Norfolk and Suffolk NHS Foundation Trust

Quality Report

Hellesdon Hospital
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Core services inspected	CQC registered location	CQC location ID
Acute and psychiatric intensive care units	Fermoy Unit	RMYXX
Acute and psychiatric intensive care units	Northgate Hospital	RMY03
Acute and psychiatric intensive care units	Woodlands	RMYX1
Acute and psychiatric intensive care units	Wedgwood House	RMYX5
Acute and psychiatric intensive care units	Hellesdon Hospital	RMY01
Forensic inpatient/secure wards	Hellesdon Hospital	RMY01
Forensic inpatient/secure wards	Norvic Clinic	RMY04
Forensic inpatient/secure wards	St Clements Hospital	RMYX3
Wards for older people with mental health problems	Julian Hospital	RMY02
Wards for older people with mental health problems	Carlton Court	RMY13
Wards for older people with mental health problems	Wedgwood House	RMYX5

Summary of findings

Community-based mental health services for older people	Trust Headquarters - Hellesdon Hospital	RMY01
Community-based mental health services for adults of working age	Trust Headquarters - Hellesdon Hospital	RMY01
Mental health crisis services and health-based places of safety	Trust Headquarters - Hellesdon Hospital	RMY01

This report describes our judgement of the quality of care at this provider. It is based on a combination of what we found when we inspected, information from our 'Intelligent Monitoring' system, and information given to us from people who use services, the public and other organisations.

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

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

We found the following issues that the trust needs to improve:

- Patients did not benefit from safe services in all areas. The breaches of regulation identified at our previous inspections had not all been resolved. Also, the board needs to take further and more timely action to address additional areas of improvement.
- Performance information and data had not yet facilitated effective learning or brought about improvement to practices in all areas. Work had been undertaken to better capture risks and a clearer governance structure had been put in place with clearer lines of accountability. However, further work is required to meet the recommendations of a recent governance review of the trust.
- The trust had not ensured that all risk assessments and care plans were in place, updated consistently in line with changes to patients' needs or risks, or reflected patients' views on their care.
- Staffing was not sufficient in community mental health teams. Patients across the trust had not all been allocated a care coordinator following assessment. We were concerned that the procedures that managers had put in place were not sufficient to mitigate this risk.
- Patients were still not always secluded safely or within appropriate environments. Ward staff were not meeting the standard for recording and monitoring of patients in seclusion.

However, the trust had addressed some of concerns that we raised at the previous inspection:

- The trust had ensured that alarms were available to staff and that staff had access to a defibrillator and life support training.
- The trust had made appropriate arrangements to manage mixed sex accommodation.
- Overall mandatory training and appraisal had rates exceeded the 75% compliance target.
- Some progress had been made in relation to recruiting additional staff to the wards and crisis teams and staffing levels were sufficient at the time of our inspection.
- Some seclusion rooms were now meeting standards.

Summary of findings

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

We always ask the following five questions of the services.

Are services safe?

We found the following areas where the service needs to improve:

- The trust had not ensured that all risk assessments were in place, updated consistently in line with changes to patients' needs or risks, or reflected patients' views on their care.
- Staffing was not sufficient in community teams. Patients across the trust had not all been allocated a care coordinator following assessment. We were concerned that processes in place were not managing this risk.
- Patients were still not always secluded safely or within appropriate environments. Ward staff were not meeting the standard for recording and monitoring of patients in seclusion.
- Not all potential high level ligature risks had been removed or managed effectively. Further work was required to remove all higher level risks and to ensure that local actions required to mitigate risks are recorded and known by staff.

However:

- The trust had made appropriate arrangements to manage mixed sex accommodation.
- All community services had access to a defibrillator and staff had received life support training
- The trust had ensured that staff had sufficient mandatory training in all key courses.
- Some progress had been made in relation to recruiting additional staff to the wards and crisis teams and staffing levels were sufficient at the time of our inspection.
- Some seclusion rooms were now meeting standards.
- The trust had addressed a large number of environmental safety concerns.

Are services effective?

We found the following areas where the service needs to improve:

- Care plans were not always in place or updated when people's needs changed. Care plans had not been reviewed or reflected latest needs. Across services the quality of care plans varied, some were generic and some lacked sufficient detail or were incorrect.

Summary of findings

- The trust had addressed technical performance issues with the electronic record system but further work was required to ensure that all staff could consistently access the system and that records were filed in the correct area of the patient record.
- While the trust had improved systems to capture supervision data further work was required to ensure all staff receive regular supervision.

However:

- Overall appraisal rates had exceeded the 75% compliance target.

Are services responsive to people's needs?

We found the following areas where the service needs to improve:

- In community mental health teams, there were delays in assessment and treatment. Almost 13% of patients across the trust had not been allocated a care coordinator following assessment.
- In crisis services it was unclear how the trust accurately monitored or assured itself that staff prioritised face to face assessments over telephone contact within the four hour emergency target as recommended within the Crisis Care Concordat 2014.

However:

- There were sufficient beds available within acute and older people's wards. The overall number of out of area placements had reduced slightly since the last inspection.
- Crisis teams had better capacity to meet patient needs due to additional recruitment to posts.
- The trust had implemented a new flow chart and protocol to try and reduce transfers and disruption and had set a standard of no inter-ward moves for non-clinical reasons after 8pm at night.

Are services well-led?

We found the following areas where the service needs to improve:

- The breaches of regulation identified at our previous inspections had not all been resolved. Patients do not benefit from safe services in all areas.
- Performance information and data had not yet facilitated effective learning or brought about improvement to practices in all areas.

Summary of findings

- Work has been undertaken to better capture risks and a clearer governance structure had been put in place with clearer lines of accountability but further work is required to meet the recommendations of a recent governance review of the trust.

However, the trust had addressed some of concerns that we raised at the previous inspection:

- The trust had ensured that alarms were available to staff and that staff had access to a defibrillator and life support training.
- The trust had made appropriate arrangements to manage mixed sex accommodation.
- Overall mandatory training and appraisal had rates exceeded the 75% compliance target.
- Performance information and data had improved.

Summary of findings

Our inspection team

Our inspection team was led by:

Head of Inspection: Julie Meikle, mental health hospitals

Inspection Manager: Lyn Critchley, mental health hospitals.

The team included CQC inspection managers, mental health inspectors, Mental Health Act reviewers, support staff, a variety of specialists.

Why we carried out this inspection

We carried out this focused inspection to check whether the trust had taken actions to improve following a warning notice served in September 2017. The warning notice related to ongoing concerns regarding:

- Systems and processes that did not operate effectively to ensure that the risks to patients were assessed, monitored, mitigated and the quality of healthcare improved in relation to:
- Systems to monitor and learn for quality and performance information
- Ligature point management and environmental risks
- Seclusion environments and seclusion practice
- Accommodation for men and women
- Staffing levels
- Management oversight and governance to ensure staff had regular supervision, appraisal and training
- Access to services
- Risk assessment and care planning
- Clinical records
- Access to alarms and emergency equipment

CQC had inspected the trust as a part of the comprehensive inspection programme in July 2017.

Following that inspection, we rated the trust overall as inadequate. The safe domain was rated as inadequate, effective was rated as requires improvement, caring was rated as good, responsive was rated as requires improvement and well led was rated as inadequate. We issued the provider with a warning notice under Section 29A of the Health and Social Care Act 2008 and instructed that significant improvement was required by 11 March 2018. The trust was also placed in Special Measures in October 2017.

In addition the warning notice we set a large number of requirement notices across services. We did not follow these up at this focused inspection. These will be reviewed at our next comprehensive inspection of the trust in September 2018.

How we carried out this inspection

Prior to this inspection we asked the trust to tell us how they had addressed the areas of concern that we had raised in the warning notice that we had served following the July 2017 inspection.

Before visiting, we reviewed this information and wider information that we hold about Norfolk and Suffolk NHS Foundation Trust and asked other organisations to share what they knew.

We carried out an unannounced inspection between 15 and 18 May 2018. Further visits were also carried out at short notice between 22 and 30 May 2018.

During this inspection we visited a sample of mental health inpatient services across the trust including some adult acute services, psychiatric intensive care units (PICUs), secure wards and older people's wards. We also inspected a sample of community mental health services including some of the trust's crisis and home treatment services, older people's and adult community teams.

During the visit the team:

- Reviewed information we had asked the trust to provide following the compliance date for the warning notice.

Summary of findings

- Visited 17 wards and 13 community and crisis team locations.
- Reviewed records for a further six community and crisis teams.
- Observed how staff were caring for people.
- Looked at the personal care or treatment records of more than 130 patients.
- Undertook a seclusion and segregation review where we observed all seclusion facilities and reviewed 29 patient's records.
- Spoke with more than 50 staff members and 30 team managers.
- Interviewed senior and middle managers who led on work streams relevant to the warning notice.
- Interviewed the chief executive and the director of nursing.

Following the inspection:

- A number of data requests were also met by the trust.
- We received an update from the trust regarding the immediate actions taken as a result of the feedback provided during and following the inspection.

Information about the provider

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

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

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

The trust is the seventh largest mental health trust in the UK. The trust has 400 beds and runs over 100 community services from more than 50 sites and GP practices across an area of 3,500 square miles. The trust serves a population of approximately 1.6 million and employs just less than 3,600 staff including nursing, medical, psychology, occupational therapy, social care, administrative and management staff. It had a revenue income of £220 million for the period of April 2017 to March 2018. In May 2018, the trust worked with over 25,000 individual patients.

Norfolk and Suffolk NHS Foundation Trust has a total of 12 locations registered with CQC and has been inspected 18 times since registration in April 2010.

When we inspected the trust in July 2017 under CQC's comprehensive inspection programme the trust was rated inadequate overall and was placed in special measures by NHS improvement following recommendation by CQC. NHS improvement appointed an improvement director who had worked with the trust to assist with improvement.

During the inspection of July 2017 we reviewed the five CQC domains of safe, effective, caring, responsive and well led. We also considered all areas of previous non-compliance. A number of areas of further non-compliance were identified. We made the following requirements:

- The trust must ensure that all services had access to a defibrillator and that staff are aware of arrangements for life support in the event of an emergency
- The trust must ensure that action is taken to remove identified ligature anchor points and to mitigate risks where there are poor lines of sight.
- The trust must ensure that all mixed sex accommodation meets Department of Health and Mental Health Act code of practice guidance and promotes safety and dignity.
- The trust must review the continued use of bed bays in the acute wards and work with commissioners to provide single room accommodation.
- The trust must ensure that seclusion facilities are safe and appropriate and that seclusion and restraint are managed within the safeguards of national guidance and the Mental Health Act Code of Practice.
- The trust must fully implement guidance in relation to restrictive practices and reduce the number of restrictive interventions

Summary of findings

- The trust must ensure there are enough personal alarms for staff and that patients have a means to summon assistance when required.
- The trust must ensure there are sufficient staff at all times, including medical staff and other healthcare professionals, to provide care to meet patients' needs.
- The trust must ensure all relevant staff have completed statutory, mandatory and where relevant specialist training, particularly in suicide prevention and life support.
- The trust must ensure that all risk assessments, crisis plans and care plans are in place, updated consistently in line with multidisciplinary reviews and incidents and reflect the full and meaningful involvement of patients.
- The trust must ensure that the prescribing, administration and monitoring of vital signs of patients are completed as detailed in the NICE guidelines [NG10] on violence and aggression: short-term management in mental health, health and community settings.
- The trust must ensure that the temperature of medicines storage areas is maintained within a suitable range, and that the impact on medicines subject to temperatures outside the recommended range is assessed and acted on.
- The trust must ensure that all staff have access to clinical records and should further review the performance of the electronic system
- The trust must ensure that there is full and clear physical healthcare information and that patients physical healthcare needs are met
- The trust must ensure that all staff receive regular supervision and annual appraisals, and that the system for recording levels of supervision is effective and provides full assurance to the trust board
- The trust must ensure that patients are only restricted within appropriate legal frameworks.
- The trust must ensure that people receive the right care at the right time by placing them in suitable placements that meet their needs and give them access to 24 hour crisis services.
- The trust must minimise disruption to patients during their episode of care and ensure that discharge arrangements are fully effective
- The trust must ensure that there are clear targets for assessment and that targets for waiting times are met. The trust must ensure that people have an allocated care co-ordinator
- The trust must ensure that they fully address all areas of previous breach of regulation
- The trust must ensure that data is being turned into performance information and used to inform practices and policies that bring about improvement and ensure that lessons are learned

Following the inspection we served a warning notice under Section 29A of the Health and Social Care Act 2008 regarding our key concerns. Requirement notices were set across services regarding the additional concerns.

In September 2017, the former chief executive retired and was replaced by the former director of finance. A substantive chief executive took up post in May 2018. There is an interim director of finance. The former director of nursing resigned in October 2017. Since that time, the deputy director of nursing has been interim director of nursing. A new chief nurse will also join the trust in the autumn of 2018.In August 2018 a substantive chief operating officer and director of human resources and organisational development will join the trust.

Since the 2017 inspection, NHS Improvement have placed an improvement director with the trust and another trust is supporting the improvement programme. Multi-stakeholder overview and assurance group meetings take place monthly to monitor the trust's performance.

Areas for improvement

Action the provider MUST take to improve

- The trust must ensure that action is taken to remove identified ligature anchor points and to mitigate risks where there are poor lines of sight.
- The trust must ensure that seclusion facilities are safe and appropriate and that seclusion and restraint are managed within the safeguards of national guidance and the Mental Health Act Code of Practice.

Summary of findings

- The trust must ensure there are sufficient staff at all times, including medical staff and other healthcare professionals, to provide care to meet patients' needs.
- The trust must ensure that all risk assessments, crisis plans and care plans are in place, updated consistently in line with multidisciplinary reviews and incidents and reflect the full and meaningful involvement of patients.
- The trust must ensure that all staff have access to clinical records and should further review the performance of the electronic system
- The trust must ensure that all staff receive regular supervision and that the system for recording levels of supervision is effective and provides full assurance to the trust board
- The trust must ensure that patients are only restricted within appropriate legal frameworks.
- The trust must ensure that people receive the right care at the right time by placing them in suitable placements that meet their needs and give them access to 24 hour crisis services.
- The trust must ensure that targets for waiting times are met and that people have an allocated care co-ordinator.
- The trust must ensure that they fully address all areas of previous breach of regulation.
- The trust must ensure that data is being turned into performance information and used to inform practices and policies that bring about improvement and ensure that lessons are learned

Norfolk and Suffolk NHS Foundation Trust

Detailed findings

Are services safe?

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

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

Summary of findings

We found the following areas where the service needs to improve:

- The trust had not ensured that all risk assessments were in place, updated consistently in line with changes to patients' needs or risks, or reflected patients' views on their care.
- Staffing was not sufficient in community teams. Patients across the trust had not all been allocated a care coordinator following assessment. We were concerned that processes in place were not managing this risk.
- Patients were still not always secluded safely or within appropriate environments. Ward staff were not meeting the standard for recording and monitoring of patients in seclusion.
- Not all potential high level ligature risks had been removed or managed effectively. Further work was required to remove all higher level risks and to ensure that local actions required to mitigate risks are recorded and known by staff.

However:

- The trust had made appropriate arrangements to manage mixed sex accommodation.
- All community services had access to a defibrillator and staff had received life support training
- The trust had ensured that staff had sufficient mandatory training in all key courses.
- Some progress had been made in relation to recruiting additional staff to the wards and crisis teams and staffing levels were sufficient at the time of our inspection.
- Some seclusion rooms were now meeting standards.
- The trust had addressed a large number of environmental safety concerns.

Our findings

Safe and clean care environments

When we inspected the trust in July 2017 we found that the trust had taken some actions to reduce environmental risks however at a number of wards some ligature risks remained. Our concerns were heightened at some wards due to difficult layouts impeding the ability of staff to observe patients. Not all planned actions to remove or replace the identified risks had been undertaken. In community services we had found that ligature audits were either incomplete or not present or risks were noted that were not included in the trust's environmental ligature risk audit. Board and committee papers showed that there was a belief that this work had been finalised in many areas.

The trust told us in March 2018 that they had changed their approach to ligature risk management with support from an external trust. Their adopted approach was to be 'clinically led and locally owned' with corporate services supporting. All services were re-assessed using a rag–rated system (red, amber, green) which would determine which identified ligature points were to be removed or were to be managed as part of a local management mitigation plan. The trust had also begun a programme of immediate remedial building works and installed additional CCTV and observation mirrors, in some areas, following the previous inspection. To support this the trust had rolled out training and workshops to team leaders to support the development of a safety culture.

During this inspection we found that assessments were in place for the majority of wards and that these detailed potential risks. Staff at most services were able to tell us about action required to manage risks. However, we found at Churchill, Great Yarmouth Acute and Yare wards, some risks had not been recorded on the ligature assessment. At Churchill ward and Abbeygate the staff were unable to locate the up to date assessment. We noted in some wards that actions to manage risks were stated as 'local management' throughout without clarifying what this meant. We were also concerned that at these wards risk assessments for patients did not all detail how to manage

their risk within the environment. At a number of wards team leaders had reported works required to address ligature risks however were awaiting confirmation of when these would be undertaken.

We found that environmental and ligature risks assessments were in place at community teams. Actions had been taken to address major ligature risks in toilets. However, we were concerned that the Norwich crisis team had recently moved to a new building without a ligature and environmental risk assessment being undertaken. We noted significant ligature risks within toilet and patient areas and staff at this service confirmed that there may be an occasion when unaccompanied patients could access these areas.

During the inspection the trust told us that they recognised that there was further work to be undertaken to fully embed the assessment process and develop the safety culture. Work was also underway to refine the assessment tool so that staff could be clearer regarding the local management actions that they would take to mitigate risks.

At the previous inspection, there were environmental risks in the interview rooms at the crisis team at the Fermoy Unit in Kings Lynn. At this inspection work had been undertaken to address this. We reviewed the environment at the assessment room used by the psychiatric liaison team at Queen Elizabeth hospital in King's Lynn. The environmental risks had been addressed and CCTV had been installed for use when there were concerns regarding a patient.

When we inspected previously, we raised concerns about arrangements to eliminate mixed sex accommodation at a number of wards. At this inspection, the trust had addressed issues of mixed sex accommodation. The trust had made a number of wards single sex. Where wards remained mixed sex the trust had installed gender specific door access systems. On the one ward within older people's services where this was not possible, Rose ward, the trust had developed a procedure for 'floor walkers' to be stationed in the areas of communal assisted bathrooms. At some acute wards the trust had previously used 'swing beds' that could be allocated to either sex. Since, the trust had closed these beds while building work was completed to designate them to a single sex. Since March 2018 the trust had reported no breaches of guidance set by the Department of Health.

At our inspection of July 2017, we had found that whilst work had been undertaken on some seclusion facilities, seclusion environments were still not compliant with guidance. We were also concerned that seclusion continued to be undertaken in facilities that were not designated for seclusion including places of safety and bedrooms.

Prior to this inspection, the trust told us that they had undertaken a major programme to upgrade seclusion facilities and, where clinically appropriate, had commissioned additional seclusion rooms. The trust had also decommissioned seclusion rooms where these did not meet the required standards. The trust had also introduced clearer policies, supported by additional staff training. The trust stated that an internal governance audit had confirmed that the seclusion facilities were now compliant.

While we acknowledge the trust had made progress in respect of seclusion environments at a number of wards, patients were still not always secluded safely or within appropriate environments:

- Seclusion rooms at Great Yarmouth Acute Service and Churchill ward had not been completed at the time of the inspection, meaning patients were secluded in potentially unsafe environments.
- We found three incidents when patients from Rollesby and Southgate wards were secluded in health based places of safety when the seclusion rooms on the wards were in use.
- A further patient was secluded on Churchill ward in April 2018. The seclusion record and continuation notes did not provide a clear record of where the patient was secluded.
- Information supplied before the inspection stated that the second seclusion room at Rollesby ward, which was not fit for purpose, had been decommissioned. However, the ward manager and two charge nurses from Rollesby confirmed the room was still used to seclude patients when the main seclusion room was in use.
- Rollesby ward had multiple seclusions at the same time. For a period of time on 30 April 2018 four patients were secluded at the same time. One patient was in the seclusion room, a second patient was secluded in the

decommissioned seclusion room, a third patient was secluded in their bedroom, and a fourth patient (a male patient) was secluded in a female ward. The fourth patient was later secluded in the section136 suite.

- At Abbeygate ward the seclusion room had been decommissioned. However, one record of seclusion showed that a patient was secluded in a corridor when their bedroom proved to be unsafe. It was unclear how the patient's safety and dignity could be maintained within a corridor.
- At Yare ward we were concerned about the safety of the metal strip screwed to the bottom of the wall within the seclusion room. The wall was also damaged in places and there was no control over heating or air conditioning and no blind in place.
- At Catton ward we also had concerns about the safety of the seclusion room environment: the ceiling was low and some patients could reach the smoke detector and CCTV camera. There was a blind spot in the bathroom not covered by CCTV. The intercom was not working. Heating and air conditioning was controlled from Hellesdon Hospital.
- At Whitlingham ward we found that the seclusion room met the code of practice standard except that staff were unable to work the two way intercom. This meant that they could not communicate effectively with patients in seclusion.
- We were also concerned that a patient on Thorpe ward was kept in seclusion for an additional 14 hours after a doctor had stated they were sufficiently calm to cease seclusion. Notes indicate that this was due to concerns from the nursing team that, should seclusion be further required, (due to an ongoing issue with another patient) this would involve the patient being moved down stairs.

When we inspected the trust previously we had some concerns about a lack of personal alarms at some services. At this inspection, we found that ward staff carried personal alarms. Community teams had personal safety alarms and alarms were fitted in most interview rooms. The trust told us that there was a further programme of work underway to install alarms within all patient areas in community services.

Safe staffing

At the previous inspection we had significant concerns about staffing levels at the trust. Staffing was sufficient on some but not all wards at the time. In addition, some wards were using very high levels of bank and agency staff to meet their staffing targets. We found that staffing levels were not always sufficient in the community teams, particularly the crisis teams at night, older people's teams, and some adult teams. This meant that staff were managing very high caseloads and there were some delays in treatment.

Since, the trust told us that they had improved their reporting and attention to risk information and ensured that safer staffing reports for wards and data on caseload numbers and waiting lists in the community were reviewed at every board meeting. A safe staffing task and finish group had been set up and had worked on improving recruitment processes and had developed a retention strategy. Initiatives had included the development of daily safety huddles and escalation processes to consider staffing levels. Additional roles had been created to free up clinicians' time for patient care. The trust had also developed a strategy to encourage allied health professionals to undertake wider roles. Recruitment hot spots had been identified and targeted recruitment had occurred in these areas. Recruitment processes had improved leading to a significant reduction in the time to hire staff. Where recruitment remained underway the trust had provided incentives to encourage long term bank and agency staff placements.

The trust acknowledged that they remained concerned about staffing levels overall but particularly within community teams. The trust had introduced a caseload weighting tool across all teams which had enabled team leaders to understand the available caseload capacity in their teams and allocate patients to care

coordinators. A standard operating procedure for caseload management had been developed setting out rag rated definitions for the safe management of patients awaiting active treatment.

At this inspection, the trust confirmed that they had an overall vacancy rate of just over 9% and that staff turnover stood at 14% in April 2018. The overall vacancy rate was less than at previous inspections, and below the national average. The overall vacancy rate for qualified nurses was higher at 16%. The overall vacancies for medical staff were 19%. Some locations had a higher vacancy rate. For

example, vacancy rates in West Norfolk were 33% for nurses and 23% for medical staff. In the Suffolk access and assessment teams these were 28% for nurses, 41% for medical staff and 18% for healthcare assistants.

Sickness absence rates had decreased slightly since our last inspection to 4%. Sickness rates for absence due to stress remained very high at 32% of those on sickness absence.

Figures published for April 2018 indicated that ward staffing as a whole had exceeded planned staffing levels at 117%. However, the overall numbers of qualified nurses deployed against the required number for the shifts was 92%. During the period, four wards fell below 80% of the monthly planned nursing shifts filled during the day and three wards by night. The lowest nursing fill rate was at Whitlingham ward with just 48% of nursing shifts during the day. The trust stated they had exceeded their temporary staff fill rate target at just over 90% in April 2018. However, on seven wards the planned total monthly staff hours for combined qualified and non-qualified staff had not been met. Due to concerns regarding staffing levels at Lark ward, the PICU in Suffolk, the trust took the decision to temporarily close the ward while targeted recruitment occurred. The staff displaced by this had joined the other acute wards providing higher than normal staffing levels.

During this inspection we found that the trust had made progress in recruiting additional staff to the wards. Overall staffing levels were sufficient to meet the patient need at the wards we visited. While there remained gaps in permanent staff, particularly nursing staff, these had largely been mitigated through the use of long term agency and bank placements and the deployment of additional healthcare assistants.

When we last inspected, the trust had some staffing shortages within crisis teams, particularly at night. Not all shifts were covered and lone working practices could not always be followed. In addition, some teams were supporting the wards and covering gaps in psychiatric liaison services. At this inspection, we found that the level of staffing within crisis teams had improved. All services now had additional staff deployed until midnight each day. Some additional permanent staff had been recruited and gaps in rotas had been filled by long term agency staff. In West Norfolk, the team no longer worked on the ward and additional staffing within the psychiatric liaison team had reduced this commitment. At Great Yarmouth, the team still covered psychiatric liaison during the night but stated they provided less cover to the wards and so had sufficient staff.

At this inspection, we found that staffing levels were not always sufficient in community teams to meet the needs of patients or safely manage risk. This meant that staff were managing very high caseloads and there were some delays in assessment and treatment:

- We were particularly concerned about the King's Lynn adult team were we found that 207 patients were on the waiting list and did not have an allocated care coordinator. Patients who were awaiting allocation were triaged and then rag rated according to their risks. 25 patients were rated as red: 120 patients were rated as amber: 62 patients were rated as green. Accordingly, patients were meant to be contacted by team members at set intervals in line with their rating. At this team we found four patients, of 12 reviewed, who had no or limited contact with the team following triage. In some case these patients had been supported by the crisis teams, had been assessed by psychiatric liaison services or had spells as inpatients while awaiting community treatment.
- We are also concerned that within the files we reviewed there were patients who had experienced significant delays in treatment. For example, we found a patient who had been referred to the King's Lynn adult team in March 2017 but remained on the waiting list. The patient had received minimal contact from the team despite being amber rated.
- Staff in South Norfolk adult community team had recorded that were unable to meet individual patient's treatment need due to capacity issues within two patient files reviewed.

Following the inspection, the trust confirmed that almost 13% of patients across the trust had not been allocated a care coordinator. This related to over 3300 individuals. In adult community teams five of 15 teams fell below 80% of patients with an allocated care coordinator: South West Norfolk at 68%, West Norfolk at 71%, Norfolk South East at 73% and South West Suffolk and Great Yarmouth at 79%. Within the information supplied there were further services across the trust, which we did not visit during this inspection, were there was an allocated care coordinator in less than 80% of cases. We were particularly concerned to

note that in CAMHs there were five teams that fell below 80% of patients with an allocated care coordinator. Children ADHD West Suffolk had only 19% of patients with a care coordinator.

At the previous inspection we had found some gaps in medical cover, particularly in acute services. The trust stated that medical cover had improved as had doctor's response to medical emergencies. Between November 2017 and January 2018, only three incidents were reported of doctor's unavailability or a delay to respond in a medical emergency.

During the last inspection, we had also found that consultant psychiatrists in the West Norfolk older people's teams only saw the most complex cases. Psychiatrists mostly reviewed the GP scan results to form a diagnosis and would then prescribe medication without a face to face consultation. At this inspection we found that this practice continued. The trust stated that the executive team had agreed a proposal to continue this practice in the short term until a full service evaluation is concluded and decisions agreed regarding the future provision. We remain concerned that the service was not following best practice and this could lead to potential diagnostic and prescribing errors.

At the previous inspection we found that the trust had not ensured that staff receive mandatory training in accordance with the trust policy. Since, a statutory and mandatory training group was established to oversee a work programme to improve mandatory training compliance and to monitor the quality of training provided. Mandatory training topics were reviewed and agreed by the executive team. The executive team set a trajectory to become 85% compliant with mandatory training by the end of March 2018 and 90% compliant by December 2018. A review of mandatory training content and delivery methodology was also completed and a wider range of options for delivery were agreed. A clinical update day had been developed to encompass a number of key courses. Since staff were offered incentives, such as additional paid time, to complete training.

At the time of the inspection the overall mandatory training rate was 91%. All courses had exceeded the 75% compliance target.

Assessing and managing risk to patients and staff

When we inspected the trust in July 2017 we found that clinical risk assessments and crisis plans were not in place or up to date for all patients. This had been a recurring failing throughout inspections of the trust since October 2014. Following our inspection of 2017, we told the trust they must ensure that all risk assessments were in place, updated consistently in line with multidisciplinary reviews and incidents and reflect the full and meaningful involvement of patients.

Prior to this inspection of May 2018, the trust told us that significant work had been undertaken to address these concerns. Staff training had been rolled out and business change teams had visited wards and community teams to support staff. Monthly audits had been undertaken and the results of these were presented to the board within the performance report. Latest results at April 2018 had indicated 88% compliance for completeness of risk assessments.

During the inspection we heard at a number of services that administration staff undertook the audit rather than clinicians. We heard that the audit was a measure of whether a risk assessment document exists rather than a measure of the quality of completeness or the accuracy of the document. This was raised with the trust during the inspection. It was acknowledged that there was a gap in audit of the quality of documents. As a result one of the matrons had developed and piloted a quality audit: this was about to be rolled out across other services.

At this inspection of May 2018 we reviewed the records of 132 community and hospital patients.

At some services, individual risk assessments were in place and addressed people's risks. However, in community adult and older people's services we found that from 64 patient records reviewed, seven records had no risk assessment. A further 28 had out of date risk assessments or risk assessments that did not link effectively with the needs identified in the patients' care plans or reflect the latest know risks. Twenty risk assessments had not been completed by the community teams and reflected inpatient needs or care from the crisis teams that was no longer relevant.

In crisis services we found three records, from 17 reviewed, without an up to date risk assessment or risk management plan that reflected know risks.

Are services safe?

For 14 inpatients from 52 records reviewed, we found that risk assessments had not been updated to reflect their inpatient needs or following changes to the patient's risks. We were particularly concerned that two patients at Rollesby had not had their risk assessments reviewed after their admission to the PICU. We were also concerned that a patient at Great Yarmouth who, was new to services and had been admitted to the ward, did not have a risk assessment for five days. Further, there were continued significant incidents with this patient throughout his stay on the ward. On the day the risk assessment was completed, that indicated a high risk of self-harm, the patient was discharged from the ward.

At six wards risk assessments and management plans viewed did not all make any reference to the management of environmental risks. We were particularly concerned at Churchill where ligature and environmental audits included stated actions that were to manage remaining environmental risks via 'local management'.

At four wards we noted that risk assessment did not include arrangements for the management of section 17 leave. We were particularly concerned about arrangements at the forensic services where eight patients were noted to be in receipt of leave.

We were particularly concerned about the risk management of community patients awaiting allocation of a care co-ordinator. Patients were assigned a rag rating in line with their assessed risks. Patients who were 'red rated' were meant to receive a weekly phone call to reassess their risks. 'Amber patients' were meant to receive a fortnightly call to reassess their risk. However, we found 12 patients who did not receive contact from the team in line with this standard. Ten of these patients did not have up to date risk assessments in place. It was also noted that there was confusion within the information supplied by the trust as to people's current rag rating. For example, when a person's rag rating was changed from amber to red at King's Lynn community adult team this had not been captured in the information.

When we inspected in July 2017 we had serious concerns about seclusion practice at the trust.

Despite the trust auditing the seclusion process and records, wards were not meeting the standard for staff recording and monitoring of patients in seclusion. We found that records and practice did not always meet the recommendations set out in the Mental Health Act Code of Practice.

In the 12 months to March 2018 the trust reported that there had been a decrease in the use of seclusion and long term segregation. There had been 292 incidents of seclusion and 26 incidents of long term segregation.

At this inspection of May 2018 we reviewed audit information and the records of 29 patients who had been subject to seclusion or long term segregation since 12 March 2018. We also visited wards with seclusion facilities across the trust and talked to managers and staff about their understanding of seclusion practice.

The trust was auditing the seclusion process and records. The trust had produced seclusion 'heat maps' following audits of seclusion records. Heat maps showed for March and April 2018 that wards were not meeting the standard for staff recording and monitoring of patients in seclusion with an 'amber' rating at 73% for March and 63% for April.

The ward managers and team leaders we spoke with at Avocet, Rollesby, Whitlingham and Yare wards, confirmed they reviewed each episode of seclusion against information provided in the heat map. However, we found six records that did not appear on the list of seclusions provided by the trust: we were also unable to confirm whether they were included in heat maps provided.

The exact location of where the seclusion was undertaken was also not clearly recorded on the trust seclusion forms. Staff told us they created an incident report and escalated to their managers when patients were secluded anywhere other than the seclusion suite. However, we were not clear that this had always occurred.

Staff on Thorpe / Eaton ward were not aware of a specific protocol for use in the management of seclusion. The protocol was not immediately to hand. It was however found and forwarded before the end of the inspection.

We also found from a review of 29 patient notes that records did not meet the recommendations set out in the Mental Health Act Code of Practice:

- Eleven records did not have a review by a doctor within one hour of commencement.
- Six did not have reviews by two nurses every two hours.

Are services safe?

- None of the five who should have had an independent multidisciplinary review had one.
- Nine out of the 28 records which should have contained a care plan did not have one.
- Nine records did not have a plan as to how nutritional and hydration needs were to be met.
- Nine records did not contain information about bedding and clothing provided.
- We were concerned that a patient on Abbeygate ward was secluded for two hours on 24 April without a Deprivation of Liberty Safeguards (DoLS) authorisation in place. The following day the team applied for an urgent DoLS authorisation however there was no consideration of assessment under the Mental Health Act, as required by the Mental Health Act Code of Practice when an informal patient is secluded.

When we last inspected the trust automated external defibrillators were not available at a number of community bases. The trust informed us subsequently that automated external defibrillators were available to community staff at co-located inpatient services however staff had not been aware that they could access these if needed. We were concerned that not all staff had received life support training.

At this inspection we found that defibrillators were available at all community teams visited.

Staff were aware about the location of the defibrillators and other emergency equipment. Overall trust compliance was 81% for both basic life support and 77% intermediate life support. In addition, some teams had received bespoke training in use of the defibrillator from medical and general nursing colleagues.

Are services effective?

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

Summary of findings

We found the following areas where the service needs to improve:

- Care plans were not always in place or updated when people's needs changed. Care plans had not been reviewed or reflected latest needs. Across services the quality of care plans varied, some were generic and some lacked sufficient detail or were incorrect.
- The trust had addressed technical performance issues with the electronic record system but further work was required to ensure that all staff could consistently access the system and that records were filed in the correct area of the patient record.
- While the trust had improved systems to capture supervision data further work was required to ensure all staff receive regular supervision.

However:

- Overall appraisal rates had exceeded the 75% compliance target.

Our findings

Assessment of needs and planning of care

Following the last inspection in July 2017, we were very concerned about the performance of the electronic records system. We had observed that it was difficult to establish a contemporaneous record of patient care in some services. We also observed that technical problems with the system, particularly in community services, meant staff could not always access records. The trust told us that since they have worked to address performance issues, to provide support and training for staff, and have made improvements to the local infrastructure. The trust had delivered a range of support to staff including the IT team visiting every service at the trust to deliver one to one training. All teams had recruited local digital champions and there had been positive feedback about on-site support.

At this inspection we found that there had been improvement to the performance of the system. Staff reported that the system was quicker and they experienced less technical issues. We did however find some community teams who still experienced technical issues. We also found that documents were not always filed in the appropriate place within the system. This meant that it could still be difficult to establish a contemporaneous record of patient care.

When we inspected the trust in July 2017 we found that care plans were not in place or up to date for all patients. This had been a recurring finding throughout inspections of the trust since October 2014. Following our inspection of 2017, we told the trust they must ensure that all care plans are in place, updated consistently in line with multidisciplinary reviews and reflect the full and meaningful involvement of patients.

Prior to this inspection, the trust told us that significant work had been undertaken to address these concerns. Staff training had been rolled out and business change teams had visited wards and community teams to support staff. Monthly audits had been undertaken and the results of these were presented to the board within the performance report. Latest results at April 2018 had indicated 82% compliance for completeness of care plans. A doctor had been appointed as the chief clinical digital information officer with a view to ensuring clinician co-operation.

At the inspection we heard at a number of services that administration staff undertook the audit rather than clinicians. We heard that the audit was a measure of whether a care plan document exists rather than a measure of the quality of completeness or the accuracy of the document. This was raised with the trust during the inspection. It was acknowledged that there was a gap in audit of the quality of documents. As a result one of the matrons had developed and piloted a quality audit: this was about to be rolled out across other services.

At this inspection of May 2018 we reviewed the records of 132 community and hospital patients.

Are services effective?

In some services we found that the care plans were detailed, individualised to the patient's needs and showed the patient's involvement in the care planning process. However, in crisis, community teams and wards we found 20 patients (of 132) that did not have a care plan in place. In some services, care plans had been reviewed following changes to people's needs but care plans had not always been reviewed or reflected latest needs in a further 25 cases. Across services the quality of care plans varied, some were generic and some lacked sufficient detail or were incorrect.

Skilled staff to deliver care

When we inspected the trust in July 2017 we were concerned about supervision and appraisal rates.

The trust could not supply data about the levels of clinical and management supervision undertaken prior to the inspection. The trust said that they did not keep central data on clinical supervision, leaving this to individual practitioners to maintain their own records as expected by their professional bodies. In April 2017 the trust introduced a new electronic system for recording management supervision. We found that this had not been implemented fully and some staff had experienced difficulty inputting data.

The trust told us that they had worked hard to embed the importance of regular supervision into the culture. Management and clinical supervision policies were redrafted to provide additional clarity. Performance reports were reviewed by the executive team on a weekly basis and the board received monthly performance updates. Additional training had been provided to managers on using the record system to record supervision and appraisal. Line managers had also been given access to data on their direct reports. They confirmed that whilst there had been significant improvement, particularly for appraisal rates, they still remained below target for supervision.

During this inspection the trust stated that overall management supervision rates were 80% for non-medical staff but 53% for medical staff. When we visited services some managers told us that they experienced difficulties with the electronic records system. We observed managers struggle to run reports. Some managers stated that the figures were incorrect. Staff at some teams told us that management supervision did not occur as frequently as required. We looked at data provided by the trust and found that 88 (of 270) teams had a compliance figure of less than 75% for management supervision. Fourteen teams were recorded at zero % compliance.

During the last inspection, trust wide appraisal rates were 62% for medical staff and 66% for other clinical staff. The trust target is 89%. At this inspection appraisal rates had risen to 83% for medical staff and 91% for other clinical staff.

Are services responsive to people's needs?

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

Summary of findings

We found the following areas where the service needs to improve:

- In community mental health teams, there were delays in assessment and treatment. Almost 13% of patients across the trust had not been allocated a care coordinator following assessment.
- In crisis services it was unclear how the trust accurately monitored or assured itself that staff prioritised face to face assessments over telephone contact within the four hour emergency target as recommended within the Crisis Care Concordat 2014.

However:

- There were sufficient beds available within acute and older people's wards. The overall number of out of area placements had reduced slightly since the last inspection.
- Crisis teams had better capacity to meet patient needs due to additional recruitment to posts.
- The trust had implemented a new flow chart and protocol to try and reduce transfers and disruption and had set a standard of no inter-ward moves for non-clinical reasons after 8pm at night.

Our findings

Access and discharge

When we inspected previously, we found that there was a shortage of beds across the trust. This meant that people may have been moved, discharged early or managed within an inappropriate service. Out of trust placements had also been very high.

The trust told us they had strengthened the bed management team managing patients placed out of area and had improved executive oversight. They had commissioned seven beds from an external partner to enable discharge for those patients that may be medically fit but of no fixed abode. The trust had introduced a rag rating system for the use of leave beds and increased staffing in crisis teams to alleviate the need for beds. The trust also participated in weekly bed status meetings with external partners to support discharge arrangements. The trust told us that they had taken a decision to close a number of beds, including PICU beds, since the previous inspection for safety reasons which had impacted on the number of patients cared for out of area.

The trust monitored bed occupancy rates. At March 2018 bed occupancy levels were at 93%. It is generally accepted that when occupancy rates rise above 85%, the quality of care provided to patients is affected. However, at the time of this inspection we found that there were sufficient beds in acute and older people's wards which had a small reserve of beds. None of the wards we visited were using 'red leave beds' to facilitate admission. Out of area placements had reduced slightly since the last inspection. During the week of our unannounced inspection there were 11 people in beds outside of the trust: nine of these were is specialist placements not available within the trust and two patients were in external PICUs.

When we last inspected the trust we found a large number of patients had been cared for on more than two separate wards during a single admission episode.

When we inspected the trust in 2017, we judged that there was insufficient capacity to manage crisis at night. The response to crisis calls out of hours was inconsistent. In Norwich crisis calls were diverted to a mobile after nine o'clock at night when the staff member was out. The staff member was unable to answer the call when they were with a patient so the call diverted to voicemail. After midnight in Great Yarmouth one member of staff had to respond to telephone calls on the crisis line, make gatekeeping assessments for admission to the inpatient wards and undertake assessments in the emergency department of the acute hospital. At times during the night in Kings Lynn, crisis staff also had to work on the inpatient ward due to the ward's shortage of staff whilst also providing a crisis service.

During this inspection, we were told that the level of staffing within crisis teams had improved. All services now had additional staff deployed until midnight each day. Some additional permanent staff had been recruited and

gaps in rotas had been filled by long term agency staff. In West Norfolk, the team no longer worked on the ward and additional staffing within the psychiatric liaison team had reduced this commitment. At Great Yarmouth, the team still covered psychiatric liaison during the night but stated they provided less cover to the wards and so had sufficient staff. This meant that there was more capacity to respond to patients in crisis. However, at March 2018 the trust had met the target for emergency referrals assessed within four hours in 85% of cases against a target of 95%.

At the previous inspection the trust had no overarching operating procedure for crisis services that clearly defined key performance indicators and targets for the services. The trust told us ahead of this inspection that they had implemented an overarching operating policy and procedure for crisis services that clearly defined key performance indicators and targets. When we visited crisis teams and asked for the policy and procedure we were provided with three different documents. We reviewed these and noted that each now included a specific KPI for responding to emergency referrals however the documents stated different activities were required within the four hours. For example, in the Norwich team document the KPI was to make phone contact with the patient within four hours while the Suffolk document stated that a face at face assessment should occur within four hours. It was, therefore, unclear how the trust accurately monitored or assured itself that staff prioritised face to face assessments over telephone contact within the four hour target as recommended within the Crisis Care Concordat 2014.

During the last inspection we found that in some community teams patients had been assessed but had a further wait for allocation to a care coordinator. We found during this inspection that staff were managing very high caseloads and there were some delays in assessment and treatment. We are concerned that across adult community teams there continued to be a delay in allocating a care coordinator following assessment. Arrangements in place were not effectively managing the risks to patients.

We are particularly concerned about the King's Lynn team where we found that 207 patients were on the waiting list and did not have an allocated care coordinator. Patients who were awaiting allocation were triaged and then rag rated according to their risks. 25 patients were rated as red: 120 patients were rated as amber: 62 patients were rated as green. Accordingly, patients were meant to be contacted by team members at set intervals in line with their rating. At this team we found four patients, of 12 reviewed, who had no or limited contact with the team following triage. In some case these patients had been supported by the crisis teams, had been assessed by psychiatric liaison services or had spells as inpatients while awaiting treatment.

We are also concerned that within the files we reviewed there were patients who had experienced significant delays in treatment. For example, we found a patient who had been referred to the King's Lynn team in March 2017 but remained on the waiting list. The patient had received minimal contact from the team despite being amber rated. We did not judge this to be a safe practice.

We noted six occasions when patients who had made contact with the community teams, sometimes in distress, in order to establish when a care coordinator would be allocated to them and when their treatment would begin.

Staff in south Norfolk community team had recorded that were unable to meet individual patient's treatment need due to capacity issues within two patient files reviewed.

At the King's Lynn community adult team we found two examples of where patients had been indicated to require psychological intervention however they could not commence this treatment until a care coordinator was assigned.

Following the inspection, the trust confirmed that almost 13% of patients across the trust had not been allocated a care coordinator. This related to over 3300 individuals. In adult community teams four of 15 teams fell below 80% of patients with an allocated care coordinator: South West Norfolk at 68%, West Norfolk at 71%, Norfolk South East at 73% and South West Suffolk and Great Yarmouth at 79%, Within the information supplied there were a further services across the trust, that we did not visit during this inspection, were there was an allocated care coordinator in less than 80% of cases. We were particularly concerned to note that in CAMHs teams there were five teams that fell below 80% of patients with an allocated care coordinator. Children ADHD West Suffolk had only 19% of patients with a care coordinator.

Most teams had procedures for when a person did not attend an appointment. Managers told us that they actively tried to engage with people who were reluctant to engage with services. People who did not attend an appointment were contacted again by phone or letter and efforts were

Are services responsive to people's needs?

made to rearrange. However, in community adult teams we were concerned to find examples of where staff had not followed the trust's 'non-access visits and missed/ cancelled appointments' policy.

Are services well-led?

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

Summary of findings

We found the following areas where the service needs to improve:

- The breaches of regulation identified at our previous inspections had not all been resolved. Patients do not benefit from safe services in all areas.
- Performance information and data had not yet facilitated effective learning or brought about improvement to practices in all areas.
- Work has been undertaken to better capture risks and a clearer governance structure had been put in place with clearer lines of accountability but further work is required to meet the recommendations of a recent governance review of the trust.

However, the trust had addressed some of concerns that we raised at the previous inspection:

- The trust had ensured that alarms were available to staff and that staff had access to a defibrillator and life support training.
- The trust had made appropriate arrangements to manage mixed sex accommodation.
- Overall mandatory training and appraisal had rates exceeded the 75% compliance target.
- Performance information and data had improved.

Our findings

Good governance

During the last inspection we had found that not all issues that were highlighted at previous inspections had been addressed and that the board had not ensured within a reasonable timeframe that the environments and practices promoted safe care and treatment.

The trust told us that they had recognised the need to implement a more robust governance structure to address our concerns. They said they had established an effective system to monitor the improvement action plans which provided a fast response to performance issues and enabled learning across the trust. A quality programme board (QPB) was established under the leadership of the chief operating officer. The quality programme board provided assurance to the trust board on the improvement action plan progress, risks and outcomes. Membership had recently included non-executive directors who provided further independent challenge and assurance to the board. Reporting to this a quality mobilisation group (QMG) which was established to provide an appropriate framework for decision-making, organisational and technical infrastructure support and problem escalation and resolution. The trust had adopted a service line approach to ensure a greater level of oversight of all improvement actions and a better focus and consistency across the trust.

The trust stated that they had placed the safety culture at the heart of its improvement plans and had made a number of changes to its approach to safety. The quality governance committee terms of reference were reviewed with an increased focus on scrutiny and challenge with regard to all aspects of quality and clinical safety, including strategy, delivery, clinical governance and audit. An outcome framework was agreed that showed the expected outcomes for patients for all areas of the improvement plan. A head of quality assurance and compliance was appointed as a key part of the improvement work and in testing that practices are sustainable and embedded. The non-executive directors and executive directors independently visited wards and community teams to ensure a frontline-to-board approach and to talk to and listen to staff and their issues. A series of safety workshops led by the director of nursing were delivered.

During the last inspection we had found that the information given to the board differed to that returned as part of the provider information return sent to us prior to the inspection in April 2017 or information requested during and after the inspection period. We also found that data was not being turned into information and then used to inform practices and policies. This showed that the data that the board relied on to assure itself about the trust's

performance was flawed and there remained room for improvement to ensure that lessons were learned from quality and safety information and that these were fully imbedded in to practice.

The trust told us that they had established a digital information improvement group (DIIG) led by the director of finance and supported by clinical, technical and corporate staff. A performance dashboard had been designed so that the improvement plans could be monitored by the QMG and QPB and through to the board. This was underpinned by a plan that drilled down into greater detail regarding works needed to deliver the improvements required. The trust stated that this structure had begun to assure the board on performance and the improvements that were being delivered under the quality improvement plan, including the risks to delivery.

The DIIG had overseen four interwoven work streams: skills, capability and capacity, systems performance, data quality, and reporting mechanisms. The trust stated that outcomes had included improvement in staff records system performance issues; an enhanced staff support programme and the implementation of information giving greater visibility of data to clinicians to effect quality improvement. A chief clinical information officer had also been appointed to support the development of information within the trust and the planned improvement in the electronic patient record to ensure it worked effectively for the benefit of patients. A new data warehouse was also in development.

During the last inspection we reviewed the risk registers for the trust and directorates and saw that some but not all risks that we identified through the inspection had been included in the risk register. A number of risks had been considered as addressed and closed on the risk register when the risks still existed and had not been fully resolved. We had also found some examples of learning from improvements that had not always been applied to other areas of the trust. This showed that further work was required to ensure that all risks were fully captured and understood by the board. We were concerned that while the trust's own governance system had highlighted some of these issues, the trust had not fully addressed these across all services.

The trust told us that they recognised that their risk management processes need to be strengthened. A new risk manager was recruited to support improved use of the risk register. The trust had established an executive risk management group to ensure that there was appropriate scrutiny and challenge associated with the review of risks across localities and service lines. The risk management strategy was reviewed to ensure that corporate risks are reported monthly to the executive leadership and governance committees. The board assurance framework was also updated to align with the corporate risk register. Each directorate was now responsible for the active management and review of risks assigned to their service areas. As part of the risk strategy the expectation is that each locality and service management team and board committee will review their respective risks via monthly locality governance meetings. Closure of risks from the risk register now required documentary evidence of the decision making process from a locality governance meeting.

A Governance Review was commissioned by NHS Improvement. The review reported in May 2018 and made a number of recommendations to strengthen governance and risk management at the trust. The recommendations included the need for a more embedded and strengthened culture of clinical leadership while addressing an overly complicated and layered management structure. Required improvements in how risks are identified and escalated and how serious incidents are reported, investigated and how learning is subsequently shared across the trust. A clearer emphasis on learning from complaints and service user feedback while engaging more effectively with staff so good practice can be shared across the trust.

At this inspection of May 2018, we have found that the trust had addressed some but not all of the concerns we raised with them in July 2017. We acknowledge that the trust had undertaken a significant amount of work and had addressed some concerns. The trust had ensured that alarms were available to staff and that staff had access to a defibrillator and life support training. The trust had made appropriate arrangements to manage mixed sex accommodation. Overall mandatory training and appraisal had rates exceeded the 75% compliance target.

Some progress had been made in relation to recruiting additional staff to the wards and crisis teams and staffing levels were sufficient at the time of our inspection. A significant amount of work had been undertaken to address ligature issue at the trust. However, further work is required to remove all higher level risks and to ensure that local actions required to mitigate risks are recorded and

Are services well-led?

known by staff. The trust had addressed technical performance issues with the electronic record system however further work was required to ensure that all staff could consistently access the system and that records were filed in the correct area of the patient record. While the trust had improved systems to capture supervision data further work was required to ensure all staff receive regular supervision.

However, we were concerned that pace of change had been slow in respect of some issues that we raised with the trust following the inspection of July 2017 including:

- Seclusion environments and seclusion practice - while we acknowledge the trust had made progress in respect of seclusion environments at a number of wards, patients were still not always being secluded safely or within appropriate environments. Despite the trust auditing the seclusion process and records, wards were not meeting the standard for staff recording and monitoring of patients in seclusion. We found that records and practice did not always meet the recommendations set out in the Mental Health Act Code of Practice.
- Staffing levels - were not always sufficient in community teams to meet the needs of patients or safely manage risk. Staff were managing very high caseloads and there were some delays in assessment and treatment.
- Access to services – the trust confirmed that almost 13% of patients across the trust had not been allocated a care coordinator following assessment. We were concerned that processes in place were not effectively managing this risk. In addition, in crisis services it was unclear how the trust accurately monitored or assured itself that staff prioritised face to face assessments over telephone contact within the four hour emergency target as recommended within the Crisis Care Concordat 2014.
- Risk assessment and care planning – from 132 records reviewed we found that ten patients did not have a risk assessment in place. A further 42 risk assessments were out of date or did not link effectively with the needs identified in the patients' care plans or reflect the latest know risks. Twenty care plans were missing and a further 25 did not contain up to date information about care needs.

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

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

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Treatment of disease, disorder or injury	Regulation 13 HSCA (RA) Regulations 2014 Safeguarding service users from abuse and improper treatment

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

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

This section is primarily information for the provider

Enforcement actions

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	Section 29A HSCA Warning notice: quality of health care **Systems and processes that did not operate effectively to ensure that the risks to patients were assessed, monitored, mitigated and the quality of healthcare improved in relation to:** - Seclusion environments and seclusion practice - Staffing levels - Access to services - Risk assessment and care planning