Good

Norfolk and Suffolk NHS Foundation Trust

Forensic inpatient/secure wards

Quality Report

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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	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. Where relevant we provide detail of each location or area of service visited.

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

Summary of findings

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?	**Requires improvement** 
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

We rated the forensic inpatient/secure wards as good because:

- Staff completed a risk assessment of every patient on admission and updated this regularly and after every incident. Managers had a clear oversight of incidents that had taken place on their wards and ensured that staff learnt from incidents and complaints by discussing them in monthly team meetings and governance meetings with senior managers
- Staff completed comprehensive and timely assessments when patients were admitted to the wards. Staff involved patients in the writing of their care plans and the staff fully documented patient's views.
- Weekly multi-disciplinary meetings took place to discuss patient care and treatment; staff and patients attended this.
- Care records showed physical examinations were undertaken and ongoing monitoring of physical health took place.
- The seclusion rooms on Earlham ward and Foxhall house met the required standard as set out in the Code of Practise. Staff fully documentation all episodes of seclusion in the case records.
- Staff interacted with patients in a caring and respectful manner. We observed staff throughout the inspection engaging patients in meaningful activities and responding to patients needs in a discreet and respectful manner. Staff took time to listen to patients so they fully understood what support the patient required.
- The majority of the patients we spoke reported they felt safe on the wards. They said staff were kind and caring and took time to support them when needed by either talking or doing activities.
- Staff demonstrated the values of the trust when they talked about their work and caring for patients. Clinical team leaders ensured that their team objectives reflected the trust organisation's values and objectives.
- The provider used key performance indicators to gauge the performance of the team. These were presented in an accessible format and discussed with staff in order to improve on them.
- Staff we spoke with reported that morale was high with their teams and felt that levels of job satisfaction were high. Staff reported that they felt listened to by their teams and were never afraid to raise issues, as the team or managers addressed them.

However:

- Ligature audits recorded what actions were required to reduce the risk for patients. However, there were no set timeframes for the work to be carried out to protect patients from the risk of ligatures. This issue had been identified at the last inspection in July 2016 and had not been addressed.
- The seclusion room on Yare Ward was not in use due to damage. In the interim, the ward had a temporary seclusion room, a converted bedroom. This temporary room did not meet the required standard set out in the Code of Practice. Whitlingham ward seclusion room was not in use at the time of the inspection due to a flood.
- Staff did not address issues with temperatures in the clinic room on Thorpe ward. Hot temperatures in clinic rooms can affect the efficacy of medication. This issue was highlighted in the 2016 inspection.
- The shower room in Yare ward had a broken extractor fan and mould on the walls and ceilings. Staff had reported this to maintenance but no action had been taken.
- Whilst ward managers were able to adjust the staffing levels daily to take into account patient need by requesting additional staff they were not always achieved for unplanned activities, for example admission to the general hospital or seclusion. This resulted in levels of staff on the ward being reduced and cancelled sessions and cancelled section 17 leave.

Summary of findings

- Managers did not ensure that staff completed a compliance level for all mandatory training of above 75%. Managers did not complete staffs annual appraisals.

Summary of findings

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

Are services safe?

We rated safe requires improvement because:

- Ligature audits recorded what actions were required to reduce the risk for patients. However, there were no set timeframes for the work to be carried out to protect patients from the risk of ligatures. This issue had been identified at the last inspection in July 2016 and had not been addressed.
- The seclusion room on Yare Ward was not in use due to damage. In the interim, the ward had a temporary seclusion room, a converted bedroom. This temporary room did not meet the required standard set out in the Code of Practice. Eaton ward patients only had access to seclusion down a flight of stairs or the use of the 'safe room', which did not the required standard. Whitlingham ward seclusion room was not in use at the time of the inspection due to a flood.
- Staff did not address issues with temperatures in the clinic room on Thorpe ward. Hot temperatures in clinic rooms could affect the efficacy of medication. This issue was highlighted in the 2016 inspection.
- The shower room in Yare ward had a broken extractor fan and mould on the walls and ceilings. Staff had reported this to maintenance but no action had been taken.
- Whilst ward managers were able to adjust the staffing levels daily to take into account patient need by requesting additional staff they were not always achieved for unplanned activities, for example admission to the general hospital or seclusion. This resulted in levels of staff on the ward being reduced and cancelled sessions and cancelled section 17 leave.
- Managers did not ensure that staff completed all mandatory training of above the compliance level of 75%. The trust classed 30 training courses as mandatory for the forensic services, 17 not meet the trust target of 90%. Ten training courses were was below 75%, which included, Mental Capacity Act at Mental Health Act, suicide prevention, basic life support and manual handling.

However:

- The seclusion rooms on Earlham ward and Foxhall house met the required standard as set out in the Code of Practise. Staff fully documentation all episodes of seclusion in the case records.

Requires improvement

Summary of findings

- Patients we spoke who had been restrained said staff were gentle with them and spoke to them continually so they were aware of what was happening throughout the incident.
- Staff completed a risk assessment of every patient on admission and updated this regularly and after every incident.
- Staff reported incidents using the electronic reporting system. Managers ensured all staff received feedback for the investigation of incidents in monthly staff meetings including lessons learnt.
- The service had good medicines management in place.

Are services effective?

Good

We rated effective as good because:

- Staff completed comprehensive and timely assessments when patients were admitted to the wards. Staff had involved patients in the writing of their care plans and the staff fully documented patient's views.
- Care records showed physical examinations were undertaken and ongoing monitoring of physical health took place.
- Staff followed the National Institute for Health and Care Excellence (NICE) guidance when prescribing medication and when providing psychological therapies.
- Staff completed the health of the nation outcome scales to assess and record severity and outcomes for all patients.
- Staff received an induction before starting working on the wards. They had access to managerial and clinical supervision. Managers held monthly meetings with staff.
- Weekly multi-disciplinary meetings took place to discuss patient care and treatment; staff and patients attended this. Weekly bed management meetings and referral meetings took place to discuss patients' movement through the service.
- Staff ensured that Mental Health Act 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.

Are services caring?

Good

We rated caring as good because:

- Staff interacted with patients in a caring and respectful manner. We observed staff throughout the inspection engaging patients

in meaningful activities and responding to patients needs in a discreet and respectful manner. Staff took their time to listen to patients so they fully understood what support the patient required.

- The majority of the patients we spoke reported they felt safe on the wards. They said staff were kind and caring and took time to support them when needed by either talking or doing activities.
- A buddy system had been introduced to the wards. This system assigned patients abuddy to new admission to support the new patient, explain the running of the ward and introduce the patient to staff and other patients until they had settled in the ward.
- Care plans highlighted that patients had been involved and participated in care planning and risk assessment. Staff recorded if patients had not been involved and the reasons for this.
- Patients had been actively involved in designing a new care plan templates so that they were more patient friendly. The aim of this was to encourage more patients to be involved plan their own care whilst in hospital.
- Patients attended daily morning meetings, weekly community meetings and service user forums, where they raised issues or provided feedback to staff. Staff involved patients in the recruitment of new staff for the service.
- Patients produced a monthly magazine of which they were very proud. Patients' decided what went in the letter, wrote the stories, took pictures, interviewed staff, and then typed up and printed the magazine.

Are services responsive to people's needs?

Good

We rated responsive as good because:

- The average bed occupancy for the service was 86%. There had been no of out of area placements or readmissions within 28 days of discharge, in the last 12 months.
- They were a range of rooms and equipment to support the care and treatment of patients, including quiet areas and rooms where patients could meet with visitors. All wards had access to outside space.
- Patients could make hot drinks and had access to snacks throughout the day and night. Patients were able to personalise their bedrooms and had a secure room to store their possessions.
- Staff provided information leaflets to patients on treatments, patient rights and how to complain in languages spoken by people who use the service.

Summary of findings

- Staff new how to deal with complaints and feedback the outcomes of the complaints to patients.

However:

- The patients we spoke with reported they the food was bland and tasteless. They did not enjoy the food and some chose to request Halal food as it was tastier.

Are services well-led?

Good

We rated well led as good because:

- Staff demonstrated the values of the trust when they talked about their work and caring for patients. Clinical team leaders ensured that their team objectives reflected the trust organisation's values and objectives.
- Staff had access to group and one to one clinical and managerial supervision.
- 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 and governance meetings with senior managers.
- Managers ensured that safeguarding issues were managed appropriately and that staff followed Mental Health Act and Mental Capacity Act procedures.
- The provider used key performance indicators to gauge the performance of the team. These were presented in an accessible format and discussed with staff in order to improve on them.
- Staff we spoke with reported that morale was high with their teams and felt that levels of job satisfaction were high. Staff reported that they felt listened to by their teams and were never afraid to raise issues, as the team or managers addressed them.
- Staff were open and transparent and explained to patients if and when something went wrong.
- The Norvic Clinic is involved with and accredited by the quality network for forensic mental health services.

However:

- Whilst managers monitored their team compliance with mandatory training, they did not ensure that all training courses achieved a compliance rate of over 75%.
- Managers did not ensure they met with staff to complete annual appraisals.

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 has four medium secure wards and a seclusion ward:

- Catton ward is a 10-bedded ward for male patient and the admission ward.
- Thorpe ward is an eight-bedded ward for male patients.
- Drayton ward is a 16-bedded ward for male patients.
- Earlham ward is a separate ward area used for seclusion.

They provide 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 require treatment over a prolonged period.

Due to a scheduled refurbishment plan, Thorpe ward was due to be closed and the patients relocated to Eaton Ward whilst the refurbishment was carried out. Thorpe ward closed on the 14 July 2017. The refurbishment will take up to a year to complete.

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 July 2016 and given an overall rating of good. However, the safe domain was rated as inadequate due to the following breaches of regulation 12, safe care and treatment and regulation 17, good governance:

- 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.

During this inspection, we found that managers had addressed the majority of these issues in regards to seclusion rooms. We found seclusion records were now fully completed and stored in electronic case records. However, issues remained with high temperatures in one clinic room.

Summary of findings

Our inspection team

The team was led by:

Chair: Dr Paul Lelliott, Deputy Chief Inspector, mental health CQC

Shadow chair: Paul Devlin, Chair, Lincolnshire partnership NHS Foundation Trust

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

Lead Inspector: Lyn Critchley, Inspection Manager, mental health CQC

The team that inspected the forensic inpatient/secure wards consisted of one inspection manager, one inspector, three 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, asked a range of other organisations for information and sought feedback from patients at three focus groups.

During the inspection visit, the inspection team:

- visited all seven of the wards at the three hospital sites and looked at the quality of the ward environment and observed how staff were caring for patients
- spoke with 16 patients who were using the service
- interviewed the managers or acting managers for each of the wards
- spoke with 35 other staff members; including doctors, nurses and psychologist and occupational therapists
- interviewed the locality manager and estates manager with responsibility for these services
- attended and observed a multi-disciplinary meetings and patient therapeutic sessions
- looked at 33 treatment records of patients
- carried out a specific check of the medication management
- looked at a range of policies, procedures and other documents relating to the running of the service.

Summary of findings

What people who use the provider's services say

The majority of patients reported that they felt safe on the wards. The patients that did not feel safe stated it was when there was a reduced numbers of staff.

They felt that the nurses were really good, kind and caring and took time to support them when needed by either talking or doing activities with them.

Patients enjoyed and were involved in recruitment of new staff, redesigning new care plans and contributing to the monthly patient magazine

Areas for improvement

Action the provider MUST take to improve

- The trust must ensure that they have set timescales to address the identified ligature points on wards.
- The trust must ensure that repairs to the seclusion rooms are carried out in a timely manner
- The trust must consistently maintain clinic rooms at correct temperatures on all wards.
- The trust must ensure all relevant staff have completed all mandatory training, particularly in suicide prevention and life support.
- The trust must ensure there are sufficient staff so that leave and activities are not cancelled

Action the provider SHOULD take to improve

- The trust should ensure that staff seeks advice from pharmacy when clinic room temperatures are out of range.
- The trust should ensure that all staff receive annual appraisals.

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
Foxhall Hose Yare ward	Hellesdon Hospital
Whitlingham ward	Hellesdon Hospital
Catton 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.

- A competent member of staff examined the Mental Health Act papers when patients were admitted to the wards.
- Staff knew who their Mental Health Act administrators are. The Mental Health Act administrators supported ward staff in making sure the Act was followed in relation to, for example, renewals, consent to treatment and appeals against detention.
- We reviewed paper work for 10 detentions and found that staff ensured the paperwork was completed correctly, was up to date and stored appropriately. In

addition, we reviewed section 17 leave papers that responsible clinicians had granted to patients. The records were concise, outlined the parameters of the leave and included risks and crisis plans.

- As at 31 March 2017, the service scored 68% compliance for the number of staff trained in the Mental Health Act. Eleven out of 12 teams did not meet the trust target of 90% compliance. Yare Ward had the lowest compliance rate with 48%. However, despite the low compliance with training, staff we spoke with had a good understanding of the Mental Health Act, 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 explained to patients their under the Mental Health Act explained to them on admission and routinely thereafter. Staff evidenced this in care records.
- The trust carried out regular audits to ensure that the Mental Health Act was being applied correctly.
- Patients had access to Independent Mental Health Advocacy (IMHA) services. Staff were clear on how to access and support engagement with the IMHA.

Mental Capacity Act and Deprivation of Liberty Safeguards

- As of 31 March 2017, the overall compliance rate for the Mental Capacity Act training course was 87%. Four out of seven wards within this service failed to achieve the trust target of 90% compliance. Thorpe ward had the highest compliance rate at 92%. Whitlingham Ward had the lowest compliance rate with 59%.
- Staff we spoke with had demonstrated an understanding of Mental Capacity Act 2005, in particular the five statutory principles.
- The service had no Deprivation of liberty Safeguard applications made in the last 6 months.
- The trust had a policy on Mental Capacity Act that included Deprivation of Liberty Safeguards, 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 Mental Capacity Act, including Deprivation of Liberty Safeguards, within the trust.

Requires improvement

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 the layout. Managers mitigated this risk by placing convex mirrors in corridors, nursing observations, and closed circuit television.
- The estate department carried out ligature audits to identify ligature points throughout the wards. Since the last inspection the audit documentation had improved, it showed pictorial evidence of the ligature point and rated the level of risk for each ligature point. In addition to the audits, the wards had heat maps, which clearly highlighted where ligature points had been identified on each ward. Managers carried out walks of the wards with staff so they could ensure that all staff knew where the risks were for the ward they worked on. However, whilst the audits recorded what actions were required to reduce the risk, there was no set timeframe for the work to be completed. At the Norvic Clinic, there were 44 outstanding actions to be completed with no set timescales. This issue had been identified at the last inspection in July 2016 and had not been addressed.
- Over the 12 months from 1 April 2016 to 31 March 2017, there were no same sex accommodation breaches within this core service.
- Wards had fully equipped clinic rooms with accessible resuscitation equipment and emergency drugs that staff checked regularly.
- At the last inspection, the 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." The Norvic Clinic now meets the standard. Work had been completed to divide the area, which provided privacy and dignity for patients when using the seclusion room. Both rooms were now ensuite. The room allowed staff to observe the patient, had an intercom system to aide communication, and a clock visible for the patient. Foxhall house seclusion room also met the required standard. However, Yare wards seclusion room was out of action due to damage. In the interim, the ward had a temporary seclusion room, a converted bedroom. This temporary room did not meet the required standard, it was not ensuite, and staff could not control the temperature of the room. Managers reported that the repairs would be completed by 28 July 2017. Whitlingham ward seclusion room was not in use at the time of the inspection due to a flood. Work had started to address the issues and repair the damage.
- Due to the refurbishment work that was due to start on 17 July 2017, Thorpe ward was closing and staff were relocating patients to the newly redecorated Eaton ward on the first floor of the Norvic Clinic. If patients required the use of seclusion staff would need to restrain patients down a flight of stairs, to access Earlham ward, which could increase the risk of injury to both parties. We discussed this with senior managers who reported that they had written guidance for staff to manage this situation. If needed, and as a last resort, staff were to contact the police to transfer the patient to the seclusion room. We were concerned that this could cause a delay in patients accessing the required intervention to support their needs and not maintain the safety of the patient. We carried out an unannounced inspection on 28 July 2017 and found that the refurbishment work had begun. Staff had relocated patients to Eaton ward. One bedroom had been set up as a 'safe room'. Staff we spoke with reported that they would seclude patients in this room if required rather than call the police to transfer the patient to Earlham. However, we were concerned that due to this room being at the end of bedroom corridor whether it would protect the patients' privacy and dignity if they were secluded in it, or impact on the patients who were in their bedrooms. In addition, there were risk items, for example, curtains that would need to be removed prior to seclusion commencing.
- All ward areas were clean, had good furnishings, and were well maintained both inside and outside of the

Requires improvement

Are services safe?

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

wards. However, the shower room in Yare ward had a broken extractor fan and mould on the walls and ceilings. Staff had reported this to maintenance but no action had been taken.

- All three locations for this core service scored above the England average for each aspect of a safe and clean environment in the 2016 PLACE assessments. The PLACE survey scored the Norvic Clinic 98%, Hellesdon Hospital 98% and 100% St Clements Hospital for cleanliness. The score for condition, appearance and maintenance was 97% at the Norvic Centre, 98% Hellesdon Hospital and 97% and 95% for St Clements Hospital.
- Staff ensured that equipment was well maintained, clean and clean stickers were visible and in date. However, staff on Catton ward had not restocked the first aid box. This was reported the clinical team leader during the inspection who took immediate action.
- 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 registered nurses across the service was 84 whole time equivalent (WTE). At the time of the inspection, there were 20 vacancies. The established level of unqualified nurses was 136. The service had 17 vacancies. The wards with the highest number of vacancies for qualified nurses were Whitlingham Ward and Foxhall House both at four vacancies. Yare ward had the highest vacancies for nursing assistants with six vacancies.
- Between 01 April 2016 to 31 March 2017 bank staff had covered 565 shifts and agency staff covered 438 shifts due to sickness, absence, or vacancies. However, 370 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 Catton ward had the highest rate of unfilled shifts at 114.
- For qualified nursing shifts, Catton Ward and Whitlingham Ward had the highest percentage of shifts filled by bank staff both with 6.7% and 6.6% respectively. Yare Ward had the highest percentage of qualified nursing shifts filled by agency staff with 12.7%. For nursing assistant shifts, Yare Ward had the highest percentage of shifts filled by bank staff, with 43.7%.
- Staff sickness rate for the service was 6.5% in the last 12 months.
- Staff turnover rate for the service was 12% 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. The majority of the time when managers requested extra staff it was due to Earlham suite (seclusion) being in use or when patients were admitted to the general hospital or to attend court. Managers explained that it was harder to cover emergencies than planned appointments.
- 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 as did patients when we spoke with them.
- Escorted leave or ward activities were sometimes cancelled because there were too few staff. Staff and patients both reported that this did happen on occasions as staff were moved to support other wardsIn April 2017, staff cancelled 19 sessions due to either staff shortages or sickness. The ward with the highest number of session cancelled was Drayton ward with nine.

Requires improvement

Are services safe?

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

- There was enough staff to carry out physical interventions, if required staff would attend from other wards to respond to staffs' personal alarms sounding.
- Medical cover was provided by a senior house officer (doctor) day and night who could attend the ward in an emergency.
- As at 31 March 2017, the compliance with mandatory training for the service was 84%, against the trusts target of 90%. The trust was unable to provide data for the full 12 month period. The trust classed 30 training courses as mandatory. Seventeen out of the 30 courses for this service did not meet the compliance rate. Ten training courses were was below 75% which included, Mental Capacity Act at 74%, Mental Health Act, 68%, suicide prevention, 67% and basic life support at 58%, the lowest rate of complaint was for manual handling at 56%.

Assessing and managing risk to patients and staff

- The service used restrictive interventions as last resort to manage patients that posed a risk to themselves or others. A restrictive intervention is defined as any intervention that is used to restrict the rights or freedom or a movement or person with a disability including restraint and seclusion.
- Between 1 April 2016 and 31 March 2017, the service reported 94 incidents of seclusion and 13 incidents of long-term segregation. The ward that used seclusion the most was Yare ward, they had used it 40 times. Of the 13 incidents of long-term segregation, seven of these were on Catton Ward.
- The service had 190 incidents of restraint. These incidents involved 85 different patients from between 1 April 2016 and 31 March 2017. Eighteen of these incidents resulted in staff administrating rapid tranquilisation to the patient. The highest number of restraints was on Yare ward, they had 64 incidents of restraint for 23 different patients.
- Staff used prone restraint 64 times from 1 April 2016 and 31 March 2017. Prone restraint means staff held patients in a facedown position. Yare ward had the highest incidents of prone restraint at 27.
- Patients we spoke who had been restrained said staff were gentle with them and spoke to them continually so they were aware of what was happening throughout the incident.
- Staff completed a risk assessment of every patient on admission and updated this regularly and after every incident. We reviewed 33 risk assessments and found that staff had updated 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, patients now had access to hot chocolate throughout the night. On Drayton ward, the clinical team leader had listened to patients concerns about the restriction on what food they could have on the ward. Together, they reviewed the policy for food for forensic services and the trust wide policy. They decided that the forensic services policy was too restrictive and the clinical team leader agreed the trust wide policy would be followed instead.
- There were policies and procedures in place for the use of observation and searching patients. We observed staff carrying out observations and searching discreetly during the inspection.
- 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 we found one prescription and this was prescribed in line with NICE guidance.
- The trust had an operational policy for the use of seclusion. During the last inspection in July 2016, staff were not following the policy in relation to the recording of seclusion incidents. There was a notable improvement in this area during this inspection. We reviewed 11 seclusion records and found that staff were now fully documenting all episodes of seclusion in the case records. Patients no longer needed to be given urine bowls as the room were ensuite. Clinical team leaders linked the improvement in this area to staff having access to a laptop. This allowed staff to begin

completing the seclusion documentation as soon as the patient had entered the room. In addition to this the band seven nurse on Catton ward carried out audits on seclusion paperwork. They identified gaps in the documentation and notified staff what action they needed to take and ensured it was taken. However, we did find some areas of concern. For example, a doctor did not attend a seclusion on Thorpe ward within the first hour but the case records stated that the seclusion should be terminated within one hour, reasons for a seclusion on Yare ward was not documented and a patient on Drayton ward medical review was left blank.

- Patients reported that staff attitudes to seclusion were positive and that they felt that staff did not want to seclude patients but they understood at times they had to, to keep the patients safe.
- On average 92% of staff were trained in safeguarding adults and 96% children level one. Staff explained the procedure for raising a safeguarding alert when interviewed. The service had made 29 adult safeguarding referrals and one child safeguarding referral to the local authority in the last year. The ward with the highest number of safeguarding referrals was Catton with 13.
- Medicines were stored securely in accordance with the provider policy. We reviewed medication administration records and found no errors, omissions.
- Staff recorded the temperature of the clinic rooms and medicines refrigerators daily to ensure the temperature did not affect the efficacy of the medication. Temperatures above 25 degrees could affect the efficacy of medication stored in the clinic. At the time of the last inspection, the temperature in the clinic rooms on Catton and Drayton was above 25 degrees and staff had not taken action to address this. During this inspection, we found that air conditioning units had been put in these clinics. Staff records of the clinic temperatures were now well within the expected range. However, from the 01 May 2017 to 11 July 2017 staff on Thorpe ward had recorded the temperature of the clinic 65 times, 48 of these recorded a temperature higher than 25 degrees. The highest recording was 27.6 degrees. The clinic did not have an air conditioning unit to lower the temperature and staff had not sought advice from the pharmacy team, in line with their policy, to assess the impact of the temperature on the medicines. We discussed this with senior managers and estates and they were not aware the clinic did not have an air conditioning unit in place. However, Thorpe ward closed for refurbishment on the 17 July 2017, which meant that the clinic is no longer in use. There were no issues with the temperature of the refrigerators used to store medication.
- The ward had policies for children visiting and visits were risk assessed when necessary.

Track record on safety

- Between 1 April 2016 and 31 March 2017, the service reported 16 serious incidents. One of these involved the death of a patient. The most common type of serious incidents were disruptive/ aggressive/ violent behaviour meeting with seven incidents and unauthorised absence meeting with three incidents. Yare ward reported the highest number of serious incidents during this period with six.
- Monthly clinical governance, business, 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 reviewed by managers before the incident could be closed. This meant managers had an overview of incidents, ensured staff were aware of lessons learnt, and action plans to reduce the risk of repeated incidents to maintain patient safety.
- Staff described 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 staff meetings.
- Managers ensured that staff debriefed and offered support after serious incidents. Psychology supported this and, if required would hold debriefs for the team. Managers would also refer staff to the wellbeing service 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 and timely assessments when patients were admitted to the wards. We reviewed 33 care plans and all were up to date, personalised, holistic and recovery orientated. Staff involved patients in the writing of their care plans and the staff fully documented patient's views.
- Care records showed physical examinations were undertaken and ongoing monitoring of physical health 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 doctors prescribed patients a high dose of anti-psychotic medication, this was flagged on the appropriate system to ensure staff monitored these patients closely. 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. At the last inspection we found that information was difficult to locate however, we noted that the system was now working more efficiently for staff, the case records held all relevant information, and it was easier to navigate through to find information.

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 and assistant psychologists 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 tool identified patient's strengths in areas such as self-care, work or social interaction. Staff then provided support to patients to increase their skills in these areas and promoted recovery.
- 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 support ward staff. This included ear irrigation; nail cutting; phlebotomy; electrocardiograms and completing the Waterlow scale. In addition to this, they completed malnutrition universal screening tools to assess patient's nutrition and hydration needs. The physical nurses also provided training to staff physiological observations.
- Staff completed the health of the nation outcome scales to assess and record severity and outcomes for all patients.
- Clinical staff participated in a total 24 audits from 01 April 2016 to 31 March 2017. These included, infection control, confidentiality awareness and safeguarding in supervision, PRN medication, risk assessment linked to section 17 leave, recording of physical observations following rapid tranquilisation, seclusion and heat map audit, POMH - UK National audit rapid tranquilisation.

Skilled staff to deliver care

- The team consisted of nurses, occupational therapists, doctors, support workers, psychologists, and assistant psychologists. Managers referred patients for specialist treatment such as physiotherapy 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. Out of 113 nursing assistants, 111 (83%) of staff had 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.
- The trust did not provide the clinical supervision data for staff, as they no longer kept central data. However,

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clinical team leaders held this information on each ward. These records showed on average 83% of staff received monthly clinical supervision and 74% of staff received managerial supervision.

- As of March 2017, the overall appraisal rate for non-medical staff was 59%. The trust target was 89%, all wards within this core service failed to meet this target. The highest appraisal rate was in Foxhall House with 87% of staff having had an appraisal. The lowest appraisal rate was in Yare Ward with 25%. All medical staff had completed their appraisals.
- 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, least restrictive interventions and the refurbishment plan.
- Managers addressed poor staff performance promptly and effectively with the support of human resources. Between 1 April 2016 and 31 March 2017, there were three cases where staff were suspended within this core service for inappropriate behaviour. All three staff were grade three, nursing assistants.

Multi-disciplinary and inter-agency team work

- Weekly multi-disciplinary meetings took place to discuss patient care and treatment; staff and patients attended this. We observed a meeting and saw there were effective discussions with the patient and they were fully involved.
- Handovers between shifts were effective. Staff took notes that were comprehensive and showed that staff had discussed staffing levels, patients risk and specific nursing duties that needed to be carried out during the shift.
- Weekly bed management meetings and referral meetings took place to discuss patients' movement through the service. Care co-ordinators or community health teams also attended the meeting.
- Staff told us that they had effective working relationships with teams outside of the organisation. Managers spoke highly of the links they had made with the local police.

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

- A competent member of staff examined the Mental Health Act papers when patients were admitted to the wards.
- Staff knew who their Mental Health Act administrators are. The Mental Health Act administrators supported ward staff in making sure the Act was followed in relation to, for example, renewals, consent to treatment and appeals against detention.
- We reviewed 10 sets of detention paper work and found that staff ensured the paperwork was completed correctly, was up to date and stored appropriately. In addition, we reviewed section 17 leave papers that responsible clinicians had granted to patients. The records were concise, outlined the parameters of the leave and included risks and crisis plans.
- As at 31 March 2017, the service scored 68% compliance for the number of staff trained in the Mental Health Act. Eleven out of 12 teams did not meet the trust target of 90% compliance. Yare Ward had the lowest compliance rate with 48%. However, despite the low compliance with training, staff we spoke with had a good understanding of the Mental Health Act, 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 explained to patients their under the Mental Health Act explained to them on admission and routinely thereafter. Staff evidenced this in care records.
- The trust carried out regular audits to ensure that the Mental Health Act was being applied correctly.
- Patients had access to Independent Mental Health Advocacy (IMHA) services. Staff were clear on how to access and support engagement with the IMHA.

Good practice in applying the Mental Capacity Act

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.

- As of 31 March 2017, the overall compliance rate for the Mental Capacity Act training course was 87%. Four out of seven wards within this service failed to achieve the trust target of 90% compliance. Thorpe ward had the highest compliance rate at 92%. Whitlingham Ward had the lowest compliance rate with 59%.
- Staff we spoke with had demonstrated an understanding of Mental Capacity Act 2005, in particular the five statutory principles.
- The service had no Deprivation of Liberty Safeguards applications made in the last 6 months.
- The trust had a policy on Mental Capacity Act that included Deprivation of Liberty Safeguards, 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 Mental Capacity Act, including Deprivation of Liberty Safeguards, 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. We observed staff throughout the inspection engaging patients in meaningful activities and responding to patients needs in a discreet and respectful manner. Staff took time to listen to patients so they fully understood what support the patient required. An example of this is a patient would not take their medication; staff liaised with the pharmacy team to obtain a liquid medicine in a different colour that the patient would take.
- We spoke with 16 patients and all but two reported they felt safe on the wards. The reason for not feeling safe were when the staffing levels were reduced. One patient said when they were on Yare ward, the nurses were good, the patient said they enjoyed being on the ward as they talked in groups all of the time. The majority of patients said that staff were kind and caring and took time to support them when needed by either talking or doing activities.
- Patients on Thorpe ward worked with staff to develop a timetable in order for them to access the smoking area when they moved to Eaton Ward. On Thorpe ward patients had access to the garden. However, as Eaton ward is on the first floor staff had to supervise the area.
- The PLACE survey score for privacy, dignity and wellbeing at the Norvic Clinic was 90%, Hellesdon Hospital was 91%, which was the same or above the national average at 90%. However, St Clements hospital and was below this average at 84%

The involvement of people in the care that they receive

- Staff ensured that the admission process informed and orientated the patients to the ward and the service. Managers introduced a buddy system to the wards. This system assigned patients abuddy to support the new patients, explain the running of the ward and introduce the patient to staff and other patients until they had settled in the ward.
- Care plans highlighted that patients had been involved and participated in care planning and risk assessment. Staff recorded if patients had not been involved and the reasons for this.
- Patients had been actively involved in designing new care plan templates so that they were more patient friendly. The aim of this was to encourage more patients to be involved plan their own care whilst in hospital.
- 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 attended daily morning meetings, weekly community meetings and service user forums, where they raised issues or provided feedback to staff. Staff attended these meetings and ensured that they follow up issues raised. We saw this evidenced in the minutes of these meetings.
- Patients completed the patient reported experience and outcome measures (PROEM). These are standardised question to measure patient's perceptions in relation to their health, disability, and quality of lie whilst in hospital. Staff used this information to improve services for patients.
- Staff involved patients in the recruitment of new staff for the service. They interviewed staff and gave feedback to the recruitment team.
- Each month the occupational therapy department support patients across forensic services to produce a monthly magazine. Patients' decided what went in the letter, wrote the stories, took pictures, interviewed staff, and then typed up and printed the magazine. The magazine was circulated for staff and patients to read. A patient we spoke with reported that their celebration of Eid was going to be in the next magazine, with pictures of their celebration food and their account of what Eid meant to them.

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

- From 01 April 2016 to 31 March 2017, the average bed occupancy for the service was 86% Drayton, Foxhall House wards average occupancy was over 90%.
- There had been no of out of area placements attributed to this core service in the last 12 months.
- There were no readmissions within 28 days of discharge reported by the service from 1 April 2016 to 31 March 2017.
- The average length of stay for patients using the service was 1375 days. The ward with the highest average length of stay across the period was Foxhall House with an average of 1291 days. The ward with the lowest average length of stay across the period was Catton Ward with an average of 137 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.
- If staff did move patients they tried to ensure this was at an appropriate time of day. However, staff moved one patient on Catton ward after ten o'clock at night this was due to a deportation order.
- In the last year, there had been a total of 42 discharges from the service. Two of these were delayed discharges from Yare and Whitlingham ward. This was due to there being no suitable service available in a less secure environment or in the 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 room, visiting room and quiet room. At Foxhall House, there was a gym and art room on the ward. The Norvic clinic had a dedicated suite of rooms that provided additional rooms for sessions.
- All ward had access to a timetable of activities. At weekends, patients chose what activities they wanted to do. The Mount at the Norvic Clinic was still being used and very popular with patients. It provided the opportunity for patients to look after animals, grow fruit and vegetables, try metalwork or woodwork, and socialise with their peers.
- Wards had quiet areas and rooms where patients could meet with visitors.
- The majority of wards had phones for patients to make phone calls. However, they were situated in the main ward area and did not offer privacy. However, if patients needed to make phone calls in private staff facilitated this by using phones in meetings rooms. The patients on Catton wards made all phone calls in a meeting room on the ward, in private. Patients that had been granted section 17 leave were allowed to use mobile phones when on leave.
- All wards had access to outside space. Patients and staff had made the areas look nice by planting flowers. The patients on Thorpe ward had full access to the garden areas. However, the ward was being moved to Eaton ward, which is situated, on the first floor. We were concerned that this could limit the access to the garden, as staff would have to present in the outside space at all times.
- The PLACE survey score for ward food was 96% for the Norvic Clinic, 100% at Hellesdon hospital and St Clements hospital. These scores were above the national average of 92%. The patients we spoke with reported they the food was bland and tasteless. They did not enjoy the food and some chose to request halal food as it was tastier.
- Patients on Drayton ward reduced the twice weekly takeaway meal to once and week and used the money to purchase food to cook a roast dinner on the ward instead. They reported they enjoyed doing this.
- Patients could make hot drinks and had access to snacks throughout the day and night. However, after 11 o'clock in the evening staff promoted positive sleep hygiene routines and staff did not provide caffeinated drinks. Staff replaced these with milk drinks, such as hot chocolate.

Are services responsive to people's needs?

Good

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

- 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 kitchen staff provided a limited choice of food to meet dietary requirements of religious and ethnic groups. However, some patients reported that they preferred the halal meals to regular meals.
- 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 received 25 complaints in the last 12 months. Staff were currently investigating 17 complaints; five were upheld; three were partially upheld. No complaints had been referred to the Ombudsman.
- Foxhall House had the most complaints with eight, four of these relating to 'Attitude of staff'. Thorpe Ward had the least complaints, with one. Complaints related to; attitude of staff (eight),for all aspects of clinical treatment (six), hotel services (including food)(three), under patients' privacy and dignity(three),under patients' property and expenses (two), other (one), aids and appliances, equipment, premises (including access) (one), and one for communication/information to patients (written and oral).
- The service had received seven compliments in the last 12 months. Five of these compliments were received in the Norvic Clinic and two were from Whitlingham Ward.
- 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.
- Learning from complaints was shared across the service through governance meetings and trust newsletters. In ward offices, posters were displayed to promote five key learning points for the wards each month. At the time of the inspection, these included learning from complaints. Staff also 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 demonstrated the values of the trust when they talked about their work and caring for patients. They were committed to supporting patients and teams to set and achieve their goals, taking time to care and welcoming feedback. Staff also supported each other. This was in line with the trusts values of 'positively, respectfully and together'. Clinical team leaders ensured that their team objectives reflected the trust organisation's values and objectives.
- Staff knew who the senior managers were in the organisation and were positive about the communications they had in regards to the refurbishment plan at the Norvic Clinic.

Good governance

- Managers told us there was a process for quality assurance. There was a local governance meeting attended by key staff that linked with the trust quality forum. Findings from complaints, incidents, surveys and audits were discussed at the meeting and learning from these taken back to individual teams. Actions from this were shared at the monthly clinical team leader meeting.
- The provider used key performance indicators to gauge the performance of the team. These were presented in an accessible format and discussed with staff in order to improve practice.
- Whilst managers monitored their team compliance with mandatory training, they did not ensure that all training courses achieved a compliance rate of over 75%.
- Managers ensured that staff had access to group and one to one clinical and managerial supervision. However, managers did not ensure they met with staff to complete annual appraisals.
- A sufficient number of staff of the right grade and experience covered the majority of shifts. The shifts that were short were due un planned activities, for example patients requiring admission to hospital or being nursed in seclusion
- We observed throughout the inspection that staff maximised 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 and improve the care and treatment that patients received.
- 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 and in governance meetings with senior managers.
- In ward offices, managers had put up posters to promote five key learning points for the wards each month. At the time of the inspection, the five points were governance, incident reports, complaints, audit feedback, and policies. This information was also discussed in monthly team meetings. In addition to this, another poster was in place for the top ten policies that staff regularly used in forensic services. This was used to signpost staff to the correct policy to update their knowledge base and use in their practise.
- Managers ensured that safeguarding issues were managed appropriately and that staff followed Mental Health Act and Mental Capacity Act procedures.
- Manager had sufficient authority and admin support to carry out their role.
- Managers had the ability to submit items to the Trust risk register. At the time of the inspection, managers reported one risk on the trust risk register in relation to lack of qualified nurses.

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.

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.

- Staff we spoke with reported that morale was high with their teams and felt that levels of job satisfaction was high. Staff reported that they felt listened to by their teams and were never afraid to raise issues, as the team or managers addressed them.
- Staff were open and transparent and explained to patients if and when something went wrong.
- Staff were offered the opportunity to give feedback on services by completing the staff survey and questionnaires. Informally staff would feedback in monthly team meetings.

Commitment to quality improvement and innovation

- The Norvic Clinic is involved with and accredited by the quality network for forensic mental health services.
- A buddy system had been introduced to the wards. This system assigned patients abuddy to new admission to support the new patient, explain the running of the ward and introduce the patient to staff and other patients until they had settled in the ward.
- Patients had been actively involved in designing a new care plan templates so that they were more patient friendly. The aim of this was to encourage more patients to be involved plan their own care whilst in hospital.
- Patients attended daily morning meetings, weekly community meetings and service user forums, where they raised issues or provided feedback to staff. Staff involved patients in the recruitment of new staff for the service.
- Patients produced a monthly magazine of which they were very proud. Patients' decided what went in the letter, wrote the stories, took pictures, interviewed staff, and then typed up and printed the magazine.

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 medication was stored in the correct temperature range. • The trust had not set timescales for work to be competed to reduce identified ligature points on wards. This was in breach of 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 15 HSCA (RA) Regulations 2014 Premises and equipment • The trust did not ensure that the seclusions rooms on Yare ward and Whittingham ward were repaired in a timely manner and due to this, they were not fit to be used for their intended purpose. This was in breach of Regulation 15

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Treatment of disease, disorder or injury	Regulation 18 HSCA (RA) Regulations 2014 Staffing • The trust had not ensured that all relevant staff had completed mandatory training, particularly in suicide prevention and life support. • The trust had not ensured that there were sufficient staff at all times, to enable all leave and activities to take place as planned. This was in breach of Regulation 18