with other providers. The inspection saw these improvements being implemented in the papers available for key governance meetings. Board members welcomed the improvement in information and intelligence rather than 'data' and the opportunity to improve assurance.

The trust completed the NHS digital data security protection toolkit including an independent audit. This found significant assurance with some improvements required all of which were low level recommendations. This work had been completed.

Our findings

Staff had access to the IT equipment and systems needed to do their work. However, the trust had considerable further work to undertake in terms of their digital transformation. The current contract for the trust's current electronic patient recording system will expire in April 2025 and the trust were in the process of deciding which system would best meet their needs going forward. This decision making was operationally led by the chief operating officer to ensure the new system met the needs of frontline staff.

The trust's current electronic patient recording system had been cited as an issue for staff and external stakeholders. The trust was currently using 3 patient record systems which did not communicate with each other. However, there is a facility in place for staff to access multiple systems.

Team managers had limited access to a range of information to support them with their management role. This included information on the performance of the service, staffing and patient care. Access to live data was limited to identify areas for improvement and inform managerial decision making. Some data was available through Power BI; however, many staff did not have the skills to access and make use of this. In the meantime, the trust had a programme in place, to make incremental changes to the electronic patient recording system to maintain and build upon its functionality.

The trust continued to implement an electronic prescribing and medicines administration (EPMA) system. Pharmacy leaders were involved in staff training and implementation of the electronic prescribing and medicines administration in clinical areas.

Engagement

The trust had a people participation team which brought together service users, carers, families, staff and the wider community to share and deliver mental health services. Their roles included the development of shared decision making; co-production and co-design; engagement and involvement; engaging with experts by experience.

Patient participation had further embedded across the trust over the last year. There were 8 people participation leads aligned to the care groups and 8 people participation co-ordinators. People participation was embedded across the trust with people with lived experiences actively involved in governance committees, quality assurance work, staff recruitment and training, research and quality improvement work. Patients and carers were represented on many groups such as restrictive practice, planning new hospital wards and on staff interview panels. The trust employed peer support workers across a range of services.

Since the last inspection an Experience of Care Committee had been established reporting to the Quality Committee. The committee led by participation leads worked with internal and external stakeholders to look at the experiences of care people received from the trust using a variety of sources.

The trust teams and care groups had access to feedback from patients, carers and staff and were using this to make improvements. The trust held a variety of participation and carer groups and had strengthened participation and engagement with staff, patients, young people and carers. These groups ranged from meeting weekly to monthly and online and face to face to engage with as many people as possible.

Communication systems such as the trust website and newsletters were in place to ensure staff, patients and carers had access to up to date information about the work of the trust and the services they used.

The trust managed complaints effectively. The complaints process was overseen and managed by a diverse and qualified central customer service team. The customer service team allocated the complaint to the appropriate care

group who allocated to an appropriate investigator to investigate with support from the central team. Information on how to complain was on the trust website. During our core service inspections, we saw that information on how to make a complaint was available locally. During the early stages of the pandemic, advice from NHS England was to suspend complaint investigations. This had led to a backlog in the number of complaints being dealt with. At the time of our review the trust were still clearing this backlog.

From 1 November 2021 to 31 October 2022 the trust received 566 complaints. At the time of our review, 338 (60%) of these complaints had been formally investigated and responded to; 168 (30%) remained live in the system; 49 (8%) had been stood down by the complainant and 11 (2%) were awaiting authorisation and / or summary. A further 241 complaints had been closed which predated this period from the backlog.

Themes from complaints were analysed and provided to directorates and teams to provide opportunities for learning and improvement. We saw evidence that these themes were shared per care group but the trust told us themes from complaints were shared across the trust via contributions to bimonthly patient safety newsletters and reported to the Quality Committee.

The trust sought to actively engage with people and staff in a range of equality groups. Governors held non-executive directors to account for the performance of the Board. Governors held annual engagement events to connect and engage with members of the local community. Governors held 4 engagement events over July and August 2022 to share activity over the last year in the trust and discuss priorities for the following 12 months to be able to gain and represent public over the following year. These priorities included ensuring services were safe; cutting waiting times and improving access to services; transforming culture and creating a fit for purpose organisation with effective governance and leadership and transforming mental health service provision across Norfolk and Suffolk with system partners.

Care group leaders engaged with external stakeholders such as commissioners and Healthwatch. The trust undertook a partners' survey to understand how they could increase their confidence in the trust and were acting on the findings.

Learning, continuous improvement and innovation

The trust was making progress with developing its programme of quality improvement work. The trust used the 'Model for Improvement' quality improvement approach. The trust had built capability through a tiered training approach to all levels of the organisation. The trust had 3 improvement experts who led, coached and taught improvement projects; 27 improvement coaches who taught and coached improvement projects; 216 staff trained in running improvement projects and 430 staff trained in the fundamentals of quality improvement. The trust was a partner in the Integrated Community System Quality Hub which sought to improve capability across the system. The trust recognised they needed to participate in more national improvement networks to further develop their work.

At the time of our inspection the trust had 48 active quality improvement projects underway. In August 2022, 13 wards concluded a year of collaborative working to enhance the well being of patients and promote recovery by providing more opportunities for people to participate in activities with a focus on the evenings and weekend.

The quality improvement team employed a people participation coordinator who connected improvement projects to people with lived experience. At the time of our inspection, 62% of the trust's quality improvement projects included people with lived experience. The trust were working on a co-produced quality improvement training session for people with lived experience and carers who wished to join improvement projects. They would be able to access this through the recovery college from January 2023.

Our findings

The trust sought to participate in national improvement and innovation projects. Staff were encouraged to share innovative ideas and supported to implement them. For example, in Suffolk, the pharmacy team identified that discharge medicines were taking a long time to process due to the location of the dispensary. In response to this satellite pharmacies had been set up.

The trust introduced new forums for managers across the organisation to share experience and good practice.

Since the last inspection there had been the addition of an Improvement Board as a sub-committee of the Board to support partner engagement and monitor trust progress. There were positive examples of collaborative working. This included mental health nurses working in primary care across both systems. Since our previous inspection 95 new primary mental health nurses had offered more than 80,000 appointments in GP surgeries across Norfolk and Suffolk supporting people in their local communities. In West Suffolk the trust was working with Mind to support people with long term mental health conditions. MIND were able to offer people up to 3 interventions a week such as help with accessing fitness activities to improve their overall health. The trust recognised that there was scope to significantly grow this collaborative working.

Since our previous inspection the trust had launched new services. These included a new rehabilitation team consisting of 22 staff who provided support for people treatment resistant psychosis. The trust had also launched a new armed forces veterans wellbeing service in partnership with Walking with the Wounded and Outside the Wire, to provide mental health support across Norfolk and Suffolk. The trust had invested an additional £2.5 million in services to support people with eating disorders, serious mental health issues and personality disorders. The trust had opened a specialist service in in Suffolk which provided dedicated support for new, expectant and bereaved mothers experiencing mental ill health which is helping more people than ever before. The trust had also introduced their first mental health response car for people in Norfolk and Waveney experiencing a mental health crisis and a second car launched in November 2022.

The trust was actively participating in clinical research studies. They were a member of the Clinical Research Network, taking part in 25 national research studies. At the time of our inspection, 1,600 patients, cares and members of the public had volunteered to take part in research. The trust had relaunched their research training programme, with 8 online courses involving more than 400 staff.

The Trust had an excellent research profile nationally and the chief medical officer planned to increase this work with the health education England via fellowship posts.

Use of reflective practice and learning had been identified and needed further consistency and monitoring, particularly in line with team culture and safety.

The trust had 9 services that were fully accredited members of Royal College of Psychiatrists networks. A further 12 services were working towards accreditation at the time of the inspection.

The trust had been nominated for 2 national Nursing Times Awards in 2022. These were for ‘Clinical Research Nursing’ and ‘Best Workplace for Learning and Development’.

Key to tables

Ratings	Not rated	Inadequate	Requires improvement	Good	Outstanding
Rating change since last inspection	Same	Up one rating	Up two ratings	Down one rating	Down two ratings
Symbol *	➔➔	↑	↑↑	↓	↓↓

Month Year = Date last rating published

* Where there is no symbol showing how a rating has changed, it means either that:

- we have not inspected this aspect of the service before or
- we have not inspected it this time or
- changes to how we inspect make comparisons with a previous inspection unreliable.

Ratings for the whole trust

Safe	Effective	Caring	Responsive	Well-led	Overall
Requires Improvement ↑ Feb 2023	Requires Improvement ↑ Feb 2023	Good ➔➔ Feb 2023	Requires Improvement ➔➔ Feb 2023	Requires Improvement ↑ Feb 2023	Requires Improvement ↑ Feb 2023

The rating for well-led is based on our inspection at trust level, taking into account what we found in individual services. Ratings for other key questions are from combining ratings for services and using our professional judgement.

Rating for mental health services

	Safe	Effective	Caring	Responsive	Well-led	Overall
Long stay or rehabilitation mental health wards for working age adults	Requires Improvement ↑ Feb 2023	Not rated	Not rated	Not rated	Not rated	Not rated
Specialist community mental health services for children and young people	Requires improvement Apr 2022	Requires improvement Apr 2022	Good Apr 2022	Requires improvement Apr 2022	Requires improvement Apr 2022	Requires improvement Apr 2022
Child and adolescent mental health wards	Good ↑↑ Feb 2023	Good ↑↑ Feb 2023	Good ↑ Feb 2023	Good →← Feb 2023	Good ↑ Feb 2023	Good ↑↑ Feb 2023
Wards for older people with mental health problems	Inadequate ↓ Feb 2023	Good ↑ Feb 2023	Not rated	Good ↑ Feb 2023	Not rated	Not rated
Forensic inpatient or secure wards	Requires improvement Nov 2018	Good Nov 2018	Good Nov 2018	Good Nov 2018	Good Nov 2018	Good Nov 2018
Community mental health services for people with a learning disability or autism	Good Jan 2020	Good Jan 2020	Good Jan 2020	Requires improvement Jan 2020	Good Jan 2020	Good Jan 2020
Community-based mental health services of adults of working age	Requires Improvement →← Feb 2023	Good ↑↑ Feb 2023	Good →← Feb 2023	Requires Improvement ↑ Feb 2023	Requires Improvement ↑ Feb 2023	Requires Improvement ↑ Feb 2023
Wards for people with a learning disability or autism	Good Apr 2022	Good Apr 2022	Good Apr 2022	Good Apr 2022	Good Apr 2022	Good Apr 2022
Community-based mental health services for older people	Good Jan 2020	Good Jan 2020	Good Jan 2020	Good Jan 2020	Good Jan 2020	Good Jan 2020
Mental health crisis services and health-based places of safety	Requires Improvement ↑ Feb 2023	Requires Improvement →← Feb 2023	Good →← Feb 2023	Requires Improvement →← Feb 2023	Requires Improvement →← Feb 2023	Requires Improvement →← Feb 2023
Acute wards for adults of working age and psychiatric intensive care units	Inadequate →← Feb 2023	Requires Improvement ↑ Feb 2023	Requires Improvement →← Feb 2023	Good ↑ Feb 2023	Requires Improvement ↑ Feb 2023	Requires Improvement ↑ Feb 2023

Overall ratings for mental health services are from combining ratings for services. Our decisions on overall ratings take into account the relative size of services. We use our professional judgement to reach fair and balanced ratings.

Long stay or rehabilitation mental health wards for working age adults

Insufficient evidence to rate

Is the service safe?

Requires Improvement ↑

Our rating of safe improved. We rated it as requires improvement.

Safe and clean care environments

The ward was not safe, well equipped or fit for purpose in all areas. However, it was clean, well furnished and well-maintained.

Safety of the ward layout

Staff completed and regularly updated thorough risk assessments of all the ward areas and reduced any risks identified. Staff completed ligature and environmental audits, these showed where risks had been identified and the actions taken. These were supported by walk arounds with the health and safety team. The ward had a comprehensive ligature risk register, ligature risks were discussed regularly in team meetings and supervisions. Staff completed ligature competency assessments to raise their individual awareness of risk.

At the time of the inspection the trust had not completed the removal of ligature risks it had identified although there were plans to do this. Staff had identified radiators and exposed pipework in the risk assessment as a potential ligature anchor point. The trust had not replaced the radiators and concealed the pipework in communal areas. The trust had reduced the risk by having CCTV and having a floor walker in communal areas, but the radiators and exposed pipework continued to be ligature risks. The trust said a programme of works to replace the remaining radiators had been approved. Staff had raised an order for the radiators on 23 August 2022 and works were expected to be completed by 21 October 2022. The trust confirmed to us after the inspection that this work had been completed.

Staff could observe patients in all parts of the ward. The ward consisted of central communal areas and separate male and female corridors that each had a kitchen, dining room and lounge. The male corridor had 2 floors. The ward had CCTV in communal areas which was monitored from the office and a staff member was allocated on floor walker duty to maintain a presence in the central communal areas of the ward including the entrance.

The ward was mixed sex and it complied with guidance on eliminating mixed sex accommodation.

Staff had access to alarms and patients had easy access to nurse call systems, which were installed in patient bedrooms and communal areas.

Staff had completed general observations of all patients. We reviewed observation records for 6 patients and these had been fully completed. Staff carried out audits of observation records and all staff had completed observation competencies.

Long stay or rehabilitation mental health wards for working age adults

At the time of the inspection patient bedroom doors had no mechanism for staff to check if patients were safe and well without opening the door. This was disruptive for patients especially at night when they were trying to sleep. However, work was underway to replace all bedroom doors, the order for the doors had been raised February 2022, with delivery 22 weeks from placing the order. The work to replace the doors commenced September 2022 and works were expected to be completed in November 2022.

Maintenance, cleanliness and infection control

Ward areas were clean, well maintained and well furnished.

Staff made sure the premises were clean. The ward had dedicated domestic staff.

Staff followed infection control policy, including handwashing. Staff wore appropriate personal protective equipment (PPE) and the ward was equipped with hand sanitiser.

Safe staffing

The service had enough medical staff. However, staff were not up-to-date with all essential training to keep people safe from avoidable harm.

Medical staff

The service had enough daytime and night time medical cover and a doctor available to attend the ward quickly in an emergency. We looked at the medical staff rota for the previous 4 weeks, all days were covered. The service had a specialist registrar onsite Monday to Friday, a consultant was available Monday to Friday and the service had on call arrangements in place.

Managers could call locums when they needed additional medical cover. Locum doctors could access trust training.

Mandatory training

Not all staff had completed and kept up-to-date with their mandatory training. Six out of the 20 mandatory training courses fell below the trust target of 85%. These were personal safety 73%, physical intervention 76%, safeguarding adults level 3 73%, safeguarding children level 2 50%, safeguarding children level 3 67% and information governance and data security 73%. However, since the previous inspection basic life support training had increased from 0% to 100%. The ward manager told us the data for physical interventions included staff who were medically exempt from completing this training.

The mandatory training programme was comprehensive and met the needs of patients and staff.

Although managers had monitored mandatory training through team meetings, supervision, governance meetings and staff could see their training record, this had not ensured staff were up-to-date with mandatory training.

Assessing and managing risk to patients and staff

Long stay or rehabilitation mental health wards for working age adults

Staff assessed and managed risks to patients and themselves well. They achieved the right balance between maintaining safety and providing the least restrictive environment possible in order to facilitate patients' recovery. Staff followed best practice in anticipating, de-escalating and managing challenging behaviour. As a result, they used restraint only after attempts at de-escalation had failed.

Assessment of patient risk

Staff completed comprehensive patient risk assessments. Patient records contained an assessment which included an assessment of the levels of patient risk. Staff updated the patient risk assessment following incidents which had occurred. Staff also reviewed the overall patient risk assessment following incidents, including reviewing levels of risk. Risk assessments were reviewed regularly, risks noted were addressed in either the crisis plan, recovery plan or patient behavioural support plan.

Patients had wristbands, which gave access to different areas of the ward based on their individual needs. Access to different areas of the ward was risk assessed and we saw evidence of this with risk assessments completed for kitchen access.

Management of patient risk

Staff knew about any risks to each patient and acted to prevent or reduce risks. Staff reviewed risk assessments regularly and any new risks were included in the overall risk assessment. Staff said they also felt well informed of any outcomes from multi-disciplinary team meetings.

Risk assessments contained clear risk management plans. Patient records reviewed contained a risk management plan to outline what action was needed to manage and mitigate risks posed towards and from patients.

When patients went out, including on section 17 leave, staff completed an assessment of patient's mental state. This meant staff could identify changes, support patients and manage risk. Daily clinical review records also provided good detail on a range of needs, including section 17 leave, risk, observations, medication, consent to treatment and rights.

Staff could observe patients in all communal areas of the ward. The ward had CCTV in communal areas, which was monitored in the unit office and a staff member was allocated on 'floor walker duty' to maintain presence of the central communal areas of the ward, including the entrance. The ward followed the trusts' observation policy and staff were required to complete general observations for all patients. The trust were in the process of replacing bedroom doors with ones that have observation panels, so that patients are not disturbed when staff carry out observations.

Staff access to essential information

Staff had easy access to clinical information and it was easy for them to maintain high quality clinical records – whether paper-based or electronic.

Patient notes were comprehensive and all staff could access them easily. Staff made sure they were up-to-date and complete.

When patients transferred to a new team, there were no delays in staff accessing their records.

Records were stored securely.

Long stay or rehabilitation mental health wards for working age adults

Medicines management

The service used systems and processes to safely prescribe, administer, record and store medicines. Staff regularly reviewed the effects of medications on each patient's mental and physical health.

Staff followed systems and processes to prescribe and administer medicines safely. Staff used ePMA (electronic) records, which were effective, clear and easy to use. There were no gaps or errors noted in the records. As part of a quality improvement (QI) project, staff were supporting patients to write their needs in preparation for multidisciplinary (MDT) reviews. Staff carried out medication audits, we saw evidence of this and 100% compliance for the previous 3 months.

Staff reviewed each patients medicines regularly, official medication reviews took place every 4 weeks, medications were also reviewed daily, using the SBAR communication tool (situation, background assessment and recommendation). Medication notes evidenced reviews of 'as and when required' medicines. One patient had 'as and when required' medication started for bowel movement and the outcome had been recorded the following day.

Staff completed medicines records accurately and kept them up-to-date.

Staff mostly stored and managed medicines and prescribing documents in line with the providers policy. However, we found a cream medicine which was out of date. Staff addressed these issues immediately after we raised them on our inspection.

Staff followed current national practice to check patients had the correct medicines.

The service had systems to ensure staff knew about safety alerts and incidents, so patients received their medicines safely.

Staff reviewed the effects of each patients medicines on their physical health according to the national institute for care and excellence guidelines, staff either completed monitoring or arranged for patients to attend specific clinics for testing and monitoring to be completed, for example, clozapine clinics.

Community-based mental health services of adults of working age

Requires Improvement ↑

Is the service safe?

Requires Improvement →←

Our rating of safe stayed the same. We rated it as requires improvement.

Safe and clean environment

Most clinical premises where patients received care were safe, clean, well equipped, well furnished, well maintained and fit for purpose.

Staff completed and regularly updated thorough risk assessments of all areas and removed or reduced any risks they identified. All services had a premises safety plan. These plans included general building information, ligature assessments, protocol for responding to alarms, lone working protocols and fire procedures. Staff managed risks identified in these assessments well, for example patients were escorted into assessment rooms and were not left unattended due to ligature risks inside the rooms. Staff had completed up-to-date health and safety assessments and fire safety assessments.

Interview rooms were not always fitted with alarms. However, in these situations, staff carried personal alarms. During the inspection we saw staff collect personal alarms from the reception desk before seeing a patient. Other staff were always available in the buildings to respond. At all the team bases doors between the waiting room and interview rooms were locked. This meant that patients could only access interview rooms and offices when they were accompanied by a member of staff.

All clinic rooms had the necessary equipment for patients to have thorough physical examinations. All clinic rooms had equipment to carry out basic physical health checks, including a thermometer, oximeter, weighing scales, equipment for measuring blood pressure and equipment for measuring patients' height.

Most areas were clean, well maintained, well-furnished and fit for purpose. The environments were clean, tidy and well maintained. Reception areas were clean and bright. Staff displayed information about complaints, local services and advocacy.

Staff made sure most cleaning records were up-to-date and the premises were clean. Most cleaning services were provided by external contractors. The contractors audited the quality of cleaning on a monthly basis and sent the audits to the team managers.

Staff followed infection control guidelines, including handwashing. Handwashing information was displayed in bathrooms and clinic rooms.

Staff made sure most equipment was well maintained, clean and in working order. In all clinic rooms, staff attached a label to equipment indicating the last time it had been cleaned. However, in the North Norfolk team there were no cleaning records. One piece of equipment was labelled as being cleaned 2 weeks before the inspection but was visibly dusty.

Community-based mental health services of adults of working age

Safe staffing

The service had enough staff, who knew the patients. The number of patients on the caseload of most individual members of staff, was not too high to prevent staff from giving each patient the time they needed. Some teams were being reconfigured with staff moving to local authorities and the impact on staff caseloads needed further consideration. Some staff had not received mandatory training needed to keep people safe from avoidable harm.

Nursing staff

The service had enough nursing and support staff to keep patients safe. All services employed registered nurses, assistant practitioners, support workers and psychologists.

Managers at the service told us that vacancy rates were reducing. The service had a vacancy rate of 9% at the time of the inspection. Across the service there were 27 unfilled posts. Vacancy rates varied across the teams. For example, at Ipswich Integrated Delivery Team (IDT) the vacancy rate for registered nurses was 20%. This was partly caused by 1 of the registered nurses acting up to a more senior position. In North-East Norfolk, there was 1 vacancy for a team of over 20 staff.

Managers said that turnover of staff had reduced. For example, at Ipswich IDT, no staff had left the service between November 2021 and September 2022. Many staff had been in post for many years. Turnover in other teams was considerably higher, for example, at Bury South IDT turnover was at 33% and at Bury North IDT it was 29%; the high turnover in these teams was mostly attributable to the movement of social workers to other areas in the local authority. This was due to joint working between health and social care (section 75 arrangements) ending.

Sickness levels varied across the teams we visited. Sickness rates for the entire service was 6.7%, which was higher than the trust target of 4.9%. Some teams had higher sickness levels than others, but managers understood the reasons for this. Managers supported staff who needed time off for ill health.

Managers made arrangements to cover staff sickness and absence. Managers told us that if there was significant staff sickness then staff would be able to employ bank or agency staff for short periods.

Managers limited their use of bank and agency staff and requested staff familiar with the service. Bank staff carried out regular shifts at some of the teams. For example, at Ipswich IDT a registered nurse from a neighbouring team facilitated the depot clinic each week. Some teams had employed agency staff for specific roles. For example, in Bury North IDT agency staff had been employed to develop care plans for service users on the waiting list.

Managers made sure all bank and agency staff had a full induction and understood the service before starting their shift. New staff shadowed more senior staff before patients were allocated to them.

Managers assessed the size of the caseloads of individual staff regularly and helped staff manage the size of their caseload. Overall, caseloads for staff across all the teams were manageable. Typically, care co-ordinators had a caseload of around 25 to 30 patients. None of the care co-ordinators had a caseload higher than 38.

Managers reviewed caseloads in supervision and ensured that work was distributed fairly. Some teams held regular caseload review meetings. However, some staff said they were unhappy with caseloads and staffing levels. They felt pressured by the amount of work they had to do and said they found it hard to provide a consistent, timely and a sustainable quality of service. Managers that we spoke to told us that staffing had improved in the last 12 months.

Managers used a recognised tool to calculate safe staffing levels. Staffing levels were calculated by senior managers in collaboration with commissioners. Overall, managers felt that staffing allocations to each team were sufficient to meet the needs of patients, if all posts were filled. However, in April 2022, the agreed level of staff within some teams had been reduced due to social workers moving to other teams with the local authorities. For example, in Ipswich, 6 members of staff had moved from the integrated delivery team (IDT) to the local authority. Whilst some of the duties and responsibilities of the IDT had also moved to the local authority, many staff felt that losing staff had a disproportionate impact.

Senior leaders acknowledged that the staffing models used by the trust had been in place for a long time and local populations had since changed. In response to this, the model of care provided within the community was under review.

Medical staff

The service had enough medical staff. Although the service had several consultant vacancies, these vacancies were covered by a combination of other permanent and locum medical and associate staff. For example, the Waveney team had created 2 non-medical prescribing posts to increase the time available for medical staff. The number of medics in post varied across the teams. For example, in Ipswich IDT there were 3.3 whole time equivalent (WTE) consultant psychiatrists and a specialist doctor. The teams had also trained some nursing staff to become non-medical prescribers. Consultant psychiatrists typically held clinics on 3 or 4 days each week. They saw between 7 and 9 patients at each clinic. In 1 team, the service had recruited a consultant psychiatrist 1 month before the inspection. This psychiatrist was completing an intensive preceptorship. Previously, there had been a consultant psychiatrist for just 1.5 days per week, supported on 3 days each week by a locum doctor. This had meant there had been a waiting list of 5 months for patients to receive routine reviews of their medication. There were still delays to routine reviews in some teams.

At the time of the inspection there were 5.2 consultant vacancies across the service. Some of these vacancies were long standing. For example, the team in Great Yarmouth had not had a permanent consultant in place since 2017. This was identified on the local risk register and the post was out for advert. At the time of the inspection, this vacancy was covered by a combination of a consultant liaison psychiatrist, the deputy clinical director and a locum consultant. A specialist doctor and advanced clinical practitioner had also been recruited to assist with medical reviews.

Managers could use locums when they needed additional support or to cover staff sickness or absence. Locum doctors worked on 3 month rolling contracts. These doctors understood the service and the needs of their patients.

The staff working in the teams could get support from a psychiatrist quickly when they needed to. Patients could contact each of the services through the duty desk. Waiting times for medical reviews varied across the service. Psychiatrists kept slots in their diaries each week to allow time to see patients who needed to be seen quickly.

Mandatory training

The mandatory training programme was comprehensive and met the needs of patients and staff. Staff received training in basic life support, infection prevention and control and safeguarding children and adults. Staff had completed and kept up to date with most elements of their mandatory training.

Overall, training compliance for the services we visited was 89%. However, completion of courses that involved face-to-face training were below the level required by the trust. The courses with the lowest compliance rates were personal

safety training and safeguarding. For example, personal safety training compliance was 67% across the service. Staff explained that there had been a backlog in staff completing these courses since the courses were suspended during the Covid related lockdown. In the meantime, there was a risk that staff may not be appropriately trained and may not respond appropriately to incidents or report safeguarding concerns effectively.

Managers monitored completion of mandatory training and alerted staff when they needed to update their training. Training compliance was discussed during monthly supervision and during team meetings. The trust was arranging additional courses to enable staff to complete the training.

Assessing and managing risk to patients and staff

Staff assessed and managed risks to patients and themselves as part of a combined core assessment. However, updates to patient risk assessments were not always recorded in the same place which meant staff may not find the latest record. They responded promptly to sudden deterioration in a patient's health. When necessary, staff worked with patients and their families and carers to develop crisis plans. Most teams monitored patients on waiting lists to detect and respond to increases in level of risk, however the Norfolk West team did not monitor patients in line with trust policy. Staff followed good personal safety protocols.

Assessment of patient risk

Staff completed a core assessment for patients which included a comprehensive assessment including a risk assessment. We reviewed 30 patient care and treatment records. Most risk assessments that we reviewed were up to date and reflected patients' current presentation. However, 4 risk assessments we reviewed were not clear about current patient risk. For example, a patient had recently self-harmed and this was not reflected in the latest risk assessment. In the records where risk assessments were not updated it was evident that patient risk was regularly assessed by staff during contacts with patients, this risk information was found in the progress notes. Staff had regular morning meetings to discuss high risk patients, staff would also discuss any recent incidents during these meetings.

Significant progress had been made across the trust since the last inspection in relation to ensuring all patients had a completed risk assessment. For example, in Waveney CMHT, 99% of patients had an up to date risk assessment.

Agencies that referred patients to the service completed a risk assessment of each patient on the referral form. This assessment included details of the patient's social circumstances, relationships, level of distress and mental health presentation. Referrers were asked to include an indicative rating of risk on a scale of red, amber and green. Teams used different systems to review new referrals. Some teams would review new referrals the following day as an MDT, whilst other teams would review new referrals twice a week.

Staff could recognise when to develop and use crisis plans and advanced decisions according to patient need. Crisis plans were in place for most patients on the waiting list. In most teams a crisis plan would be created when a patient was accepted onto the waiting list.

Management of patient risk

Staff responded promptly to any sudden deterioration in a patient's health. Staff reviewed the risks presented by patients at multidisciplinary team meetings that were held at least once a week. Staff assigned a risk rating to each patient, with red indicating a high risk, amber showing a medium risk and green indicating low risk. In Ipswich IDT, 21 patients were rated red, 60 were rated amber and 69 were rated as green. These ratings were used to determine the

minimum frequency of contact with care co-ordinators. For example, 1 patient on a Community Treatment Order was refusing their depot medication. Staff had rated this patient as 'red'. They increased the number of visits to this patient and were regularly speaking with the patient's family to assess risk. Staff were making arrangements for the patient to be admitted to hospital. Notes of discussions within multidisciplinary team meetings were added to the patient's record. If a patient's health deteriorated, the care co-ordinator would carry out a further assessment. On the basis of this assessment, staff would manage increasing risks by increasing the frequency of contact, completing a review of their medication with a consultant psychiatrist, making a referral to the crisis team or referring the patient for an assessment for admission to hospital under the Mental Health Act 1983.

The services in North Norfolk operated a flexible assertive community treatment (FACT) service that enabled them to provide additional, flexible support to patients presenting a heightened risk.

Staff on the duty desks made welfare calls, either by telephone or in person, to patients presenting a high risk.

Staff continually monitored patients on waiting lists for changes in their level of risk and responded when risk increased. Most teams ensured that patients on the waiting list were contacted in line with trust policy. Teams had different processes to ensure that patients on the waiting list were regularly contacted. Staff created a personal safety plan for patients on the waiting list at the initial assessment. This plan included details of who the patient could contact if they felt their condition was deteriorating. The teams in North-East and North-West Norfolk had a dedicated team to support patients on the waiting list. This included a senior clinical lead, a registered nurse and 4 support workers. This team ensured that all the patients on the waiting list had care and support plans. In Norfolk West, the service also had a dedicated waiting list team. We reviewed 4 patient records at the Norfolk West team who were on the waiting list. Three out of 4 patients were not contacted in line with trust policy. There was no evidence that patients came to harm due to this. Staff told us that patients rated as amber, should be contacted fortnightly, however staff were contacting them monthly. The manager felt that fortnightly contacts was not appropriate for a lot of amber patients on the waiting list. In response to this the team manager was reviewing the policy with a plan to introduce a new process that would allow staff to individually assess frequency of contact for each patient. All other records we reviewed, evidenced that patients were contacted in line with the clinical harm reduction policy. In Bury IDT, the service produced a list once a week of patients on the waiting list who needed to be called. Staff made regular telephone calls to patients on the waiting list. Staff contacted patients with a red risk rating at least once a week. Patients with an amber rating were contacted every 2 weeks. Patients with a green rating were contacted every 4 to 6 weeks.

Staff followed clear personal safety protocols, including for lone working. Staff completed a risk assessment before they conducted a visit to a patient's home. If the visit presented a heightened risk, the member of staff would be accompanied by a colleague. If staff needed urgent assistance, they could telephone their office and state an emergency code. All visits were recorded in a calendar. The records included the address of the visit. At the end of each day, staff were required to contact their office to confirm that all their visits had been completed. If staff did not confirm that their visit had ended, the service would contact them.

Safeguarding

Staff understood how to protect patients from abuse and the service worked well with other agencies to do so. Most staff had training on how to recognise and report abuse, although there were variations between teams, and they knew how to apply it.

Staff were offered training on how to recognise and report abuse, appropriate for their role. Staff discussed safeguarding concerns at team meetings. The trust's safeguarding team provide support and advice to all the community mental health teams.

Some elements of safeguarding training compliance were low. The overall training compliance for safeguarding adults level 1 was 99% and level 3 was 78% and 82% for safeguarding children level 3. However, there were variations between teams. Completion of safeguarding adults training at level 3 was 62% in Ipswich and 58% in Bury South. Completion of safeguarding children level 3 in Ipswich was 54%.

Staff knew how to recognise adults and children at risk of or suffering harm and worked with other agencies to protect them. For example, staff said they had raised safeguarding referrals when young children had been left at home on their own and when they were concerned that vulnerable patients were potentially being exploited.

Staff could give examples of how to protect patients from harassment and discrimination, including those with protected characteristics under the Equality Act.

Staff knew how to make a safeguarding referral and who to inform if they had concerns. Staff said they would speak to their manager or a senior colleague if they were concerned about safeguarding. Safeguarding concerns were also discussed during the daily handover meeting.

Staff access to essential information

Staff kept detailed records of patients' care and treatment. Records were clear, up-to-date and easily available to all staff providing care.

Patient notes were comprehensive, and all staff could access them easily. Patients' records were stored on an electronic patient record system. These records included risk assessments and care plans. Care co-ordinators regularly updated these records.

When patients transferred to a new team, there were no delays in staff accessing their records.

Most patient records were detailed. All records we reviewed had sufficient information about patients' care and treatment in the progress notes, however, it was not always available in the risk assessments and care plan sections. This meant staff could not access it quickly. Managers were aware of this and were working with staff to improve record keeping.

Records were stored securely. Staff were required to enter and individual username and personal password in order to access the electronic patient records.

Medicines management

The service used systems and processes to safely prescribe, administer, record and store medicines. Staff regularly reviewed the effects of medications on each patient's mental and physical health.

Staff followed systems and processes to prescribe and administer medicines safely. All medicines were prescribed by a doctor or non-medical prescriber. Staff recorded any administration of medicines on a medicines administration record. All records were complete and signed by the prescriber.

Staff reviewed each patients medicines regularly and provided advice to patients and carers about their medicines. Patients discussed their medicines with their co-ordinator at each appointment. Care co-ordinators could request a review of medicines by a doctor whenever this appeared necessary. Doctors explained the purpose of the medication in order to help patients understand their illness.

Staff completed medicine records accurately and kept them up-to-date. Medicine administration records were fully complete and signed by a doctor. They included details of any allergies the patients had. There were no gaps in recording.

Staff stored and managed all medicines and prescribing documents safely. Medicines were stored in locked cabinets. Each service had an up-to-date list of medicines in the clinic room. There was no evidence of excess stock. Two members of staff checked the stocks of medicines each week to ensure that none of the medication had passed its expiry date. Staff recorded the temperature of fridges used for storing medicines each day. All entries on these records were within the acceptable range. There were no gaps in recording.

Staff learned from safety alerts and incidents to improve practice. Staff discussed safety alerts at monthly team meetings.

Staff reviewed the effects of each patient's medicines on their physical health according to National Institute for Health and Care Excellence guidance. Doctors and care co-ordinators continually reviewed the effects of medicines on patients' physical health. For example, each service carried out regular blood tests on patients receiving clozapine. One patient received an urgent medical review after the GP contacted the service with concerns about Lithium levels causing renal problems.

Track record on safety

Reporting incidents and learning from when things go wrong

The service managed patient safety incidents well. Staff recognised incidents and reported them appropriately. Managers investigated incidents and shared lessons learned with the whole team and the wider service. When things went wrong, staff apologised and gave patients honest information and suitable support.

Staff reported serious incidents clearly and in line with trust policy. All staff told us they knew the process for raising serious incidents.

In the period from September 2021 to September 2022, there were a total of 11 serious incidents reported on Strategic Executive Information System (STEIS) community adults services. Most of these incidents were in relation to self-inflicted harm.

Staff knew what incidents to report and how to report them.

Staff raised concerns and reported incidents and near misses in line with trust policy. For example, staff had reported a medicines error as soon as they became aware that both they and the GP had been prescribing a patient anti-psychotic medication. This had resulted in the patient taking a dose above the maximum recommended in the British National Formulary (BNF). Staff acted immediately to review the patient's medication and carry out blood tests to ensure there had been no adverse side effects.

Community-based mental health services of adults of working age

Staff understood the duty of candour. They were open and transparent and gave patients and families a full explanation if and when things went wrong. For example, staff had met with the family of a patient who had died. They also offered to share the full report of the investigation into the incident with the family.

Managers debriefed and supported staff after any serious incident. For example, staff were offered support and counselling from the in-house psychology team after a serious incident.

Managers investigated incidents thoroughly. Patients and their families were involved in these investigations. For example, managers conducted a serious incident review into the medicines error mentioned above. This involved interviews with staff, the GP, and a pharmacist. Staff from the patient safety incident team were involved in this review. Managers completed 72-hour reports after each incident. These reports were sent to the patient safety team who conducted a learning review. Reports by the patient safety team were all reviewed by a panel of senior managers who decided whether to commission a full root-cause analysis of the incident. Service managers and clinical team leaders attended a monthly serious incident meeting, chaired by the medical director. All serious incidents were reviewed at this meeting.

Staff met to discuss the feedback and look at improvements to patient care. For example, in reviewing 1 serious incident, staff considered whether they had missed any indications of risk. They found there had been a 'near miss' 3 months before the incident, when a telephone call was not followed up. Staff introduced systems to ensure they would be alerted if future calls were not acted upon.

Managers shared learning with their staff about never events that happened elsewhere. For example, 1 manager had talked to the staff about the patient in another team who had died of a rare complication of treatment relating to antipsychotic drugs.

Is the service effective?

Good ↑↑

Our rating of effective improved. We rated it as good.

Assessment of needs and planning of care

Staff assessed the mental health needs of all patients. They worked with patients and families and carers to develop individual care plans and updated them as needed. Care plans reflected the assessed needs, were personalised, holistic and recovery-orientated.

Staff completed a comprehensive mental health assessment of each patient. Staff completed a combined assessment at their initial meeting with each patient. This included an assessment of physical health, mental health and risks.

Staff developed a comprehensive care plan for each patient that met their mental and physical health needs. As part of the inspection we reviewed 30 care plans. Overall, care plans were personalised, holistic and recovery-orientated. The wording of the care plans was person centred and suggested service user input. Care plans contained goals and ambitions of the service users. For example, 1 service user's goal to recovery was to return to employment, in response the care co-ordinator had submitted a referral to MIND employment.

Community-based mental health services of adults of working age

Best practice in treatment and care

Staff provided a range of treatment and care for patients based on national guidance and best practice. They ensured that patients had good access to physical healthcare and supported them to live healthier lives. Staff used recognised rating scales to assess and record severity and outcomes. They also participated in clinical audit, benchmarking and quality improvement initiatives.

Staff provided a range of care and treatment suitable for the patients in the service. The services provided care and treatment for patients with mental illness including bi-polar affective disorder, low mood, anxiety and depression, post-traumatic stress disorder and psychosis. The service provided care and treatment including medication, psychological therapies, psycho-social education and signposting to social opportunities or specialist groups.

Services provided regular clinics for patients who required depot medication and offered physical health monitoring to attendees.

Staff delivered care in line with best practice and national guidance (from relevant bodies such as National Institute for Health and Care Excellence). Bury IDT was, for example, piloting a programme of support and treatment for patients based on national guidance for cognitive behavioural therapy. The programme planned care around 3 areas of need: unusual experiences, low mood and personality disorder. The unusual experiences programme was for patients who were hearing voices or experiencing hallucinations. It involved support groups, one-to-one psychology and medication. The low-mood programme aimed to stabilise patients' mood. The personality disorder programme provided support and therapy. Packages were delivered by nurses. The service had developed a workbook for each programme to provide a clear structure to each intervention. We reviewed the records of 1 patient who was receiving a comprehensive programme of interventions including online cognitive behavioural therapy, attending the living with emotions group and receiving additional individual support from a psychologist.

The service was well supported by psychologists. For example, the psychology service in North Norfolk provided a comprehensive programme of 9 evidence-based treatment including cognitive behavioural therapy, dialectical behavioural therapy, psychodynamic therapy, behavioural family therapy and mindfulness-based interventions. They also ran groups, including an acceptance and commitment therapy group, and workshops on understanding anxiety and depression.

Staff made sure most patients had support for their physical health needs, either from their GP or community services. At each of the community mental health teams, staff monitored whether patients with severe mental illness had received an annual physical health check. There were different commissioning arrangements across the service. For example, in Suffolk, the trust had been commissioned to provide annual health checks through a specific physical health team. The national data for physical health checks for people with severe mental illness showed that 64% of service users in East Suffolk and 57% of service users in West Suffolk had a physical health check, placing both areas in the top 10 areas in the country. In Norfolk, the annual physical health check is offered by GPs, supported by the trust's clinical teams for those whose conditions are not stable. In Norfolk, 38% of service users had all their physical health indicators measured. In response to this the service had developed a severe mental illness register which made it easier for teams to identify who needs a check. A business case for new staff in Norfolk had been put forward, as senior leader identified that this was an area for improvement.

Staff supported patients to live healthier lives by supporting them to take part in programmes or giving advice. For example, staff supported patients to engage in a 'Healthier Together' programme. This included social prescribing and access to gym membership. Patient care and treatment records evidenced that patients were regularly signposted to smoking cessation services and substance misuse services where appropriate.

Staff worked closely with other organisations to improve the range of interventions offered by the service. For example, the Norfolk West team had recently been provided with naloxone kits by a local substance misuse service. Naloxone is used in an emergency to reverse the effects of an opioid overdose. Staff at the service were waiting for training on naloxone use before providing service users with the kits.

Staff used recognised rating scales to assess and record the severity of patient conditions and care and treatment outcomes. Each service used a rating scale to measure the severity and outcomes for patients. The care plan involved asking patients 11 questions about their mental health, physical health and social circumstances. The questionnaire asked patients how satisfied they were with their medication, meetings with mental health professionals, and their mental health. Answers to these questions were scored at each care plan review. Reviews were held at least once a year. These scores were monitored to show indications of improvement or deterioration. Nearly all records we reviewed had these outcome measures in place. Leaders told us that all new patients had these outcome measures recorded and teams were in the process of ensuring all patients currently on the caseload had them in place. A dashboard was in development to provide daily updates and to provide oversight of all outcome measured used by services.

Staff used technology to support patients. Patients were able to access the service remotely; this had been put in place during the Covid-19 pandemic. At the time of inspection, the service was using a hybrid model of face-to-face and remote appointments. Staff were able to work remotely when needed.

Staff took part in clinical audits, benchmarking and quality improvement initiatives. Teams carried out regular audits of care plans, clinic rooms, medication charts, supervision and personal protective equipment. The trust had carried out a comprehensive Quality and Safety Review (QSR) at each service once a year. This review covered the following areas of confidence; leadership, medication, environment, patient/carer experience, staff experience, clinical documentation.

Managers used results from audits to make improvements. For example, an audit of the implementation of the care programme approach (CPA) in Bury South had found that only 48% of patients had an up-to-date care plan. Managers met with staff to discuss this and consider ways of improving this performance. After implementing actions agreed at this meeting, 96% of patients on the CPA had an up-to-date care plan.

Skilled staff to deliver care

The teams included or had access to the full range of specialists required to meet the needs of patients under their care. Managers made sure that staff had the range of skills needed to provide high quality care. They supported staff with appraisals, supervision and opportunities to update and further develop their skills. Managers provided an induction programme for new staff.

The service had access to a full range of specialists to meet the needs of each patient. Services employed peer support workers. This involved employing former patients to provide advocacy and intensive support to patients. These roles focused on empowerment and recovery. All the services had access to extensive teams of psychologists. For example, Ipswich IDT employed 4 clinical psychologists. The services in North Norfolk referred patients to a team comprising of a lead consultant clinical psychologist, 4 clinical psychologists and 2 clinical associates in psychology.

Managers made sure staff had the right skills, qualifications and experience to meet the needs of the patients in their care, including bank and agency staff. There was scope for some staff to develop special interests, for example physical health care.

Managers gave each new member of staff a full induction to the service before they started work. All staff completed a full induction. Managers assessed the competency of staff completing the induction before they began working unsupervised. During this period, they spent time in different areas of the service, such as the depot clinic and the duty desk.

Managers supported non-medical staff through regular, constructive clinical supervision of their work. Managers were required to hold supervision sessions with their staff once every month. Compliance with this target was monitored each week. Supervision statistics were discussed with administrators and recorded on a live supervision app for which provided an up to date data. In the Waveney Team, managers held a monthly meeting where they discussed any missed supervisions and investigated reasons for this with staff. At Ipswich IDT, between 5 August and 5 September 2022, compliance with this met the target of 90%. At the time of the inspection, supervision rates at West and South Norfolk Adult Community Services was 75%. Managers told us that improving supervision rates was a priority and they were planning to introduce a line management supervision quality audit. Staff said they were happy with the support they received from their managers.

Managers supported staff through regular, constructive appraisals of their work. The overall appraisal rate for the service met the trust target. In the Ipswich IDT the appraisal rate was 100% and in the West Norfolk team it was 90%. Leaders told us that members of the team were supported to reflect on their experience, wellbeing and areas for development through the appraisal process.

Managers made sure staff attended regular team meetings and gave information to those who could not attend. These meetings were held on the team's 'protected' day, when staff did not schedule appointments. Meetings typically involved discussions about learning from incidents, risk register, personal safety, arrangements for duty desk rota, changes to policy and updates from the psychology team. These meetings were well attended.

Managers identified any training needs their staff had and gave them the time and opportunity to develop their skills and knowledge. For example, peer support workers described their training as being very comprehensive, covering coaching, dialectical behavioural therapy and solution focused therapy.

Managers made sure staff received any specialist training for their role. For example, at Bury South IDT, 2 registered nurses were involved in training to become non-medical prescribers. A senior support worker was completing a phlebotomy course to enable them to take blood. Psychologists provided training and supervision to help care co-ordinators provide psychologically informed approaches to working with their patients.

Managers recognised poor performance, could identify the reasons and dealt with these.

Multidisciplinary and interagency team work

Staff from different disciplines worked together as a team to benefit patients. They supported each other to make sure patients had no gaps in their care. The teams had effective working relationships with other relevant teams within the organisation and with relevant services outside the organisation.

Staff held regular multidisciplinary meetings to discuss patients and improve their care. The services held daily and weekly meetings to review, plan and reflect on the operations of the unit. This was highly valued by both the staff and the management team. Services also held debriefing sessions and supervisions sessions. These sessions were used to discuss patients and their health needs, risk management, allocation and review of responsibilities.

Staff made sure they shared clear information about patients and any changes in their care, including during transfer of care.

Staff had effective working relationships with other teams in the organisation. For example, staff on the duty desk regularly attended ward reviews for patients who were in hospital.

Staff had effective working relationships with external teams and organisations. We attended a multi-disciplinary meeting in the West Norfolk team. Representatives from local mental health charities, local substance misuse services and the crisis team all attended this meeting. During this meeting, staff from across the services discussed service users who were under these services. All the representatives were involved in discussions and staff were knowledgeable about patient risk and their personal circumstances. The teams had strong links to the voluntary sector. For example, the services referred patients to an employment service run by a local voluntary sector organisation. This programme provided interview coaching and support to people in both voluntary work and paid employment. Staff from the programme regularly attended multidisciplinary team meetings. Staff from voluntary group also supported services to provide enhanced packages of care to patients on the flexible assertive community treatment programme.

All the services we visited had link primary care workers working within GP practices. These workers were qualified mental health workers. These roles had been set up by the trust to improve the integration of primary and secondary care services. These roles were more embedded and staffed across the different regions. For example, these roles had not been fully implemented in Great Yarmouth but in Bury North nearly all GP practices in the locality had access to the primary care workers. Managers in Bury North were positive about the impact of these workers and felt that it had significantly improved the patient pathway.

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

Staff understood their roles and responsibilities under the Mental Health Act 1983 and the Mental Health Act Code of Practice.

Each team supported a small number of patients who were subject to community treatment orders. For example, in North-West Norfolk there were 5 patients subjects to CTOs and 2 patients subject to supervision in the community.

Staff received and kept up to date with training on the Mental Health Act and the Mental Health Act Code of Practice and could describe the Code of Practice guiding principles. They knew how to access support and advice on implementing the Mental Health Act and its Code of Practice. Staff knew who their Mental Health Act administrators were and when to ask them for support.

Staff followed clear, accessible, relevant and up-to-date policies and procedures that reflected all relevant legislation and the Mental Health Act Code of Practice. For example, when the service believed that a patient required an assessment under the Mental Health Act, they spoke to staff at the crisis team in the first instance. Mental Health Act assessments usually took place within 7 to 10 days of the referral being made. Patients awaiting a Mental Health Act assessment were placed in the ‘red’ risk zone. This meant staff increased the frequency of their contact with the patient.

Community-based mental health services of adults of working age

For patients subject to a Community Treatment Order, staff completed all statutory records correctly. For example, at North-West Norfolk, we found all statutory documents relating to community treatment orders were stored on the electronic patient record.

Good practice in applying the Mental Capacity Act

Staff supported patients to make decisions on their care for themselves. They understood the trust policy on the Mental Capacity Act 2005 and assessed and recorded capacity clearly for patients who might have impaired mental capacity.

Staff received and kept up to date with training in the Mental Capacity Act and had a good understanding of at least the 5 principles. In a recent team meeting, staff in North Norfolk had discussed assessments of mental capacity for patients who were refusing treatment for physical health conditions.

Staff gave patients all possible support to make specific decisions for themselves before deciding a patient did not have the capacity to do so. Staff assessed and recorded capacity to consent clearly each time a patient needed to make an important decision.

When staff assessed patients as not having capacity, they made decisions in the best interest of patients and considered the patient's wishes, feelings, culture and history. Staff said that if they had concerns about mental capacity, they would discuss this in the multidisciplinary team meeting.

Is the service caring?

Good 

Our rating of caring stayed the same. We rated it as good.

Kindness, privacy, dignity, respect, compassion and support

Staff treated patients with compassion and kindness. They understood the individual needs of patients and supported patients to understand and manage their care, treatment or condition.

As part of the inspection we spoke to 24 patients and 13 carers. Overall, patients and carers were extremely positive about the service they were receiving. Patients described staff as friendly and professional.

Staff gave patients help, emotional support and advice when they needed it. Patients told us that their care co-ordinators were supportive and responsive. One patient said they had been impressed by how responsive the service had been. They said that when they needed to change their medication, an appointment had been arranged very quickly. One patient said that they had waited a long time for the service, and, during that time, they did not know what was going on. They said that staff had frequently telephoned them but were unable to say when a full assessment would take place. The patient found this frustrating. However, they said that when they were seen, staff were kind and listened to them. Overall, they were happy with the outcome.

Community-based mental health services of adults of working age

Staff supported patients to understand and manage their own care treatment or condition. Patients told us that staff always made sure that they understood their care plan and any decision was mutually agreed. For example, patients said that staff had supported them to reduce their medication. Staff would discuss treatment options routinely with patients. Patients who were under the care of the Bury South team expressed their frustration about the turnover of consultants. Patients told us that they had to wait for long periods before being seen and had to explain their medical history each time the consultant changed.

Staff directed patients to other services and supported them to access those services if they needed help. For example, 1 patient told us how they had been supported to access a local foodbank, another patient told us how they had been supported to access housing support.

Patients said staff treated them well and behaved kindly. Everyone we spoke to was overwhelmingly positive about the behaviour of staff at the service.

Staff understood and respected the individual needs of each patient. We attended multiple meetings throughout the inspection, and during these meetings staff showed that they had an extensive knowledge of patients' personal relationships. For example, staff agreed to contact a patient's husband as a patient was proving hard to engage with.

Staff felt that they could raise concerns about disrespectful, discriminatory or abusive behaviour or attitudes towards patients and staff. Most staff we spoke to told us that they felt able to raise any concerns with their managers.

Staff followed policy to keep patient information confidential.

Involvement in care

Staff involved patients in care planning and risk assessment and actively sought their feedback on the quality of care provided. They ensured that patients had easy access to independent advocates.

Involvement of patients

Staff involved patients and gave them access to their care plans. Nearly all patients that we spoke to told us they felt involved in their care, and they received a written a written copy of what was discussed and agreed following 1:1s with their care co-ordinator.

Staff made sure patients understood their care and treatment. All patients that we spoke to told us that staff took the time to explain their care and treatment. Patients could give feedback on the service and their treatment and staff supported them to do this. Most patients we spoke to told us that they never had to raise a concern or complaint, however everyone told us that they know what to do if they need to give feedback about the service. One patient told us that they had previously raised a concern and they were immediately offered an opportunity to discuss it with staff. The trust carried out a quality and safety review of each team once a year. Within this review, the trust sought feedback from patients.

Staff made sure patients could access advocacy services. Information about patient advocacy was shared with patients when they were assessed by the teams.

Community-based mental health services of adults of working age

Staff informed and involved families and carers appropriately. Although families and carers were not always referenced in patients' care plans there were many entries in patients' progress notes detailing contact and the patients' specific circumstances.

Involvement of families and carers

We spoke to 13 family members of patients Everyone we spoke to was positive about the service. Many carers that we spoke to wanted to thank care co-ordinators for the support provided to their relative.

Staff helped families to give feedback on the service. Carers said there was good communication with GPs, care co-ordinators and psychiatrists. The partner of 1 patient explained how the service followed the 'triangle of care' model, involving the patients, the mental health team and the patient's carers in planning treatment and making decisions.

Staff in all teams supported, informed and involved families or carers in the care of their relative or friend. On occasion, such as when the patient withheld their consent to this and had the capacity to do so, staff recognised this was not appropriate.

Staff gave carers information on how to find the carer's assessment. For example, we attended an MDT meeting where a carers assessment was arranged with a social worker from the local authority.

Is the service responsive?

Requires Improvement 

Our rating of responsive improved. We rated it as requires improvement.

Access and waiting times

Access to the services had improved but were variable. Its referral criteria did not exclude patients who would have benefitted from care. Staff assessed and treated patients who required urgent care promptly however patients who did not require urgent care may have to wait for long period of time to start treatment. Staff followed up patients who missed appointments.

In the last 2 years, the trust has experienced an increase of 5000 patients receiving secondary mental health services. In previous years the numbers of patients had been relatively stable. This increase has placed extreme pressures on the adult community mental health services.

At the time of the inspection, the average waiting time for an assessment was 45 days. This did not meet the trust target of 28 days for non-urgent referrals, but it was similar to most other trusts.

Teams within the service had different processes in place to carry out assessments. In Great Yarmouth and Waveney, assessments were carried out by a separate team. This was in response to care co-ordinators being unable to meet the demands of their caseload and to carry out new assessments due to an increase in referrals. Staff told us that they had recently been asked to support the assessment team with assessments and this was increasingly difficult. The team lead

for the service told us that there had been an improvement with how long patients were waiting for an assessment in Great Yarmouth. Most patients were now assessed within 28 days. Other teams carried out their own assessments. Some teams had much longer waiting times for assessments. In the Waveney area, patients had to wait up to 8 weeks for an assessment although urgent referrals were assessed within 72 hours in line with trust policy.

The service had clear criteria to describe which patients they would offer services to and offered patients a place on waiting lists. These teams provided support and treatment to patients with enduring mental illness. Often, patients had a long-term history of mental illness and multiple agencies involved in providing support. Staff regularly reviewed waiting lists to ensure that patients on the list continued to meet the criteria for referral. When patients referred to the service did not meet the admission criteria, letters detailing their decision would be sent to the referrers and staff signposted them to a more appropriate service. To ensure that services were able to accept new patients, managers reviewed caseloads to ensure that patients were discharged when it was appropriate to do so. For example, in Bury South IDT, the manager talked to staff about how they could resolve any barriers to discharge whenever casework was reviewed in supervision

The service did not always meet trust target times for seeing patients from assessment to treatment. The average waiting time to begin treatment was 100 days. Waiting lists were present in all the teams we visited; staff contacted service users on the waiting lists depending on their level of risk. However, in the assessment team in Great Yarmouth and Waveney we were told it was not possible to check in with service users while they were waiting for an assessment. Senior leaders told us that they were aware that this was a current risk. To mitigate the risk of reduced oversight, staff sent a letter to the referrer explaining the delay and provided crisis details to service users that were waiting. Waiting lists were reducing across the service. For example, in the Waveney team, the waiting lists had been reduced from 300 service users down to 56. Staff told us this had been achieved by setting up a new short-term intervention pathway, which had improved waits and tailored care to specific patients.

Waiting lists were present in all the teams we visited, patients would be placed on a waiting list if they were waiting for assessment, treatment or waiting to be allocated to a care co-ordinator. Teams used the waiting lists inconsistently and the size of the waiting lists varied significantly between teams. In the Norfolk West team there were approximately 170 service users on the waiting list and in the Bury North team there were 28 service users on the waiting list. In all the teams we visited the waiting lists were reducing. It was not always clear why some patients were on the waiting list or what they were waiting for. Some patients had been on the waiting list for several years; however, they were receiving interventions regularly.

The waiting times for patients to see a psychologist varied. Whilst there were very short waiting times for psychology in most, 4 of the 13 teams had long waiting times. Some patients experienced long delays to accessing one-to-one psychology. The average waiting time for psychology is 55 weeks. Teams were reducing the psychology waiting list across the trust. For example, in Waveney the psychology waiting list had reduced from 60 patients to 20 patients. Staff told us they had transferred some patients waiting to external agencies. Staff were also trained in low level therapeutic intervention and this would be offered while patients were waiting for one-to-one psychology. Patients could also attend therapy groups offered in the community. At Ipswich IDT, there had been no waiting list to see a psychologist since May 2022. Senior leaders had identified that there was inconsistency across the teams. The trust psychological lead was in the process of reorganising psychology services to reduce these variations.

High risk patients could receive routine medical reviews promptly; however, patients waiting for routine reviews could face delays of 8 to 12 weeks. Staff told us that there remained a backlog for routine medical reviews however these were reducing as the medical vacancies became filled. Non-medical prescribers and specialist doctors had been recruited to reduce the waiting times.

Community-based mental health services of adults of working age

Staff saw urgent referrals quickly. Staff said urgent referrals were reviewed and followed up within 24 hours to 72 hours.

Staff tried to engage with people who found it difficult, or were reluctant, to seek support from mental health services. In some teams, peer support workers were assigned to patients who were reluctant to engage. Their aim was to build a therapeutic rapport with patients. Community organisations also facilitated groups to engage patients, such as the Mindset group in Bury. Teams in North Norfolk provided additional support to patients through their flexible assertive community treatment programme.

Patients had some flexibility in respect of appointment times. Patients told us they had a choice of times to suit their personal lives.

Staff worked hard to avoid cancelling appointments and when they had to, they gave patients clear explanations and offered new appointments as soon as possible.

The service used systems to help them monitor waiting lists and to support patients. At all the services staff monitored waiting lists. Managers explained that waiting lists had reduced during the previous 12 months. For example, at Ipswich IDT, the number of patients on the waiting list had fallen from 180 in December 2021 to 60 in September 2022. In North-East and North-West Norfolk, the service had a dedicated team to support patients on the waiting list. Staff in this area also ran additional clinics on Saturdays in order to reassess patients on the waiting list.

Staff supported patients when they were referred, transferred between services, or needed physical health care. Care records showed arrangements for a safe and well-supported transfer between services. The care records included planning and assessments details, letters to GPs and other service providers and discharge documents.

The facilities promote comfort, dignity and privacy

The design, layout, and furnishings of treatment rooms supported patients' treatment, privacy and dignity.

The service had a full range of rooms and equipment to support treatment and care. Each service had consultation rooms, clinic rooms, office space and meeting rooms.

Most interview rooms in the service had sound proofing to protect privacy and confidentiality. However, the West Norfolk teams held consultations with service users in rooms that were made of frosted glass. Staff had identified the potential issues with confidentiality and there was clear signage by the consultation rooms to remind staff of this. Patients did not have access to these areas without a staff member.

Meeting the needs of all people who use the service

The service met the needs of all patients – including those with a protected characteristic. Staff helped patients with communication, advocacy and cultural and spiritual support.

The service could support and make adjustments for people with disabilities, communication needs or other specific needs. Most premises were wheelchair accessible and there was suitable lift access.

Staff made sure patients could access information on treatment, local service, their rights and how to complain.

The service provided information in a variety of accessible formats so the patients could understand more easily.

Community-based mental health services of adults of working age

The service had information leaflets which were available in languages spoken by the patients and local community. Staff told us that information could be accessed in any language. Staff had a good understanding of the make-up of the local population.

Managers made sure staff and patients could get hold of interpreters or signers when needed.

Listening to and learning from concerns and complaints

The service treated concerns and complaints seriously, investigated them and learned lessons from the results, and shared these with the whole team and wider service.

Patients, relatives and carers knew how to complain or raise concerns. Patients told us that they knew how to make a complaint.

Staff knew how to acknowledge complaints and patients received feedback from managers after the investigation into their complaint. Complainants received a thorough response to their complaints, signed by the Chief Executive. Complaint response letters included details of the investigation and the conclusions that had been reached.

Managers investigated complaints and identified themes. For example, in the 6 months before the inspection, Bury South IDT had received 12 complaints. These complaints related to disagreements about care provided, an alleged failure to follow-up on agreed actions and the quality of assessments

Staff understood the policy on complaints and knew how to handle them. They protected patients who raised concerns or complaints from discrimination and harassment. Staff knew how to acknowledge complaints and patients received feedback from managers after the investigation into their complaint.

Managers shared feedback from complaints with staff and learning was used to improve the service. For example, complaints had been raised at Ipswich IDT about patients not receiving discharge letters. These complaints were discussed at a monthly governance meeting and a new process was approved during the meeting. Staff told us that complaints from patients has significantly reduced since this new process was introduced.

The service used compliments to learn, celebrate success and improve the quality of care. Thank you cards from patients were displayed in the offices of staff.

Is the service well-led?

Requires Improvement ↑

Our rating of well-led improved. We rated it as requires improvement.

Leadership

Leaders had the skills, knowledge and experience to perform their roles. They had a good understanding of the services they managed and were visible in the service and approachable for patients and staff.

Community-based mental health services of adults of working age

The senior managers led the service using appropriate skills and knowledge to perform their roles. Most team managers had worked within the trust for a number of years.

Staff said they found managers to be supportive. They recognised that managers were often very busy but were always approachable if staff needed help.

Staff said that recent changes in leadership had been positive. They said that managers provided clear leadership and undertook their responsibilities well. Staff valued managers who carried out assessments and held a caseload that included some high-risk patients. Staff felt the service was managed well at a local level. They said managers were supportive and available. However, staff thought the pressure from senior leaders was relentless and short term, focused solely on resolving issues identified at previous Care Quality Commission inspections. Staff felt that managers at senior levels were unsupportive and did not recognise the pressure that staff were working under.

We found senior leaders had a good knowledge of the strengths and weaknesses of the teams within the service and the systems in place. Both senior leaders and local leaders were open and honest about their successes and challenges.

Vision and strategy

Staff knew and understood the provider's vision and values and how they (were) applied to the work of their team.

The trust's senior leadership team had successfully communicated the provider's vision and values to the frontline staff in this service. Most staff interviewed knew of the trust's vision and strategy. For example, staff told us that improving access and quality of care was 1 of the key strategies.

Culture

Staff felt respected, supported and valued. They said the trust promoted equality and diversity in daily work and provided opportunities for development and career progression. They could raise any concerns without fear.

Staff spoke positively about the support they received from colleagues within their multidisciplinary teams. Most staff said they felt valued by their team members.

Career development was supported. Staff supervision included conversations about career development. Staff said managers supported them in identifying professional development opportunities.

Staff said there was a notable turnover of staff and managers. They said there were persistent staff shortages which affected individual and team morale and delivery of care to people in a timely manner. Staff expressed feelings of being overwhelmed, burnt-out, exhausted, and frustrated by the volume of work and caseloads, covering for staffing shortages and spreading themselves widely to provide care to every patient on the waiting list. Staff told us there was an emphasis on managing the waiting list and bringing it in line within the acceptable timescales set by the Trust. They said this was not always attained due to staffing shortages. However, the pressure that staff were experiencing was not consistent with the data we reviewed during the inspection. Evidence showed the number of staff vacancies was below 20% in all services. Data showed that staff typically had 25 patients on their caseload. Data also showed that staff had reduced waiting lists.

Community-based mental health services of adults of working age

Staff had access to support for their own physical and emotional health needs through an occupational health service. Managers told us they supported staff members to access counselling if that need was identified.

Staff knew how to whistle blow allegations of abuse to internal and external agencies to help keep people safe. Staff felt able to approach their managers with any concerns and said they were listened to. Staff said they did not fear any reprisals as managers discussed with them why things had happened and what actions they needed to take to improve their practice.

Governance

Senior leaders did not have access to data that was consistently recorded to monitor risk and outcomes. The services did not have a consistent model for how to use and record waiting lists. Leaders needed to make further changes to ensure the service's delivered high-quality care that met patients' needs. However, the trust had implemented many improvements since the previous inspection.

Although areas of concern were identified during the inspection, senior managers were already aware of these issues which had been identified through the governance processes within the trust. Some of the issues, such as delays to assessment and recording of information, were improving however further work was required to ensure all teams met trust targets.

Process were in place for teams to monitor performance. For example, the leadership team at Ipswich IDT held weekly improvement cycle meetings where they review data in relation to compliance and performance. This included a review of data for rating scales that showed the severity of patients' conditions and measured the improvement they had achieved.

The services did not have a consistent model for how to use waiting lists. Some teams used waiting lists for patients waiting assessment and treatment, whilst in other teams patients waiting for a care-coordinator were also on the waiting list. Senior leaders knew about the differences between teams and told us they were working to ensure that staff across the trust used them consistently. Senior leaders told us that waiting lists should only be used for patients waiting for assessment and treatment. The data provided by the trust in relation to waiting lists was different to what team leads told us onsite.

Managers had a good understanding of their objectives and priorities for the forthcoming year. For example, at Ipswich IDT, the teams had clear priorities to recruit staff and maintain stability in the team, to further reduce waiting lists and to extend the use of rating scales to evaluate the effectiveness of treatment.

Clinical and managerial leaders met once a month for a clinical governance meeting. Staff at these meetings reviewed data on staffing, referrals and discharges. They reflected on work that had gone well and areas of work that need more development.

Staff were clear about their roles and responsibilities and they understood the management structure within the service.

Management of risk, issues and performance

Community-based mental health services of adults of working age

Teams had access to the information they needed to provide safe and effective care and used that information to good effect. However, data collection across the teams, particularly in relation to waiting lists, was not consistent. This meant that teams which were outliers in terms of performance might not be identified.

Staff maintained and had easy access to the risk register at team and service line level. Staff could escalate concerns when required from team to service line level. The risks recorded reflected those we found during the inspection and reported to us by staff.

Managers received data relating to the performance of their team once a week. This included an overview of performance for the previous 6 months. However, data on waiting lists was frequently inconsistent and based on different criteria of what waiting lists involved. For example, in Ipswich IDT, staff stated that on 9 September 2022, there were 61 patients on the waiting list, waiting for a care co-ordinator. Information on the performance dashboard showed there were 12 people on the waiting list. Similarly, in North-East Norfolk, staff said that there were 127 patients on the waiting list, whereas the performance dashboard showed there were 52 people waiting. In Bury South IDT, staff said there were 99 patients on the waiting list. The dashboard showed there were 23. The trust told us this was due to patients who had been assessed and treatment initiated but who were waiting for allocation. Not all staff were not aware of this.

Staff told us the management team developed contingency plans to enable them to manage the workload when there were staffing shortages. For example, services rotated staff on the duty desk.

Information management

Staff engaged actively in local and national quality improvement activities.

Team managers had access to information to support them in their management role. Managers collected and reviewed data about outcomes and performance and used this to report on key performance areas of the teams. Managers used information to oversee team performance. This included information on completion of patient risk assessments, care plans and community physical health assessments. For example, managers at Ipswich IDT had access to the East Suffolk community dashboard. The dashboard displayed information about the number of patients with a risk assessment in place and the number of patients with combined assessments in place. The dashboard also allowed staff to monitor the number of patients on the waiting list.

Engagement

Managers engaged actively other local health and social care providers and were working to deliver integrated health and care to meet the needs of the local population.

Engagement with other health and social care providers was fundamental to the delivery of the service services and this took place at all levels of the service. At a strategic level, there were regular meetings between the trust and local partners. At an operational level, managers from the services regularly met with managers from primary care networks. Staff from other organisations, such as counselling services and drug and alcohol services, attended the teams' complex care meetings.

There was concern amongst senior leaders that the current model was unsustainable due to a large increase in demand for the service. Senior leaders had commenced a review into the model of care, this review would be carried out alongside main stakeholders, to ensure the remit of the community mental health teams was clear.

Staff, patients and carers had access to up-to-date information about the service. Patients and carers had opportunities to give feedback on the service they received. Managers and staff had access to the feedback from patients, carers and staff and there was evidence that staff acted on this feedback. For example, in response to complaints from patients disagreeing with the care provided and staff members being dismissive, staff attitudes and approaches to patient care were explored during reflective practice. Staff told us there had been a focus on how to communicate better with patients and their families.

Learning, continuous improvement and innovation

All staff that we spoke to were pleased with the progress that they had made following the previous Care Quality Commission inspection. Staff had worked hard to improve the service, for example waiting lists had reduced across the service.

A monthly community mental health forum was in place, this allowed for best practice and learning to be shared across the service. This forum had recently been set up, in response to inconsistent practice that was identified across the teams.

Managers had developed a culture within the service that supported continuous learning and improvement and being creative with solutions to people's problems. This enhanced the quality of care.

Managers spoke about improvements to services that had recently been introduced. This included the introduction of clinical assistant psychology roles and running clinics on Saturdays in order to reduce waiting lists. Face-to-face away days had restarted, and staff could suggest quality improvement projects.

Most teams had introduced protected days once a month when staff did not book appointments. This allowed staff time to catch up on administrative tasks and ensure that all staff could attend team meetings.

Child and adolescent mental health wards

Good ↑↑

Is the service safe?

Good ↑↑

Our rating of safe improved. We rated it as good.

Safe and clean care environments

All wards were safe, clean well equipped, well furnished, well maintained and fit for purpose.

Safety of the ward layout

Staff completed and regularly updated thorough risk assessments of all wards areas and removed or reduced any risks they identified.

Staff could observe children and young people in all parts of the wards.

Ligature anchor point reduction work had taken place throughout the service to create a safe environment. Staff knew about any potential ligature anchor points and mitigated the risks to keep children and young people safe.

Staff had easy access to alarms and children and young people had easy access to nurse call systems.

Maintenance, cleanliness and infection control

Ward areas were clean, well maintained, well-furnished and fit for purpose.

Staff made sure cleaning records were up-to-date and the premises were clean.

Staff followed infection control policy, including handwashing.

Clinic room and equipment

Clinic rooms were fully equipped, with accessible resuscitation equipment and emergency drugs that staff checked regularly.

Staff checked, maintained, and cleaned equipment.

Safe staffing

The service had enough nursing and medical staff, who knew the children and young people and received basic training to keep people safe from avoidable harm.

Child and adolescent mental health wards

Nursing staff

The service had enough nursing and support staff to keep children and young people safe.

The service had low vacancy rates and a new team had recently been appointed over the last 6 months to lead and implement change.

The service used low numbers of temporary nursing staff and when needed managers requested staff familiar with the service.

Managers told us they used regular bank nurses who were block booked to work at the service.

Managers made sure all bank and agency staff had a full induction and understood the service before starting their shift.

Managers supported staff who needed time off for ill health. Staff gave us examples of reasonable adjustments and phased returns that had helped them return to work.

Managers accurately calculated and reviewed the number and grade of nurses, nursing assistants and healthcare assistants for each shift.

The ward manager could adjust staffing levels according to the needs of the children and young people. The new team ensured there was a band 7 manager on the unit 7 days per week and they were able to effectively escalate and address any staffing issues.

Children and young people had regular one to one sessions with their named nurse.

Children and young people rarely had their escorted leave, or activities cancelled, even when the service was short staffed.

The service had enough staff on each shift to carry out any physical interventions safely. Managers could check the training status competencies of any staff member on the electronic rota by clicking on their name and accessing the data.

Staff shared key information to keep children and young people safe when handing over their care to others.

Medical staff

The service had enough daytime and night-time medical cover and a doctor available to go to the ward quickly in an emergency. However, the current consultant psychiatrist was a locum, and the substantive role was out for recruitment.

A new staff grade doctor had recently been recruited and was currently onboarding.

Mandatory training

Staff had completed and kept up to date with their mandatory training. For example, 90% of staff had completed the prevention and management of violence and aggression (PMVA) training. This had improved significantly since our last inspection in October 2021 when 33% of staff on the unit had completed the PMVA training.

The mandatory training programme was comprehensive and met the needs of patients and staff.

Managers monitored mandatory training and alerted staff when they needed to update their training. This included staff having protected time to attend training, email reminders when training was due and training compliance was monitored through audits which were presented at the governance meetings.

Assessing and managing risk to children and young people and staff

Staff assessed and managed risks to children, young people and themselves well and followed best practice in anticipating, de-escalating and managing challenging behaviour. Staff used restraint and seclusion only after attempts at de-escalation had failed. The ward staff participated in the provider's restrictive interventions reduction programme.

Assessment of patient risk

Staff completed risk assessments for each child and young person on admission, using a recognised tool, and reviewed this regularly, including after any incident.

Staff used a recognised risk assessment tool.

Management of patient risk

Staff knew about any risks to each child and young person and acted to prevent or reduce risks. Risk management was discussed daily at staff handovers and care plans were updated to reflect change in risks.

Staff identified and responded to any changes in risks to, or posed by, children and young people. We saw examples where patient observation levels had been changed due to risks changing.

Risks were regularly reviewed including before and after going on leave and after any incidents.

Staff followed procedures to minimise risks where they could not easily observe children and young people. Observations were carried out sensitively and we saw patients being involved with deciding how they would like to be observed when in their rooms. This included a preference of the gender of the staff carrying out the checks and lights to be used.

Staff followed trust policies and procedures when they needed to search children and young people or their bedrooms to keep them safe from harm. We saw that the unit had an allocated security nurse on each shift who ensured that safety of the environment was maintained. This included counting cutlery after it had been used at mealtimes.

Practical training had been completed and staff had competencies signed off for carrying out searches on patients and their rooms.

Child and adolescent mental health wards

There were clear guidelines about patient expectations on the unit and these were co-produced by the patients and displayed in communal areas.

These included guidance around restricted and prohibited items on the ward.

Use of restrictive interventions

Levels of restrictive interventions were low. We saw staff working to increase patient choice and explain the rationale for decisions that were made on the unit.

Staff participated in the provider's restrictive interventions reduction programme, which met best practice standards.

Staff made every attempt to avoid using restraint by using de-escalation techniques and restrained children and young people only when these failed and when necessary to keep the child, young person or others safe.

Staff were trained in the use of dialectical behaviour therapy (DBT) skills and used these effectively as a tool for de-escalation. All patients had been involved in creating a positive behaviour support plan and staff worked with them to implement this.

Patients had identified triggers and interventions they would or wouldn't like from staff if they needed to be kept safe.

Staff understood the Mental Capacity Act definition of restraint and worked within it.

Safeguarding

Staff understood how to protect children and young people from abuse and the service worked well with other agencies to do so. Staff had training on how to recognise and report abuse and they knew how to apply it. The provider had a named nurse and doctor for child safeguarding and the teams had a safeguarding lead.

Staff received training on how to recognise and report abuse, appropriate for their role. Staff completed safeguarding level 2 or 3 as appropriate for their roles as part of their mandatory training.

Staff kept up to date with their safeguarding training and this was monitored as part of mandatory training compliance which was 95% across the unit.

There was a dedicated safeguarding lead who was a senior social worker on the unit, and they worked with patients, their families and across other services.

We saw examples of active safeguarding referrals made by staff and observed the process for escalation at a unit level.

Monthly safeguarding supervision sessions were available for all staff to attend.

Staff could give clear examples of how to protect children and young people from harassment and discrimination, including those with protected characteristics under the Equality Act.

Staff knew how to recognise adults and children at risk of or suffering harm and worked with other agencies to protect them.

Staff followed clear procedures to keep children visiting the ward safe.

Staff knew how to make a safeguarding referral and who to inform if they had concerns.

Managers took part in serious case reviews and made changes based on the outcomes.

Staff access to essential information

Staff had easy access to clinical information and it was easy for them to maintain high quality clinical records – whether paper-based or electronic.

Patient notes were comprehensive and all staff could access them easily.

When children and young people transferred to a new team, there were no delays in staff accessing their records.

Records were stored securely.

Medicines management

The service used systems and processes to safely prescribe, administer, record and store medicines. Staff regularly reviewed the effects of medications on each child or young person's mental and physical health.

Staff followed systems and processes when safely prescribing, administering, recording and storing medicines. We looked at the clinic room and saw evidence of storing, checking and recording medicines correctly.

Medicines audits took place weekly and there was a rolling programme for re-ordering stock about to expire. The clinical nurse specialist and non-medical prescriber had oversight of this at ward level and escalated concerns to the pharmacy team as needed.

Staff reviewed children and young people's medicines regularly and provided specific advice to children, young people and carers about their medicines. The multidisciplinary team (MDT) reviewed medicines weekly and patient and relatives were involved in those discussions.

We saw an example of a dosage of an as required medication being queried with the responsible clinician at the MDT and pharmacy advice was sought and the matter resolved.

Out of the 6 patients on the ward 2 were currently not prescribed any medicines.

We asked staff about patients being adversely affected by medicines for example appearing over sedated. Staff told us this was not apparent, and any concerns were raised with the MDT for urgent review.

Patients and carers we spoke with also said there was no evidence of over sedation.

We did not observe any patients appearing as over sedated.

The 4 medication charts we reviewed were all within British National Formulary limits and dose appropriate for the age of the patient.

The unit had a clinical nurse specialist who was a non- medical prescriber and able to write prescriptions.

Staff stored and managed medicines and prescribing documents in line with the provider's policy.

Staff followed current national practice to check patients had the correct medicines.

The service had systems to ensure staff knew about safety alerts and incidents, so children and young people received their medicines safely.

Decision making processes were in place to ensure people's behaviour was not controlled by excessive and inappropriate use of medicines.

Staff reviewed the effects of each child or young person's medication on their physical health according to National Institute for Health and Care Excellence guidance.

Track record on safety

Reporting incidents and learning from when things go wrong

The service managed patient safety incidents well. Staff recognised incidents and reported them appropriately. Managers investigated incidents and shared lessons learned with the whole team and the wider service. When things went wrong, staff apologised and gave children and young people honest information and suitable support.

Staff knew what incidents to report and how to report them. Staff received training in using the incident reporting system and reviewing incidents.

Staff raised concerns and reported incidents and near misses in line with trust policy.

Staff reported serious incidents clearly and in line with trust policy.

Staff understood the duty of candour. They were open and transparent, and gave children, young people and families a full explanation if and when things went wrong.

Managers debriefed and supported staff after any serious incident.

Managers investigated incidents thoroughly. Children, young people and their families were involved in these investigations.

Staff received feedback from investigation of incidents, both internal and external to the service.

Child and adolescent mental health wards

Staff met to discuss the feedback and look at improvements to patient care.

There was evidence that changes had been made as a result of feedback. Managers told us that the amount of incidents reported had reduced by 66% in the past 6 months due to changes in staff teams and models of care implemented on the unit.

Additional staff had been recruited to work a twilight shift in the evening after it was identified by an audit of incidents that having extra staff on shift at the time was helpful. This meant patients had the choice of 1:1 time with staff in their bedroom before sleep which helped reduce incidents of self-harm and distress

Is the service effective?

Good 

Our rating of effective improved. We rated it as good.

Assessment of needs and planning of care

Staff assessed the physical and mental health of all children and young people on admission. They developed individual care plans which were reviewed regularly through multidisciplinary discussion and updated as needed. Care plans reflected children and young people's assessed needs, and were personalised, holistic and recovery-oriented.

Staff completed a comprehensive mental health assessment of each child or young person either on admission or soon after.

Children and young people had their physical health assessed soon after admission and regularly reviewed during their time on the ward.

Staff developed a comprehensive care plan for each child or young person that met their mental and physical health needs.

Staff regularly reviewed and updated care plans when children and young people's needs changed.

Care plans were personalised, holistic and recovery orientated.

Best practice in treatment and care

Staff provided a range of treatment and care for children and young people based on national guidance and best practice. They ensured that children and young people had good access to physical healthcare and supported them to live healthier lives. Staff used recognised rating scales to assess and record severity and outcomes. They also participated in clinical audit, benchmarking and quality improvement initiatives.

Staff provided a range of care and treatment suitable for the children and young people in the service.

The staff team used a trauma informed approach with dialectical behavioural therapy (DBT) as a model of care.

All staff including reception and support staff had received specialist 2-day DBT skills training.

This training helped staff deliver effective, consistent care whilst maintaining therapeutic boundaries.

Patients attended an educational facility at the unit called the Horizon school. The school was well staffed and resourced and had an Ofsted rating of good.

This school enabled patients to continue studying in a supportive environment whilst an inpatient.

A comprehensive timetable was in place, and we observed sessions taking place. Patients were engaged and took part in lessons with specialist staff available to help. The educational team included educational psychologists and teachers.

Some patients also attended college outside of the unit and provision was made for this by the team.

Staff identified children and young people's physical health needs and recorded them in their care plans. There was a registered children's nurse working on the unit who carried out physical health checks at least weekly on each patient. Some patients had more frequent checks for example those with eating disorders.

Staff made sure children and young people had access to physical health care, including specialists as required.

Staff met children and young people's dietary needs and assessed those needing specialist care for nutrition and hydration.

The unit had an eating disorder pathway and patients received specialist monitoring and support.

This included kitchen staff being aware of dietary needs and all meals having nutritional values available. Patients were supported at mealtimes by staff and also accompanied by staff on leave outside the unit if support was needed at mealtimes.

Staff helped children and young people live healthier lives by supporting them to take part in programmes or giving advice. Fitness classes took place on the unit and a personal trainer ran sessions. Individual risk assessments were carried out to ensure physical activity was suitable. For example, for those patients with an eating disorder.

Information and support were also available on sexual safety and consent.

Smoking cessation advice and substance misuse services were also featured on posters on the unit.

Staff used recognised rating scales to assess and record the severity of children and young people's conditions and care and treatment outcomes.

Staff benchmarking and quality improvement initiatives.

Managers used results from audits to make improvements used technology to support children and young people.

Staff took part in clinical audits. Across the service there were regular audits to check the quality of record keeping, for example care plans and medicines management audits.

Skilled staff to deliver care

The ward team(s) included or had access to the full range of specialists required to meet the needs of children and young people on the ward(s). Managers made sure they had staff with the range of skills needed to provide high quality care. They supported staff with appraisals, supervision and opportunities to update and further develop their skills. Managers provided an induction programme for new staff.

The service had access to a full range of specialists to meet the needs of the children and young people on the ward. These included a DBT clinical nurse specialist, CAMHS psychotherapist, OT, educational psychologists, dietician, social worker and family workers. These professionals worked closely alongside the medical, nursing and education team to provide a comprehensive range of care and treatment on the unit.

Managers ensured staff had the right skills, qualifications and experience to meet the needs of the children and young people in their care, including bank and agency staff.

Staff on the ward had a range of specialist skills and experience including children's nurses, DBT therapists and non-medical prescriber.

Managers gave each new member of staff a full induction to the service before they started work.

Managers supported staff through regular, constructive appraisals of their work.

Managers supported non-medical staff through regular, constructive clinical supervision of their work. On inspection the staff line management supervision for the unit was 100% up to date. Administrative staff helped with the process by scheduling supervision sessions for when both staff were on duty and additional staff cover was available so both could attend as protected time.

Managers made sure staff attended regular team meetings or gave information from those they could not attend. Staff meetings were held twice weekly so all staff had chance to attend. Bite size learning sessions also took place at some staff team meetings.

Managers identified any training needs their staff had and gave them the time and opportunity to develop their skills and knowledge.

Managers made sure staff received any specialist training for their role. Staff were offered training in DBT skills, autism awareness and eating disorders on the unit in addition to mandatory training.

Managers recognised poor performance, could identify the reasons and dealt with these.

Multi-disciplinary and interagency teamwork

Child and adolescent mental health wards

Staff from different disciplines worked together as a team to benefit children and young people. They supported each other to make sure children and young people had no gaps in their care. The ward team(s) had effective working relationships with other relevant teams within the organisation and with relevant services outside the organisation.

Staff held regular multidisciplinary meetings to discuss children and young people and improve their care.

Staff made sure they shared clear information about children and young people and any changes in their care, including during handover meetings.

Ward teams had effective working relationships with other teams in the organisation.

Ward teams had effective working relationships with external teams and organisations.

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

Staff understood their roles and responsibilities under the Mental Health Act 1983 and the Mental Health Act Code of Practice and discharged these well. Managers made sure that staff could explain children and young people's rights to them.

Staff received and kept up to date with training on the Mental Health Act and the Mental Health Act Code of Practice and could describe the Code of Practice guiding principles.

Staff had access to support and advice on implementing the Mental Health Act and its Code of Practice.

Staff knew who their Mental Health Act administrators were and when to ask them for support.

The service had clear, accessible, relevant and up-to-date policies and procedures that reflected all relevant legislation and the Mental Health Act Code of Practice.

Children and young people had easy access to information about independent mental health advocacy and children and young people who lacked capacity were automatically referred to the service.

There was an advocacy service which visited the ward weekly and patients could contact them in between visits.

Staff explained to each child or young person their rights under the Mental Health Act in a way that they could understand, repeated as necessary and recorded it clearly in the child or young person's notes each time.

Staff made sure children and young people could take section 17 leave (permission to leave the hospital) when this was agreed with the responsible clinician.

Staff requested an opinion from a Second Opinion Appointed Doctor (SOAD) when they needed to. We saw evidence of patients MHA medication forms being completed by a SOAD correctly and placed in patients notes.

Staff stored copies of children and young people's detention papers and associated records correctly and staff could access them when needed.

Child and adolescent mental health wards

Children and young people admitted to the service informally knew that they could leave the ward freely and the service displayed posters to tell them this. Some of the patients when we visited were informal and all patients were aware of their MHA status and associated rights.

We saw evidence recorded of patients having their S132 rights read to them by staff.

Care plans included information about after-care services available for those children and young people who qualified for it under section 117 of the Mental Health Act.

Managers and staff made sure the service applied the Mental Health Act correctly by completing audits and discussing the findings.

Good practice in applying the Mental Capacity Act

Staff supported children and young people to make decisions on their care for themselves. They understood the trust policy on the Mental Capacity Act 2005 applied to young people aged 16 and 17 and the principles of Gillick competence as they applied to children under 16. Staff assessed and recorded consent and capacity or competence clearly for children and young people who might have impaired mental capacity or competence.

Staff received and kept up to date with training in the Mental Capacity Act and had a good understanding of at least the 5 principles.

There was a clear policy on Mental Capacity Act and Deprivation of Liberty Safeguards, which staff could describe and knew how to access.

Staff knew where to get accurate advice on the Mental Capacity Act and Deprivation of Liberty Safeguards.

Staff gave children and young people all possible support to make specific decisions for themselves before deciding a child or young person did not have the capacity to do so.

Staff assessed and recorded capacity to consent clearly each time a child or young person needed to make an important decision.

When staff assessed a child or young person as not having capacity, they made decisions in the best interest of the child or young person and considered their wishes, feelings, culture and history.

Staff made applications for a Deprivation of Liberty Safeguards order only when necessary and monitored the progress of these applications.

The service monitored how well it followed the Mental Capacity Act and made and acted when they needed to make changes to improve.

Staff understood how to support children under 16 wishing to make their own decisions under Gillick competency regulations.

Child and adolescent mental health wards

Staff knew how to apply the Mental Capacity Act to young people aged 16 to 18 and where to get information and support on this.

Is the service caring?

Good  

Our rating of caring improved. We rated it as good.

Kindness, privacy, dignity, respect, compassion and support

Staff treated children and young people with compassion and kindness. They respected children and young people's privacy and dignity. They understood the individual needs of children and young people and supported them to understand and manage their care, treatment or condition.

Staff were discreet, respectful, and responsive when caring for children and young people. We saw staff interacting positively with patients across a range of activities on the unit. These included use of de-escalation skills and distraction techniques which were carried out sensitively.

Patients said staff were kind and treated them well even when they were not cooperating with staff. Patients said they had confidence in staff doing the right thing for them and knew they were acting in their best interests.

Some patients compared the care they received at this unit to other previous admissions in other places and said it was much better and they felt happier here.

Patients said they knew they could always ask for support and staff would respond.

Patients commented that staff would also respect their space and time and knew when to not talk.

Staff gave children and young people help, emotional support and advice when they needed it.

Staff supported children and young people to understand and manage their own care treatment or condition.

Some patients said the skills and attitude of the staff had been really helpful in managing their mental health. Patients appreciated staff honesty and transparency and did not feel patronised by staff.

Staff directed children and young people to other services and supported them to access those services if they needed help.

Children and young people said staff treated them well and behaved kindly.

Staff understood and respected the individual needs of each child or young person.

Staff felt that they could raise concerns about disrespectful, discriminatory or abusive behaviour or attitudes towards children and young people. Staff were very confident about speaking up and described the new team as being able to challenge any negative language or attitudes constructively across the team and with visiting professionals.

Staff followed policy to keep patient information confidential. We saw evidence of notes stored securely and patient information boards closed in the office.

The CCTV was also positioned so that people could not view it from outside the staff office.

Patients felt confident that they would be treated fairly, and their confidential information not shared inappropriately.

Staff checked sensitively that patients and carers gave their consent for Care Quality Commission inspectors to be present at MDT meetings and to contact them for an interview.

Involvement in care

Staff involved children, young people and their families in care planning and risk assessment and actively sought their feedback on the quality of care provided. **They ensured that children and young people had easy access to independent advocates and to child helplines.**

Involvement of children and young people

Staff involved children and young people and gave them access to their care planning and risk assessments.

All patients had been involved in developing their care plans and positive behaviour support plans.

Patients could ask for a review of their care plans at any time including adjusting periods of leave off the ward.

Patients were also encouraged and supported to complete their own individual wellness recovery action plans (WRAP)

Staff made sure children and young people understood their care and treatment (and found ways to communicate with children and young people who had communication difficulties).

Staff involved children and young people in decisions about the service, when appropriate.

A community meeting was held weekly and this was chaired by patients. All the ward team were invited, and a variety of topics were discussed.

There was also an opportunity for patients to raise concerns for discussion anonymously.

Children and young people could give feedback on the service and their treatment and staff supported them to do this.

Staff supported children and young people to make decisions on their care.

Staff made sure children and young people could access advocacy services.

Child and adolescent mental health wards

Involvement of families and carers

Staff informed and involved families and carers appropriately.

Staff supported, informed and involved families or carers. The carers we spoke to said they felt involved in their relatives care and treatment and overall the communication was good.

They said they appreciated being able to join the MDT meetings remotely and knew they could raise any concerns.

Carers fed back that the staff treated their relatives very kindly and with compassion.

Is the service responsive?

Good 

Our rating of responsive stayed the same. We rated it as good.

Access and discharge

Staff planned and managed the discharge of children and young people well. They worked well with services providing aftercare and managed children and young people's move out of hospital. As a result, children and young people did not have to stay in hospital when they were well enough to leave.

The unit had capacity for 10 beds. However, at the time of inspection this was capped to 6 patients due to the lack of a substantive consultant psychiatrist and senior psychologist.

This reduced bed capacity was constantly under review by managers.

Managers told us some of the improvements on the ward were due to a change in the referral process for the unit and exclusions that were in place to avoid inappropriate referrals.

Previously at last inspection several patients had very complex needs and required specialist placement including low secure services and were not deemed suitable for a general CAMHS ward.

Exclusions for admission to the service now included no patients fed by naso-gastric tubes and no patients with moderate and severe learning difficulties. Patients were each assessed on an individual basis however those with recent history of substance misuse and violence and aggression which may require a psychiatric intensive care bed were not admitted.

Managers regularly reviewed length of stay for children and young people to ensure they did not stay longer than they needed to.

Managers and staff worked to make sure they did not discharge children and young people before they were ready. Staff held discharge planning meetings and invited relatives and community teams. We saw evidence of staff working with specialist eating disorder day services.

Child and adolescent mental health wards

When children and young people went on leave there was always a bed available when they returned. 2 patients were on leave during the inspection and beds were available for them on return.

Children and young people were moved between wards during their stay only when there were clear clinical reasons, or it was in their best interest.

Staff did not move or discharge children and young people at night or very early in the morning.

The unit did not have a seclusion room or PICU on site. Therefore, if a patient needed an enhanced level of care which couldn't be safely provided on the unit they were moved to another unit. Staff told us this happened very rarely and most patients remain on the unit throughout their stay.

The unit did have a small extra care area (ECA) which was used regularly and featured in care plans for some patients as part of a de-escalation strategy.

Discharge and transfers of care

Managers and staff recognised children and young people whose discharge was delayed, knew which wards had the most delays, and took action to reduce them.

Children and young people did not have to stay in hospital when they were well enough to leave.

Staff carefully planned children and young people's discharge and worked with care managers and coordinators to make sure this went well.

Staff supported children and young people when they were referred or transferred between services.

Facilities that promote comfort, dignity and privacy

The design, layout, and furnishings of the ward supported children and young people's treatment, privacy and dignity. Each child and young person had their own bedroom with an en-suite bathroom and could keep their personal belongings safe. There were quiet areas for privacy. The food was of good quality and children and young people could make hot drinks and snacks at any time.

Each or young person had their own bedroom, which they could personalise.

Children and young people had a secure place to store personal possessions.

Staff used a full range of rooms and equipment to support treatment and care.

The service had quiet areas and a room where children and young people could meet with visitors in private.

Children and young people could make phone calls in private.

The service had an outside space that children and young people could access easily.

Children and young people could make their own hot drinks and snacks and were not dependent on staff.

The service offered a variety of good quality food.

Children and young people's engagement with the wider community

Staff supported children and young people with activities outside the service and made sure children and young people had access to high quality education throughout their time on the ward.

Staff made sure children and young people had access to opportunities for education and work and supported them.

Staff helped children and young people to stay in contact with families and carers.

Staff encouraged children and young people to develop and maintain relationships both in the service and the wider community.

Meeting the needs of all people who use the service

The service met the needs of all children and young people – including those with a protected characteristic. Staff helped children and young people with communication, advocacy and cultural and spiritual support.

The service could support and make adjustments for disabled people and those with communication needs or other specific needs.

Staff had undertaken training about working with people with learning disabilities and autistic people. We saw evidence that the doctor had done an assessment for autism spectrum disorder with a patient and were working with specialist services.

There were 2 dedicated sensory rooms on the unit with a variety of equipment and resources. Patients were sometimes directed to these as part of de-escalation techniques.

Staff made sure children and young people could access age appropriate information on treatment, local service, their rights and how to complain.

The service had information leaflets available in languages spoken by children, young people and the local community.

Managers made sure staff, children and young people could get help from interpreters or signers when needed.

The service provided a variety of food to meet the dietary and cultural needs of individual children and young people. The food was cooked on site and the cooks were able to prepare appropriate diets as needed.

Children and young people had access to spiritual, religious and cultural support. There was a multi faith room and quiet room available on the unit.

A variety of faith materials were available including key texts.

There was a notice on the board showing different faith leaders to contact and the unit had a visiting chaplain.

Listening to and learning from concerns and complaints

The service treated concerns and complaints seriously, investigated them and learned lessons from the results, and shared these with the whole team and wider service.

Children, young people, relatives and carers knew how to complain or raise concerns.

The patients and families we spoke with said they did know how to complain and felt confident they would be listened to by managers.

The service clearly displayed information about how to raise a concern in patient areas.

Staff understood the policy on complaints and knew how to handle them.

Managers investigated complaints and identified themes.

Staff regularly reviewed informal complaints and ward managers had offices on the unit where an open-door policy meant patients or staff could easily raise concerns.

Managers evidenced recording of informal complaints and shared lessons learnt for solutions with staff.

A monthly quarterly dashboard highlighted complaint status data and managers could access this.

The customer service team met with the matron on a 2-weekly basis to review complaint response flow.

Collaboration was taking place with people's participation leads to develop a Talk to Us First early resolution opportunity for complainants where appropriate.

Staff protected children and young people who raised concerns or complaints from discrimination and harassment.

Staff knew how to acknowledge complaints and children, young people and their families received feedback from managers after the investigation into their complaint.

Managers shared feedback from complaints with staff and learning was used to improve the service.

The service used compliments to learn, celebrate success and improve the quality of care.

Is the service well-led?

Good ↑

Our rating of well-led improved. We rated it as good.

Child and adolescent mental health wards

Leadership

Leaders had the skills, knowledge and experience to perform their roles. They had a good understanding of the services they managed and were visible in the service and approachable for children, young people, families and staff.

The unit leadership team had been developed and expanded since the last inspection.

A new service lead had been appointed following beds on the unit being closed in May 2022 due to unsafe staffing levels and concerns about the ward environment.

Recruitment and staff development had enabled 6 beds to be re-opened and the senior leadership team acknowledged that no further beds could be opened until the lead consultant psychiatrist and senior psychologist roles were filled.

The unit had strong dedicated leaders and we saw the ward managers leading by example in working positively with the patients.

Some ward managers had completed leading confidently training and were pursuing other management development opportunities.

Staff worked well together and said having shared DBT training across the team help maintain therapeutic boundaries and provide the best care.

All the ward managers offices were based on the unit and patients and staff said they were approachable and accessible.

The ward team came from a variety of backgrounds and used their skills to enhance the care delivered. For example, a dedicated DBT therapist and registered children's nurse.

The ward managers also worked clinical shifts as part of the nursing team 2 days per week. This ensured there were opportunities to monitor care provided and have current oversight of any emerging issues.

Patients and staff said they valued this visibility of ward managers and it helped them keep in touch with life on the ward.

The ward managers were on the unit 7 days a week, so senior clinical and managerial support was available to support patients and staff.

Vision and strategy

Staff knew and understood the provider’s vision and values and how they (were) applied to the work of their team.

Staff had a clear vision and had worked well to improve the service in response to the previous inspection findings.

Managers had produced and shared with all staff a Dragonfly unit crib sheet and project brief with identified actions and evidence required to ensure they had been achieved.

This document was red, amber, green RAG rated and outlined objectives within a realistic timeframe.

We saw improvements across several areas outlined on the plan and we checked the evidence to ensure those changes were embedded. For example, care plan audits and medication management audits.

Culture

Staff felt respected, supported and valued. They said the trust promoted equality and diversity in daily work and provided opportunities for development and career progression. They could raise any concerns without fear.

The staff team had developed and grown together as it worked to improve services.

We saw evidence of collaborative working and shared learning.

All staff we spoke with described a positive working environment with good leadership and effective teamwork.

Staff who had previously worked at the unit described the change in staff morale as significant and felt more empowered, valued and supported in their roles.

Some staff had been promoted from within the existing team and described good mentoring and management support.

Staff said they felt confident speaking up and raising concerns as well as advocating for patients and felt they would be listened to**.**

Governance

Our findings from the other key questions demonstrated that governance processes operated effectively at team level and that performance and risk were managed well.

The senior management team (SMT) met daily to discuss ongoing service development and governance issues.

A clear line management structure was in place for the SMT.

The gatekeeping process for all referrals was reviewed by SMT daily and admissions accepted or rejected in conjunction with a risk matrix to support decision making.

There was an established process in place to ensure ward managers had robust governance systems and audits in place to assure themselves that patients are always safe and well cared for.

Across the team there were a series of dedicated champions to complete and share audits.

The ward managers checked for compliancy issues and outcomes were discussed in the staff meeting fortnightly and lessons learnt shared monthly.

Audit outcomes were also shared monthly at the governance meeting by the unit matron.

Child and adolescent mental health wards

Management of risk, issues and performance

Teams had access to the information they needed to provide safe and effective care and used that information to good effect.

Incident reporting was reviewed, and themes identified by the SMT and fed into governance meetings.

The ongoing risk of the unit potentially being unable to remain open if the current locum consultant psychiatrist left before a substantive consultant had been appointed remained an issue.

The SMT were aware and working to address through trust recruitment processes in the UK and internationally.

Engagement

Managers engaged actively with other local health and social care providers to ensure that an integrated health and care system was commissioned and provided to meet the needs of the local population. Managers from the service participated actively in the work of the local transforming care partnership.

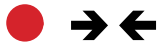
Learning, continuous improvement and innovation

Staff engaged actively in local and national quality improvement activities.

Acute wards for adults of working age and psychiatric intensive care units

Requires Improvement 

Is the service safe?

Inadequate 

Our rating of safe stayed the same. We rated it as inadequate.

Safe and clean care environments

Staff completed risk assessments of the ward environments, but some risks had not been addressed which meant wards were not always safe in all areas.

Safety of the ward layout

Staff completed and regularly updated environmental risk assessments of all ward areas and aimed to remove or reduce any risks they identified.

All wards had ligature risk assessments that were reviewed on a monthly basis. Overall, staff knew where ligature risks were and there was a programme of work in place to reduce ligature risks further. Where there were risks, staff worked to mitigate these by increasing observations of patients and presence of staff in communal areas. There was ongoing work to reduce or remove some identified ligature risks. We saw that staff had taken action to reduce risks. However, in the seclusion room on Southgate ward, we saw that there was a ligature risk which had not been specifically identified in the ligature risk assessment.

We identified that there was a fire risk assessment with actions that had not been completed at Great Yarmouth and Waveney Acute service. However, when we asked the trust about this, they ensured that the actions were reported straight away.

The ward complied with guidance on mixed sex accommodation. There had been no mixed sex accommodation breaches in the time period between 1 April 2022 and the time of our inspection.

Staff had easy access to alarms and patients had easy access to nurse call systems on all wards apart from on Samphire ward, where 7 of the patients' alarms had been turned off. There was no clinical reason for this. This posed a risk to patients' safety. However, when we told leaders they immediately made sure the alarms were turned back on. Managers ensured the issue was discussed in handover and that a trust wide safety alert was raised.

Maintenance, cleanliness and infection control

As part of our inspection we reviewed historical incidents on closed circuit television. We observed that staff had not always worn masks in line with the trust policy in response to the COVID-19 pandemic.

We saw that there were some environmental issues at Great Yarmouth ward. There was a bath that had needed repairing for some time and females could not use the outdoor area due to a missing brick in the outdoor space.

Acute wards for adults of working age and psychiatric intensive care units

Seclusion room

Seclusion rooms allowed clear observation and two-way communication and had a toilet and a clock. However, we identified some apparent safety hazards at the seclusion room on Southgate ward, where patients could potentially harm themselves because of the construction of the room.

Not all wards had easy access to seclusion rooms. Therefore, staff had occasionally used patients' bedrooms for seclusion. We were aware that 1 seclusion had taken place in a bedroom on Waveney ward where staff did not record that they had removed potentially risky items. This was not in line with trust policy.

Safe staffing

The trust had improved staffing, but some wards did not always have enough permanent nursing and medical staff, who knew the patients and could deliver consistent care. Whilst the completion of mandatory training had improved there were still wards where further training was needed to keep people safe from avoidable harm.

Nursing staff

Managers and staff told us that staffing had improved, and that there were usually enough staff to keep patients safe. There was a low level of reports of staffing shortages reported in incident data. However, staff said there were still staffing challenges. Following our inspection, we received an anonymous report of an incident on Lark ward where there was insufficient staffing.

The trust provided us with data for overall vacancy rates across the 10 wards we visited during our inspection and this was 16%. This had reduced from 22% at our last inspection. The wards with the highest vacancies, between 24% and 19% were Northgate, Southgate, Glaven, Yare and Thurne wards. The ward with the lowest level of vacancies was Samphire with a vacancy rate of 11%.

The safer staffing establishment on wards was a minimum of 2 nurses for day and night shifts and 3 or more support workers during the day and 2 at night. The *safest* staffing establishment on the wards was 1 registered nurse with 3 or more support workers during the day and 2 at night.

We reviewed rotas that the trust provided for the period between 16 August 2022 and 16 September 2022. All shifts we reviewed had at least 1 qualified nurse on duty. We reviewed rotas for Samphire, Northgate, Southgate and Great Yarmouth and Waveney acute wards. We saw there was only 1 nurse on duty for 15% of shifts.

Patients did not always have a one-to-one session with their named nurses. The trust provided data for 4 wards which indicated only 50% of patients were offered a named nurse session on Yare, Thurne and Waveney wards. On Glaven ward, 85% of patients had been offered a named nurse session. The trust did not provide data for any of the other wards we visited.

The trust used agency and bank nurses to maintain safer staffing levels and meet additional staffing requirements. For example, agency and bank staff were used to meet the needs of patients prescribed enhanced observations. The trust tried wherever possible to use nurses who knew the wards they worked on. At the end of August 2022, on average the wards had used bank and agency staff to fill 35% of qualified nursing shifts and 30% of support worker shifts. However, on Northgate ward 55% of qualified nursing shifts had been filled by temporary staff and on Southgate ward 42% of support worker shifts were filled with temporary staff.

The trust was working hard to recruit qualified nurses and had an international recruitment programme to increase their qualified nursing staff.

The service had turnover rates of 16%, this had reduced from 19% at our last inspection.

Managers accurately calculated and reviewed the number and grade of nurses, nursing assistants and healthcare assistants for each shift. The ward manager could adjust staffing levels according to the needs of the patients.

Some wards did not always have enough trained staff on each shift who were able to carry out physical interventions safely. Staff on Samphire and Southgate wards told us there were not always enough staff to carry out a restraint. The ward manager on Southgate ward explained there were 7 staff employed on the ward who could not carry out a restraint for physical health reasons. However, we did not see evidence that there had been any incidents as a result of there not being enough staff to manage physical interventions. We were also told by managers and staff that when staff needed to update their training, they were not carrying out physical interventions. In addition, mangers ensured via their daily meetings, that there were staff between neighbouring wards, to ensure that a restraint team would be available.

Staff shared key information to keep patients safe when handing over their care to others. We reviewed handover records and attended handover meetings. Staff used the SBAR communication tool (situation, background assessment and recommendation) to structure handovers. Staff handovers contained up to date risk information about patients which was accessible for staff and recorded in patients' care records.

Mandatory training

The trust had made progress in respect of mandatory training since our last inspection. Overall, 84% of staff were up to date with this, although Northgate ward had a compliance rate of 73%.

However, there was room for further improvement as wards had low compliance levels for some certain mandatory training courses. For example, Immediate Life Support training compliance was on average 70% across all wards. However, the percentage compliance on other wards was lower; 42% on Glaven, 55% on Thurne, 46% on Yare and 63% on Northgate ward. This low level of training could result in an impact on patient safety. In addition, only 56% of staff on Great Yarmouth and Waveney Acute and 55% on Thurne ward had undertaken fire training.

At our last inspection, we identified that staff were not up to date with their physical intervention training. At this inspection, we saw that this figure had improved, as on average, 75% of staff were up to date. However, on some wards percentage compliance was lower. For example, compliance on Southgate ward was 59%, Northgate ward 57%, Thurne ward 60% and Yare ward 65%. The trust had endeavoured to book staff onto the training, but staff said that rotas were booked months ahead, which meant they had sometimes had to decline training as they were needed to work on the ward. Of the 25% of staff who were not up-to-date with this training 16% had already been booked on future training. Staff who had not completed their physical intervention training, were not all able to restrain patients.

Managers monitored mandatory training and alerted staff when they needed to update their training. Managers knew which training courses required better compliance and were continuing to work to improve this.

Assessing and managing risk to patients and staff

Acute wards for adults of working age and psychiatric intensive care units

Staff followed best practice in anticipating, de-escalating and managing challenging behaviour, they used restraint and seclusion only after attempts at de-escalation had failed. Staff assessed risks to patients but did not always manage the risks consistently well particularly in relation to carrying out searches of patients and ensuring they had the necessary physical health checks after receiving rapid tranquilisation medication.

Assessment of patient risk

Staff completed risk assessments for each patient on admission and reviewed this regularly, including after incidents. We reviewed 36 risk assessments and found that overall, these were updated when they needed to be and were detailed. Occasionally we saw that a risk assessment did not include all risks or that an update had been missed, but when we reviewed the care records fully, we were able to locate this information in other sections of patients' records.

Management of patient risk

Staff knew about any risks to each patient and acted to prevent or reduce risks. The ward used the comprehensive risk assessments but also used the SBAR communication tool, for a daily update of patient's risk and how this should be managed.

It was not clear that staff followed trust policies and procedures when they needed to search patients or their bedrooms in line with their individual risk assessments to keep them safe from harm. Not all staff had completed the trust's revised search training which was part of the restrictive interventions training. We did not see that searches were routinely recorded in patient's notes. Staff told us that they searched all patients who had returned from unescorted leave, except for Great Yarmouth and Waveney Acute service where staff said they did not complete searches. A patient's bag was searched on Avocet ward, but the patient was not present, this was not in line with trust policy.

During our last inspection not all wards had informed staff, visitors and patients what constituted restricted items on the ward, for example, risk items which may be used to cause harm. At this inspection we saw this had been improved and this information was available for everyone who required this.

Use of restrictive interventions

During our inspection we reviewed both observation and audits of observation records. It was clear that observations records were usually completed and recorded by staff. Audits involved a review of CCTV and documentation. However, we saw that there had been an omission on Yare ward earlier in the year where a patient had been able to self-harm as their observations had not been completed according to the plan. We also reviewed another incident including CCTV where staff had observed a patient but had not recorded that they had done so.

The trust had completed audits of observations regularly, to check that staff were following care plans and National Institute for Health and Care Excellence guidance. These had been completed daily on Northgate and Southgate and at least monthly on other wards. We looked at the completed audits from August 2022 and saw there were some omissions where staff had not observed the patient in line with the observation plan. We also looked at seclusion records. In 23 records the observing staff completed a written record of their observation every fifteen minutes, which was in line with policy. However, in 2 seclusion records we were unable to find written records of observations and in 3 records we found gaps in the records. In 1 case this was for a 3-hour period.

Acute wards for adults of working age and psychiatric intensive care units

On 9 out of 10 wards there was a blanket restriction in place to search all patients who returned from unescorted leave; this was not individually risk assessed. However, all patients could access hot and cold drinks and snacks. This had improved since our last inspection.

Levels of physical restrictive interventions on all wards were either low or reducing. The trust kept data that was accessible to all staff including medical staff about this. We reviewed this data for 3 months between 1 June and 31 August. The data indicated that on all wards (except for Northgate ward), the use of restraint, rapid tranquillisation and use of seclusion was decreasing. On Northgate ward there had been a moderate increase in the use of restraint.

Staff made every attempt to avoid using restraint by using de-escalation techniques and restrained patients only when these failed and when necessary to keep the patient or others safe. During the inspection, we observed de-escalation taking place on the ward, care plans evidenced that de-escalation was used as an initial technique and staff were able to tell us how they responded to incidents. We compared data from June 2022 with data from August 2022, which demonstrated that across 10 wards, the incidents of rapid tranquillisation had reduced form 56 occasions to 45. seclusion had reduced from 69 occasions to 35, and the numbers of restraint had reduced from 194 occasions to 89.

Staff used medicines for rapid tranquilisation as a last resort, however staff did not always follow the national institute for health and care excellence guidance when using rapid tranquilisation. Patients usually received post dose physical health monitoring every hour for 4 hours after the administration. However, there were some gaps in records where this had not always occurred. In addition, we saw that where patients had received a dual dose of rapid tranquilisation, staff had not increased the frequency of physical health checks to manage the increased risk to the patient. We reviewed 23 occasions of rapid tranquillisation and saw that on 7 occasions, staff had not recorded that they had completed physical health observations post rapid tranquillisation.

Staff kept clear and detailed records of seclusion and followed best practice guidelines in completion of seclusion reviews.

Long-term segregation was not used on the wards

Staff access to essential information

Bank and agency staff had access to care records systems to record and view patient records. However, although access is available to bank and agency staff, managers at Great Yarmouth and Waveney Acute service did not facilitate this. This was an improvement since our last inspection, but it was unclear why this was not facilitated to all staff on all wards.

The trust used a care records system that did not always make it easy to locate information about patients. Not all staff found it easy to use.

Medicines management

The service used systems and processes to safely prescribe, record and store medicines. However, staff had not always completed records to show they had considered the reasons for administering 'as and when' medication.

Overall staff followed systems and processes to prescribe and administer medicines safely. The trust had systems and process in place to safely administer and record medicines usage. Staff completed medicines records accurately and kept them up to date. There was an EPMA (electronic prescribing and medicines administration) system in place that supported staff to administer medicines safely and reduce medicines errors. However, we saw 1 instance where a

medicine with additional administration requirements had not been administered correctly over an extended period. Failure to administer this medicine correctly could have led to unintended harm, the medicine not working as intended or interacting with other medicines in unexpected ways. We informed the ward and they immediately took steps to rectify this.

Mental Health Act certificates were in place and were up to date with the correct medicines that patients were prescribed.

We reviewed whether staff recorded the sites where they had administered depot injections, we identified 5 occasions where this had not been done.

Staff reviewed each patient's medicines regularly and provided advice to most patients and carers about their medicines. Pharmacists supported the ward with this. We saw this in patients' care records and most patients were happy with the information they received about medicines. However, not all patients on Avocet and Poppy wards thought they were given enough information about medicines.

Staff stored and managed all medicines and prescribing documents safely. Medicines were stored safely and securely. Each ward had a dedicated clinic room with air conditioning and remote temperature monitoring of ambient room and fridge temperatures. Some wards also conducted daily physical checks to provide additional assurances. Medicines cabinets were locked when not in use and only accessible to authorised staff. Controlled drugs (medicines with additional storage and recording requirements) were stored securely and checks of these were conducted at each shift change on the wards. Where oxygen was stored in clinic rooms this was kept secured to an anchor point and there was appropriate signage on the door to the room to make people aware of the risk.

The service had not always ensured that people's behaviour was not controlled by excessive and inappropriate use of medicines. "As and when required" medicines (PRNs) for the management of agitation and aggression or anxiety were usually used safely and appropriately by the trust. However, staff did not always record the reason for administration or its effect. On occasions, where a medicine had been prescribed for a dual reason (such as agitation or insomnia), staff did not clearly record the reason why the medicine had been administered. Where PRN medicines had been prescribed with a variable dose, records did not make it clear why the decision was made to use 1 dose over another. Documents available at the point of administration did not provide any guidance to staff about what dose would work best depending on how a patient was presenting. We saw 11 examples where either there was no rationale given for the dose or reason for administration.

Staff reviewed the effects of each patient's medicines on their physical health according to the national institute for health and care excellence guidance. The trust ensured that all patient's had regular physical health monitoring completed. Staff were often trained in phlebotomy and how to take an echo cardiogram to ensure that patients had the correct baseline observations completed before starting any new medicines. Where patients were prescribed medicines with additional monitoring requirements such as clozapine, lithium or high dose anti-psychotic therapies (HDAT) their physical health was monitored in line with trust policy and national best practice guidance.

Reporting incidents and learning from when things go wrong

The service managed patient safety incidents well. Staff recognised incidents and reported them appropriately. Managers investigated incidents and shared lessons learned with the whole team and the wider service.

Acute wards for adults of working age and psychiatric intensive care units

Staff knew what incidents to report and how to report them. We reviewed incidents between the 1 June and the time of our inspection. We saw that staff had reported a range of incidents and that incidents had been regularly reported. We also saw that incidents such as restraint were reported with enough detail, which we had not seen at our last inspection.

Staff raised concerns and reported incidents, serious incidents and near misses in line with trust policy. This had improved since our last inspection. All staff including bank and agency staff were responsible for reporting incidents and were clear about what they should report. We checked patients' care records and saw when there were incidents staff reported them.

Managers debriefed and supported staff after any serious incident. The trust had introduced a clear process and approach for debrief. Debriefs took place for patients so that they were supported after incidents and distress.

The trust was working to improve the quality of debriefs with a focus on what they called 'The Three R's' which focused on 'Restore' restoring the emotional wellbeing of those involved with the incident, 'Reflect' reflection on the causes of the incident and 'Revise' thinking about whether a different approach would be beneficial. The trust audited debriefs to support wards to improve.

Managers investigated incidents thoroughly. We checked all incidents in the reporting system from the 1 June 2022 until the time of our inspection and saw that incidents were investigated. We saw approximately 25% of incidents were not closed but this did not have an impact on investigation or learning from incidents, which was recorded. The trust monitored any incidents that had taken more than 7 days to review, we saw delays in completing reviews were infrequent. At the time of our inspection there were only 29 outstanding incidents across ten wards that had taken longer than 7 days to be reviewed.

Staff received feedback from the investigation of incidents, both internal and external to the service. We saw evidence that staff had met to discuss the feedback and had looked at improvements to patient care in team meetings and supervision. We saw an example of how managers had implemented change following a recent serious incident.

There was evidence that changes had been made as a result of feedback. For example, in respect of required environmental changes, to ensure patients' safety.

Is the service effective?

Requires Improvement 

Our rating of effective improved. We rated it as requires improvement.

Assessment of needs and planning of care

Staff assessed the physical and mental health of all patients on admission. They developed individual care plans which were reviewed regularly. Care plans reflected patients' assessed needs, and were personalised, holistic and recovery oriented. However, staff did not always act consistently to address patients' physical health care needs.

Staff completed a comprehensive mental health assessment of each patient either on admission or soon after. Staff used the trust's combined assessment which could include information from previous admissions or from other services within the trust.

At this inspection we saw that physical health care assessments for patients were competed at admission and that overall patient's physical health was reviewed regularly. We saw records that indicated when patients declined physical health checks staff did reattempt to offer these again. The trust had appointed physical health nurses to support staff with physical health care.

However, we did identify that there were still some omissions in physical health care. On Poppy ward, staff had omitted to carry out daily physical health checks on a patient who required them. This had occurred 5 times in a 21-day period.

On Samphire ward there had been omissions regarding the management of patients with diabetes. Blood sugar monitoring had not been completed daily for 3 patients and there was a lack of action taken for these patients when their blood glucose levels were high. On Thurne ward a patient had not had their chronic health needs met. When we asked staff about this patient's needs, staff had been unsure about them. We spoke to the trust about our concerns and they took immediate action and provided assurance about what they would do to improve.

We reviewed 36 care plans and overall saw staff developed a comprehensive care plan for each patient that met their mental and physical health needs. However, on 2 occasions we saw that patient's physical health needs had not been integrated in the care plan, in relation to blood glucose monitoring and a chronic health condition.

Staff regularly reviewed and updated care plans when patients' needs changed.

Care plans were personalised, holistic and recovery-orientated, and covered a wide range of areas. Patients had identified which elements they wanted to include in their care plan. Staff used the 'Dialog+' outcome measures tool directly with patients to inform care planning. Care plans included patients' strengths, were recovery focused and included triggers for risky behaviours and maintaining protective factors.

Best practice in treatment and care

Staff ensured that patients had good access to physical healthcare and participated in clinical audit and quality improvement initiatives.

Staff made sure patients had access to physical health care, including specialists as required.

Staff met patients' dietary needs and assessed those needing specialist care for nutrition and hydration. We reviewed food and fluid monitoring charts and saw these were fully completed for patients who required this.

The trust had an audit programme in place. Staff took part in clinical audits and managers used results from audits to make improvements. The trust ensured that audits took place monthly on all wards. Monthly ward audits were completed for seclusion records and processes, rapid tranquilisation, specifically physical observations post rapid tranquilisation, debriefs, therapeutic observations and care processes. In addition, there were further annual audits that took place. Audits were closely monitored by managers and senior managers to ensure there was continued improvement. Where there were concerns about therapeutic observations being completed effectively, wards had increased the frequency of monitoring.

Acute wards for adults of working age and psychiatric intensive care units

The trust had a quality improvement programme in place and was working to engage managers and staff in an improvement plan in response to the concerns set out in the Care Quality Commission's 29A warning notice.

Skilled staff to deliver care

Managers made sure they had staff with the range of skills needed to provide high quality care. They supported staff with appraisals, supervision and opportunities to update and further develop their skills. Managers provided an induction programme for new staff and made sure patients had access to the specialists they needed.

At our last inspection we had identified a gap in the number of specialists required for patients at the Great Yarmouth and Waveney Acute service. During our inspection, we were told this was no longer an issue. A clear pathway had been shared with all staff, so that staff could refer patients to a speech and language therapist or dietician.

Managers had worked hard to make improvements and were keen to ensure staff had the right skills, qualifications and experience to meet the needs of the patients in their care, including bank and agency staff. There was a range of specific training staff completed in addition to their mandatory training which was suitable for their roles. For example, the trust had developed a senior nurse training programme and had increased staff training in delivering physical health care.

Staff told us that managers made sure staff, including bank and agency staff had received an induction and understood the service before starting their shift. The trust had made improvements since our last inspection in respect of the induction of their permanent staff. At the time of our inspection 87% of staff had completed their local induction and 92% of staff had completed their trust wide induction.

Managers supported non-medical staff to develop through yearly, constructive appraisals of their work. At the end of August 2022, 90% of staff had completed their appraisal. All staff who required an appraisal had completed one on Southgate and Northgate wards, Samphire ward's compliance rate was lower at 74%. Overall appraisal compliance had improved since our last inspection.

Managers supported non-medical staff through regular, constructive clinical supervision of their work. Management supervision had a clear format with specific items for discussion to ensure that key items and areas for learning and development were discussed. This format for supervision was used across the wards. Some wards offered combined management and clinical supervision, other wards offered group reflective practice sessions where they could talk about specific patients or other clinical issues. There had been a significant improvement of staff compliance with supervision. At the end of August 2022, 93% of staff were up to date with their supervision. Four wards had achieved 100% compliance; Yare, Avocet, Lark and Poppy. The lowest level of compliance was on Thurne and Samphire wards with 74% and 76% respectively. However, these wards told us they had faced recent staffing challenges.

Overall, managers made sure staff attended regular team meetings or gave information from those they could not attend. Team meetings took place on most wards, although these had been less frequent on Thurne and Samphire wards. We looked at team meeting minutes and saw that overall actions were taken following meetings.

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

Managers made sure that staff explained patients' rights to them.

Staff explained to each patient their rights under the Mental Health Act in a way that they could understand, repeated this as necessary and recorded it clearly in the patient's notes each time.

Acute wards for adults of working age and psychiatric intensive care units

Informal patients knew that they could leave the ward freely and the service displayed posters to tell them this. This had improved since our last inspection.

Is the service caring?

Requires Improvement 

Our rating of caring stayed the same. We rated it as requires improvement.

Kindness, privacy, dignity, respect, compassion and support

Overall staff treated patients with compassion and kindness. However, there were several examples where staff had not always respected patients' privacy and dignity or been respectful and responsive.

Overall staff were discreet, respectful, and responsive when caring for patients. However, on Avocet ward 2 patients said staff were not always polite and kind, and on Northgate ward 4 patients told us that night staff were not responsive or motivated.

We saw that in most cases staff kept patient information confidential. However, we saw an example of where staff had not kept information about a patient's health confidential on Samphire ward. When we raised this with managers, they took immediate action.

Patients told us that staff did not always maintain their privacy and dignity. We viewed an incident on CCTV where a patient's privacy and dignity had not been maintained on Glaven ward when they were receiving rapid tranquilisation. Six patients told us staff did not always respect their privacy and came into their rooms without knocking on the door or letting them know. Four of these patients were on Thurne ward. The trust had introduced signs on each patient's door which indicated how the patient wanted to be made aware there were staff entering their room. However, on Thurne ward a number of these were not completed so that staff were not clear about patient's wishes.

On Southgate, Thurne and Yare wards, patients told us there were not enough female staff to carry out enhanced observations of female patients, this had impacted on female patients' dignity.

Involvement in care

Overall staff involved patients in care planning and risk assessment and actively sought their feedback on the quality of care provided.

Involvement of patients

Staff told us that they introduced patients to the ward and the services as part of their admission. We saw the newly designed information booklet for all patients who were admitted to the service. However, a third of patients told us that they did not think they were given enough information about the ward.

Staff involved patients and gave them access to their care planning and risk assessments. We saw that patient's views were included in these documents and the patient's voice was clear. The 'Dialog+' provided patients with the opportunity to focus on what was important to them in their care plan.

It was not always clear from patients' care records, whether patients received a copy of their care plan. Nine of 31 patients told us that they did not have a copy of their care plan. We asked the trust for further information about this, but we did not receive a response. However, we found that patients were engaged in care planning and their voice could be heard in care plans.

Staff involved patients in decisions about the service, when appropriate. There were daily planning meetings and community meetings on each ward. Patients could give feedback on the service and their treatment and staff supported them to do this. Overall staff made sure the actions identified in community meetings were completed. However, community meetings did not always take place regularly on Thurne ward and actions were not always completed at Great Yarmouth and Waveney Acute service.

Involvement of families and carers

Staff informed and involved families and carers appropriately.

Staff supported, informed and involved families or carers. We saw that staff had worked to improve their communication. The wards had initiatives to support and meet with families and carers and there was evidence in patient's care records that (where patients wanted families involved) staff had involved them. Each ward had a carer's champion.

Staff helped families to give feedback on the service. The trust used a family and friends test - Your Service Your Say. The trust reviewed the information that was shared and used it to make changes. We asked the trust for data about the feedback that they had received from families, but at the time of reporting, we had not received this information.

The trust had a carer's information pack which they shared when patients were admitted to the ward, this included information about how to access a carer's assessment.

Is the service responsive?

Good ↑

Our rating of responsive improved. We rated it as good.

Facilities that promote comfort, dignity and privacy

The design, layout, and furnishings of the ward supported patients' treatment, privacy and dignity. Patients had access to hot and cold drinks and snacks at any time.

At our last inspection we identified that the outside spaces on Poppy male and Avocet female wards were visible to each of the other wards. At this inspection we saw this had been resolved and privacy screening had been used on the windows so that patients from 1 ward could not see the other ward's outside space.

Patients could make their own cold drinks and snacks. However, on most wards, patients had to ask staff for access to hot drinks due to levels of risk on the ward. Staff told us this was reviewed depending on risk levels on the ward. Patients did not describe problems being able to access hot drinks however and that staff responded to them quickly.

Listening to and learning from concerns and complaints

The service treated concerns and complaints seriously, investigated them and learned lessons from the results, and shared these with the whole team and wider service.

Patients knew how to complain or raise concerns. The service clearly displayed information about how to raise a concern in patient areas on all wards.

Staff understood the policy on complaints and knew how to handle them. Staff understood the difference between local and formal complaints. There was evidence that there were local resolutions found if appropriate and that staff followed process when they responded to formal complaints. We reviewed complaints with managers and saw that in all cases these had been or were being reviewed and investigated within the trust timescale of 30 days.

Staff knew how to acknowledge complaints and patients received feedback from managers after the investigation into their complaint. Staff attended meetings to discuss complaints and managers worked with the trust complaints department in respect of formal complaints.

Managers investigated complaints, identified themes and had received training to do so. They shared feedback from complaints with staff and learning was used to improve the service.

Is the service well-led?

Requires Improvement ↑

Our rating of well-led improved. We rated it as requires improvement.

Leadership

Leaders had the skills, knowledge and experience to perform their roles. They had a good understanding of the services they managed.

Leaders had the skills knowledge and experience to perform their roles and understood the service that they managed. Each ward had a permanent ward manager, with the exception of Northgate ward, (who had an interim ward manager at the time of our inspection), and also had senior leadership supporting the ward. All managers were all able to talk about how they were improving the quality of care that they offered and where there had been specific improvements made or further work required. All staff were well informed about our previous inspection, the concerns identified and demonstrated where they were actively engaged in making improvements. Ward managers told us they were well supported by their managers and could access training to help them to develop. The trust had begun a ward manager's induction programme which was offered to all ward managers including existing staff.

Acute wards for adults of working age and psychiatric intensive care units

Managers told us they had enough time to carry out their role effectively. They did work clinically on the ward on occasion but demonstrated that they supervised and supported their staff team.

Governance

Our findings from the other key questions demonstrated that governance processes had improved at team level and that there were improvements in performance and risk management. However, there was further progress that still needed to be made to ensure services are delivered to a consistently high standard.

The service had made progress in the management of incidents and complaints. There was evidence that there had been significant improvements in staff supervision and appraisal compliance. Care planning and risk management had improved and was more consistent, and there had been concerted effort for the patient to be better involved with this. The trust was working hard to increase staffing and managed staffing challenges and used temporary staffing.

However, further improvements were still required in a number of areas. We found that environmental risk and repairs had not always been well managed or completed promptly. This presented wards with ongoing environmental risks. In relation to patient's physical health monitoring and physical health care, we found that staff had not always ensured that patients' physical healthcare needs had been addressed as required. Whilst managers had an ongoing audit programme which included audits of patient care plans, omissions had continued to occur.

Despite an improvement in staff training compliance, staff had not always received the mandatory training required in order to keep patients safe. There was evidence that medicines management had improved but there continued to be issues in respect of the use of 'as and when required' medicines, the administration of medicines and physical observations after the administration of rapid tranquillisation**.**

Wards for older people with mental health problems

Insufficient evidence to rate

Is the service safe?

Inadequate ↓

Our rating of safe went down. We rated it as inadequate.

Safe and clean care environments

Most wards were safe, clean well equipped, well furnished, well maintained and fit for purpose. On Blickling and Sandringham Ward potential ligature risks remained in place.

Safety of the ward layout

At our last Inspection we found risks including ligature anchor points at Blickling ward and in the communal garden at Carlton court Laurel ward. At this inspection we found that monthly ligature audits had been completed by the health and safety lead jointly with the lead nurse on each of the wards by the middle of every month and were then submitted to the risk review team. This included the communal gardens and the ward gardens at Carlton court Laurel ward. However, on Blickling ward we found the ligature point audits were completed, however the environmental ligature risks identified at the last inspection remained in place. We were told that the works had been due to be started to manage the environmental ligature risks by October 2022. During our inspection we were advised that this work had commenced.

As there had been a delay in arranging the maintenance works, the mitigation planned to manage these risks was in enhanced patient observations and with a staff member in the day area at all times. However, during our inspection, it was clear that staff were not always present in these areas to mitigate the risk. However, at the time of the inspection the ward did not receive patients who were risk assessed to be suicidal or have a self-harming history.

On Blickling Ward the staff told us they used controlled circuit television (CCTV) to mitigate the risks, however staff told us that they only viewed this following an incident, so the use of CCTV was not considered to be a preventative measure. We were told that only 1 toilet on the ward was unlocked for use and this was in front of the communal lounge, which was a high traffic area. This was to reduce the risk associated with the ligature points in the toilet. However, during the inspection we found another bathroom with multiple ligature points open and unlocked on 1 of the bedroom corridors.

Most bedrooms on Blickling ward contained electric beds with visible wires and additional ligature risks such as handbags with long straps and we could find no individual risk assessments to manage this. Across the ward the common ligatures included ceiling and wall lights, grab handles, curtain rails, wires from the water dispensing machine, door handles window handles and air vents. There was insufficient mitigation to manage all of these risks.

On Sandringham ward we noted in the ligature risk assessment that on the 11th of May 2022 a request was sent to the maintenance team to secure wires behind the television in the main lounge. These wires remained a ligature risk and had not been secured.

Wards for older people with mental health problems

The issues relating to ligatures found on Blickling ward and Sandringham ward, evidenced that the trust had not fully complied with the warning notice around ligatures.

On the last inspection we found that Sandringham ward did not comply with the guidance on the elimination of mixed sex accommodation. During this inspection we found that most wards had complied with the guidance on mixed sex accommodation. We were told that there had been 1 breach on Sandringham ward. However, staff had put processes in place on the ward to ensure patients privacy and dignity.

Maintenance, cleanliness and infection control

Ward areas were mostly clean, and staff made sure cleaning records were up-to-date and the premises were clean. However, the environment on Reed ward required updating, and we saw that the curtains in 1 bedroom were soiled.

Staff followed infection control policy, including handwashing. We saw that adequate signage was in place across all wards and there was personal protective equipment available for all staff.

Safe staffing

Although wards were currently running at high sickness rates the services had enough nursing and medical staff, who knew the patients and received basic training to keep people safe from avoidable harm.

Nursing staff

In the previous inspection the trust were required to ensure sufficient staff were deployed to meet the needs of the service users. In this inspection we found that Abbeygate, Reed and Sandringham wards all had high vacancy rates and sickness levels. The data provided by the trust confirmed that, Abbey gate ward sickness levels were running at 14.8% and Willows ward running at 10.66% sickness, the trust target was 4.91%.

Data provided by the trust also showed us that Sandringham ward, Reed ward, and Abbeygate ward all had high vacancy rates with Reed ward and Abbeygate ward both running at over 18% vacancy rate.

The trust used bank staff to cover vacancies pending the recruitment of permanent staff and when staff were sick or on leave. Bank staff were often staff who had previously worked permanently on the wards. When we spoke with bank staff, they were familiar with trust procedures and knew the wards and patients well.

The trust used agency nursing staff on occasions when bank staff could not be identified to work on the wards. We requested to review data from the trust showing us whether vacant shifts had been filled or not by bank overtime and agency staff. The trust were using agency and bank nurses to maintain safer staffing levels.

The data showed us that at the end of August 2022 Sandringham ward was running on 16% agency registered nurse and 25% agency support worker and Abbeygate ward was running on 21% agency registered nurse and 31% agency support workers.

Staff on all the wards told us they could not recall any recent occasions when a shift had not been covered. Consequently, there were no instances of the cancellation of patient activities or leave due to a shortage of staff.

Wards for older people with mental health problems

On each of the wards the staff had a daily staffing huddle where they would review their staffing levels and look to move staff around the wards wherever clinically appropriate to maintain patient safety.

The staffing levels on the wards allowed patients to have regular one-to-one time with their named nurse.

Patients and carers told us that staff were always available to answer their questions and offer support.

Care records included daily progress notes and records of interviews with patients. We observed that staff were patient and calm when interacting with patients.

Ward managers were able to increase staffing levels to meet patient need. For example, if a patient was identified through risk assessment as requiring one-to-one support to ensure their safety or the safety of others. We found that when necessary ward managers had booked additional staff to meet the needs of patients placed on increased observations

Both permanent and temporary staff received appropriate information about the ward and patients when they started work. We saw induction checklists which experienced staff used when introducing new staff to the ward. This also included information on the ward layout and fire procedures. Staff confirmed they were introduced to patients and ward routines when they started work. They told us they were taken around the ward and shown the location of emergency equipment.

Staff carried out physical interventions on patients rarely. Ward managers ensured there were always enough staff available on a shift to safely carry out physical interventions when required.

Mandatory training

At the last inspection we had concerns that staff were not kept up to date with mandatory training. As part of this inspection, we reviewed the statutory and mandatory training figures for each of the wards for older people and found the training compliance to be above 85% across all wards. We found this to be satisfactory and to have met the warning notice.

The trust specified the mandatory training that staff should receive and monitored take-up of this training. Mandatory training was comprehensive, subjects included equality and diversity, fire safety, information governance, the prevention and management of violence and aggression and life support.

Managers monitored mandatory training and alerted staff when they needed to update their training.

Assessing and managing risk to patients and staff

Staff assessed and managed risks to patients and themselves and mostly followed best practice in anticipating, de-escalating and managing challenging behaviour. Staff used restraint and seclusion only after attempts at de-escalation had failed. Observations of patients and physical interventions were not always carried out appropriately.

Assessment of patient risk

Wards for older people with mental health problems

Staff completed risk assessments for each patient on admission, using a recognised tool, and reviewed this regularly, including after any incident.

We reviewed 32 sets of individual patient risk assessments and found that most risk assessments were regularly checked and reviewed and individual risk assessments for patients had been updated following incidents. We found this was satisfactory and now met the requirements of the warning notice from the previous inspection. However, we found that 1 patient's risk assessment had not been updated after the patient had been found naked and confused in their bedroom.

Where a patient was assessed as being at risk of falls, a physiotherapist had made further checks on of the patient's mobility. For example, we saw that a physiotherapist in Willow Ward had assessed a patient's safety when using stairs.

The ward psychiatrists and pharmacists reviewed the impact of prescribed medicines in relation to the risk of falls on all wards.

Staff used a recognised screening tool to assess a patient's risk of developing a pressure ulcer. Staff were able to tell us the risk factors associated with skin damage and how to prevent pressure ulcers. They were alert to signs such as reddening of the skin. At the time of the inspection none of the patients on the wards for older people wards currently had a pressure ulcer.

The wards used a recognised screening tool to assess each patient's risk of malnutrition. Staff assessed every patient's food and fluid intake for the first 72 hours they were on the wards. Staff completed a food and fluid intake chart during this period in order to assess whether the patient need support with eating and drinking. Staff calculated and charted the patient's body mass index to enable continuous assessment of risks.

Physiotherapists were part of the multidisciplinary team on all of the wards. Care and treatment records showed physiotherapists were involved in checking whether patients would benefit from the provision of walking aids.

Staff understood and implemented trust policies and procedures on the observation of patients to ensure the patient and others were safe. The multidisciplinary team decided what level of observation was required for each patient to ensure their safety and the safety of others. Risk management plans covered the risk to the patient from ligatures on the ward. During the inspection we saw that staff effectively implemented plans to observe patients. For example, where a risk management plan noted a patient should receive one-to-one observation, a member of staff was allocated to this task.

Staff told us that they had not carried out any recent patient searches or searches of patient bedrooms. However, they were aware of the trust policies on this.

Use of restrictive interventions

Levels of restrictive interventions were low. Staff participated in the provider's restrictive interventions reduction programme which met best practice standards.

Staff applied blanket restrictions on patient's freedom only when justified. Staff made every attempt to avoid using restraint by using de-escalation techniques and restrained patients only when these failed and when necessary to keep the patient or others safe.

Wards for older people with mental health problems

Staff understood the Mental Capacity Act definition of restraint and worked within it. Staff followed National Institute for Health and Care Excellence guidance when using rapid tranquilisation, which was rarely used.

During our inspection we reviewed several incidents together with a review of CCTV footage. During our review, we identified 2 areas of concern. The first instance related to a patient who had a fall on the ward. The patient had remained on the floor unchecked for 45 minutes. This was despite the patient being on 15-minute observations. The second incident of concern related to a patient who was restrained. During the restraint a nurse did not use an approved technique for restraint.

Medicines management

The service used systems and processes to safely prescribe, administer, record and store medicines. Staff regularly reviewed the effects of medications on each patient's mental and physical health.

In the previous inspection we found that staff did not always follow systems and processes to prescribe and administer medicines safely and patients weren't always given their medication on time.

The trust had implemented an electronic system for prescribing and administering medication. The electronic system supported staff to administer medicines safely and reduce medicines errors. Staff told us this was a positive change. When we reviewed medication administration audits, we could see that staff were recording a reason as to why medications may have been given later than prescribed on the system. On all occasions we could see this was due to a clinical reason such as a patient returning late from a therapy session.

Staff reviewed each patient's medicines regularly and provided advice to patients and carers about their medicines.

Decision making processes were in place to ensure people's behaviour was not controlled by excessive and inappropriate use of medicines. When a medicine was prescribed to be administered 'as and when required' there was information provided so that staff understood when it was needed. The need for these medicines were reviewed regularly during multidisciplinary team meetings. However, we found that for patients who were receiving their medications covertly that the necessary records of how to administer the medication were not always in place.

Medicine allergies or sensitivities were recorded on all medicine charts we reviewed. This ensured staff were alerted to prevent the prescribing and administration of medicines causing allergic reactions.

Medicines advice and supply from pharmacy were available 5 days a week. Staff knew the routes to obtain medicines out of hours, if required.

Staff stored and managed all medicines and prescribing documents safely.

Is the service effective?

Good ↑

Our rating of effective improved. We rated it as good.

Wards for older people with mental health problems

Assessment of needs and planning of care

Staff assessed the physical and mental health of all patients on admission. They developed individual care plans which were reviewed through multidisciplinary discussion and updated as needed. Care plans reflected patients' assessed needs, and were personalised, holistic and recovery-oriented.

At the previous inspection it was found that care plans did not reflect patients current care needs and lacked vital information about the patients. In this inspection we found the care plans were produced to a much higher and consistent standard across all wards.

We reviewed 32 sets of care and treatment records and found staff had developed personalised, holistic and recovery orientated care plans for patients that met their mental and physical care needs. Staff regularly reviewed and updated care plans when patients' needs changed.

Staff completed a comprehensive mental health assessment of each patient either on admission or soon after and this fed into the multidisciplinary reviews. However, we found that assessments for patients with dementia contained limited details of patients' history.

Staff on wards for older people developed care plans that met the needs identified during assessment. Care plans were personalised, holistic, recovery-oriented and regularly reviewed. Care plans reflected the views of patients and their relatives about their care and treatment. Patients had a care plan in relation to physical health conditions which included their input in terms of their awareness of their symptoms and how the condition should be managed.

Care plans were comprehensive and covered all aspects of the support the patient required and how it would be delivered. For example, on Abbeygate ward some patients had an assessed need for support with continence management. A care plan clearly explained how the staff team would support the patient to be as clean and comfortable as possible.

All care plans we read accurately covered the patient's current needs. If the patient had an on-going physical health condition, such as diabetes or epilepsy, there was a care plan which explained how staff supported the patient to manage the condition. Staff amended the care plans when the patient's circumstances changed. For example, when staff observed a patient was unsteady on their feet, care plans were updated. Staff ensured there was appropriate follow up in relation to the patient's physical health and ensured they monitored the patient more closely.

Staff assessed patients' physical health needs in a timely manner on admission to the older people's wards. On the day of the patient's admission, staff ensured they had a record from the GP of the patient's current physical health needs and medicines. Staff then carried out an initial physical health check. They measured the patient's blood pressure when lying down and standing, measured their pulse and temperature and weighed and measured the patient to calculate their body mass index.

Where patients had very complex health needs, the staff team ensured there was liaison with the appropriate medical team. For example, when appropriate, the staff spoke with the medical team prior to the patient's admission to the ward and had on-going liaison. Staff developed a comprehensive care plan for each patient that met their mental and physical health needs.

Wards for older people with mental health problems

Staff routinely checked patients' physical health at least once a day by taking their temperature, blood pressure and pulse. These checks were increased if the staff had concerns that the person's physical health may be deteriorating. We saw evidence that staff responded well to any adverse results from these checks. For example, there was discussion in multidisciplinary team meetings to decide next steps in terms of possible further health checks and blood tests.

Skilled staff to deliver care

At our last inspection we found that staff were not in receipt of regular supervision and appraisal. During this inspection, we were told that the appraisal figure was 91% and the supervision rate was 89%. We were assured that the trust had met this aspect of the section 29A warning notice.

Is the service responsive?

Good 

Our rating of responsive improved. We rated it as good.

Facilities that promote comfort, dignity and privacy

At the previous inspection we found that Laurel Ward at Carlton Court was found to be not dementia friendly.

The trust had made improvements to the ward environment to ensure the privacy and dignity of patients and to meet recent dementia friendly guidance. The ward had followed guidance from the Kings fund for maintaining a dementia friendly ward. There were dementia friendly day and night clocks on the walls and the flooring was due to be changed the week after the inspection to the same colour to allow flow around the ward and make it easier for patients with dementia to navigate the ward.

The outside spaces had been levelled and made suitable and safe for patients with dementia and new furniture was due to be delivered in October 2022 for the lounge and dining room.

Wards for older people had a full range of rooms for use by patients, including communal lounges, and activities rooms. All wards had pictorial signs on toilet doors and other signs to assist patients to find their way around the ward.

Each ward had an outside space which patients could access easily. On non-dementia wards the patients could make their own hot drinks at the drinks station or tea trolley and access a range of snacks including fresh fruit and biscuits and were not dependent on staff. The service offered a variety of good quality food.

Patients we spoke with told us they liked the meals on the wards. Most families and carers told us the food was good. Families and carers thought the wards tried to encourage patients to eat healthy meals and exercise regularly.

Mental health crisis services and health-based places of safety

Requires Improvement ➔➔

Is the service safe?

Requires Improvement ➔

Safe staffing

The service did not always have enough staff. This led to delays in completing assessments following emergency referrals. The number of patients on the caseload of the mental health crisis teams was not too high to prevent staff from giving each patient the time they needed. Staff received essential training to keep people safe from avoidable harm, although some staff were not up to date.

Nursing staff

At the last inspection the service did not always have enough staff and at this inspection the staffing position remained challenging. The caseloads for team members had remained manageable which meant they could meet the needs of patients receiving a service from the team. At the previous inspection staff had described being pulled into work on the acute wards but this was no longer an issue. However, on 13 occasions in a 3-month period from the start of June to end of August 2022, the team had been unable to respond to emergency referrals within the 4 hour time-scale. Whilst we were not told of any associated incidents, this delay in carrying out an assessment could present a risk to patients.

Most of the teams had high vacancy rates although this varied across the teams. West Suffolk had an overall vacancy rate of 38%, Great Yarmouth was 32%, West Norfolk was 31%, East Suffolk was 19% and Norwich was 4%. However, most of the teams were recruiting staff linked to the trust wide recruitment strategy.

The service had variable turnover rates, most above the trust target of 15%. West Suffolk had the highest turnover rate of 29%. East Suffolk had a turnover of 24%, West Norfolk and Norwich teams were 19% and Great Yarmouth had no staff who had left in the 12 months prior to our inspection. This turnover was higher than a year ago where it had been below 15% for this core service.

Managers supported staff who needed time off for ill health. Levels of sickness were higher than the trust target of 4.91% in all services. Sickness levels averaged 6.8% across all Crisis Resolution and Home Treatment Teams. This had also increased since the last inspection where most teams were within the trust target.

Managers used a recognised tool to calculate safe staffing levels. The trust had met their safest staffing numbers consistently across their services since March 2022. Safest staffing numbers are the minimum staffing levels the trust has determined the services need to run safely.

On the day we visited, caseloads for each team ranged from 13 to 30. Kings Lynn had the lowest and Norwich City was the highest. Staffing was enough to meet demand for that day and met with the team's minimum standards.

The teams filled vacant shifts through permanent staff working additional shifts and by accessing bank and agency staff. We requested bank and agency usage from September 2021 to September 2022. The data provided by the trust included all permanent staff working additional hours as bank as well as other bank and agency staff. The trust told us 30% of

shifts were filled by permanent staff working additional hours as bank, 37% were bank and 33% were provided by agency staff. West Norfolk had the highest use of bank and agency qualified nurses with 595 hours covered in this time period. In West Suffolk, bank and agency covered 539 hours. The data for the Norwich teams was split into Norwich city and Norwich county integrated Crisis Resolution and Home Treatment Teams. In Norwich county bank and agency covered 271 hours whilst in Norwich city they covered 246 hours. Great Yarmouth had 85 hours covered by bank and agency. No data was provided for East Suffolk.

The service had variable rates of bank and agency unqualified nurses. We requested bank and agency usage from September 2021 to September 2022. The data provided by the trust included all permanent staff working additional hours as bank as well as other bank and agency staff. The trust told us 30% of shifts were filled by permanent staff working additional hours as bank, 37% were bank and 33% were provided by agency staff. West Norfolk had the highest use of bank and agency unqualified nurses with 466 hours covered in this time period. The data for the Norwich teams was split into Norwich city and Norwich county integrated Crisis Resolution and Home Treatment Teams. In Norwich city bank and agency covered 281 hours whilst in Norwich county they covered 184 hours. Great Yarmouth had 72 hours covered by bank and agency and West Suffolk had 27 hours covered by bank and agency. No data was provided for East Suffolk.

Managers requested bank and agency staff familiar with the service to ensure consistency of care. Managers made sure all bank and agency staff had a full induction and understood the service before starting their shift.

Medical staff

Medical staffing had improved overall since the last inspection but remained challenging. The Great Yarmouth service had no specific Crisis Resolution and Home Treatment consultant for the 4 months prior to our inspection. The consultant from the psychiatric liaison service provided cover 2 days a week and which meant they were not easily accessible and the wait to see a consultant under the Crisis Resolution and Home Treatment Team was 1 week. We were told that all prescribing was done by the non-medical prescriber who only worked 3 days a week and on the other days the team had to look for cover elsewhere to prescribe medicines for patients. However, a consultant had been appointed and was starting in post in October 2022.

The West Suffolk team had medical cover from the psychiatric liaison service, supported by a junior doctor and non-medical prescriber. This had improved since our previous inspection. They were recruiting for a full-time consultant psychiatrist.

The East Suffolk team had 2 consultants in working age and 2 speciality consultants in working age. A support model for the crisis pathway had been put in place in East Suffolk. This had improved since previous inspection. The service now had full medical cover.

The Crisis Resolution and Home Treatment Teams in Kings Lynn and Norwich had medical cover.

The trust had also embraced the NHS Long Term Plan and had utilised other professions to upskill such as; physicians associates, nurse consultants, advanced clinical practitioners and non-medical prescribers.

Mandatory training

Not all staff had completed and kept up-to-date with their mandatory training.

Mental health crisis services and health-based places of safety

Prevention and management of aggression personal safety (PMA) training had the following completion levels, West Norfolk 53%, West Suffolk 65%, Norwich 70%, Great Yarmouth 74% and East Suffolk 82%. Prevention and Management of Aggression physical intervention training had completion rates of Great Yarmouth 78% and West Norfolk 47%. Other teams were not required to complete this training due to not being co located with other ward based teams. Whilst this had significantly improved since the last inspection it was still below the trusts own target and the Care Quality Commission target of 75%. Further training slots were being provided by the trust.

West Norfolk were below the Care Quality Commission target of 75% for infection prevention and control Level 2 at 60%, health, safety and welfare at 63% and fire training at 73%. Great Yarmouth were below the Care Quality Commission target of 75% for information governance and data security at 50%, fire training at 71% and infection prevention and control Level 2 at 71%. However, overall compliance rates for West Norfolk were 76%, Great Yarmouth at 77%, West Suffolk at 87%, East Suffolk at 89% and Norwich at 95%. The provider compliance target was 90%.

The mandatory training programme was comprehensive and met the needs of patients and staff. The trust has a new standard operating procedure for section 136 which included the need for bespoke training for staff.

Managers monitored mandatory training and alerted staff when they needed to update their training. The trust had employed a temporary dedicated administrative staff member who booked time with managers and administrative staff to identify and book individuals who required training. Staff were also emailed 4 weeks prior to the course start date to remind them.

Assessing and managing risk to patients and staff

Staff assessed and managed risks to patients. When necessary, staff working in the mental health crisis teams worked with patients and their families and carers to develop crisis plans.

Assessment of patient risk

Staff triaged patients when they were referred to the service. Staff used a comprehensive triage tool, which determined the level of urgency of the assessment. Emergency assessments were meant to be seen within 4 hours and urgent referrals within 72 hours. However, there was no consistency among the teams and each crisis team used a slightly different triage tool.

Staff could recognise when to develop and use crisis plans and advanced decisions according to patient need. We reviewed 27 crisis plans and care plans. Two patients were not able to engage in the process and therefore 2 were missing and not completed. However, 25 were completed to a good standard, were individualised and included information about patients preferred treatment choices.

Medicines management

The service used systems and processes to safely prescribe, record and store medicines. Staff working for the mental health crisis teams regularly reviewed the effects of medications on each patient's mental and physical health. In 1 team we found a few gaps in medicines records which will be addressed by the new electronic prescribing system.

Staff followed systems and processes to prescribe medicines safely. Staff used a paper system to prescribe medicines but were in the process of upgrading to a full electronic prescribing and supply record. Each Crisis Resolution and Home

Mental health crisis services and health-based places of safety

Treatment Team had a named pharmacist and pharmacy technician who worked to support staff in the safe prescribing and use of medicines. In Norwich a member of the pharmacy team was permanently assigned to that team. In every other team, they were shared between the Crisis Resolution and Home Treatment Teams and the other wards on those sites. The team in Great Yarmouth were not as well established as in Norwich, with limited access to independent prescribers and a small team working on the day of the inspection. Pharmacy only offered a service Monday to Friday during working hours. Outside of these hours, prepacked medicines, medical prescriptions (when a prescriber was available on site) and emergency dispensing could be used out of hours. Any use of the emergency dispensing procedure was clearly recorded by staff and audited by pharmacy. All prescriptions were legally authorised with a prescriber's signature. This had improved since our previous inspection.

Staff reviewed each patient's medicines regularly and provided advice to most patients and carers about their medicines. Regular multidisciplinary team meetings were held to review patients and their medicines. Pharmacy were involved in these meetings and could provide expert advice around medicines if required. Nursing staff saw patients frequently and depending on the level of risk, would review and assess a patient's treatment daily. However, 1 patient told us they had received no advice regarding their medicines. This had improved since our previous inspection.

Staff did not always complete medicines records accurately and keep them up-to-date. Staff at Norwich were not always completing medicine records accurately. We looked at 12 medicine cards and found 2 did were not complete records. Paper prescription cards sometimes had unexplained gaps between where a supply of medicine should have finished and where the next one was given. We found this in 2 of the 12 medicine cards we looked at. Review of the clinical records did not always make it clear when a medicine had been given to a patient and how much. Staff told us that there were 3 places this information should be recorded (prescription card, the staff electronic record system and the Situation Background Assessment Recommendation tool) but it was not always being completed across all 3. We were told the new electronic prescribing and recording system would fix this. Staff across the other teams had recorded medicines accurately on prescription cards.

Staff stored and managed all medicines and prescribing documents safely. Each Crisis Resolution and Home Treatment Team had its own clinic room where medicines were stored securely. Access to medicines cabinets were limited to authorised staff only. Medical prescriptions were kept securely and had their own audit and check paperwork in place that ensured these were being used appropriately. Pharmacy staff performed clinical checks of all prescribing documents as well as review to ensure they were being completed properly.

Staff followed national practice to check patients had the correct medicines when they were admitted, or they moved between services. Staff had recently gained access to a system which allowed prescribers or pharmacy staff access an up to date list of a patient's medicines with their permission, as well as information from the latest GP consultations where relevant. At some of the services, pharmacy staff would perform a medicines reconciliation (formal process of obtaining, verifying and documenting an accurate list of a patient's current medications) where appropriate. Staff told us that they would contact a patients GP when someone entered the service and inform them that they would take over prescribing of all mental health medicines for the time being. If a patient was admitted to an inpatient ward, then all their prescription cards as well as electronic care records would be accessible to the ward teams taking over their care. If a patient was discharged, then a letter would be sent to their GP to inform them of any changes to their medicines.

Prescription charts accurately reflect the medicines the medics had prescribed or were dispensing. Medicine charts listed all patients' prescribed medicines, including those prescribed by their GP, and clearly indicated where these medicines were GP supply and where they were given by the crisis team. This enabled the crisis team to prescribe any new medicines in a safe way to patients.

Mental health crisis services and health-based places of safety

All patients received their medicines at the correct dose in a timely manner. All patients and carers we spoke with told us patients received their medicines on time. This had improved since our previous inspection.

Staff learned from safety alerts and incidents to improve practice. Staff were informed about safety alerts and medicines related concerns by the pharmacy team. Locally staff would discuss and reflect on any reported incidents and share learning from these.

The service ensured people's behaviour was not controlled by excessive and inappropriate use of medicines. Prescriptions for medicines that control behaviour were only ever given in small quantities, especially where prescribed as and when required. We saw examples of daily reviews of the use of these types of medicines and that prescribing was stopped when it was felt that it was no longer needed.

Staff reviewed the effects of each patient's medicines on their physical health according to National Institute for Health and Care Excellence guidance. Physical health medicines were regularly included on people's medicine charts. Physical health monitoring would be conducted when necessary. Before any treatment with an antipsychotic is started, baseline observations and blood testing were conducted. We saw examples of clozapine (a medicine for treatment resistant schizophrenia with increased monitoring requirements) being re-titrated in the community. Staff provided hourly checks where appropriate during the first day of treatment and continued to monitor the patient's physical health until they were returned to their regular dose.

Is the service effective?

Requires Improvement 

Our rating of effective stayed the same. We rated it as requires improvement.

Assessment of needs and planning of care

Staff assessed the mental health needs of all patients. Staff working for the mental health crisis teams worked with patients and families and carers to develop individual care plans and updated them when needed. Care plans reflected the assessed needs, were personalised, holistic and recovery-oriented. However, not all care plans were detailed enough to meet patient's physical health needs.

Staff attempted to complete a comprehensive mental health assessment of each patient. We reviewed 27 care records across the 5 Crisis Resolution and Home Treatment Teams. We found although 1 patient in East Suffolk and 1 patient in Kings Lynn did not have a care plan, staff had documented, and we saw evidence, that staff had tried to engage with the patients to complete these.

Staff did not always ensure patients had a full physical health assessment. Out of the 27 care records we looked at, 3 patients from West Norfolk did not have a physical health assessment. Although we found a physical health assessment for a further 2 patients in West Norfolk and 2 patients in West Suffolk, these were only documented in clinical notes and not on the allocated physical health form.

Most care plans were personalised, holistic and recovery orientated and detailed enough to meet patients' mental health needs. They included patients' strengths and goals and were written in the patient voice. However, not all care

plans were detailed enough to meet patients' physical health needs. We found 1 patient in East Suffolk where their care record identified physical health concerns but did not detail what they were. The care plan referred to useful structures and routines but did not include individual details of these. We found teams that used the Situation Background Assessment Recommendation (SBAR) communication tool to assess and record risk and care interventions, did not always include this information in the patients' combined assessment and recovery plan. This meant patient information was not recorded consistently.

Staff regularly reviewed and updated care plans when patients' needs changed. Staff updated care plans and crisis plans in safety huddles and multidisciplinary team meetings.

Best practice in treatment and care

Staff used recognised rating scales to assess and record severity and outcomes although these were not always completed consistently. They also participated in clinical audit, benchmarking and quality improvement initiatives.

Staff provided a range of care and treatment suitable for the patients in the service. Staff saw patients face to face for the first 3 days of treatment and then worked with patients to meet their needs on how often they spoke to patients following this initial 3-day period. Most patients were called on alternate days.

Staff made sure patients had support for their physical health needs, either from their GP or community services. Physical health champions were available in teams for consultation and advice.

The trust had introduced a recognised rating scale at the end of 2021 to assess and record severity and outcomes which was in use across all the teams although not always used consistently. We found the Situation Background Assessment Recommendation tool was only being used by East Suffolk and Great Yarmouth. We found the rating tool used to record the severity of patient conditions was not being reviewed or recorded consistently across all teams. We found most teams were reviewing this daily, however, West Norfolk reviewed this twice a week or more often if required based on patient risk. This was not consistently recorded across all teams. Most teams recorded this in handover documents daily, however in Norwich although this was discussed daily it was not recorded in handover documents.

Staff working for the crisis teams and in the health-based places of safety participated in clinical audit, benchmarking and quality improvement initiatives.

Managers used results from audits to make improvements.

Staff delivered care in line with best practice and national guidance.

Skilled staff to deliver care

The mental health crisis teams included or had access to the full range of specialists required to meet the needs of patients under their care. Managers made sure that staff had the range of skills needed to provide high quality care. They supported staff with appraisals, supervision and opportunities to update and further develop their skills. Managers provided an induction programme for new staff.

Mental health crisis services and health-based places of safety

Managers supported staff to develop through yearly, constructive appraisals of their work. At the time of our inspection West Norfolk had a compliance rate of 75%, East Suffolk was 87%, Great Yarmouth and Norwich were both 91% and West Suffolk was 100%.

Most managers supported staff through regular, constructive clinical supervision of their work. At the time of our inspection West Suffolk and East Suffolk had a compliance rate of 100%, Norwich was 90%, West Norfolk was 86%. However, the compliance rate at Great Yarmouth was 44%.

Is the service caring?

Good 

Our rating of caring stayed the same. We rated it as good.

Involvement in care

Staff in the mental health crisis teams involved patients in their care planning and risk assessments. Some patients and their carers said they were not given a copy of their care plan.

Staff involved patients in their care planning and risk assessments. We could see patient involvement in all care plans and risk assessments we reviewed.

Staff did not always give patients access to their care plans. Three out of 11 patients said they had no care plan and were not given a copy. Four out of 9 carers said their relative had no care plan and 5 out of 9 carers said they had not been given a copy.

Is the service responsive?

Requires Improvement 

Our rating of responsive stayed the same. We rated it as requires improvement.

Access and discharge

People in crisis were advised to call 111 and select the mental health option to speak to the urgent mental health helpline. The mental health crisis service was available 24-hours a day. However, different teams had varying telephone arrangements which meant that when team members were out of the office, they may not pick up messages that quickly. The referral criteria for the mental health crisis teams did not exclude patients who would have benefitted from care. Staff followed up people who missed appointments.

The referral pathway differed across teams. For example, patients could self-refer to the teams in Norwich and West Norfolk, patients in Great Yarmouth could only self-refer within 6 weeks of discharge and patients could not self-refer to teams in other locations. However, each team had clear criteria to describe which patients they would offer services to and did not exclude patients who would benefit from their care and treatment.

Mental health crisis services and health-based places of safety

The trust set target times for seeing patients from referral to assessment. Staff triaged patients when they were referred to the service. Staff used a comprehensive triage tool, which determined the level of urgency of the assessment. Trust targets determined how quickly a patient would be assessed; emergency referrals within 4 hours, urgent referrals within 72 hours. The trust target was to meet these 95% of the time. As part of the triage process staff would ring and speak to the patient and give them a time, they would come out to see them. We were told the teams always fed back to the referrer after triaging the patient.

Staff did not always see emergency referrals quickly and within the trust 4 hour target. We reviewed referral data from 1 June to 31 August 2022. There were 99 referrals made across the 5 crisis teams in this time period. We found 36 of the 99 referrals were breaches (where the patient was not seen in the 4 hour target). We found that 13 of the 36 breaches were due to the teams being short staffed. We found 11 of the 36 breaches were patient choice and the patient had either work commitments, were not available or they wanted to be seen the next day. We found 2 of the 36 breaches were referrer choice and the referrer did not want the patient to be seen within the 4 hour timeframe. We found the final 10 of the 36 breaches were not breaches but were down to a data inputting issue. The trust did not monitor the 72-hour target.

The Crisis Resolution and Home Treatment Teams had skilled staff available to assess patients 24 hours a day 7 days a week. The teams tried to respond quickly when referrals came in. Most patients and carers we spoke with said they were seen within the timeframe the staff told them when they initially called them, and they were seen regularly, which changed frequency dependant on their level of need. However, 1 patient told us the staff did not turn up to see them and 2 carers told us the patient had to wait a long time in the emergency department.

The health-based place of safety was not always available. There were still times when the health-based place of safety was used as an overspill bed. However, ward managers and matrons advised it was available for patients detained under section 136 more than for other use and we reviewed records which confirmed this. Staff recorded an incident whenever the health-based place of safety suite was used for purposes other than detention of patients under section 136. We found that between 1 June 2022 and 31 August 2022 only 3 patients remained in the health-based place of safety following a Mental Health Act assessment for between 5 and 10 days. This had improved since our previous inspection. The health-based place of safety at Great Yarmouth had had the door changed to enable patients to open the suite door to re-join the main ward if they are using the bed as an overspill bed. This had improved since our previous inspection.

There was increased oversight of the use of the health-based place of safety across the trust. The status of the health-based place of safety suites are discussed during daily safety huddles which include management teams from each locality. The patient flow lead had oversight on where patients detained under section 136 were admitted from and discharged to and timeframes.

The telephone systems varied between Crisis Resolution and Home Treatment Teams which meant some patients might have to wait longer for a response to their call. For example, the Norwich team had installed a dedicated telephone system which ensured staff were aware of all patient calls waiting and could ensure resources were redeployed to meet the demand when needed. In West Norfolk the telephone system had options to direct you through to different areas depending on the nature of your call. If the phone was not answered callers were able to leave a voicemail and the system would email staff with the voicemail so they could pick this up wherever they were and ring the caller back. This had not been implemented by other teams which meant that if all the team were away from the base it might take a while to return a call.

Mental health crisis services and health-based places of safety

The team tried to engage with people who found it difficult, or were reluctant, to seek support from mental health services. Staff were flexible and could see patients in different settings or at different times of the day. We saw evidence of staff trying to contact patients on multiple occasions and in different ways to engage with patients.

The team tried to contact people who did not attend appointments and offer support.

Is the service well-led?

Requires Improvement 

Our rating of well-led stayed the same. We rated it as requires improvement.

Leadership

Leaders had the skills, knowledge and experience to perform their roles. They had a good understanding of the services they managed and were visible in the service and approachable for patients and staff.

Staff were complimentary about their immediate managers and leaders. They were approachable, visible and supportive. Managers were knowledgeable and experienced.

Governance

Teams did not operate consistently which made it challenging to have clear governance processes

The Crisis Resolution and Home Treatment Teams had varying models of care across the trust. This included their referral pathways, tools for triaging and staffing. This meant that patients could have a different experience based on which team they were accessing. Example of good practice were not being implemented across the teams. For example, the telephone system used in Norwich meant that patients could potentially reach staff when they were out of the office with greater ease than patients being supported by other teams.

Management of risk, issues and performance

Risks were identified, collated and escalated effectively. Data was not always accurate and collated consistently

Each team had a risk register which was clear and detailed. All risks had clear actions for improvement and clear appropriate timeframes in place. This was an improvement since our previous inspection. Local managers met regularly to discuss and review the risk register. However, these meetings were not recorded in East Suffolk therefore there was no record of decision making.

Information management

Managers and staff used key performance indicators to monitor their effectiveness, such as 4-hour target for emergency referrals. The trust recording systems did not always fully allow for accurate recording of data. We found 10 of the 36

breaches where patients were not always seen in the trust target of 4 hours, were down to a data inputting issue and therefore not genuine breaches. The system did not allow for managers or staff to input a narrative for this data and therefore showed inaccurate data. Data inputting issues included; inaccurate recording of date or time the patient was seen and wrongly recording if the referral emergency or urgent.

Teams did not record or capture section 136 data consistently. All locations kept a section 136 log or spreadsheet which captured data. Each of these logs comprised different categories, for example, only West Suffolk kept data on where patients were detained; only Great Yarmouth kept data on patients who were detained under section 2 or section 3 in the suite and then remained in the suite because of a lack of beds and this data had only been collected since June 2022.