Requires improvement

Norfolk and Suffolk NHS Foundation Trust

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

Quality Report

Hellesdon Hospital
Drayton High road
Norwich
Norfolk
NR6 5BE
Tel: 01603 3421412
Website:www.nsft.nhs.uk

Date of inspection visit: 24 - 25 February 2020
Date of publication: 01/05/2020

Locations inspected

Location ID	Name of CQC registered location	Name of service (e.g. ward/ unit/team)	Postcode of service (ward/ unit/ team)
RMYNR	Wedgwood House	Northgate Ward	IP33 2QZ
RMYNR	Wedgwood House	Southgate Ward	IP33 2QZ

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.

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	Requires improvement 
Are services safe?	**Requires improvement** 
Are services effective?	**Requires improvement** 
Are services caring?	**Good** 
Are services responsive?	**Requires improvement** 
Are services well-led?	**Requires improvement** 

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

Contents

Summary of findings

Overall summary

This was a focused inspection looking at specific areas of concern. The inspection was of two acute wards, Southgate and Northgate, located at the Wedgwood Unit, West Suffolk Hospital, Bury St Edmunds. The ratings shown in the report are from the previous inspection of acute wards across the trust which took place in October 2019.

We found the following areas the trust needed to improve at Southgate and Northgate wards:

- There were a number of occasions where the staffing levels on the wards were below the safer staffing levels set by the trust. Vacancies for registered nurses were 51% and 26% for support workers although recruitment was taking place with some staff due to come into post. Staff and patients described the impact of this. Leave and activities were sometimes cancelled and both patients and staff did not always feel safe on the wards.
- Care records had not been fully updated to reflect all the patients' risks following concerning incidents. There were not always records of a risk assessment being undertaken prior to a patient leaving the ward.
- Learning from incidents was not always shared and embedded systematically across the wards. However, staff knew what safety incidents to report and had reported incidents appropriately.
- Some mandatory training still needed to take place. Whilst overall compliance across the two wards was 80% some courses had lower completion rates such a fire safety, intermediate life support and adult safeguarding level 3.
- Staff were not all receiving regular supervision with their manager, although the trust was working to make improvements and learn from other parts of the organisation where this was going better.
- Prior to our inspection there had been gaps and changes to leadership at the hospital. Some staff told us that while senior staff had visited the wards, they did not feel they were being listened to. However, the trust had recently appointed a lead nurse, a temporary modern matron, a permanent ward manager for Northgate ward and a temporary manager for Southgate ward. Staff were positive about the recent appointments. Ward managers told us they felt they had support from senior leaders and that senior leaders had acknowledged staff's concerns and spent significant time at the wards since January 2020.
- Some governance systems needed to be strengthened. For example, it was difficult to get accurate data on staffing levels during the inspection which was essential information needed to manage and monitor the service. However, the trust had recognised prior to the inspection that improvements were needed at the Wedgwood Unit establishing a rapid improvement board and improvement plan.

Summary of findings

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

Are services safe?

Requires improvement

The rating provided was the rating given following the inspection which took place in October 2019. This has not been revised.

- There were a number of occasions where the staffing levels on the wards were below the safer staffing levels set by the trust. Vacancies for registered nurses were 51% and 26% for support workers although recruitment was taking place with some staff due to come into post. Staff and patients described the impact of this. Leave and activities were sometimes cancelled and both patients and staff did not always feel safe on the wards.
- Care records had not been fully updated to reflect all the patients' risks following concerning incidents. There were not always records of a risk assessment being undertaken prior to a patient leaving the ward.
- Learning from incidents was not always shared and embedded systematically across the wards. However, staff knew what safety incidents to report and had reported incidents appropriately.
- Some mandatory training still needed to take place. Whilst overall compliance across the two wards was 80% some courses had lower completion rates such a fire safety, intermediate life support and adult safeguarding level 3.

Are services effective?

Requires improvement

The rating provided was the rating given following the inspection which took place in October 2019. This has not been revised.

- Staff were not all receiving regular supervision with their manager, although the trust was working to make improvements and learn from other parts of the organisation where this was going better.

Are services caring?

Good

We did not inspect this domain

The rating provided was the rating given following the inspection which took place in October 2019. This has not been revised.

Are services responsive to people's needs?

Requires improvement

We did not inspect this domain

The rating provided was the rating given following the inspection which took place in October 2019. This has not been revised.

Summary of findings

Are services well-led?

The rating provided was the rating given following the inspection which took place in October 2019. This has not been revised.

- Prior to our inspection there had been gaps and changes to leadership at the hospital. Some staff told us that while senior staff had visited the wards, they did not feel they were being listened to. However, the trust had recently appointed a lead nurse, a temporary modern matron, a permanent ward manager for Northgate ward and a temporary manager for Southgate ward. Staff were positive about the recent appointments. Ward managers told us they felt they had support from senior leaders and that senior leaders had acknowledged staff's concerns and spent significant time at the wards since January 2020.
- Some governance systems needed to be strengthened. For example, it was difficult to get accurate data on staffing levels during the inspection which was essential information needed to manage and monitor the service. However, the trust had recognised prior to the inspection that improvements were needed at the Wedgwood Unit establishing a rapid improvement board and improvement plan.

Requires improvement

Summary of findings

Information about the service

Norfolk and Suffolk NHS Foundation Trust was formed when Norfolk and Waveney Mental Health NHS Foundation Trust and Suffolk Mental Health Partnership NHS Trust 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. Several specialist services are also delivered including a community-based eating disorder service.

The Care Quality Commission placed Norfolk and Suffolk NHS Foundation Trust in special measures in 2017. There were further inspections in 2018 and 2019. Following the October 2019 inspection, there was an improvement in rating from inadequate to requires improvement overall. The core service acute wards for adults of working age and psychiatric intensive care units (PICU) was rated as requires improvement for safe, effective, responsive and well led and requires improvement overall. Despite the improved overall rating, the trust remained in special measures as it was too soon to judge if the early improvements made could be sustained.

The trust has been inspected six times in the previous 12 months including this inspection.

The trust provides 12 acute wards and psychiatric intensive care units (PICU) for adults of working age at five locations across Norfolk and Suffolk.

This was a focussed inspection and we looked solely at the two acute wards, Southgate and Northgate, located at the Wedgwood Unit, West Suffolk Hospital, Bury St Edmunds.

Our inspection team

The team that inspected the service comprised of one inspection manager and two CQC inspectors.

Why we carried out this inspection

We carried out this inspection of Southgate and Northgate Wards, located at the West Suffolk Hospital, Bury St Edmunds, in response to a range of concerning information as a result of whistleblowing information and other intelligence. This was a focussed, unannounced inspection specifically to look at patient case management, staffing and team management/leadership and actions following serious incidents.

All requirement notices issued in the last inspection remain in place. The Section 29a warning notice amended in 2018 also remains in place.

We do not revise ratings following an inspection of this type. Ratings seen in this report were issued following the comprehensive inspection in October 2019 and remain in place.

How we carried out this inspection

We have reported on the following domains:

- Is it safe?
- Is it effective?
- Is it well-led?

We did not follow up all the requirement notices issued at the last inspection. They will be looked at in detail during the next comprehensive inspection. This was an unannounced inspection. We focused on issues raised following whistleblowing concerns and other intelligence.

Summary of findings

Therefore, our report does not include all the headings and information usually found in a comprehensive inspection report. We did not explore all key lines of enquiry within each domain, the inspection team focussed on specific areas of concern.

Before the inspection visit, we reviewed information that we held about the location.

During the inspection visit, the inspection team:

- spoke with two ward managers and three senior managers
- spoke with nine other staff members; including nurses and occupational therapists
- spoke with six patients
- looked at six care and treatment records of patients
- looked at incident information and staff records
- looked at a range of policies, procedures and other documents relating to the running of the service.

What people who use the provider's services say

We spoke with six patients during this inspection.

Patients told us that there was not always enough staff to meet their needs, and that leave from the ward and activities were sometimes cancelled or delayed as a result. This was particularly evident during evenings and at weekends. Three patients told us that at times the ward did not feel safe due to staffing levels. All patients, including informal patients, told us that they were unable to access the outside space after 22.00.

Three patients told us that they did not get to speak with their doctor when they had requested this.

Patients stated that while most staff were caring and did their best to meet their needs there was a lack of consistent staff meaning that some staff did not know them well.

Most patients stated that the two ward managers were good and accessible. However, three patients stated that they had complained about the service and had not received a response to their complaints.

Areas for improvement

Action the provider MUST take to improve

- The trust must ensure there are sufficient nursing staff to keep people safe from avoidable harm. Regulation 18: Staffing 18 (1)
- The trust must ensure that staff have undertaken mandatory training, supervision and appraisal in line with trust policy. Regulation 18: Staffing 18 (1) and (2)
- The trust must review their systems to ensure that patients have risk assessments which are robust and updated as needed. This must include the risk assessment processes prior to patients being allowed leave from the ward. Regulation 12: Safe care and treatment 12 (2)(a), (b)
- The trust must ensure that there is robust learning from patient safety incidents and that learning is shared and implemented by staff. Regulation 17: Good governance 17(1), (2) (a) and (b)
- The trust must review governance systems to ensure compliance with actions from past CQC inspections in the acute services. Regulation 17: Good governance 17(1), (2) (a), (b) and (f)
- The trust must ensure they support all managers to use the trust's governance systems and performance management systems in the acute service. Regulation 17 (1), (2) (a), (b), (c) and (f)

Norfolk and Suffolk NHS Foundation Trust

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

Detailed findings

Name of service (e.g. ward/unit/team)	Name of CQC registered location
Northgate Ward	Wedgewood House
Southgate Ward	Wedgewood House

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 staffing

The service did not have enough nursing staff, who knew the patients well. Patients stated there was a lack of consistent staff meaning that some staff did not know them well.

The managers informed us that Northgate and Southgate wards had vacancies. At the time of inspection, the overall vacancy rate for registered nursing staff was 51% and for health care workers was 26%. Sickness absence was above the trust target at 5.8%.

The trust were not filling all the shifts and meeting their safer staffing levels. The trust told us that they would attempt to cover staffing gaps by use of bank and agency staff. Managers stated that where possible they used long term bank and agency staff to cover. However, in the week prior to our inspection 12 different agency staff had been deployed across the wards alongside many bank staff.

We also reviewed the incident reports for the wards for the six months prior to our inspection. These showed that staff had reported concerns about inadequate staffing levels on 171 separate occasions. Thirty of these related to Northgate Ward and 141 to Southgate ward. Thirty of these reports had been made in February 2020. On 22 February 2020, there were reported to be unsafe staffing levels across Northgate ward, Southgate ward and no staff were available from the neighbouring ward Abbeygate to support the acute wards.

On five occasions staff reported that there were insufficient staff to form a prevention and management of aggression team should physical intervention be required. Staff told us that there were occasions when a nurse from another ward had to visit Southgate Ward or Northgate Ward to give service users their routine medication. The trust confirmed this was due to the lone nurse on the ward at the time not having completed their medicines competency training.

Staff from Southgate ward had responsibility for the management of the place of safety based at the hospital. The incident reports reviewed, documented that the section 136 suite was closed on five occasions in February 2020 in order to mitigate staff shortages at the wards.

The trust told us that there was a comprehensive and varied programme of activities delivered at the wards including during evenings and weekends. However, the management team and patients told us that there were occasions when occupational therapy staff had to make up staff numbers. This had led to occupational therapy activities being cancelled on occasion. Staff told us that they did not have capacity to support service users when they needed to be escorted outside the building. This information was supported by patients who told us that there was not always enough staff to meet their needs, and that time off the ward and activities were sometimes cancelled or delayed as a result. This was particularly evident during evenings and at weekends. Three patients told us that at times the ward did not feel safe due to staffing levels.

We observed and saw in records that senior staff were frequently deployed within staffing numbers, but this was not effective in alleviating the staff's concerns or providing support for day to day decision making.

The trust told us that overall mandatory training rates were at 82%. However, staff had not received all required basic training to keep patients safe from avoidable harm. For example, immediate life support training was at 67%; health, safety and welfare at 63%; safeguarding adults' level three at 68%; fire safety at 42%. Staff told us that they did not have sufficient time to complete all required training.

Assessing and managing risk to patients and staff

We reviewed care records for six patients in detail. We found that for four patients, risk assessments had not been fully updated to reflect all the patients' risks following concerning incidents. Staff also completed a situation, background, assessment, recommendation (SBAR) tool, which was a structured method for communicating critical information that required immediate attention and action. However, we found that some information was incomplete

Requires improvement

Are services safe?

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

and not all information was recorded in a clear manner. We found examples where patients had indicated that they were at increased risk however these had not resulted in changes to risk management plans.

The wards have a process in place for assessing a patient's risk prior to them commencing leave which required registered staff to undertake a risk assessment. However, we found that there were not always records of the assessment being undertaken prior to leave. Staff told us that an administration staff member inadvertently signed a service user off the ward without the service user having been seen by a clinician.

The wards had implemented the Safewards initiative which included the use of daily safety huddles. These were informal meetings where staff met to discuss ward or unit safety. These meetings included a discussion of staffing, incidents, environmental risks and individual patient risk. Staff we spoke with told us these meetings had a positive impact on safety. However, at the time of the inspection the safety huddles were not being held daily on Southgate ward. We raised this with the trust who immediately ensured that huddles were implemented on both wards twice daily.

Track record on safety

There had been three serious incidents relating to patients who were receiving inpatient care. One of these incidents had taken place whilst the patient was on leave and another while the patient was receiving treatment at another hospital. Two of the incidents had occurred in January 2020. Both were subject to a full root cause analysis investigation that had not yet been completed at the time of the inspection. We reviewed the early learning reports for these incidents and found that there were areas of risk management that could be improved.

Reporting incidents and learning from when things go wrong

Staff including agency staff had access to an incident reporting system. Staff knew what incidents to report and how to report them. We saw evidence of incidents being reported. There had been 880 reports made by staff since September 2019.

The managers confirmed that they would look at themes for learning however there had been a delay in completing incident reviews and investigations due to staff capacity. The trust confirmed that the psychologist had offered staff a debrief following these incidents. However, some staff told us that while ward managers had been supportive following the serious incidents there had not been an opportunity for a full debrief.

There was a lack of structure for feeding back lessons learned at meetings or via other methods of communication. Local team meetings did not have a clear meeting agenda and we saw that few meetings were documented as actually taking place. Of those meetings that did take place, there were several where lessons learned were not discussed at team level, despite there being discussions at clinical governance meetings. However, we did see some safety bulletins that had been shared with staff.

Following a serious incident in 2019, the trust had implemented a process to manage access to plastic bags on the acute wards. There had been a significant incident involving a patient accessing a plastic bag on Northgate ward just prior to our inspection.

Are services effective?

Requires improvement

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

Staff we spoke with during the inspection told us they had not been receiving regular managerial and clinical supervision in line with the trusts policy due to staffing capacity and management gaps. Ward managers confirmed that they were attempting to ensure supervision occurred, but this had been challenging. The percentage of staff that had received regular supervision prior to our inspection was 50% on Northgate ward and 46% on Southgate ward.

The trust told us that 83% of staff on Northgate and 90% of staff on Southgate had received an appraisal. On Northgate Ward the ward manager told us that three staff due their appraisal in January 2020 had not had these as scheduled.

Good

Are services caring?

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

Our findings

We did not inspect this domain.

Are services responsive to people's needs?

Requires improvement

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

Our findings

We did not inspect this domain.

Are services well-led?

Requires improvement

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

Good governance of risk, issues and performance

Some governance systems needed to be strengthened. For example, it was difficult to get accurate data on staffing levels during the inspection which was essential information needed to manage and monitor the service.

The trust told us about a number of quality improvement initiatives that staff had been involved in. These included programmes focussing on the multi-disciplinary meeting and care planning, reducing restrictive interventions, medication management and discharge planning.

Staff told us they did not have regular opportunities to meet, discuss and learn from the performance of their service. There were few records that team meetings had taken place. Where meetings had taken place, there was a lack of agenda structure and several where lessons learned from safety incidents had not been discussed at team level, despite there being discussions about these incidents at clinical governance meetings. In addition, staff and managers confirmed that safety huddles had not been occurring daily on Southgate ward.

Managers did not have effective systems in place to ensure staff were undertaking clinical risk assessment processes appropriately. This included assessments of risks prior to allowing patients to leave the ward. We found staff had not updated risk assessments following significant incidents, or fully completed leave risk assessments for the patients we reviewed. Managers had not identified or addressed these gaps with staff members.

In response to the concerns raised within this report, the trust leadership team provided assurance of action that had begun to take shape just prior to the inspection and immediately following the inspection. This included the development of an improvement plan and rapid improvement board to oversee this work. The trust redeployed 13 whole time equivalent staff from other services, to ensure safer delivery while recruitment efforts continued. Staffing levels were increased on Southgate ward and the temporary staff booking process was strengthened. Senior managers were ensuring a presence on the wards and holding twice daily escalation meetings. Safety huddles were increased to twice per day.

Leadership, morale and staff engagement

Prior to our inspection there had been significant gaps and changes to leadership at the hospital. Since the establishment of the care group in September 2019 the lead nurse had left and there were gaps within the modern matron and ward manager roles. At the time of the inspection a lead nurse and temporary modern matron had been appointed. A permanent ward manager had come in to post for Northgate ward and a temporary manager had been recruited for Southgate ward following a long gap in these posts.

Ward managers told us they felt they had support from senior leaders and had autonomy to make daily decisions in their role. The manager on Northgate ward had recently held an away day for substantive staff to begin to address their concerns and improve morale. Managers told us that senior leaders had acknowledged staff's concerns and spent significant time at the wards since January 2020. However, local managers acknowledged that there had been significant staffing difficulties and that this had negatively impacted on the service and staff morale. Managers also acknowledged that their capacity to manage the ward was limited due to the significant time they spent working on shift to fill gaps.

Staff told us that some local leaders were approachable however they did not know or feel engaged with the senior leadership team. Staff told us that while senior staff had visited the wards, they did not feel they were being listened to. Morale was poor, and staff felt that managers did not recognise that they were stressed and burnt out or understood their concerns, particularly around staffing levels and feeling safe on the wards. Staff were, however, more positive about the recent appointment of the ward managers and the matron.

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 must review their systems to ensure that patients have risk assessments which are robust and updated as needed. This must include the risk assessment processes prior to patients being allowed leave from the ward.

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Treatment of disease, disorder or injury	Regulation 17 HSCA (RA) Regulations 2014 Good governance • The trust must ensure that there is robust learning from patient safety incidents and that learning is shared and implemented by staff. • The trust must review governance systems to ensure compliance with actions from past CQC inspections in the acute services.

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 must ensure there are sufficient nursing staff to keep people safe from avoidable harm. • The trust must ensure that staff have undertaken mandatory training, supervision and appraisal in line with trust policy.

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	Regulation 17 HSCA (RA) Regulations 2014 Good governance Norfolk and Suffolk NHS Foundation Trust is in special measures and all enforcement action taken following the previous inspections in 2018 remain in place as they had not been addressed. A Section 29a Warning notice was amended in 2018 and is not yet compliant. There were no new areas for improvement noted at this inspection. Due to the significant concerns regarding safe staffing we issued a Section 31 notice of decision to pause admissions. This was lifted four days later due to the swift response by the trust. The concerns raised in this report were escalated to NHS Improvement/England for their consideration and action.