Good

Norfolk and Suffolk NHS Foundation Trust

Forensic inpatient/secure wards

Quality Report

Hellesdon Hospital
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Locations inspected

Location ID	Name of CQC registered location	Name of service (e.g. ward/ unit/team)	Postcode of service (ward/ unit/ team)
RMY01	Hellesdon Hospital	Yare ward	NR6 5BE
RMY01	Hellesdon Hospital	Whitlingham ward	NR6 5BE
RMY04	Northside House	Catton ward	NR7 0HT
RMY04	Northside House	Acle ward	NR7 0HT
RMY04	Northside House	Drayton ward	NR7 0HT
RMY04	Northside House	Thorpe ward	NR7 0HT
RMY04	Northside House	Earlham ward (seclusion)	NR7 0HT
RMYMV	St Clements Hospital	Foxhall House	IP3 8LS

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

Summary of findings

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

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

Summary of findings

Ratings

We are introducing ratings as an important element of our new approach to inspection and regulation. Our ratings will always be based on a combination of what we find at inspection, what people tell us, our Intelligent Monitoring data and local information from the provider and other organisations. We will award them on a four-point scale: outstanding; good; requires improvement; or inadequate.

Overall rating for the service	Good
Are services safe?	Inadequate
Are services effective?	Good
Are services caring?	Good
Are services responsive?	Good
Are services well-led?	Good

Mental Health Act responsibilities and Mental Capacity Act / Deprivation of Liberty Safeguards

We include our assessment of the provider's compliance with the Mental Health Act and Mental Capacity Act in our overall inspection of the core service.

We do not give a rating for Mental Health Act or Mental Capacity Act; however we do use our findings to determine the overall rating for the service.

Further information about findings in relation to the Mental Health Act and Mental Capacity Act can be found later in this report.

Summary of findings

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Summary of findings

Overall summary

W**e rated the forensic services as good overall because**:

- Staff completed detailed risk assessments for every patient on admission and reviewed these regularly.
- The service had good medicine management systems in place.
- Staff completed comprehensive care plans that were personalised, holistic and recovery orientated for all patients.
- Care records showed that physical examinations had been undertaken and there was ongoing monitoring of physical health problems for patients.
- The majority of patients told us they felt safe on the wards and staff were kind and supportive of them.
- Patients were actively involved in the writing of their care plans and risk assessments, and attended weekly ward rounds and care programme approach meetings.
- Managers ensured that they shared the outcomes of investigations and complaints in team meetings.
- Managers had access to key performance indicators to gauge team performance and compare against other wards within the service.
- Staff reported that team morale was good and they felt support by all members of the team.

However:

- Seclusion rooms at the Norvic Clinic and Hellesdon Hospital did not meet the required standard as set out by the Code of Practice. Although, the trust had a refurbishment plan in place to improve the seclusion facilities at the Norvic Clinic, which will begin in August 2016.
- Staff had not completed seclusion records as per trust policy and they could not locate all seclusion records. Some seclusion records were on case notes however, staff had not completed them fully. We found evidence within the notes that staff offered patients urine bowls instead of using the toilet facilities adjacent to the seclusion room.
- Staff used prone restraint in 47 out of 130 restraint incidents.
- Senior managers did not ensure that they had the required number of nurses for all shifts at Foxhall House and Acle ward.
- Managers completed ligature and environmental risk assessments, but no action had been carried out to minimise assessed risks to patients.
- Not all staff received regular supervision.
- Patient's records were difficult for staff to navigate to find important patient information easily.

Summary of findings

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

Are services safe?

Inadequate

We rated safe as inadequate because:

- Seclusion rooms at the Norvic Clinic and Hellesdon Hospital did not meet the required standard as set out by the Code of Practice although there was a refurbishment plan in place to address these issues. The facilities compromised safety and this had been identified at the previous inspection.
- Staff had not completed seclusion records as per trust policy and they could not locate all seclusion records. Some seclusion records were on case notes however, staff had not completed them fully. We found evidence within the notes that staff offered patients urine bowls instead of using the toilet facilities adjacent to the seclusion room.
- Staff used prone restraint in 47 out of 130 restraint incidents. This is a high proportion.
- Senior managers did not ensure that they had the required number of nurses required for all shifts at Foxhall House and Acle ward.
- Managers had completed ligature and environmental risk assessments, however no actions had been carried out to minimise assessed risks to patients.
- The temperature in the clinic room on Catton and Drayton ward was consistently above 25 degrees, which could affect the efficacy of the medication.

However:

- Staff completed detailed risk assessments for every patient on admission and reviewed them regularly.
- The service had good medicine management systems in place.
- Staff ensured incidents were reported using the electronic reporting system. Managers ensured all staff received feedback for the investigation of incidents in monthly staff meetings including lessons learnt.
- Staff had received, and were up to date with mandatory training.

Are services effective?

Good

We rated effective as good because:

- Staff completed comprehensive care plans that were personalised, holistic and recovery orientated for the majority of patients.

Summary of findings

- Care records showed that physical examinations had been undertaken and there was ongoing monitoring of physical health problems for patients.
- Staff used recognised rating scales to assess and record severity outcomes.
- Support workers completed the care certificate standard.
- Staff attended regular and effective multi-disciplinary meetings to discuss patient care and treatment.
- Staff ensured that MHA paperwork was fully completed and consent to treatment and capacity requirements were adhered to.
- Staff assessed capacity to consent and recorded this for patients who might have impaired capacity.
- Managers addressed poor performance with staff with the support of Human Resources.

However:

- Staff had not been receiving regular individual supervision although they took part in group case discussions.
- Staff had difficulty finding specific patient information within the electronic patient record.

Are services caring?

Good

We rated caring as good because:

- Staff interacted with patients in a caring and respectful manner, remained engaged and interested in providing good quality patient care.
- Patients told us staff were kind and supportive of them. Some reported they felt this way during restraint and seclusion incidents too.
- Patients were actively involved in the writing of their care plans and risk assessments. They attended weekly ward rounds and care programme approach meetings.

Are services responsive to people's needs?

Good

We rated responsive as good because:

- The service had systems in place to ensure that staff saw referrals within two weeks of receiving them.
- Senior staff met weekly to discuss discharges and movement through the pathway.
- They were a range of rooms and equipment to support the care and treatment of patients.
- Patients had access to outside spaces.

Summary of findings

- Patients had access to drinks and snacks 24 hours a day at the Norvic Clinic and Foxhall House.
- Staff provided information leaflets to patients on treatments, patient rights and how to complain.

Are services well-led?

Good

We rated well led as good because:

- Staff knew and agreed with the organisations values.
- Senior managers visited the service and had attended staff meetings.
- Staff participated in clinical audits.
- Managers ensured they shared the outcomes of investigations and complaints in team meetings.
- Managers ensured that safeguarding, Mental Health Act (MHA) and Mental Capacity Act (MCA) procedures were followed.
- Managers had access to key performance indicators to gauge team performance and compare against other wards within the service.
- Staff reported that team morale was good and they felt supported by all members of the team.
- Staff were able to describe their duty of candour as the need to be open and honest with patients when things go wrong.

However:

- Insufficient attention had been given to the seclusion facilities in the interim period prior to the planned refurbishments. Local managers had raised their concerns about some of the facilities.
- Some managers reported that staff were not engaging with individual clinical supervision and had not addressed this formally with staff.

Summary of findings

Information about the service

Norfolk and Suffolk NHS Foundation Trust provided secure inpatient mental health services for adults aged 18 years and over who were detained under the Mental Health Act.

The Norvic Clinic had four medium secure wards and a seclusion ward:

- Catton ward was a 10-bedded ward for male patient and the admission ward.
- Acle ward was an eight bedded ward for females aged 18 or over.
- Thorpe ward was an eight-bedded ward for male patients.
- Drayton ward was a 16-bedded ward for male patients.

They provided assessment and treatment for males and females patients detained under the Mental Health Act who required care in a medium secure setting. The patients may have had a forensic history and required treatment over a prolonged period of time.

Low secure services were based at Hellesdon Hospital in Norwich and St Clements Hospital in Ipswich. At Hellesdon Hospital there were two wards:

- Yare ward was a 15-bedded ward for male patients.
- Whitlingham ward was 12-bedded ward for female patients.

At St Clements Hospital there was one ward:

- Foxhall house was an 11-bedded ward for male patients.

They took referrals from medium secure units, Ministry of Justice, National Offender Management Service and other wards within the trust. The team determined the best treatment based on risk reduction and assessment of individual patients.

The service was last inspected in October 2014 and given a rating of inadequate due to the following:

- Environmental issues including poor lines of sight and ligature risks in patient areas.
- Seclusion facilities were not appropriate at the Norvic Clinic and Foxhall House.
- At the Norvic Clinic staff had to move patients through corridors and down stairs to enter seclusion.
- There were insufficient levels of staff which meant that patients' leave and activities could not take place as planned.
- There was a reliance on temporary staff from NHS professionals.
- Statutory and mandatory training was not being undertaken, particular the management of violence and aggression training.
- Staff did not have access to support, supervision, and appraisal. This was particularly relevant to newly qualified staff.
- Staff did not receive feedback when they had raised concerns and there was no learning from incidents.
- Care plans did not reflect the direct views of the patients.
- Physical healthcare needs were not monitored or managed by staff.
- They did not have good medicine management systems in place.
- Staff did not fully understand the governance structure.

During this inspection, we found that managers had addressed the majority of these issues.

Our inspection team

Chair: Paul Lelliott, Deputy Chief Inspector (Lead for mental health), CQC

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

Inspection Manager: Lyn Critchley, Inspection Manager (mental health), CQC

Summary of findings

The team that inspected the forensic inpatient/secure wards consisted of one inspection manager, two inspectors, four specialist advisors and an expert by experience.

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

Why we carried out this inspection

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

How we carried out this inspection

To fully understand the experience of people who use services, we always ask the following five questions of every service and provider:

- Is it safe?
- Is it effective?
- Is it caring?
- Is it responsive to people's needs?
- Is it well-led?

Before the inspection visit, we reviewed information that we held about these services and asked a range of other organisations for information.

During the inspection visit, the inspection team:

- inspected all wards within the service, looked at the quality of the ward environment and observed how staff were caring for patients
- spoke with 23 patients
- interviewed 6 ward managers and 1 acting ward manager
- reviewed 35 individual care and treatment records
- interviewed 36 other staff members: including doctors, nurses, support workers, occupational therapists, and psychologists
- reviewed 29 Mental Health Act detention papers
- looked at 29 prescription charts
- inspected 36 physical health records
- looked at 10 seclusion records
- we observed one ward round meeting, one care programme approach meeting, and one clinical supervision meeting.
- looked at a range of policies, procedures and other documents relating to the running of the service.

What people who use the provider's services say

Patients reported they felt safe on the wards and that staff had supported them with their treatment. Staff were approachable and treated everyone with dignity and respect.

Patients told us they were involved in their care plans and attended weekly meetings to discuss their care with the multidisciplinary team. They felt listened to and that staff understood their care.

Areas for improvement

Action the provider MUST take to improve

- The trust must ensure that seclusion facilities meet the standards set out in the Code of Practice.
- The trust must consistently maintain clinic rooms at correct temperatures in all areas.

Summary of findings

- The trust must ensure that staff fully complete seclusion records and store them within patient records in an easily accessible format.

Action the provider SHOULD take to improve

- The trust should ensure that staff attend monthly clinical supervision.
- The trust should ensure they have set timescales to address identified ligatures points on wards.

Norfolk and Suffolk NHS Foundation Trust

Forensic inpatient/secure wards

Detailed findings

Locations inspected

Name of service (e.g. ward/unit/team)	Name of CQC registered location
Yare ward	Hellesdon Hospital
Whitlingham ward	Hellesdon Hospital
Catton ward	Norvic Clinic
Acle ward	Norvic Clinic
Drayton ward	Norvic Clinic
Thorpe ward	Norvic Clinic
Earlham ward (seclusion)	Norvic Clinic
Foxhall House	St Clements Hospital

Mental Health Act responsibilities

We do not rate responsibilities under the Mental Health Act 1983. We use our findings as a determiner in reaching an overall judgement about the Provider.

- 80% of staff had received training in the Mental Health Act.
- Staff we spoke with had a good understanding of the MHA, the Code of Practice and the guiding principles.
- Staff adhered to consent to treatment and capacity requirements, copies of consent to treatment forms were attached to all medication charts where applicable. We found entries in patients' notes that doctors had conversations with patients about their treatment and assessed their capacity prior to the treatment commencing.
- Staff read patients their Section 132 rights to them on admission and routinely thereafter. Staff evidenced this in care records.

Detailed findings

- The trust provided administrative support and legal advice on implementation of the MHA and code of practice when required.
- We reviewed 29 sets of detention paperwork, and found staff ensured detention paperwork was completed correctly, was up to date, and stored appropriately.
- The trust carried out regular audits to ensure that the MHA was being applied correctly.
- Patients had access to Independent Mental Health Advocacy (IMHA) services.

Mental Capacity Act and Deprivation of Liberty Safeguards

- 76% of staff had received training in the Mental Capacity Act and 86% of staff were trained in Deprivation of Liberty Safeguards (DoLS). Staff we spoke with had some understanding of MCA 2005, in particular the five statutory principles.
- The service had made no DoLS applications in the last six months.
- Staff were trained in and had a good understanding of MCA 2005.
- The trust had a policy on MCA that included DoLS, which staff were aware of and could refer to if needed.
- We saw evidence that staff recorded capacity assessments in patients' care records for people who might have impaired capacity. Staff completed the assessments on a decision-specific basis about significant decisions.
- Staff knew where to get advice regarding MCA, including DoLS, within the trust.

Inadequate

Are services safe?

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

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

Our findings

Safe and clean environment

- Staff could not observe all parts of the wards due to its layout. Managers mitigated this risk by placing mirrors in corridors, nursing observations and closed circuit television (CCTV). However, staff did not always monitor the CCTV.
- Managers completed ligature audits to identify ligature points throughout the wards. The audits recorded actions to reduce the risk but there was no set timeframes for the work to be completed. On Whitlingham ward senior nurses had completed additional ligature assessments whilst building works were taking place. However, they had not risk assessed all ligature points.
- Wards within the service complied with guidance for same-sex accommodation.
- Wards had fully equipped clinic rooms with accessible resuscitation equipment and emergency drugs that were accessible to all staff. Staff checked these regularly to ensure medication was fully stocked, in date and equipment was working effectively.
- Seclusion rooms at the Norvic Clinic and Yare ward did not meet the required standard as defined in the Code of Practice. Seclusion is defined as "the supervised confinement of a patient in a room, which may be locked. Its sole aim is to contain severely disturbed behaviour which is likely to cause harm to others." Whitlingham ward did not have a seclusion room although staff used the de-escalation room to seclude patients if required. This practice had been agreed by senior managers although the room did not meet the required standards defined in the Code of Practice. The trust had a refurbishment plan in place to improve the seclusion facilities at the Norvic Clinic, which will begin in August 2016.
- The seclusion rooms at the Norvic Clinic and Yare ward and the de-escalation room on Whitlingham ward were not ensuite. Staff did not provide a clock that patients could see whilst in seclusion. Staff could observe patients whilst in seclusion at the Norvic Clinic. However, staff could not fully observe patients in seclusion on Yare ward unless they stood outside in the adjacent courtyard. The seclusion room at Foxhall House did meet the required standards, although if the patient used the ensuite toilet staff could not observe them fully. There was no intercom system in any of the seclusion rooms. Staff could control the temperature of the seclusion rooms. Staff could not change the temperature in the de-escalation room on Whitlingham ward.
- The two seclusion rooms at the Norvic Clinic were located on Earlham ward. Staff used this ward for patients who required long-term segregation (LTS). This meant that male and female patients had been secluded or nursed in LTS in the same area and did not promote privacy and dignity due to the positioning of seclusion rooms. Patients could see each other whilst in seclusion and would not be able to speak with staff confidentially.
- All ward areas were clean, had good furnishings that were well maintained both inside and outside of the wards.
- The PLACE survey scored the Norvic Clinic 99%, Hellesdon Hospital 99% and 100% St Clements Hospital for cleanliness. This was above the national average of 97%.
- We saw that all staff adhered to infection control principles including handwashing.
- Staff ensured that equipment was well maintained, clean and clean stickers were visible and in date.
- Cleaning records were up to date and demonstrated that staff regularly cleaned the environment. We saw a dedicated team of domestic staff working throughout the service during the inspection.
- Managers ensured that environmental risk assessments were undertaken regularly and they shared these with staff in monthly meetings.
- Staff carried personal alarms, which they used to summon help in an emergency. There were call systems in patients' bedrooms for patients to call for help if needed.

Safe staffing

- The trust set the core staffing levels for the service. The established level of regstered nurses across the service was 83 whole time equivalent (WTE). At the time of the

Inadequate

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inspection, there were 10 vacancies. The established level of unqualified nurses was 110. The service had five vacancies. The ward with the highest number of vacancies was Thorpe ward.

- Between 01 January 2016 to 31 March 2016 bank staff had covered 1335 shifts and agency staff covered 155 shifts due to sickness, absence or vacancies. However, 343 shifts had not been covered, which resulted in wards working below the numbers required to meet the needs of patients. We reviewed duty rotas and found that Acle ward and Foxhall House had the highest rate of unfilled shifts.
- Staff sickness rate for the service was 8% in the last 12 months.
- Staff turnover rate for the service was 15% in the last 12 months.
- Managers tried to book agency and bank staff that were familiar to the ward whenever possible.
- Ward managers were able to adjust the staffing levels daily to take into account patient need by requesting additional staff using the e-rostering system. They reported the system worked well however, they could not always find staff who would work the same day the request had been made.
- We saw that a qualified nurse was often in the communal areas of the ward, although a support worker was present in the communal areas at all times.
- There was enough staff to provide patients with regular 1:1 time with their named nurse. Care notes evidenced when these sessions had taken place.
- Escorted leave or ward activities were rarely cancelled due to short staffing. Patients requested escorted leave in the morning meetings and staff planned patient leave throughout the day to ensure that all patients went out. However, patients on Drayton ward reported that sometimes staff were moved to other wards which meant their leave did not happen or they did not get to use all of their leave, staff confirmed this.
- There was enough staff to safely carry out physical interventions, if required staff would attend from other wards to respond to staffs' personal alarms sounding.
- Doctors reported that they responded to emergencies within half an hour throughout the day and night.
- Compliance with mandatory training for the service was 82%, which was higher than the trust overall compliance rate of 77%. The trust had set on overall compliance rate of 90% to be achieved by September 2016 and were addressing training topics which fell below 80%. The lowest compliance with mandatory training was Drayton ward.

Assessing and managing risk to patients and staff

- There were 58 incidents of seclusion and three incidents of long-term segregation from January to June 2016. The ward that used seclusion the most was Acle ward, they had used it 25 times.
- There were 130 incidents of restraint, which involved 15 different patients from January to June 2016. 13 of these incidents resulted in staff administrating rapid tranquilisation to the patient. The highest number of restraints was on Acle ward, they had 61 incidents of restraint for four different patients.
- Staff used prone restraint 47 times from January to June 2016. Prone restraint means staff held patients in a facedown position. Acle had the highest incidents of prone restraint at 24. The length of time staff held the patient in the prone position varied from 30 seconds to 12 minutes. Data provided showed that 10 incidents lasted two minutes in the prone position and there were eight incidents that lasted between 10 and 12 minutes.
- Staff completed a risk assessment of every patient on admission. We reviewed 35 risk assessments and found that staff had updated 34 of them at regular intervals and after every incident.
- Staff used the following risk assessment tools, Short-Term Assessment of Risk and Treatability (START) and Historical Clinical Risk Management-20 (HCR-20)
- Managers ensured that staff justified the use of blanket restrictions. For example, staff turned off hot water appliances from eleven o'clock at night, but would provide hot drinks if requested.
- There were good policies and procedures in place for the use of observation and searching patients.
- Staff told us that de-escalation and other interventions for example, distraction techniques, were tried before using restraint. Three patients we spoke with confirmed this.
- Doctors rarely prescribed rapid tranquilisation, however when this was prescribed, they followed NICE guidance.
- The trust had an operational policy for the use of seclusion, although staff were not following the policy in relation to the recording of seclusion incidents. We reviewed 10 records with staff and found that eight records were not fully completed. Staff completed part

Inadequate

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of the seclusion records directly onto patients' electronic care records and part by hand and scanned into the electronic record, therefore, these were difficult to collate. Nine of the records evidenced staff had informed doctors of the seclusion and they attended the ward to review the patient. However, we found evidence that staff did not allow patients to access toilet facilities, instead they were given urine bowls to use. Staff told us this was because of the risk the patient posed. Although on three observation records, we found that staff had not recorded any risk concerns half an hour prior to the patient requesting to use the toilet.

- 96% of staff were trained in safeguarding adults and children and they explained the procedure for raising a safeguarding alert when interviewed.
- Medicines were stored securely and in accordance with the provider policy and manufacturers' guidelines. We reviewed all medication administration records (MAR) and found no errors, omissions or missing nurse signatures when the medication had been administered. Staff recorded the temperature of the clinic room and refrigerator that stored medication daily to ensure the temperature did not affect the efficacy of the medication. However, the temperature in the clinic room on Catton and Drayton ward was above 25 degrees, which could affect the efficacy of the medication, and no action had been taken to address this.
- The ward had policies for children visiting and visits were risk assessed when necessary.

Track record on safety

- Between 15 January 2015 and 12 March 2016, the service reported nine serious incidents. These included abuse or alleged abuse of adult patients by staff, unauthorised absence, and failure to obtain an appropriate bed for a child who needed it, apparent or actual self-inflicted harm, medication error or disruptive, aggressive or violent behaviour.
- Monthly clinical governance and staff meetings took place to discuss risk incidents and lessons learnt from them.

Reporting incidents and learning from when things go wrong

- Staff knew what incidents to report and how to do this. Staff reported incidents using electronic forms, which were forwarded to managers who then had to review the information before the incident could be closed. This meant managers had an overview of incidents and ensured staff were aware of lessons learnt and action plans to reduce the risk of repeated incidents to maintain patient safety.
- Staff were able to describe their duty of candour as the need to be open and honest with patients when things go wrong.
- Managers gave feedback to staff on the outcomes of incident investigations both internal and external to the service in monthly meetings. There was evidence of managers implementing changes because of feedback, for example increased staffing presence in courtyards at the Norvic Clinic due to patients being able to access the roof space.
- Managers ensured that staff were debriefed after serious incidents. The initial debrief took place informally on the ward, then the psychology team would offer formal debriefs. Managers would refer staff to the wellbeing service for additional support if required.

Are services effective?

Good

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

Our findings

Assessment of needs and planning of care

- Staff completed comprehensive assessments for all service users, which they completed within a timely manner. We reviewed 35 care plans and they were all up to date, personalised, holistic, recovery orientated. We saw evidence that patients had been fully involved in writing their care plans and staff offered them copies of their care plans at the Norvic Clinic and Foxhall House.
- Care records showed physical examinations were undertaken and ongoing monitoring of physical health problems took place. Staff recorded physical observations, blood pressure, temperature, pulse, weight, and used the national early warning sign form to identify when a patient was becoming unwell. Care records had electrocardiogram (ECG) and blood results, which doctors reviewed. If patients were prescribed a high dose of anti-psychotic medication, this was flagged on the appropriate system to ensure staff monitored these patients closely. Staff completed The Liverpool University Neuroleptic Side Effect Rating Scale (LUNSERS) for patients' prescribed anti-psychotic medication. Staff recorded in care notes if patients refused to have their physical health monitored. Staff repeatedly encouraged patients to engage with them.
- The information needed to deliver care and treatment effectively was stored securely within computer-based records. However, we found that electronic patient records were difficult to navigate, making it difficult for staff to locate requested information during the inspection.

Best practice in treatment and care

- Staff followed the National Institute for Health and Care Excellence (NICE) guidance when prescribing medication. This included regular reviews and physical health monitoring such as electrocardiograms and blood tests.
- Psychologists, cognitive behavioural therapists and art therapists provided patients with psychological therapies as recommended by NICE in group or individual sessions.
- Occupational therapists completed the model of human occupation screening tool (MOHOST). This meant staff had a good understanding of the needs of each patient when taking on a different task or when in different settings. For example the patients ability in areas such as self-care, work or social interaction. This allowed staff to provide support and encouragement to the patient to increase their skills.
- The Norvic Clinic employed two physical health nurses who supported ward staff to monitor the physical health of patients. They had a dedicated physical health clinic. Part of their role was to promote good health and we found evidence that they offered smoking cessation to patients. On Catton ward, we observed one physical health nurse working with three patients. They were raising awareness of testicular cancer by showing the patients how to check themselves using prosthetic testacies.
- Managers ensured that staff attended medication training. Across the service an average of 70% of qualified nurses were trained in compliance with medication and 82% were trained in rapid tranquilisation administration.
- Staff used the mental health clustering tool, which included health of the nation outcome scales to assess and record severity and outcomes for all patients.
- Clinical staff participated in the following clinical audits: measuring compliance with NICE standards for smoking cessation, monitoring obesity in medium secure units and monitoring of patients prescribed antipsychotic medication.

Skilled staff to deliver care

- The team consisted of nurses, occupational therapists, doctors, support workers and psychologists. Managers referred patients for specialist treatment such as physiotherapy and speech and language therapy if required.
- The staff we spoke with were experienced and qualified to carry out their duties.
- Staff received an appropriate induction before starting work on the wards. An average of 93% of support workers completed the Care Certificate standards. The Care Certificate is an identified set of standards that health and social care workers adhere to in their daily working life.
- Across the service, an average of 62% of staff attended monthly clinical supervision. The ward with the lowest level of compliance for clinical supervision was Yare ward at 39% and the highest was Drayton ward at 79%.

Are services effective?

Good

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

- Staff had access to monthly team meetings. We reviewed the minutes of the meetings and found that they covered a variety of topics, which included incidents and lessons learnt, clinical supervision, risk register, and least restrictive interventions.
- Managers ensured that 72% of non-medical staff had completed their appraisals in the last 12 months.
- Staff received the necessary specialist training for their role.
- Managers addressed poor staff performance promptly and effectively with the support of human resources.

Multi-disciplinary and inter-agency team work

- Weekly multi-disciplinary meetings took place to discuss patient care and treatment, this was attended by staff and patients. We observed a meeting and saw there were effective discussions with the patient and they were fully involved.
- Staff reported that handovers between shifts were effective. The notes taken in handover were comprehensive, and showed that staff had discussed staffing levels and specific nursing duties that needed to carried out during the shift.
- Managers attended weekly bed management meetings and referrals meetings to discuss patients' movements through the service, and patients who needed admission or discharge from the service. Other teams in the organisation, for example care co-ordinators or community mental health teams, attended this meeting.
- Managers reported effective working relationships with teams outside of the organisation for example local authority social services.

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

- 80% of staff had received training in the Mental Health Act
- Staff we spoke with had a good understanding of the MHA, the Code of practice and the guiding principles.
- Staff adhered to consent to treatment and capacity requirements, copies of consent to treatment forms were attached to all medication charts where applicable. We found entries in patients notes to evidence discussions between doctors and patients about their treatment. We saw evidence to show doctors assessed patients capacity prior to the treatment commencing
- Staff read patients their Section 132 rights on admission and routinely thereafter. Staff evidenced this in care records.
- The trust provided administrative support and legal advice on implementation of the MHA and code of practice when required.
- We reviewed 29 sets of detention paperwork, we found that detention paperwork was completed correctly, up to date and stored appropriately.
- The trust carried out regular audits to ensure that the MHA was being applied correctly.
- Patients had access to Independent Mental Health Advocacy (IMHA) services. Staff supported patients to access this service.

Good practice in applying the Mental Capacity Act

- 76% of staff were trained in the Mental Capacity Act and 86% of staff were trained in Deprivation of Liberty Safeguards (DoLS). Staff we spoke with had some understanding of MCA 2005, in particular the five statutory principles.
- The service had no DoLS applications made within the last six months.
- The trust had a policy on MCA, which included DoLS, which staff were aware of and could refer to.
- We saw evidence that staff recorded capacity assessments in patients' care records for people who might have impaired capacity. Staff completed the assessments on a decision-specific basis about significant decisions.
- Staff knew where to seek advice regarding MCA, including DoLS, within the trust.

Good

Are services caring?

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

Our findings

Kindness, dignity, respect and support

- Staff interacted with patients in a caring and respectful manner and remained interested when engaging patients in meaningful activities. We saw that staff were responsive to patients' needs, discreet and respectful. We saw staff approached all patients differently in order to meet their needs.
- We spoke with 23 patients and they all reported they felt safe on their wards. The majority of staff were supportive of them and their individual needs. Three patients told us staff were caring, even during restraint and seclusion. However, patients on Yare ward reported that staff did not want to speak to them and spent long periods in the office.
- The PLACE survey score for privacy, dignity and wellbeing at the Norvic Clinic was 94%, Hellesdon Hospital was 92%, which was above the national average of 86%. However, St Clements hospital was below this average at 85%.

The involvement of people in the care that they receive

- Staff ensured the admission process informed and orientated patients to the ward and the service.
- We saw evidence in the majority of care plans which showed patients had been fully involved in writing their care plans and that staff offered them copies. Patients told us they participated in MDT reviews and care programme approach meetings. Although, three patients on Yare ward told us they were given copies of their care plans the day before the inspection, and had not been involved in writing them.
- Advocacy visited the wards on a weekly basis. If patients wanted to speak to an advocate outside of these times, staff contacted the service on the patient's behalf.
- Where appropriate, staff ensured patients' families and carers were involved in their care.
- Patients had daily morning meetings and weekly community meetings where they could make requests to use their section 17 leave or feedback on issues within the ward. Patients attended monthly service user meetings.

Are services responsive to people's needs?

Good

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

Our findings

Access and discharge

- The average bed occupancy for the service was 90% over the last six months. Catton, Drayton, Foxhall House, Thorpe and Yare wards average occupancy was over 90%.
- There had been no of out of area placements attributed to this core service in the last 6 months.
- The average length of stay for patients using the service was 1015 days.
- Beds were available when needed to people living in the 'catchment area'.
- There was access to a bed on return from leave.
- Staff did not move patients between wards during an admission episode unless this was justified on clinical grounds and was in the interests of the patient.
- Staff ensured patients were moved and discharged at an appropriate time of day.
- Between 1 October 2015 and 31 March 2016 there had been two delayed discharges on Whitlingham and Yare Ward. This was due to there being no suitable service available in a less secure environment or community.

The facilities promote recovery, comfort, dignity and confidentiality

- All wards had a range of rooms and equipment to support treatment and care. This included treatment rooms to examine patients, a kitchen, group therapy visiting room and quiet room. At Foxhall House there was a gym and art room on the ward.
- The Norvic Clinic had an outside area called The Mount. Patients had to be referred to The Mount. It provided the opportunity for patients to look after animals, grow fruit and vegetables and try metalwork or woodwork and socialise with their peers.
- All wards had quiet areas and rooms where patients could meet visitors.
- The wards had phones for patients to make phone calls. However, they were situated in the main ward area and did not offer privacy. The majority of phones at the Norvic Clinic were broken so staff offered patients access to a phone in a meeting room. Patients were allowed to use mobile phones when on section 17 leave. If patients did not have section 17 leave granted, staff allowed them to use their phones in the visiting room in reception.
- All wards had access to outside space; patients had worked with staff to make the areas look nice by planting flowers and bird feeders.
- Patients reported being unhappy with the quality of food. There was a lack of choice and the food was not freshly cooked.
- The PLACE survey score for ward food was 91% for the Norvic Clinic, 94% Hellesdon hospital. However, St Clements hospital scored 86%, which was below the national average of 88%.
- Patients at the Norvic Clinic had access to hot and cold drinks and snacks 24 hours a day. However, patient on Yare and Whitlingham ward had to ask staff for hot water after 11 o'clock in the evenings.
- Patients were able to personalise their bedrooms and had a secure room to store their possessions.
- All ward had access to timetables activities. At weekends, patients chose what activities they wanted to do, but staff did not timetable these.

Meeting the needs of all people who use the service

- The service was accessible for people requiring disabled access.
- Across the service there was a provision of accessible information on treatments, local services, patients' rights and how to complain. This information was available in languages spoken by people who use the service.
- Staff could provide access to interpreters or signers when required.
- The service offered a limited choice of food to meet dietary requirements of religious and ethnic groups. Patients told us the Halal food was good and the menu changed weekly
- The Norvic Clinic and Foxhall House had a multi-faith room on site. If required, staff would access the appropriate spiritual support for patients.

Listening to and learning from concerns and complaints

- The service had 23 complaints in the last 12 months. The complaints were about patient experience, property, contacting staff, application of policy, and care pathways. Staff were currently investigating ten complaints, six were upheld, seven were partially upheld. No complaints had been referred to the Ombudsman.

Are services responsive to people's needs?

Good

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

- The service had received 13 compliments between 01 May 2015 and 30 April 2016.
- Patients we spoke with knew how to complain and received feedback from staff once their complaint had been investigated.
- Staff knew how to handle complaints in line with the trust policy.
- Staff received feedback on the outcome of investigations of complaints in the monthly meetings.

Are services well-led?

Good

By well-led, we mean that the leadership, management and governance of the organisation assure the delivery of high-quality person-centred care, supports learning and innovation, and promotes an open and fair culture.

Our findings

Vision and values

- Staff knew and agreed with the organisation's values.
- Managers reported their team objectives reflected the organisation's values and objectives.
- Staff knew who the most senior managers in the organisation were as they had visited the ward. At Foxhall house they had attended a staff meeting.

Good governance

- Managers ensured they monitored their teams compliance with mandatory training
- Staff were appraised and had access to clinical supervision, although the compliance rate with supervision was low at 62% for the service.
- The majority of shifts were covered by a sufficient number of staff of the right grade and experience.
- We observed staff maximise shift-time on direct care activities as opposed to administrative tasks.
- Staff participated actively in clinical audit to ensure they could demonstrate their practice was in line with NICE guidance.
- Managers had a clear oversight of incidents that had taken place on their wards and ensured that staff learnt form incidents and complaints by discussing them in monthly team meetings.
- Safeguarding issues were managed appropriately. Managers ensured that MHA and MCA procedures were followed by staff.
- The provider used key performance indicators to gauge the performance of the team. These were presented in an accessible format and used by the staff team who developed active plans where there were issues.
- Ward managers had sufficient authority and administrative support to carry out their role.
- Managers had the ability to submit items to the trust risk register.
- Managers had placed staff under supervision or made restrictions to clinical work due to concerns about their practise.

Leadership, morale and staff engagement

- Managers completed return to work interviews when staff returned to work after a period of sickness, if needed they would refer staff to the wellbeing service or occupational health.
- There were no active bullying and harassment cases across the service.
- Staff knew how to use whistle-blowing process and felt that they were able to raise concerns if needed without fear of victimisation.
- The majority of staff we spoke with reported that morale was high within their teams and felt levels of job satisfaction were high. However, therapy staff that were in a process of change had lower levels of morale and felt senior managers had not communicated the changes well.
- Staff reported they worked well as a team and felt the whole team supported each other well.
- The patient experience was greatly improved since the last inspection. The trust and staff have worked hard to change the culture.
- Staff were offered the opportunity to give feedback on services by completing the staff survey and questionnaires.

This section is primarily information for the provider

Requirement notices

Action we have told the provider to take

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

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Treatment of disease, disorder or injury	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment • The trust had not ensured that seclusion facilities are safe and appropriate and that seclusion is managed within the safeguards of the Mental Health Act Code of Practice • The trust had not ensured effective systems for the storage of medication. **Regulation 12**

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Treatment of disease, disorder or injury	Regulation 17 HSCA (RA) Regulations 2014 Good governance • The trust had not ensured that clinical information systems were robust. There was not a clear and accurate contemporaneous record of patient care during episodes of seclusion. **Regulation 17**