Norfolk and Suffolk NHS Foundation Trust

Inspection report

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Ratings

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

Our findings

Our reports

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

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

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

Overall summary

What we found

Overall trust

We carried out this unannounced inspection of eight of the mental health core services provided by this trust because at our most recent inspection we rated the trust overall as requires improvement and it was in special measures, and we received information giving us concerns about the safety and quality of some of the services. We also inspected the well-led key question for the trust overall.

We inspected five mental health inpatient services and three community mental health services:

- acute wards for adults of working age and psychiatric intensive care units long stay or rehabilitation mental health wards for working age adults.
- child and adolescent mental health wards.
- wards for older people with mental health problems.
- wards for people with a learning disability or autism.
- community-based mental health services for adults of working age.
- mental health crisis services and health based places of safety.
- specialist community mental health services for children and young people.

We did not inspect the following core services at this inspection:

- community based services for older people
- forensic inpatient wards
- community mental health services for people with a learning disability
- We are monitoring the progress of these services and will re-inspect them as appropriate.

Our rating of services went down. We rated them as inadequate because:

Our findings

We rated safe overall as inadequate in four out of the eight services inspected in this domain, this was a deterioration from the earlier inspection.

We rated effective overall as inadequate in three of the core services inspected this time in this domain, five services required improvement, three service were good in this domain.

We rated caring overall as good, as two services required improvement in this domain and the remainder were good.

We rated responsive as requires improvement overall, as five of the services required improvement, one was inadequate, and the remainder good.

We rated well led as inadequate overall, as two core services inspected were inadequate in this domain, and six services inspected required improvement, and two as good.

At this inspection we rated three of the trust's services as inadequate overall in this domain, five as requires improvement and three as good. In rating the trust overall, we took into account the current ratings of the three services we did not inspect this time.

During the inspection of the core services, we served the provider with a letter of intent under Section 31 of the Health and Social Care Act 2008, to warn them of possible urgent enforcement action. We told the provider that we were considering whether to use our powers to urgently impose conditions on their registration. The effect of using Section 31 powers is serious and immediate. The provider was told to submit an action plan that described how it was addressing the urgent concerns. Their response provided enough assurance that they had acted to address immediate concerns and so we did not take forward urgent enforcement action.

However, following the inspection we served the provider with a Section 29A Warning Notice relating to five registered locations; Trust Headquarters, Julian Hospital, St Clements Hospital, Northgate Hospital, Carlton Court. The Commission served a Section 29A Warning Notice because the quality of health care provided required significant improvement in the following areas:

- The trust did not consistently maintain safe staffing levels or ensuring there were enough suitably qualified staff to meet the needs of people using services. We found this was impacting on the level of safety staff and patients feel, the governance within teams and multidisciplinary team effectiveness and patent safety.
- The trust did not ensure staff had the mandatory training and specialist training to undertake safe care and treatment of patients.
- The trust did not ensure staff received supervision and appraisals to support the development of staff in their roles and to support safe and effective care.
- The trust did not ensure staff were aware of ligature assessments or mitigated or removed ligature points effectively to maintain patient safety.
- The trust did not ensure patients had up to date risk assessments and risk management plans to manage risks and ensure patient safety.
- The trust did not manage long waiting lists or monitor the risk within the waiting lists effectively.
- The trust did not ensure staff reported, managed and learnt from incidents in order to protect patients and staff from harm.

Our findings

- The trust was not ensuring staff carried out patient observations in accordance with trust policy and NICE guidance in order to protect people from harm.
- The trust did not ensure staff had access to patient records or maintained accurate records regarding patient care, physical health checks and nutrition in order to meet or demonstrate patient needs had been met.
- The trust did not ensure patients were introduced to the ward area, privacy was respected in both the environment and by knocking on doors or through patient involvement in their care.
- The trust did not ensure patient outcomes were measured to demonstrate progress being made.
- The trust did not ensure effective medicine management was taking place effectively to maintain patient safety.
- The trust did not ensure that cultures were supportive of staff to work in to provide care.
- The trust did not provide support to teams to maintain good governance in providing high quality care.

The Warning Notice set out a legally-set timescale for the provider to become compliant. A further inspection will be carried out to ensure action has been taken to comply with the Warning Notice.

Overall Summary

- The trust did not consistently maintain safe staffing levels or ensure there were enough suitably qualified staff to meet the needs of people using services. We found this was impacting on the level of safety for staff and patients. It also impacted on governance within teams, multidisciplinary team effectiveness and patient safety. The trust did not provide support to teams to maintain good governance in providing high quality care.
- The trust did not ensure effective management of medicines was taking place effectively to maintain patient safety.
- The trust did not ensure staff were aware of ligature risks assessments and did not mitigate or remove ligature points in a timely manner to maintain patient safety.
- The trust did not ensure all patients had up-to-date risk assessments or plans to manage risks to ensure patient safety.
- The trust did not manage long waiting lists or monitor the risk within the waiting lists effectively to ensure patients did not deteriorate whilst awaiting treatment.
- The trust did not ensure staff carried out patient observations in accordance with trust policy and National Institute of Health Care and Excellence guidance to protect patients from harm.
- The trust did not ensure patient outcomes measures were used to demonstrate progress made.
- The trust did not ensure staff had access to patient records or maintained accurate records regarding patient care, physical health checks and nutrition to meet or demonstrate meeting patient needs.
- The trust did not ensure staff undertook the mandatory training required to deliver safe care and treatment of patients.
- The trust did not ensure staff received training, supervision, and appraisals to support the development of their roles to support safe and effective care.
- The trust did not ensure staff reported, managed, and learnt from patient incidents to protect patients from harm.
- The trust did not ensure that cultures were supportive of staff to work in to provide care in some service areas.

Our findings

- The trust needed to strengthen relationships with stakeholders to improve patient pathways, especially in relation to children and young people.
- The trust did not demonstrate information provided to the board and media was open and transparent relating to CQC initial feedback and ward closures.

However:

- The trust maintained its services throughout the pandemic, and staff teams supported each other during this crisis.
- The trust had made progress in implementing a model of patient participation in all aspects of its work.
- The trust had made progress in developing clinical leadership and in investing in leadership development.
- The trust was making good progress in developing an overall engaging culture which staff reported as going in the right direction.
- The trust improved relationships and worked well with trade unions and governors resulting in joint working.
- The trust participated in the integrated care systems as an equal partner and led on mental health. Stakeholders and staff described “green shoots” developing in the trust, implying it was going in the right direction.
- The trust participated in a range of research projects and quality improvement initiatives involving staff, patients, carers and the community. Training, research and quality improvement worked well together around quality improvement.
- The trust had implemented a successful restraint reduction programme, by taking a human rights approach there had been significant reductions.
- The trust will continue to work with the NHS England and Improvement Intensive Support for Challenged Systems team (a team that works with challenged providers).

How we carried out the inspection

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

- visited the wards and observed how staff cared for patients.
- toured the clinical environments on the wards and in community locations.
- visited four health based places of safety suites.
- spoke with 301 operational staff including matrons, nurses, clinical support workers assistant practitioners, occupational therapists, psychologists, doctors, social workers physiotherapists, activities coordinators and technical instructors.
- spoke with 15 ward managers.
- spoke with three students.
- spoke with 75 patients.
- spoke with 41 carers.
- spoke with 3 advocates.

Our findings

- looked at 144 medicines prescription charts.
- looked at 212 care records.
- looked at 37 observation records.
- looked at 35 risk assessments.
- looked at 37 observation records.
- looked at 17 leave risk assessments.
- observed two virtual clinical appointments and a therapy session.
- looked at closed circuit television on the acute admission wards and child and adolescent mental health inpatient ward.
- also observed a range of meetings including staff handovers, care programme approach meetings, multidisciplinary team meetings, team huddles, patient community meetings, reflective practice, duty meeting and referral meeting, after care meeting, red and green risk meeting, safety huddle and bed management meeting, and a meeting with a voluntary mental health organisation.

The well led inspection was carried out virtually due to the increased concerns about the COVID-19 pandemic at the time. The inspection team:

- interviewed the executive directors and non-executive directors.
- undertook focus groups with governors, non-executive directors, modern matrons, service directors, clinical directors, consultants, junior doctors, equality, and diversity leads, and research training and quality improvement leads.
- observed a private and public trust board meeting, a finance committee meeting, patient participant meeting, governors meeting and Mental Health Act meeting.
- spoke and received information from a range of statutory stakeholders such as the National Health Service England/ Improvement (NHSE/I) lead, Clinical Commissioning Groups (CCGs), public health director, acute hospitals, Nursing and Midwifery Council, Integrated Care Systems (ICS) leads, Health Education England.
- spoke with and received information from voluntary stakeholders and campaign groups.
- interviewed a range of senior managers including heads of information management and technology, quality, estates, finance, pharmacy, guardian of safe working hours, speak up guardian, staff side officer, complaints, risk, clinical safety officer, fire safety officer, patient safety officer, trade union, Mental Health Act administrator, advocacy and Mental Health Act leads.
- looked at a range of board papers, documents, and strategies.

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

What people who use the service say

Across the core services inspected there was a mixed response by patients and carers.

Our findings

Patients and carers provided positive feedback about staff, their involvement in care on the wards for older people, long stay rehabilitation and for people with learning disability and autism. Patients told us staff treated patients with compassion and kindness. They respected patients' privacy and dignity. They understood the individual needs of patients and supported patients to understand and manage their care, treatment, or condition. Patients could keep in contact with their family and friends. They had access to advocates and care coordinators from the community mental health teams. They knew how to give feedback on their care including how to make a complaint.

In the community child and adolescent mental health service, people told us staff were always polite and interested in the young persons' wellbeing and always asked how the parent or carer was doing.

In the crisis team we spoke with 25 patients and six carers. Feedback was positive. They said staff were respectful, compassionate, polite, and caring. Patients were involved in their care and decisions made about them. Carer involvement occurred with patient consent. Staff considered carers needs and signposted them to local services where required. Staff were efficient and responded quickly to concerns.

In the adult community team nine patients were happy with their care and treatment. Two patients said they had had the same coordinator for a long time and had experienced no problems. Two patients described staff as being kind. One patient told us "Everybody's friendly, nice and really good", adding that their care coordinator "came to work to see me one day when I was struggling and took me to get a cup of coffee". One patient stated staff were "always positive, understanding, caring, will listen to you moan, will give you another idea if something isn't working, always on your side, give you a reality check that what your feeling is normal. They're brilliant."

Within the community child and adolescent service young people and carers told us that it was a frustrating and lengthy process accessing the service. Two out of the 23 people we spoke with had not been involved in their care planning. Out of the 16 carers we spoke to, 12 said they had not received a carers assessment offer.

Young people in the child and adolescent services told us not all staff were kind to them or understood their mental health issues. They said some staff spoke to them in a negative way. For example, saying they "were wasting their opportunities to get better and behaving in an immature way or behaving in ways to get attention".

Three young people told us some staff did not seem to know what they were doing or how to care for them. These patients said that they felt staff were afraid to challenge them and did not enforce ward rules or structures. Young people told us this meant some staff did not seem concerned about what they did as long as they did not hurt themselves or cause damage.

Within the adult acute admission services, two patients on Glaven ward reported they would often retreat to their bedroom to protect themselves during incidents occurring on the ward. A patient on Southgate ward told us that staff made inappropriate jokes about him and one relative from Glaven ward told us staff could be rude over the telephone.

On Southgate, Northgate and Glaven wards, patients did not feel carers were always involved in their care and treatment. Carers who we spoke to also confirmed they did not always feel informed about their relative's care and treatment and or receive any information when their relative was admitted to the ward.

Our findings

Patients from all adult acute admission wards did not feel involved regarding decisions relating to the running of the service and did not feel they had opportunities to supply feedback on the wards. Two patients on Southgate ward, four patients on Northgate ward and one patient on Glaven ward did not feel involved within their own care. Three patients on Glaven ward told us they had not received an information pack on admission or shown around when they arrived at the ward.

Patients from three wards told us they felt the wards were short staffed, two on Southgate, five on Northgate. On Glaven ward, one patient told us that the lack of staff impacted on their ability to make a hot drink during the daytime, as the coffee was locked away, and staff had to get this for them. A carer for a patient on Glaven ward told us they were concerned about the number of illegal substances on the ward, and staff were not always taking appropriate action when they were informed about this.

In the crisis team some patients said they would have liked to see the same staff member on a regular basis to prevent repetition and for continuity of care. One patient said there was a long wait to see a psychologist. Patients reported limited activities across all wards and said there was not a lot to do and internet access across all wards was poor.

In the adult community mental health team, five patients raised concerns about the standard of care they had received. Individual patients told us:

- Their care coordinator "neither cared nor coordinated", adding they had asked to change care coordinator.
- Their care coordinator had not responded to a request made over two weeks ago.
- Staff "didn't have my wellbeing at heart".

Out of seven carers, two carers expressed concerns about the service. Feedback included:

- The care-coordinator situation as a "nightmare due to swaps between teams and sickness" and told us "the impact was that the patient has had no support since July and was now unwell".
- Their relative had had lots of consultants, one who was particularly good who had left, which meant it had now been difficult to get an appointment with a consultant.

Areas for improvement

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

Action the trust MUST take to improve:

We told the trust that it must take action to bring services into line with 109 legal requirements. This action related to seven services.

On the 5 November 2021, we served the provider with a letter of intent under Section 31 of the Health and Social Care Act 2008 telling the provider we had identified areas of significant concern during the inspection and to warn them of possible urgent enforcement action. We told the provider that we were considering whether to use our powers to urgently impose conditions on their registration. The effect of using Section 31 powers is serious and immediate. The

Our findings

provider was told to submit an action plan that described how it was addressing the concerns. Their response, including their decision to close two wards to admissions as well as continuing with the closure to admissions of a third ward already in place prior to inspection, provided enough assurance they had acted to address the urgent and immediate concerns and therefore we did not take forward urgent enforcement action.

However, on 24 December 2021 we issued a Section 29A Warning Notice.

Location/core service

Acute wards for adults of working age and psychiatric intensive care units (PICU's)

- The trust must ensure all patients receive information about their medicines and options for alternative medicines. (Regulation 9 (3)(g)).
- The trust must ensure staff are completing physical health assessments with patients on admission, and regularly reviewing patient's physical health care needs. (Regulation 9 (3)(a)).
- The trust must ensure staff are completing comprehensive, personalised care and risk plans for patients to meet their mental and physical health needs. Including regular review in line with patient needs and in conjunction with the patient. (Regulation 9 (3)(a-f)).
- The trust must ensure carers and relatives are kept informed about patient care and treatment, where consent permits, and are provided opportunities to feedback about the service. (Regulation 9 (3)(c-f)).
- The trust must ensure staff offer all patients a copy of their care plan. (Regulation 9 (3)(g)).
- The trust must ensure staff provide patients with information about the ward on admission, an introduction to the ward and information on their Mental Health rights. (Regulation 9 (3)(g)).
- The trust must ensure facilities such as use of the health-based place of safety, protect patients' dignity when in use, and protect the safety of the patient. (Regulation 10 (1)(2)(a)).
- The trust must ensure patients' dignity is protected on the male ward, Poppy and female ward, Avocet by preventing ward areas from overlooking one another. (Regulation 10 (2)(b)).
- The trust must ensure staff are responsive to patient's immediate needs for hot drinks and patient requests regarding dignity. (Regulation 10 (1)).
- The trust must ensure staff treat patients and carers respectfully and politely. (Regulation 10 (1)).
- The trust must ensure staff are able to safety manage aggressive behaviours displayed by patients and that staff can evidence consideration of a range of interventions as identified in patient care plans, when met with aggression from patients. (Regulation 12 (2)(c)).
- The trust must ensure patient observations are completed in line with patient care plans. and National Institute for Health and Care Excellence (NICE) violence and aggression guidance. Ensuring accurate recording and review of patient observations. (Regulation 12 (2)(a-c)).
- The trust must ensure staff are completing food and fluid monitoring for patients who require this. (Regulation 12 (2)(a-b)).
- The trust must ensure staff follow the NICE and trust guidance, when administering rapid tranquilisation. (Regulation 12 (2)(g)).

Our findings

- The trust must ensure staff providing depot injections to patients' records the site of administration. (Regulation 12 (2)(g)).
- The trust must ensure staff are using appropriate decision-making processes when providing 'as and when required' medicines to patients, to prevent over sedation and/or dependence. (Regulation 12 (2)(g)).
- The trust must ensure patient physical health checks are recorded in patient notes and that staff re-attempt a physical health check if a patient initially declines one. (Regulation 12 (2)(a-c)).
- The trust must ensure patients' risk assessments are completed in a timely manner upon admission and updated at appropriate times. For example, following an incident or following a change in patient behaviour. (Regulation 12 (2)(a-b)).
- The trust must ensure staff follow trust policy and directives within patient care plans to search patients for restricted items, in order to keep patients, staff and others safe from harm. (Regulation 12 (2)(a-b)).
- The trust must ensure they inform staff, visitors and patients of items of risk that are restricted on the wards. (Regulation 12 (2)(b))
- The trust must ensure staff update environmental risk assessments of all ward areas and record ligature risks accurately on the ward ligature audit. (Regulation 12 (1)(a,b,d)).
- The trust must ensure when staff are secluding patients in bedrooms, they remove items of risk within the room prior to seclusion and offering the patient use of a toilet, and that staff accurately record when they do this. (Regulation 12 (1)(a,b,d)).
- The trust must ensure all wards inform informal patients they are able to leave the ward freely. (Regulation 13 (4)(b)).
- The trust must ensure staff review blanket restrictions on all wards in line with trust policy. (Regulation 13 (4)(b)).
- The trust must ensure patients on all wards are able to make their own hot drinks and snacks, in line with patient risk. (Regulation 13 (4)(b)).
- The trust must ensure staff are adhering to the Mental Health Act Code of Practice when secluding patients. (Regulation (13)(4)).
- The trust must ensure staff appropriately support patients following distressed behaviour, to prevent immediate re-occurrence. (Regulation 13 (1)).
- The trust must ensure all staff understand and enact the trust policy on handling complaints, including informal complaint processes. The trust must ensure managers investigate and respond to complaints within the trust timescale of 30 days. (Regulation 16 (2)).
- The trust must ensure managers are reviewing patient observation records for quality checks in line with the trust's policy. (Regulation 17 (2)(a)).
- The trust must ensure medical staff have system access to key information for their role, such as rates of rapid tranquilisation. (Regulation 17 (2)(c)).
- The trust must ensure patients medical records are up-to-date with relevant information, such as dates of medicines reviews. The trust must ensure prescribed medicines are recorded on patient's Mental Health Act certificates of treatment. (Regulation 17 (2)(c)).
- The trust must ensure staff keep clear and detailed records when secluding patients. (Regulation 17 (2)(c)).
- The trust must ensure staff report incidents in line with trust policy and accurately record details of restraint incidents and actions taken as a result of patient incidents. (Regulation 17 (2)(c)).

Our findings

- The trust must ensure managers review and investigate incidents within trust timescales to prevent incidents occurring again, share learning and to prevent further harm to patients. (Regulation 17 (2)(a)).
- The trust must ensure managers implement all recommendations from serious incidents within appropriate time frames, and complete scheduled ward audits to provide assurance of patient safety and quality of care. (Regulation 17 (2)(f)).
- The trust must ensure managers complete scheduled ward audits to provide assurances of patient safety and quality of care. (Regulation 17 (2)(a)).
- The trust must ensure staff are completing medicines audits on all wards to review patients on high doses of antipsychotic medicines. (Regulation 17 (2)(b)).
- The trust must ensure managers are setting appropriate actions in staff and patient meetings, to ensure concerns raised are addressed, and monitored to ensure completion. (Regulation 17 (2)(e-f)).
- The trust must ensure bank and agency staff have access to systems to record and monitor patient clinical information. (Regulation 17 (2)(c)).
- The trust must ensure there are enough staff on each shift to carry out any physical interventions safely and that staff keep up to date with their restraint training. (Regulation 18 (2)(a)).
- The trust must ensure staff keep up to date with their mandatory training. (Regulation 18 (2)(a)).
- The trust must ensure staff are provided with regular, constructive, clinical supervision of their work, in line with trust policy. (Regulation 18 (2)(a)).
- The trust must ensure new staff, including ward managers, complete induction training prior to starting in their role. (Regulation 18 (2)(a)).
- The trust must ensure all staff are provided with annual appraisals of their work in line with trust policy. (Regulation 18 (2)(a)).
- The trust must ensure patients on Great Yarmouth acute ward have access to a dietician and speech and language therapist based on patient need. (Regulation 18 (1)).
- The trust must ensure managers are provided with a reasonable amount of protected time to complete managerial duties, when also working clinical shifts on the ward. (Regulation 18 (2)(a)).
- The trust must ensure all ward managers have the skills and support to perform their roles and have a good understanding of the ward they manage including oversight of essential information used to manage the ward. (Regulation 18 (2)(a)).

Long stay or rehabilitation mental health wards for working age adults

- The trust must ensure environmental risks to the health and safety of patients are assessed, managed and mitigated. This must include comprehensive assessments of all the potential ligature anchor points and the timely removal of potential ligature anchor points which can reasonably and practicably be removed. (Regulation 12 (1)(2) (a)(b)).
- The trust must ensure that a procedure is implemented and followed to make sure staff check patients are safe and well in line with National Institute for Health and Care Excellence guidelines. (Regulation 12 (1)(2) (a)(b)).
- The trust must review and consider how staff will ensure patients are safe and well in their bedrooms without unnecessarily disturbing the patients. (Regulation 12 (1)(2) (a)(b)).

Our findings

- The trust must ensure risks to the health and safety of patients posed by and towards them are assessed, managed and mitigated. This must include comprehensive patient risk assessments and clear risk management plans. (Regulation 12 (1)(2) (a)(b)).
- The trust must ensure the safe and proper management of medicines. This must include the regular review of the use of "as and when required" medicines. (Regulation 12 (2)(g)).
- The trust must ensure the service has sufficient numbers of medical staff. (Regulation 18 (1)).
- The trust must ensure staff keep up to date with their mandatory training. (Regulation 18 (1)(2) (a)).

Child and adolescent mental health wards

- The trust must ensure all staff have the required training, skills and experience to safely manage patients' risk in a timely manner. (Regulation 12 (2)(c)).
- The trust must ensure that staff know how to implement the model of care used on the ward and use the search policy correctly and consistently to minimise patient risk. (Regulation 12 (2)(c)).
- The trust must ensure all staff have completed all relevant mandatory training for their role including prevention and management of aggression (PMA), basic life support, and intermediate life support. (Regulation 12)
- To assure themselves that staff are using de-escalation and restraint procedures correctly and only when necessary. (Regulation 12 (2)(c)).
- The trust must ensure staff administer medicines at the times prescribed and review the effects of the medicines on patient's health and function, to prevent over sedation. (Regulation 12 (2)(g)).
- The trust must ensure all staff have sufficient training and support to understand the needs of patients, how to empower patients to make informed decisions and take control of their own mental health condition in a positive way. (Regulation 18 (2)(b)).
- The trust must ensure all staff receive supervision and appraisal in line with trust policy and procedures. (Regulation 18 (2)(a)).
- The trust must ensure all staff understand the principles of Mental Health Act, Mental Capacity Act and Gillick competency and how they apply to the patient group. (Regulation 11 (1)(2)).
- The trust must ensure all staff always respect the confidentiality of all patients. (Regulation 11 (1)(2)).
- The trust must ensure ward managers have robust governance systems and audits in place to assure themselves that patients are always safe and effectively cared for. (Regulation 17 (2)(f)).
- The trust must ensure all staff know how to complete observation forms correctly. (Regulation 17 (2)(c)).
- The trust must ensure managers address cultural change on the ward that enables staff to maintain therapeutic boundaries, ward routines and structures at all times without imposing blanket restrictions. (Regulation 17 (2)(b)).
- The trust must ensure they have measures in place to assure themselves that having investigated complaints and incidents the lessons learned are clearly identified, implemented and embedded in practice to ensure continuing improvement in the service. (Regulation 17 (2)(e)).

Wards for older people with mental health problems

- The trust must ensure care plans are updated, are personalised, holistic and recovery oriented. (Regulation 9 (1)).

Our findings

- The trust must ensure environmental risks including ligature anchor points are identified and mitigated against at Blickling ward; and include checks of the communal garden at Carlton Court Laurel ward. (Regulation 12 (1)).
- The trust must ensure staff on Blickling and Sandringham ward review and update patient risk assessments following incidents. (Regulation 12 (1)).
- The trust must ensure all wards comply with guidance on the elimination of mixed-sex accommodation. (Regulation 12 (1)).
- The trust must ensure patients are given their medicines on time. (Regulation 12 (1)).
- The trust must ensure the environment at Carlton Court Laurel ward meets dementia friendly guidance and promotes patients' comfort, dignity, and privacy. (Regulation 15 (1)).
- The trust must ensure effective systems and processes that enable them to identify and assess risks to the health, safety and welfare of patients that use the service. (Regulation 17 (1)(2)).
- The trust must ensure staff are up to date with mandatory training including intermediate life support training, physical intervention, care planning, safeguarding, Mental Health Act, and Mental Capacity Act training. (Regulation 18 (1)).
- The trust must ensure staff receive regular appraisals and management and clinical supervision. (Regulation 18 (1)).
- The trust must ensure sufficient staff are deployed to meet the needs of the service. (Regulation 18 (1)).

Community-based mental health services for adults of working age.

- The trust must ensure all patients have a care plan and that this addresses their needs. (Regulation 9 (1)(3).
- The trust must ensure risk assessments are updated routinely and after incidents to reflect the patient's current presentation. (Regulation 12 (1) (2)(a)).
- The trust must ensure waiting lists for assessment and treatment are addressed. (Regulation 12 (1) (2)(c)).
- The trust must ensure psychology waiting lists are reduced. (Regulation 12 (1) (2)(c)).
- The trust must ensure patients on the waiting list are contacted in line with trust policy, by suitably qualified staff. (Regulation 12 (1)(2) (c)).
- The trust must ensure physical health checks are undertaken and recorded on their electronic system. (Regulation 12 (1)(2) (a)).
- The trust must ensure all staff have access to up-to-date environmental risk assessments. Managers and staff are made aware of the outcomes of environmental risk assessments, identified risks and mitigation. (Regulation 12 (1) (2)(d)).
- The trust must ensure all cleaning records are kept up to date. (Regulation 12 (1) (2)(d-e)).
- The trust must ensure that all the cleaning of medical equipment is up to date. (Regulation 12 (1) (2)(d-f)).
- The trust must ensure local teams continue to report and assess the impact of staff shortages and have robust plans in places to mitigate the identified risk. (Regulation 12 (1) (2)(c)).
- The trust must address consistency of medical cover across all teams. (Regulation 12 (1)(2) (c)).
- The trust must ensure all mandatory training in all teams meets the trust target. (Regulation 18 (1) (2)(a)).

Our findings

- The trust must ensure all emergency medicines are in date and regular checks of emergency medicines and equipment are carried out and recorded in line with trust policy. (Regulation 12 (1)(2) (g)).
- The trust must ensure that senior managers are visible, approachable and listen to staff concerns and opinions. (Regulation 17 (1) (2)(e)).

Mental health crisis services and health based places of safety

- The trust must ensure that all patients have a care plan which encompasses their needs and is updated. (Regulation 9 (1) (3)).
- The trust must ensure that recognised rating scales are used to assess and record the severity of patient symptoms and care and treatment options. (Regulation 12 (1) (2) (d)).
- The trust must ensure staff follow the trust policy when prescribing and dispensing medicines. (Regulation 12 (1) (2)(g)).
- The trust must ensure patients receive their medicines at the correct dose in a timely manner. (Regulation 12 (1) (2)(g)).
- The trust must ensure prescriptions are legally authorised with a prescriber's signature. (Regulation 12 (1)(2)(g)).
- The trust must ensure emergency referrals are seen within the trust target of four hours. (Regulation 17 (1) (2)(a)).
- The trust must ensure identified risks are included on the local risk register. (Regulation 17 (1) (2)(a)).
- The trust must ensure there is adequate medical cover in the West and East Suffolk crisis teams. (Regulation 18 (1)).
- The trust must ensure there are enough nursing staff to meet the needs of the service. (Regulation 18 (1)).
- The trust must ensure staff complete and are up-to-date with mandatory training. (Regulation 18 (2)(a)).
- The trust must ensure staff receive regular supervision, in line with the trust policy. (Regulation 18 (2)(a)).

Specialist community mental health services for children and young people

- The trust must ensure all care plans are comprehensive, regularly reviewed, personalised, holistic and recovery orientated. (Regulation 9 (1) (3) (a)(b)).
- The trust must ensure young people have a physical health assessment where required. (Regulation 9 (1)(2)(3)).
- The trust must ensure care plans are regularly reviewed and updated when needs change. (Regulation 9 (1)(2)(3) (b-c)).
- The trust must ensure crisis plans are completed where appropriate. (Regulation 12 (1) (2) (a-b)).
- The trust must ensure a comprehensive mental health assessment is completed for each young person. (Regulation 12 (1) (2)(a)).

Action the trust SHOULD take to improve:

Trust wide

- The trust should ensure non-executives have enhanced Disclosure and Barring Service checks.

Location/core service

Our findings

Acute wards for adults of working age and psychiatric intensive care units (PICU's)

- The trust should ensure there are enough suitably trained and qualified nursing and support staff to keep patients safe.
- The trust should ensure staffing records are accurate and provide detail of staff movements during a shift'
- The trust should ensure that the environment on Lark ward is updated and stains on walls and furniture are removed.
- The trust should ensure therapeutic and medical staff are involved within the trust's strategy.
- The trust should ensure staff are aware of the location of key ward records and information, such as seclusion logs and observation records.
- The trust should ensure when staff meetings are cancelled, there is an alternative process to share key information with staff.
- The trust should ensure levels of prone restraint are reviewed by an appropriately trained and skilled individual, to ensure prone restraint is being used proportionately. Prone restraint is face-down restraint when someone is pinned on a surface and is physically prevented from moving out of this position.
- The trust should ensure internationally recruited staff are provided with cultural adaption support in line with the trust's equality and diversity strategy.
- The trust should ensure all complaint responses respond to patient's immediate safety needs, such as consideration of a referral to an alternative service.
- The trust should consider routinely using technology to support patients.
- The trust should consider recording safeguarding referrals collectively, to provide assurances that referrals have been made following safeguarding incidents.
- The trust should consider implementing their planned smoke free strategy, to improve the health and wellbeing of patients.

Long stay/rehabilitation mental health wards for working age adults

- The trust should ensure a nurse call alarm system is implemented in the care environments.
- The trust should ensure there are clear medicines care plans for "as and when required" medicines.
- The trust should use recognised risk assessment tools.
- The trust should ensure information systems and processes are reliable.
- The trust should ensure care plans are holistic and reflect patient involvement and views.
- The trust should ensure patients have access to psychological therapies.
- The trust should ensure patient records contain evidence of discussion relating to care and treatment and consent.
- The trust should ensure patients have access to the internet.

Child and adolescent mental health wards

- The trust should ensure there is cohesion amongst the staff group on the ward and all staff understand each other's roles and responsibilities.

Our findings

- The trust should ensure all staff feel confident to challenge patients when therapeutic boundaries and ward routines are not upheld.

Wards for older people with mental health problems

- The trust should consider improved working relations with managers and staff at ward levels, so they feel listened to and valued.
- The trust should ensure staff follow trust policy and check emergency medicines regularly.

Wards for people with a learning disability or autism

- The trust should ensure vacant posts are recruited to so there is a full multidisciplinary team of professionals to support patients.
- The trust should ensure all repairs and redecoration are undertaken in a timely manner.

Community-based mental health services for adults of working age

- The trust should ensure all team bases are well maintained.
- The trust should ensure all staff are aware of the duty of candour.
- The trust should ensure clinical audits are undertaken in line trust policy and schedule.
- The trust should ensure all staff are aware of the trust policy in managing patients who did not attend appointments.
- The trust should review the patient's care pathways between teams and remove blocks in the transfer of patients to other teams, when clinically indicated.
- The trust should ensure staff document the rationale behind decision making within the patients' clinical record.
- The trust should review its governance systems and processes to ensure these are effective in assessing, monitoring and improving the quality of the services provided.

Mental health crisis services and health based places of safety

- The trust should ensure all staff have access to formal team meetings.
- The trust should ensure approved mental health practitioners are contained within the patient care record following assessment in the health-based places of safety.
- The trust should ensure they work with system partners to improve accessibility and patient experience in the health-based places of safety.

Specialist community mental health services for children and young people

- The trust should ensure carers of young people are offered a carers assessment.
- The trust should consider a designated waiting area for children under 14 years old at Thurlow House.
- The trust should ensure pregnancy testing kits are in date.

Our findings

Is this organisation well-led?

Leadership

Leaders had the skills, knowledge and experience to perform their roles. They understood the portfolio they managed, and the issues the trust faced. However, leaders did not respond quickly to address these. Leaders were not constantly visible in services and approachable for patients and staff. They supported staff to develop their skills and take on more senior roles.

The trust board had the right range of skills, knowledge, and experience to perform its role.

The trust board ran as a unitary board. This meant one tier of executive and non-executive directors made strategic decisions as a group sharing the responsibility and liability.

There had been changes to the board since the most recent comprehensive inspection, although the majority of directors had been in post two years. It consisted of six executive directors and eight non-executive directors. A new chief executive started in September 2021. The chair was leaving the post and a designate chair was in place at the time of the inspection to ensure a smooth transition.

The board lacked diversity to fully represent the population they served. The trust intended to improve the diversity amongst its senior leadership teams. The diversity of the executive board was 50% females, with no black and minority ethnic background members at the time of inspection. The makeup of the non-executive board consisted of 63% females and one black and ethnic minority member.

Non-executive directors had a wide range of skills and connections with national bodies. However, there was a lack of clinical skills experience. Agreement from the Governors to recruit a non-executive with clinical skills background was being sought as part of succession planning and to complement the team. Elected governors are either members of staff or members of the public and they are elected by the members of the trust. They hold office for three years represent a constituency.

In the sub board and board meetings we saw the non-executive board members provided challenge to the board. Since the most recent comprehensive inspection, the non-executive board members reported that the board was now more outward looking, prepared to have a voice in the system, and were more self-confident, cohesive, and collaborative. There was recognition of ongoing work for the board to do as they reported not being the “finished article”.

A board development programme continued during the COVID-19 pandemic relating to a range of strategic topics with external facilitators and Integrated Care System leaders (Integrated Care Systems are new partnerships between the organisations that meet health and care needs across an area, to coordinate services and to plan in a way that improves population health and reduces inequalities between diverse groups).

The leadership team sought ways to measure their progress. The NHS England and Improvement Intensive Support for Challenged Systems team (a team that works with challenged providers) were asked by the trust to provide an independent board level well-led review in March 2021, the overall self-assessment scores for the eight key lines of enquiry bordered between requires improvement and good. The report made 13 recommendations covering seven key lines of enquiry and resulted in the trust implementing an action plan. The trust directors also carried out well led reviews in the care groups.

Our findings

The trust had a senior leadership team in place, and we found most leaders had an appropriate range of skills, knowledge, and experience. At the most recent comprehensive inspection we recommended further improvement of leadership, culture, and safety of services. Staff explained that the culture of a command and control board had changed.

There were nine care groups consisting of similar services across the geographical area the trust served. Care groups had devolved management, with service directors, clinical directors, lead nurses and patient participation leads to form senior management structures. Care groups had not fully matured to be autonomous. Stakeholders reported that decision making at care group level was often delayed corporately. The trust was addressing the variability within care group leadership and performance measures. The number of care groups had risen from five to nine since the last inspection and there were concerns by executive directors and stakeholders that there were too many, the trust planned to review the care groups.

Medical, nursing, and allied health professional roles had access to professional leadership. We held focus groups with clinical directors, consultants, and modern matrons. They said there was now good clinical leadership and their voice was heard. They said the trust was heading in the right direction in developing an inclusive culture and acknowledged there was ongoing work to undertake to embed this.

We found in five out of the eight core services inspected leaders had the skills, knowledge, and experience to perform their roles. They had a good understanding of the services they managed and were visible in the service and approachable for patients and staff. However, in some services the leaders were new to the role and were getting to know the service or did not understand their service.

Three core services inspected reported that senior leaders were not visible. Not all services reported visibility of the board members and senior managers. Visibility of senior leaders was also a theme from our previous inspection.

Whilst positive changes in leadership and culture had occurred, we found safety of services remained a concern because leaders lacked oversight and did not respond at pace which had led to services such as acute admission services and child and adolescent mental health services not making improvements quickly enough.

We raised issues at the most recent comprehensive inspection about management of medicines and were concerned that improvement had not taken place. Pharmacy staff told us the senior leadership team within the pharmacy department were not always visible and approachable for staff. A weekly team meeting took place via virtual platforms since the COVID-19 pandemic began, however some staff told us these were not always useful. There was not enough resilience built into the current pharmacy workforce structure which did not meet the needs of the service.

The trust said it was actively addressing individual performance issues within the medicine management team and the board of directors had received a medicines management deep dive report in May 2021. The trust commissioned an external review of pharmacy services which was due to report back in January 2022. A quality improvement plan was in place for the medicine management workstream.

The trust had a lead for child and adolescent mental health, learning disability and autism. At board level this was the interim chief operating officer who led all services.

Our findings

We saw that trust board members focused on changing the culture of the organisation, with a strong focus on modelling values and positive behaviours. Feedback from stakeholders and focus groups was that the trust was becoming more open and transparent since the last inspection, acknowledging ongoing action needed to continue. However, we were concerned that initial feedback from our core service inspections and reasons behind ward closures were not accurately shared with the board or media.

Fit and proper person checks were in place. The trust had reviewed the fit and proper person policy. The trust undertook an annual fit and proper person test with all directors, as well as upon recruitment. In the six files reviewed, non-executives had standard disclosure and barring checks in place, however we expected enhanced disclosure and barring checks to be in place as they go to clinical areas. All directors had annual appraisals, regular supervision, and external coaching.

Newly appointed non-executive directors undertook a bespoke induction programme, following the national good governance guide to support directors understanding their role. Non-executive directors had regular supervision meetings with the chair. All directors attended the national executive director and non-executive courses to understand their duties.

When senior leadership vacancies arose the recruitment team reviewed ability and capability needs. The remuneration and culture committee oversaw the whole recruitment process for executive positions including reviewing capacity and capability within the remaining team and the main constructs of the executive role.

The trust reviewed leadership capacity and capability on an ongoing basis. An annual review of each director's portfolio and their relevant departments and directorates occurred to ensure there was enough capacity and capability to meet annual plans. Within corporate teams the relevant director reviewed capacity and capability relating to senior roles with the corporate team and discusses this with the wider executive team.

The review of senior operational and clinical roles in care groups involved the wider care group team as well as the human resource business partner and finance adviser. The chief operating officer oversaw this and ensured appropriate attention was given to the overall structure, capacity, and capability within the care group.

Succession planning and careers advice featured as part of annual appraisal. The trust had also used benchmarking and other external inputs to assess capacity and capability in services with business cases for change presented to the executive's agenda every week.

The trust leadership team had a comprehensive knowledge of current priorities and challenges, however pace of action to address them was slow allowing ongoing risk to continue and some services to deteriorate. Stakeholders expressed concerns that the pace of change and decision making was slow. The pandemic worsened an already strained urgent care pathway. We had carried out four focused inspections in the acute admission areas prior to this inspection and found that pace of improvement was slow. The child and adolescent mental health ward had declined significantly in a short space of time.

During the COVID-19 pandemic the trust had managed to maintain its services. However, the pandemic had slowed down the trusts intentions to use a range of demand and capacity models to assist in demand and capacity developments. The trust experienced unprecedented levels of referrals, such as 50% increases leading to long waiting lists in its community, crisis and young people's mental health teams. This was a concern raised at the most recent comprehensive inspection. Given the impact of the pandemic would continue to increase the need for mental health services, we saw no evidence of how the trust intended to respond to demands as part of its recovery plan.

Our findings

There was a programme of board visits to services and staff fed back that leaders were approachable during visits. From April 2021 to October 2021 non-executive directors carried out 29 virtual visits to services, these included quality and performance reviews and staff network visits.

Leadership development opportunities were available, including opportunities for staff below team manager level. The trust developed its leadership development strategy in May 2020. The trust provided a range of leadership development programmes for all staff grades and access to national programmes. The trust provided an induction programme for new managers and coaching programmes. Investment in coaching supported the development of executive leaders and senor leaders.

Succession planning was in place throughout the trust. Since the most recent comprehensive inspection the trust had commenced a programme of talent management and succession planning. The trust was developing a range of deputy roles as part of succession planning. Leaders gained experience through a shadow board.

Vision and strategy

The trust had a vision for what it wanted to achieve and a strategy to turn this into action, developed with all relevant stakeholders. The vision and strategy were focused on sustainability of services and aligned to local plans within the wider health economy. However not all staff understood and knew how to apply them and there was limited measurement of the effectiveness and outcomes of the strategy.

The trust had a clear vision and set of values with quality and sustainability as the top priorities.

The trust mission was “supporting people to live their hopes, dreams and aspirations”. The vision was “to be in the top quarter of mental health trusts for quality and safety by 2023”. There were five strategic outcomes each with individual set of objectives:

1. engage, develop, and inspire our staff
2. co-production, partnership, and recovery
3. align our governance and systems
4. building improvement skills
5. immediate projects

There was a strategy for achieving trust priorities and developing sustainable care. The trust strategy was written in 2019 and refreshed in September 2021. The strategy was available on the internet, and was codesigned by stakeholders, and underpinned by a series of sub-strategies at departmental and theme level. Leaders told us that some strategies refreshment depended upon the completion of the clinical strategy, to align with the refreshed overall strategy. The board had approved a plan to co-produce a clinical strategy in July 2021 and implement in 2022. At the time of inspection, the clinical strategy had not been produced.

The refreshed trust strategy from September 2021 identified further work to undertake on culture, staff wellbeing, staff recruitment and retention, managing COVID-19, co-production with patients and carers as priorities. It also had working with partners to improve access and quality of care as a priority. There was recognition of further work to do with communities to tackle the wider factors relating to health and health inequalities.

Our findings

The trust did not have a medicines optimisation strategy, and we found this impacted on the governance of medicines management.

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

Local providers and people who use services had been involved in developing the strategy and the refreshed strategy.

The trusts values were; "positively, respectfully, together". The majority of staff knew and understood the trust's vision, values and strategy and how achievement of these applied to the work of their team., However, in two core services inspected staff did not understand how these applied within their teams. Pharmacy staff were not clear of the trust's vision and values and how this applied to their work. We did not observe in trust board meeting clear links made to the values and strategy during discussions although there were links in the board papers.

The trust embedded its vision, values and strategy in corporate information received by staff. All sub strategies linked to the trust strategy. We observed trust values information across trust notice boards and in newsletters. Value based recruitment interviews occurred. The trust vision and values on the internet were not easily visible, this was raised at the most recent comprehensive inspection.

The trust aligned its strategy to local plans in the wider health and social care economy and had developed the strategy with external stakeholders. This included active involvement in sustainability and transformation plans. The trust system leadership included chairing the mental health transformation board, and the mental health inequalities board in Norfolk. Co-production work was occurring with statutory and voluntary stakeholders in Suffolk in conjunction with patients and carers.

The trust actively collaborated in the East of England provider collaborative and at provider and place level within the Integrated Care Systems. As part of system transformation, the trust had established primary care network mental health workers and community transformation.

The trust had planned services to consider the needs of the local population. Stakeholders said there were good relationships to address public health needs assessments. The trust participated in the joint strategic needs' assessment and data provision for this had improved. The trust was implementing all age mental health transformation programme. A joint public health approach to working with schools and children and young people's services was in place. There was engagement with the workplace smoke free policies.

The leadership team regularly monitored and reviewed progress on delivering the strategy and local plans. Monitoring of deliverables and outcomes relating to the strategies occurred through executive directors' meetings and the board and was reported in the trust quality account. We were concerned there were limited measurements as to how much of the strategy had been implemented and its outcomes, although the trust had produced a "yesterday, today and tomorrow" guide for its staff.

The trust had a physical health strategy for meeting the physical healthcare needs of patients but our findings from the core services identified the effectiveness of this strategy was unclear. The deputy chief nurse was responsible for managing the physical health team. Their function was largely training and to provide some expert advice on the wards. There were physical health link nurses on inpatient wards.

Our findings

The quality account report provided the physical health objectives and actions taken. However, this lacked detail regarding the impact. There was a quality improvement project on physical health within community teams. We found in some core services physical health assessment required improvement.

The physical healthcare team supported the annual health care checks for any patients on the case load who required one. Stakeholders told us they were concerned the trust consistently underperformed on routine physical health check on admission, and they had been advised by the trust that it was a data collection issue. However, no solutions to address this by the trust had been provided.

Culture

Not all staff felt respected, supported and valued. Staff were focused on the needs of patients receiving care. The service promoted equality and diversity in daily work and provided opportunities for career development. The service was promoting an open culture where patients, their families and staff could raise concerns. The trust handled concerns however did not effectively communicate that concerns had been addressed.

Not all staff felt respected, supported, and valued. Staff from four out of eight core services did not feel fully respected, supported, and valued by managers. Pharmacy staff did not feel respected or valued. We were told concerns were not dealt with adequately and staff felt unsupported.

Focus groups held with middle managers reported that the culture was changing in the right direction and reported being listened to and valued. Stakeholders acknowledged the work the trust was undertaking to embed an open inclusive culture. The staff survey engagement score had increased from the previous year.

The trust's strategy, vision and values underpinned a culture which was patient centred. The trust was making progress in developing a patient centred culture. Co-production was a thread running through many of its projects and initiatives. The patient participation leads played a central leadership role in the development of a patient centred culture. Stakeholders acknowledged the co-production efforts the trust had made.

Staff felt positive and proud about working for the trust and their team. All staff we spoke with were proud of the teamwork and team support that had occurred in the face of the pandemic to keep services open.

The trust recognised staff success by staff awards and through feedback. Annual staff excellence awards had occurred virtually during the pandemic. The chief executive recognised and rewarded staff through the weekly trust staff briefings and trust newsletters. An 'Excellent in Action' event in 2021 allowed individual care groups to recognise people for specific work.

As appreciation of the hard work of staff during the pandemic crisis, the trust offered an extra day leave and a £20 voucher for everyone. The trust held a wellbeing festival in the second week of November 2021.

The trust worked appropriately with trade unions. Industrial relations had greatly improved since the most recent comprehensive inspection. Partnership working had built a greater degree of trust that allowed for more productive conversations around challenging subjects and a greater willingness to address issues. There was good attendance by executive directors at the staff meetings. There was partnership working on reviewing the grievance processes.

Managers addressed poor staff performance where needed. We reviewed the trust disciplinary spreadsheet and five cases. The spreadsheet gives overview of case progress and notes of the huddles that take place to review cases,

Our findings

However, there were no notes made in the learning review column of lessons learnt. There were 57 disciplinary cases from November 2020 to October 2021. The number of days taken to investigate ranged from 66 to 221 days against a trust target of 90 days. We found letters written were compassionate and contained information about staff support and were written using an appropriate tone. A recently appointed independent investigation officer role was to help manage the investigations efficiently.

However, we were concerned about one case of management of performance and adherence to trust policy, in which the quality and frequency of supervision provided was not clearly documented and had not resulted in changes in behaviour. We raised this with the trust to take action.

The trust had developed with the trade unions “People Before Process” policies resulting in an improved disciplinary policy. The policy adopted a just and learning approach based on the principles of restorative justice. This resulted in fewer cases progressing to a formal disciplinary process, less staff suspended, and a reduction in the inequality of black and ethnic minority staff being more likely to move into a formal process.

Staff we spoke with reported the trust did address poor staff performance and gave examples.

There were 65 referrals to the Nursing and Midwifery Council between November 2018 to November 2021. Of these 30 required no further investigation.

The trust had appointed a Freedom to Speak up Guardian and provided them with sufficient resources and support to help staff to raise concerns. Staff knew how to use the whistleblowing process and about the role of the Freedom to Speak up Guardian.

The Freedom to Speak up Guardian operated independently with direct access to the chief executive and non-executive for serious concerns. Senior leaders were aware of and followed the National Guardian Office and NHS England guidance. The Speak up Guardian presented reports to the board monthly.

There was a systematic process of measuring culture within the organisation with the Freedom to Speak up Guardian as an integral part within the cultural steering group. A range of the metrics were reviewed. Since April 2021, the Speak up Guardian had 92 cases which were down from 170 from 2019 and 107 in 2020. From December 2019 to March 2020 the trust appeared to be reporting fewer cases to the National Guardian Office and was now similar to the national median and to peers.

Nine culture change agents had been trained in the trust, with the aim to have one in every team to support staff speaking up. Staff received speak up training.

Staff we spoke with reported a greater encouragement to speak up and a notable change in culture since the most recent inspection. There were changes in clinical leader behaviour, although acknowledgement of issues remaining in some care groups which were actively managed.

The handling of concerns raised by staff always met with best practice. However not all staff felt able to raise concerns without fear of retribution. The Freedom to Speak up Guardian had not received reports of any detriment from staff following speaking up. However, said staff remained fearful of speaking up. This had been discussed with the leadership group who could state the actions they were undertaking, however there was acknowledgement that communication of this needed to improve. Some stakeholders reported they were aware that some staff were afraid to speak up.

Our findings

The trust applied duty of candour appropriately. During 2020 and 2021 the trust applied the duty of candour on 181 occasions. Staff gave examples of situations in which this occurred. The trust took appropriate learning and action as a result of concerns raised. However, the trust did not communicate effectively that action has been taken to staff.

Not all staff had the opportunity to discuss their learning and career development needs at appraisal. This included agency and locum staff and volunteers. We found appraisal rates were low in two core services inspected which was a continued concern from the most recent inspection.

Staff had access to support for their own physical and emotional health needs through occupational health. The trust had invested in a range of staff wellbeing initiatives and provided external employee assistance support.

Sickness and absence figures were in line with national figures. The trust employed 4,227 staff. The trust's annualised sickness absence rate was 5.3. The monthly sickness absence at the end of September 2021 had deteriorated to 5.5%, the highest rate in the 13-month review period above the trust target of 4.9%. The top reason for staff absence remained as: stress, anxiety, depression and other mental health conditions.

The trust annualised vacancy rate was 11.8%. The overall vacancy rate in November 2021 had improved to 8.3% and was below the 8.7% trust target.

The trust annualised medical vacancies rate was 10.7%. In November 2021, it was 8.1%. This equated to 21 medical vacancies. Offers had been made to several doctors and further interviews were planned.

The trust annualised registered nurse vacancy rate was 17.2%. In November 2021, the rate was 16.5%. which represents 234 registered nurse vacancies across the trust. As part of the trust recruitment plan, recruitment of nine overseas nurses and six asylum seeker nurses were recruited.

The trust annualised staff turnover was 11.8%, with the highest turnover being with allied health professionals at 16.8%. Those staff leaving with less than two years of service was 41.2%, significantly above trust target. Action plans were in place in an attempt to improve staff retention.

The average day time shift fill rates for registered nurses was 83% and the night-time fill rate was 84%.

The average shift fill rates for registered allied health professionals was 43%, all were below the trust target of 90%. The trust used bank and agency staff and locum medical staff to fill shifts.

Annual staffing reviews were led by the chief nurse. The pandemic led to further staffing reviews resulting in the minimum standard of one registered nurse on a ward. Modern matrons, lead nurses, ward managers and clinical specialists undertook two clinical shifts per week. Whilst this provided good visible clinical leadership it also impacted on their core roles leading to concerns raised within the core services. All clinical services conducted daily huddles to review staffing levels. A trust wide 'on call' tactical huddle occurred chaired by a director in which each clinical care group provide a situation report including staffing issues.

Four of the core services inspected raised issues related to short staffing and its impact. Staffing appeared on the risk register with mitigating actions. Mitigating actions were affected by national clinical staff shortages. The trust utilised national recruitment agencies and held national recruitment drives. It offered incentives such as "hello handshakes", three months paid accommodation, referring a friend, and relocation allowances in order to recruit staff.

Our findings

Staff in seven out of eight core services inspected felt equality and diversity was promoted in their day to day work and when looking at opportunities for career progression. Workforce race equality standards data is shared with the black and ethnic minority network and the network is actively involved in the implementation of action plans. The trust refreshed its workforce equality standard data, to address data quality issues and found progress in fairness in its recruitment process. The data on the likelihood of black, Asian and minority ethnic staff compared to white staff being appointed from shortlisting across all posts had improved.

Talent management for band 3 staff was in place. The director of nursing provided mentorship to some individuals and there were pathways developing for band 8 for black and ethnic minority staff. Some individuals received external mentorship. The trust ran the Springboard Women's Development training course, designed for women to enhance their skills and abilities.

Staff networks were in place promoting the diversity of staff. These included: black and ethnic minority network, disability network, LGBT+ network, spirituality network, women's network and an autism network. They had been refreshed and were at varying stages of maturity. The black and ethnic minority network and women's network had carried out reverse mentoring at board level. We received positive feedback on the impact the networks on promoting diversity. The focus group said middle management level required further work to promote understanding.

The network chairs meet with the chief executive each quarter who held them to account for the delivery of change. The network leads described the culture change and compassionate leadership as positive and supportive.

Teams had positive relationships, worked well together, and addressed any conflict appropriately.

Governance

Leaders operated governance processes throughout the service and with partner organisations. However, our findings from our core service inspections identified governance processes in place failed to identify or address all risks leading to significant patient safety concerns. Staff at all levels were clear about their roles and accountabilities and had regular opportunities to meet, discuss and learn from the performance of the service.

The trust had structures, systems, and processes in place to support the delivery of its strategy including sub-board committees, divisional committees, team meetings and senior managers. Leaders regularly reviewed these structures. We were concerned that the operation of the governance structures did not generate prompt and effective action.

Our findings from six out of the eight core services inspected showed that governance processes did not always operate effectively at team level.

The executive board received medicines optimisation reports via the quality committee. The medicines safety committee were effective in monitoring incidents and shared learning with staff. However, the medicine management policy and the medicines formulary had not been reviewed or updated.

Papers for board meetings and other committees were of a reasonable standard and contained appropriate information. We reviewed board papers and observed a trust board meeting, finance committee and people's participation committee. All meetings were virtual due to the COVID-19 pandemic but were well attended. A staff story was held prior to the public board meeting commencing and it was not clear why this occurred as members of the public

could join, we were told this was due to change from January 2022 and incorporated into the main public board meeting. Board meetings took place every other month and started with a patient story. Private board meetings occurred on a different day to the public meeting. All papers presented linked to the strategy, board assurance framework, risk, and compliance.

The board evaluated the effectiveness of each public board meeting at the board development sessions, after the public board meeting. The chair reviewed subcommittee effectiveness with the non-executive directors. Evaluation of executive meetings occurred, and changes made. All committees and meetings had an annual self-assessment. These led improvement, shaped the meetings and updated the workplan for each.

The board evaluated the effectiveness of each public board meeting at the board development sessions, after the public board meeting. The chair reviewed subcommittee effectiveness with the non-executive directors. Evaluation of executive meetings occurred, and changes made. All committees and meetings had an annual self-assessment. These led improvement, shaped the meetings and updated the workplan for each.

Non-executive and executive directors were clear about their areas of responsibility. However, it was not clear if enough capacity existed to meet the requirements of two integrated care systems and the rapid change management required in the improvement of services.

Appropriate governance arrangements were in place in relation to Mental Health Act administration and compliance. Staff reported improvements in governance since the most recent inspection which had resulted in more robust monitoring and a clear quality improvement agenda. The Mental Health Act Committee cross referenced information with the quality subcommittee of the board. An annual Mental Health Act report was provided to the board to discuss and review.

We observed a Mental Health Act subcommittee of the board meeting taking place. It was chaired by a non-executive director and led by the chief medical officer. A patient participation lead and advocacy service were part of the committee. Within the meeting a care group presented its governance arrangements in relation to the administration and compliance of the Mental Health Act, audits, and performance charts relating to various aspects of the Mental Health Act. There was good challenge by the non-executive directors. Multi-agency working was discussed. Discussion relating to issues about data quality occurred and how this could be improved.

A quality improvement project had commenced to improve compliance with the Mental Health Act. Each ward had a Mental Health Act compliance officer visiting clinical teams to review and audit documents, give advice and prompts for key dates requiring action.

A monthly Mental Health Act Law meeting took place which looked at the compliance of core data metrics and looked at health inequalities. Any breach of the Mental Health Act Code of Practice or processes were reportable via the electronic incident reporting system, and the trends, themes and lessons learnt were reviewed by the committee. Health inequalities were being monitored, for example the higher ratio of community treatment orders amongst black male patients. Care groups reviewed equality reports and implemented improvements in their own areas.

The hospital associate managers reported to the non-executives. During the COVID-19 pandemic the hospital associate managers carried out hospital managers hearings remotely. The hospital associate mangers were represented on the Mental Health Act committee. They received training for their role and were supported well by the Mental Health Act compliance team. They reported the culture had changed in the trust and was more open and transparent. Hospital managers held monthly meetings. There were attempts being made to have a diverse panel of hospital managers.

Our findings

The trust provided advocacy (this is a service in which a mental health advocate provides a voice for patients). On the whole, staff welcomed and understood the role of advocacy. Whilst some staff referred patients to advocacy, there was a concern that some acute admission wards and psychiatric intensive care units did not make many referrals. Advocates helped resolve many issues raised by patients at ward level.

The Mental Health Act lead contributed to the staff Mental Health Act training in conjunction with patient participation leads. The lead and Mental Health Act compliance team received external training to keep up to date with the Mental Health Act and law cases.

The trust had an audit schedule that was set by the board sub-committee board. Audits had taken place. There were several key areas where compliance required improvement and a plan was in place. The effectiveness of the audit schedule was unclear given the slow improvement we identified during this and previous inspections.

A service level agreement was in place with acute trusts to provide mental health training and advice. A section 75 agreement was not in place with the Norfolk local authority, and the one in Suffolk was due to end in March 2022. The trust was not anticipating it would affect the availably of approved mental health professionals. A section 75 agreement is a joint agreement between parties that allows pooling of council and NHS budgets to deliver adult mental health services.

There had been a successful restraint reduction programme. The trust was part of the advancing mental health equalities collaborative focused on reaching out to poorly served communities to ensure excessive restrictive practices did not occur under the use of the Mental Health Act. The restrictive practice reduction rate was initially 25%, and by taking a human rights approach there had been further reductions of 50%.

A clear framework set out the structure of ward or service team, division, and senior trust meetings. Managers used meetings to share essential information such as learning from incidents and complaints and to act as needed. We found that not all teams had held team meetings and there was a lack of evidence of sharing learning from incidents and complaints.

Staff at all levels of the organisation understood their roles and responsibilities and what to escalate to a more senior person. The care group leadership teams received training to understand their roles and responsibilities during the formation of the care groups, followed by leadership training and coaching.

The trust was working with third party providers to promote good patient care. The trust had worked to establish good links with the voluntary sector, who supported trust services in a variety of ways, for example in the young peoples' emotional wellbeing hub. There was evidence of liaising with local mental health charities. Voluntary stakeholders reported they had good relationships with operational staff and found operational staff to be caring and compassionate.

The trust worked with a voluntary sector agency, to deliver sport and gardening projects to the Woodlands unit with the aim of providing patient activities in the ward and community. The evaluation of projects occurred in conjunction with the trust's psychologists and benefited patients.

Third party providers reported the improvement in communication from the trust was required for example through invitations to care programme meetings and discharges. They raised concerns about the level of capacity the trust had to work with people with complex needs who are reluctant to engage with services. They also raised concerns about the inconsistency of approach between teams in managing people with a personality disorder.

Our findings

A partnership arrangement was in place for the provision of psychiatric liaison services with appropriate governance arrangements. The psychiatric liaison services provided to acute trusts were part of the trust block contracts arrangements. The governance reporting was through the care group governance processes, and further reviewed by executives at the quality performance reviews and through sub-committees such as finance, business investment committee and quality assurance committee and thence to board.

Stakeholders reported that since the most recent inspection relationships between the trust and acute trusts had improved and led to much stronger working relationships. Examples of jointly funded trust service manager and modern matron posts enabled more consistent information and data sharing between the trusts and aided understanding of what the needs of an acute trust were.

The trust provided a mental health liaison team to cover 24 hours a day within the Norfolk acute trusts. The team supported patients in the emergency department and inpatient areas but did not have the capacity to provide support to outpatient areas.

Due to increased severity of mental illness, needs and demand across the acute trusts for mental health support and advice, the psychiatric liaison team were not always able to respond within specified timeframes and meet targets. However, they worked collaboratively with the acute trust to ensure those patients most in need were triaged as priority. There remained gaps in medical provision within the psychiatric liaison team and led to delays in advice being passed to acute hospital clinicians regarding medicines. There were concerns that senior staff within the Norfolk and Suffolk NHS Foundation Trust did not respond to the acute trusts in a timely manner and this led to difficulties in progressing some actions.

Stakeholders told us their main concerns were the lack of options and treatment pathways for the mental health patients requiring inpatient beds. They said waiting lists were extremely long for community services which had an impact on the number of patients with mental health needs falling into crisis and therefore needing to access emergency mental health within acute trusts. The waiting lists were particularly long for under 18's or older persons beds.

Acute trusts and the mental health trust had set up regular multi-disciplinary team meetings to jointly discuss complex presentations for acute trust inpatients and for those people in the community experiencing crisis and who may need an admission. This led to a decrease in physical interventions, enabling staff to have an opportunity to talk about and plan care as well as discuss pathways and risks. The trust had improved their attendance at the complex care and mental health board meetings in the acute trust.

The community child and adolescent mental health teams provided in-reach to support the acute trust patients, including eating disorders, during any periods of admission. The trust had started a daily youth huddle with acute trusts to discuss overnight presentations and fast track referrals as appropriate depending on risk.

A governance framework was in place to meet people's physical health care needs. Whilst the governance framework was satisfactory, we found during our inspection that improvements were required.

The trust had an infection control and prevention assurance framework which outlined the responsibilities, service delivery arrangements, infection prevention control structure and reporting lines.

Our findings

There was an infection control committee which monitored reports and audits from care groups monthly. The infection control committee reports went to the quality and safety committee which then reported to the board on their performance and improvement. The board received an infection prevention and control annual report.

The trust had an infection control strategy on a page. There was a sepsis policy and no cases of sepsis had occurred in the last year. Level 2 infection prevention and control training was at 77% which was below the trust target of 90%. All clinical teams had a link infection prevention control staff member to disseminate guidance and provide advice.

The trust had a system in place for staff to undertake lateral flow tests. However, there were difficulties in producing monitoring reports. The trust had learnt lessons from the pandemic management and changed practice accordingly and staff gave examples.

As well as monitoring COVID-19 infection rates, the team carried out catheter audits, hand hygiene audits and compliance with infection policies. They monitored methicillin-resistant staphylococcus aureus (MRSA), clostridium difficile, *tuberculosis* rates which were very low. The team worked with estates to plan capital developments where there were no en-suite bathrooms to ensure adequate numbers of washbasins for patients.

There were concerns about the capacity within the infection control team, as for three months of the year there had been a focus on vaccinations, at the expense of other infection prevention and control work. COVID-19 vaccination levels for staff were 93% in September 2021. At the time of our inspection, 69% of staff had received the seasonal flu vaccine.

Management of risk, issues, and performance

Leaders and teams used systems to manage performance. They identified and escalated relevant risks and issues and identified actions to reduce their impact. However, performance in a number of areas remained low and the trust failed to identify or mitigate a number of risks identified during our core service inspections. The trust had plans to cope with unexpected events. Staff contributed to decision-making to help avoid financial pressures compromising the quality of care.

The trust had systems in place to identify learning from incidents, complaints and safeguarding alerts and make improvements. The governance team regularly reviewed the systems.

The patient safety department included teams relating to people's experience, complaints, safeguarding, incidents, improvement, assurance, suicide prevention and a legal team. The department also worked closely with the Freedom to Speak up Guardian. This enabled sharing and triangulation of safety intelligence and provided opportunity for escalation and supportive interventions.

The trust had a patient safety strategy in place, which aligned to the patient safety specialist priorities outlined within the NHS England strategy.

The trust benchmarked incident reporting with other trusts, the number of patient safety incidents reported was in the top 25% with a high rate of no or low harm incidents, this profile was consistent with a safety culture. Over the previous three years, there had been a 60% year on year reduction of serious incidents linked to care and treatment.

The trust successfully piloted a new national Patient Safety Incident Response Framework introduced within the NHS. Lessons were being shared with the national group.

Our findings

From January 2021, the Suffolk based care groups moved to the new framework and a new style of review of incidents was implemented through a panel which included: people participation lead, senior clinical staff and members of the patient safety team.

The patient safety incident review group provided an arena for presentation of recent incidents and learning, plus oversight and analysis of the trust mortality data.

The trust had recently attained accreditation with the Royal College of Psychiatry in respect of the quality and inclusivity of patient safety incident reviews.

During April 2019 to March 2020 the trust received 598 complaints. During April 2020 to March 2021 it received 476 complaints, a reduction of 24.1% from the previous year. The trust told us the impact of the COVID-19 pandemic created a backlog in responding to complaints. Of the complaints received in 2021, 195 complaints were ongoing (40.9%), 224 complaint responses had been issued (47%), of these 18.7% were upheld, 41.5% were partially upheld and 39.7% were not upheld. 57 (11.9%) were not completed for reasons such as authorisation forms not being signed by the patient or complaints being retracted.

Themes of complaints remained consistent, such as: disagreement about care provided, staff attitude, waiting time for treatment or services, discharge with insufficient care package, failure to follow through on promised actions. A thematic review to refine understanding of themes was being undertaken.

Changes in practice as a result of learning from complaints had occurred, for example: photographic procedures were introduced to record property and valuables on admission, enhanced protocols for discharges scheduled to occur at weekend, developed staff competencies and procedures for Section 136 admission and a revised understanding of community treatment order recall procedures for staff.

We reviewed five complaints and found the trust responded to complaints in a sensitive and responsive way which was compliant with national guidance. Where there were delays these were acknowledged. Responses to complaints were open and detailed. The trust admitted liability and offered recompense when things had not been resolved.

The Parliamentary and Health Service Ombudsman had opened investigations into three complaints between April 2019 and March 2020, compared to six in 2018/2019 and 11 in 2017/2018. The Ombudsman concluded two complaint investigations. One of these was partially upheld, the other was not upheld. Learning from complaints was shared via the care groups. The trust piloted models of learning to develop a standardised approach to disseminating learning in the trust.

There were 1,220 compliments in 2020/2021, an 18% rise from the previous year. These related predominantly to access to service, attitudes of staff, communication and information, privacy and dignity. The trust had planned, but not completed at the time of the inspection, a ‘deep dive’ to understand what had led to the increase and what had improved to enable the sharing of improvement activities to other areas of the trust.

We found the safeguarding team were skilled at meeting their statutory requirements in terms of their priorities. Their reporting and accountability systems were comprehensive and delivered in a prompt way. Routine meetings with the clinical commissioning groups and other partners occurred. There was good involvement in the whole system safeguarding arenas and forums.

Our findings

The team leaders were visible and team structures meant they addressed issues as a team and leaders were engaged with current issues. Operational teams had safeguarding champions and clinical leads.

Independent safeguarding adult reviews occurred via the multi-agency Safeguarding Adult Board, and the trust responded to issues identified and shared and embedded the learning. The trust communicated to the teams via a comprehensive newsletter and dissemination of seven-minute briefs. The trust supported change as a consequence of safeguarding concerns.

However, the safeguarding team's capacity was stretched. Safeguarding was high profile in the trust and the number of referrals to the advice line reflected the need for safeguarding support and relevant clinical risk support.

Clinical Commissioning Groups reported good relationships with the trust, which was fully engaged within the system networks. The reporting framework to the clinical commission groups was satisfactory, however could be further improved.

An enquiry is undertaken by a local authority, under Section 42 of the Care Act 2014, in response to indications of abuse or neglect in relation to an adult with care and support needs who is at risk and is unable to protect themselves because of those needs. Stakeholders expressed concerns about trust capacity to complete section 42 enquiries in partnership with police and local authority in a prompt way, with a lack of resource to attend multi agency risk assessment conferences for risk and safety planning. The capacity affected the quality of the reviews, the safety action planning and implementing action into learning. There were 42 cases outstanding at the time of the inspection.

The trust had recently implemented an electronic prescribing and medicines administration (EPMA) system. There were limited quality performance indicators reported to the trust board, and therefore they had limited oversight of delivery of pharmacy services.

Medicines related issues raised in the previous inspection had not been addressed or placed on the trust risk register. Pharmacy did not have oversight of quality improvement audits and there was no regular programme of clinical and internal audit to monitor medicines optimisation.

The trust had trained over 100 non-medical prescribers which included pharmacist and nursing staff. The board had also agreed to invest in specialist pharmacists within the primary care networks. We found medicines management issues in six out of eight core services inspected and raised concerns at the most recent inspection.

Management committees and the board reviewed performance reports. Leaders regularly reviewed the processes to manage current and future performance, however performance targets were not met. For example, we found mandatory training figures had not met the trust targets in six out of the eight core services inspected. Stakeholders expressed concern that mandatory training numbers were low, which could affect delivering safe and responsive care. They had challenged training numbers for previous 18 months and there was clear correlation between very poor training compliance and increased restrictive practice.

Clinical supervision concerns were raised in two of the core services inspected and at the most recent inspection. The trust had a digital app for recording supervision, however staff and directors expressed concerns about its accuracy. The COVID-19 pandemic had impacted on the frequency of supervision and the trust told us it was in the process of reintroducing formal supervision.

Our findings

The trust told us the COVID-19 pandemic had impacted upon mandatory training, especially face to face training. Subsequently the trust set recovery trajectories for all mandatory and statutory training, offering staff protected time to complete online training and increasing face to face sessions. It was too soon to evaluate the impact of this, and we found significant shortfalls existed with mandatory training at the time of our inspection.

The trust had made progress in managing its out of area placements, these were mostly made appropriately.

Leaders were satisfied that clinical and internal audits were sufficient to provide assurance. Teams acted on results where needed.

Staff had access to the risk register either at a team or division level and were able to effectively escalate concerns as needed. However, robust arrangements were not in place for identifying, recording, and managing risks, issues, and mitigating actions. Recorded risks were not consistently aligned with what staff said were on their 'worry list'. Medicines related issues raised in the previous inspection had not been addressed or placed on the trust risk register. Pharmacy did not have oversight of quality improvement audits and there was no regular programme of clinical and internal audit to monitor medicines optimisation.

The trust board had sight of the most significant risks and however mitigating actions were either not always clear or slow to complete. The trust had a risk management strategy, framework, and policies in place. We saw an extended corporate risk register, which had controls, actions and updates cited. The register held operational risks linked to the delivery of operational objectives.

There was a board assurance framework which was a record of the strategic risks, linked to the delivery of the trust strategic objectives, with assurances on the effectiveness of controls to mitigate these risks. It was informed by high rated operational risks from the corporate risk register. Board meetings, board sub committees and the audit and risk committee were responsible for monitoring the trust risk management processes and reviewing the board assurance framework.

Internal auditors carried out reviews of the effectiveness of risk management processes.

As part of system working, the trust was working towards ensuring its governance would interface with integrated care systems and collaborative governance structures to ensure a seamless approach to decision making, governance and assurance. For example, in key transformational work. The board assurance framework and corporate risk register captured system links that impacted on the trust.

There were plans in place for emergencies and other unexpected or expected events. For example; adverse weather, a flu outbreak, or a disruption to business continuity and to meet the Emergency Preparedness, Resilience and Response Civil Contingencies Act 2004. The risks and mitigation were part of the trust resilience plan and care groups and corporate services identified risks, controls and mitigations as part of their business continuity plans. There was a resilience officer in post and the trust undertook exercises to test plans.

The trust buildings did not have cladding issues. Fire drills and exercises were carried out. Containment of approximately 30 fires in the room of origin in the previous year had occurred.

Our findings

Where cost improvements were taking place there were arrangements to consider the impact on patient care. Managers monitored changes for potential impact on quality and sustainability. The chief nurse and chief medical officer signed off projects following the review of quality impact assessments. Where cost improvements were taking place, they did not compromise patient care.

Information management

The service collected data and analysed it; however, it was not consistently reliable. Staff could find the data they needed, however did not always have the understanding to utilise it to understand performance, make decisions and improvements. The information systems were integrated and secure. Data or notifications were consistently submitted to external organisations as required.

The trust has a digital strategy 2020-2024 and a non-executive lead. The digital strategy linked to the trust strategy and awaited refreshment following publication of the clinical strategy. The board discussed the wider systems digital strategy with local NHS providers, and ensured its digital strategy reflected this.

The Service Desk Institute audit results showed a score of 3.4 overall which meant the trust was a three star accredited 'customer led' service delivery operation. The lowest results were for management information and performance information although structural improvements were being made in all categories.

The board did not receive holistic information on all service quality and sustainability. The trust had recently implemented an electronic prescribing and medicines administration system. There were limited quality performance indicators reported to the trust board, and therefore they had limited oversight of delivery of pharmacy services.

Leaders used meeting agendas to address quality and sustainability at all levels across the trust. However, there were concerns about the reliability of data, and effectiveness of response where there were concerns. Not all staff said they had access to all necessary information and were encouraged to challenge its reliability, for example in relation to mandatory training and waiting lists.

The trust used key performance indicators and other metrics. This data fed into a board assurance framework. Care groups adhered to the performance metrics detailed in the trust performance and accountability framework and quality, workforce, finance, and performance dashboards. Local governance meetings discussed matrices, and this formed the basis of the assurance framework scrutinised at the monthly quality performance meetings for all services and informed the performance reports to the board.

Not all Team managers had access to a range of information to support them with their management role. This included information on the performance of the service, staffing and patient care.

We found in four out of eight core services inspected, staff collected analysed data about outcomes and performance and engaged actively in local and national quality improvement activities. However, others reported slow access, or lack of time due to service pressures in utilising the information effectively.

The board and senior staff expressed confidence in the quality of the data and welcomed challenge. The trust was working to strengthen and improve data reliability and use PowerBI (a performance dashboard) to provide improved data analysis from the electronic patient record data systems. The trust was working to improve managers

understanding of using data to inform service improvement and safety, it was too soon to evaluate the effectiveness of this. The trust also told us this would improve the ability of staff who are patient facing to easily access and record data. For example, an application to carry out and review ligature audit, perfect ward, estate's assurance tools as well as to improve access to incident dashboards, mortality data and themes from incidents.

Some stakeholders did not always feel assured that the trust had robust data around waiting lists, response times for crisis services, psychiatric liaison, access and assessment and underperforming services. They had been told by the trust this was due to data recording issues.

Systems were in place to collect data from wards and service teams and this was not over burdensome for front line staff. However, it was not consistently used by teams.

IT systems and telephones were working well, and they helped to improve the quality of care. During the COVID-19 pandemic the trust maximised the use of Microsoft Teams and skype with staff and patients. Patients choices included 'attend anywhere' – video consultations offer. Evaluations occurred showing mixed results.

The chief information officer is a medical consultant providing good support to roll out clinical digital solutions. The trust had approved a chief nursing information officer and a patient participation lead to support clinical electronic solutions.

Electronic prescribing had been introduced in the inpatient areas. There were plans to roll out in the community teams. An electronic patient record system was in place. Improving access to psychological therapies (IAPTus) electronic system was in use in the wellbeing hub.

Stakeholders worked with the trust to improve the first response service, a crisis telephone line, due to the performance of responding, long waits for calls to be answered and abandoned calls. We were told there were challenges, partly due to the pandemic. Patients did know who to call. Following user feedback, the music was changed whilst on hold.

Staff had access to the IT equipment and systems needed to do their work. Community staff had access to laptops and mobile phones. The integrated care system had rolled out "govroam" so that trust staff could go to partner organisations and log on from any space.

Leaders submitted notifications to external bodies as required. Notifications to the CQC were received in a timely way.

The trust had completed the Information Governance Toolkit assessment. An independent team had audited it and the trust acted where needed.

Information governance systems were in place including confidentiality of patient records. Staff training on information governance occurred. No data breaches required reporting to the Information Commission Office in the previous 12 months. The trust used the data security protection toolkit and an annual cyber security audit was undertaken.

The trust learned from data security breaches from national information as it had not had any data security breaches.

Engagement

Our findings

Leaders and staff actively and openly engaged with patients, staff, equality groups, the public and local organisations to plan and manage services. They collaborated with partner organisations to help improve services for patients.

The trust had a structured and systematic approach to engaging with people who use services, those close to them and their representatives. Patients and partners helped develop "Our People Participation Strategy" 2021-2024 it covered every aspect of patient involvement, experience, co-production, and engagement. Learning and implementation of the model took place from its buddy trust.

Patient participant leads helped improve communication between the trust and the people who used services, carers, and their families. They were part of each care group leadership team and on each of the trust's governance committees. Patients and carers were represented on many groups such as restrictive practice, planning new hospital wards and on staff interview panels.

We observed a trust board meeting and Mental Health Act committee which always includes a patient story with board discussion of lessons learnt and areas to develop.

The trust had engaged with young people and their carers to involve them in the trust participation strategy. This had led to changes in the letter templates, involvement in chief executive recruitment and quality improvement projects. A young persons' recovery college had been co-designed. There was regular feedback via the "Monday" young peoples' social group.

Captain Tom funding obtained was used to provide activity packs during the COVID-19 pandemic as well as a community mental health library, gardening equipment and artwork for clinical areas.

Stakeholders confirmed the trust engaged with people with lived experience in their safeguarding forums. They listened to their experiences and concerns and engaged them in working with the service to improve. For example, "Wednesdays Child" are now commissioned to work with their patients with eating disorders, a service run by a previous patient.

Stakeholders confirmed the trust had actively encouraged involvement and greater dialogue with clinical staff and experts by experience. However, observed a lack of equal footing where operational voice overpowered the clinical leadership voice leading to delay or clinical leadership unable to make decisions.

The wards, service teams and divisions had access to feedback from patients, carers and staff and were using this to make improvements.

Communication systems such as the intranet and newsletters were in place to ensure staff, patients and carers had access to up-to-date information about the work of the trust and the services they used. "Safety together" newsletters brought together learning from patient safety, medicines management, restrictive interventions, suicide prevention, resuscitation, safeguarding, quality, and risk management.

From April 2021, the trust held 40 Culture Road Shows attended by 1,432 staff. The chief executive held weekly "Hear to Listen" sessions with an average live attendance of 254 since November 2020.

The Medical Engagement Survey dated May 2020 showed respondents felt that levels of engagement have improved in all areas since 2018.

Our findings

Patients, carers, and staff had opportunities to give feedback on the service they received in a manner that reflected their individual needs. The Family and Friends Test was re-branded Your Service Your Say during 2020. The 2021 survey results evidenced 55% respondents rated their experience of services as very good (580), and 11% of respondents rated them as very poor (121).

During June to August 2020, the trust conducted a COVID-19 care snapshot survey with 256 patients. This showed that 68% felt their recent mental health care experience was good, 43% wanted the 24 hour psychological helpline to continue, 56% wanted the telephone support to continue and 30% wanted video support to continue. Respondents identified areas for improvement such as; consistency in care and setting, talking to a psychiatrist, increased access with flexible responsive appointments.

The Mental Health Community Service Users Survey 2020 received responses from 311 people. Due to the pandemic the results of the survey should be cautiously compared with previous services. Scores were worse than the national average for patients being seen by staff who knew their previous history and for those told who was in charge of organising their care. The trust had an action plan in place that included supporting patients in their medicine management, establishing quality and safety reviews and giving information on who and how to contact outside of office hours.

The NHS Staff Survey undertaken in October 2020 received 2,011 responses (46%), 2.4% lower than the previous year's response rate and 3.3% points below the national average (49.3%). It showed the staff engagement score had improved from 6.5 (out of 10) to 6.7 (out of 10). Three further key themes showed statistically significant improvement: health & wellbeing, support from immediate managers and morale. A further three key themes showed an improved score compared to 2019, although not statistically significant. These themes were bullying and harassment, safety culture and team working.

Three key themes remained unchanged from the previous survey which were equality, diversity and inclusion, quality of care, safe environment and violence. We reviewed a staff survey action plan in place dated April 2020 which showed actions were mainly green and amber rated. The culture steering group oversaw the delivery of the culture change programme, reporting to the remuneration committee. The trust undertook a detailed diagnostic assessment to identify further action.

The trust sought to actively engage with people and staff in a range of equality groups. The trust equality, diversity, and inclusion strategy 2019-2021 had four main objectives, bringing together recommendations in the NHS People Plan Action Plan 2020/2021, Workforce Race Equality Standard and Workforce Disability Equality Standard and Gender Pay Gap.

The equality and diversity group meeting brough together seven employee networks groups; Ability, Black and Ethnic Minority, Faith Spirituality and Belief, Out and Proud (LGBT+), Women, Carers and Lived Experience. Service directors from the care groups and specialist services leadership also met with the network groups to create a shared vision of equality, propose action plans and report results.

The trust offered public governors in foundation trusts, training on appointment. They were actively involved in the operation of the trust. The trust secretary organised the training for governors. Governors told us the culture had changed to being more open and transparent and made it easy for them to challenge and hold non-executives to account.

Our findings

Governors said there now were more and better opportunities to question the non-executive directors and exchange ideas, especially through the joint board of director and council of governor meetings, county forums and significant business committee. Non-executive directors regularly attended the council of governor meetings and development sessions. Due to the COVID-19 pandemic all meetings had been held virtually. We observed a council of governors meeting taking place.

Governors found it easy to talk to staff and held staff governor drop in sessions. They did engagement events with patients and carers who set the priorities for the governors for the forthcoming year. Some governors attended weekly drop-in sessions for carers. Monthly visits to service areas occurred pre-pandemic. Prior to the COVID-19 pandemic, member conferences were held. Governors had links with Healthwatch to obtain information about patient experiences.

Governors told us they found information from attendance at board sub committees more useful than the board meetings. The board papers were long and not delivered in an accessible format. Governors submitted questions in advance of the board meeting and executive directors responded.

The trust had a structured and systematic approach to staff engagement. Staff were involved in decision making about changes to the trust services. Patients, staff, and carers were able to meet with members of the trust's leadership team and governors to give feedback through a variety of forums, roadshows, and events.

Division leaders and middle managers, on behalf of front-line staff, engaged with external stakeholders such as commissioners and Healthwatch, however relationships with some stakeholders were fragile. Service directors, lead nurses and modern matrons engaged with external stakeholders in the integrated care system and primary care networks. Staff we spoke with reported a few years ago it was difficult for them to "have a seat at the table" in the health and care system, this had changed and their contribution as leaders was listened to and valued. Most stakeholders and staff said they saw "green shoots" emerging in the trust and it was going in the right direction, with further work to do.

Stakeholders we spoke with said relationships between the children and young people care group and system partners are fragile. They had experienced inadequate leadership and response to the Emotional Wellbeing Hub, eating disorders, attention deficit hyperactivity disorder (ADHD), autism spectrum disorder, and community teams from the trust. Trust plans appeared slow and resistant to external offers of support. Reduced risk to children and young people was not evident. Stakeholders voiced frustration as the lack of solution focussed leadership, operational grip of risk and clinical safety and transparency relating to system working and that the trust was too inward focused.

The trust had presented a plan for the emotional well being hub and the reduction of the 2000 plus waiting lists to the Chair of the Suffolk Safeguarding Partnership Board in August 2021. The trust agreed to present monitoring information to the partnership board so they could be held accountable for their delivery plan.

Stakeholders said there were significant issues regarding the interconnectivity between the different care groups, which affected ability to work effectively together across care groups to find a solution in the best interests of the patient.

Stakeholders said prolonged elongated corporate processes led to delays in effective changes. Stakeholders gave examples where support and funding had been provided, however the trust had not implemented plans quickly. This had increased clinical risk and showed the disconnect between the care groups and corporate teams to drive improvement.

Our findings

Some stakeholders we spoke with expressed concerns the trust did not always consider the impact of their decisions on system partners. For example, by using health-based places of safety as beds to detain patients for long periods. This impacted on the number of people who remained in police custody or diverted to the accident and emergency department.

Multi-agency meetings were held in relation to the health-based places of safety. Whilst there were good local operational relationships, stakeholders said the trust lacked a strategic overview of the health based place of safety. Stakeholders said issues raised were not dealt with by the senior leaders in the trust in a timely manner, there were difficulties out of hours in talking to directors on call who did not understand the service to make decisions. Stakeholders such as the police requested to have more system operational involvement in relation to the health-based place of safety to support the patient's journey and experience and to be able to make direct referrals.

The trust was actively engaged in collaborative work with external partners, such as involvement with sustainability and transformation plans. The trust worked as equal partners in the system on transformation, pathways, demand and capacity planning and assurance. The trust was a key player in the mental health alliance boards. Stakeholders said operational staff engaged in transformation work as they want to see improvement. However, stakeholders said further transparency from the trust was required to build trust. The trust told us the COVID-19 pandemic had some impact on work, for example the transformation primary care mental health project with the integrated care systems was postponed.

The pharmacy team engaged with the integrated health and care system and antimicrobial leads. The chief pharmacist was also the controlled drug accountable officer and attended the local intelligence network.

Not all external stakeholders said they received open and transparent feedback on performance from the trust. Stakeholders had mixed views about the quality of data. National reporting data was considered to be good. However, there were concerns about the accuracy of data related to waiting lists. For example, in the wellbeing hub, and the accuracy of data related to contracting and key performance indicators. Stakeholders had concerns about the inconsistency of data input at clinical level.

Learning, continuous improvement and innovation

All staff were committed to continually learning and improving services. They had a good understanding of quality improvement methods and the skills to use them. Leaders encouraged innovation and participation in research.

The trust actively sought to take part in national improvement and innovation projects. For example, the medical director was participating in a national project by the Royal College of Psychiatry on black men getting access to services.

Staff were encouraged to make suggestions for improvement and gave examples of ideas which had been implemented. Staff were involved in 64 quality improvement projects and had managed to sustain these during the COVID-19 pandemic. The quality improvement projects were in progress and it was too soon to evaluate the impact on clinical practice. Changes in practice had occurred with young peoples' input into quality improvement projects such as changes to discharge letters.

The trust had a planned approach to take part in national audits and accreditation schemes and shared learning. During 2020/21, five national clinical audits and two national confidential enquiries covered the services provided by the trust.

Our findings

During that period, the trust participated in 100% of the national clinical audits and 100% of the national confidential enquiries it was eligible to participate in. These were for example; The Royal College of Physicians falls and fragility fractures audit programme, the national audit of inpatient falls, the national clinical audit of psychosis, antipsychotic prescribing for people with a learning disability and the use of Clozapine.

The trust participated the national enquires such as the National Enquiry into Suicide and Homicide, National Confidential Enquiry into Patient Deaths and the Physical Health in Mental Health Audit.

The trust had an annual programme of local clinical audits led by the care groups and specialist services such as enhanced observations, restrictive interventions, care programme approach, physical health, infection prevention and control and electronic pharmacy medicine management. Local audit plans and learning were shared in the quality committee and a clinical audit forum.

Services also undertook audits online management supervision and quality of referrals in community eating disorder services.

The trust was actively participating in clinical research studies. The trust had a research strategy. Service uses, carers and the wider community assisted in the coproduction of research. The trust was amongst the first to undertake COVID-19 research. The research department, quality improvement, training and workforce development worked collaboratively together.

The trust took part in more than 50 national research studies, involving more than 1,236 patients and carers in 2020/21. The internal research audit team audited 15% of active research studies. All studies showed a good-to-excellent level of management and oversight, and no critical research conduct findings related to patient safety or scientific integrity. No adverse events relating to the research had occurred. The team was a finalist in the Nursing Times Clinical Research Nursing Award 2020.

The trust received three major national research grants in the areas of older people carers' support and young people's mental health.

There were organisational systems to support improvement and innovation work. The trust had a quality improvement strategy which reflected the trust strategic priorities. A coaching network was in place to support quality improvement leads. A quality improvement forum chaired by the medical director provided the governance arrangements for the projects, over 350 staff participated in the forum. Staff undertook presentations of projects at the forum, for example, improving community interventions, providing physical health monitoring in the adult community teams. The trust worked with the integrated care system in which leads had come together to form a quality academy.

Staff had training in improvement methodologies and used standard tools and methods. The trust had been building up its capacity by providing quality improvement training for its staff and executive directors, over the previous two years. The trust aimed to train 30% of its staff in quality improvement to provide an essential tipping point, at the time of the inspection 14% of staff were trained. It had also invested in 23 people to undertake an external coaching programme to support projects, a six month improvement leads programme, for teams to learn skills for project delivery. There were plans to improve people participation in quality improvement by adapting the quality improvement training for carers and community people. There were plans to participate in an activity collaborative to improve activities out of hours across 15 wards.

Our findings

Effective systems were in place to identify and learn from unanticipated deaths. The trust was rated 'worse' for consistency of reporting to the National Reporting and Learning System (October 2018 to– March 2019), which showed a downward trend when compared to the previous period. However, the trust was successfully participating in the national patient safety pilot which would be replacing the National Reporting and Learning system.

There were 115 unexpected or potentially avoidable deaths reported to Strategic Executive Information System (STEIS) from 1 September 2019 to 30 September 2021. In the two years before COVID-19, on average 49 people per month died within six months of contact with the trust's services. STEIS is NHS England's web-based serious incident management system that is used by all organisations providing NHS funded care. Serious incidents must be reported by the provider no later than two working days after the incident was identified.

During the first and second waves of COVID-19 there was a significant increase in the number of people who died within six months of contact with trust services. On average, during the year of the pandemic 2020, 70 people died within six months of contact with trust services, each month.

Between May 2021 to July 2021, mortality rates had recovered to pre-pandemic figures. In the previous three months, August to October 2021, in total 133 people died within six months of contact with trust services. 71 (53%) of those people identified as male and 62 (47%) as female. The mean age of those who died was 67 years. This was slightly younger than had been the trend over the preceding 18 months, 70 years. The ethnicity of the person who died was recorded in 72% of these cases. In all but two cases the person who died was of a white background, all but six of whom were British. 15 people who were in contact with trust services are thought likely to have taken their own lives in the previous three months. This was not a significant change from the number of people who had taken their own lives over the previous three years. Ten of these 15 people were men and five were women. These people were aged between 18 and 85 years of age, mean 48 years, median 46 years. Where the person's ethnicity had been recorded, all identified as White and British.

In all instances where a person takes their own life, the trust carried out an investigation following the principles of root cause analysis to identify changes in local and trust wide practice which might lead to improvements in care and treatment.

Five coroners' reports were submitted to the trust for deaths between November 2019 to May 2021. A further death was currently with the coroner. The trust had received one prevention of future deaths notification in this reporting period, in July 2021.

Since October 2020, the trust had had five deaths in detention, of which all the patients were on unescorted leave.

There were 11 inpatient deaths within 28 days of a positive COVID-19 test during April 2020 and March 2021. Two of these occurred in the first wave in a trust setting, nine inpatients died during wave two with five of those deaths occurring following transfer to an acute setting. Older people's services were severely affected, with high numbers of patients and staff testing positive during outbreak in these areas. Many of these deaths were related to end of life care and to do not resuscitate decisions. The trust received specialist support from the community trust. No staff deaths reported due to COVID-19 infections. The trust reviewed the learning from these deaths to make improvements.

We reviewed five serious incidents. We found the investigation team completed the serious incident reviews in accordance with national standards. There was a clear protocol for assessment and decision to complete a full serious

incident review. An investigation and improvement manager led an independent team commissioned to review the cases. Root cause analysis tools supported the investigation. There was evidence of family involvement in the investigation. Families had a single point of contact through a senior member of the care group following a death to maintain continuity of communication. Clinical teams received an inhouse debrief and additional via supervision.

In one case identified areas for improvement required whole pathway reviews. However, no action plan or accountability was evidenced to demonstrate completion of actions.

In September 2021, the trust joined the inaugural session of the East of England region's learning from death forum. The trust told us participation in this forum would ensure the needs of those affected by poor mental health would be considered in the development of learning and strategy to reduce preventable deaths.

The trust shared lessons learned via its mortality group, quality subcommittee, care group meetings and team meetings. We saw that prohibition of plastic bags in ward areas was as a result of lessons learnt. However, we also found the trust had not widened this to consider ensuring visitors to wards were aware of all prohibited items. We saw serious incident lessons learnt briefings for staff.

We saw seven-minute briefings that shared learning. For example, in relation to domestic abuse, deaths of young people and factitious disorders.

The trust had recently moved data into a mortality dashboard to provide a trust wide and care group level of detail in respect of all mortality. This included demographics and cause of death which would support the organisation to decide on priority areas for focus and safety actions including improvement projects.

Stakeholders said serious incidents appeared to be responded to in a timely manner with learning taken forward within the trust's governance.

Stakeholders said a recurrent theme of serious incidents related to patients with dual diagnosis, drug and alcohol and the effectiveness of working together as a multiagency approach. Partnership working was underway to mitigate this ongoing issue.

Staff had time and support to consider opportunities for improvements and innovation and this led to changes. Despite the COVID-19 pandemic challenges, staff had engaged in quality improvement projects, in particular there had been outcomes in the young people's quality improvement agenda.

External organisations had recognised the trust's improvement work. Individual staff and teams received awards for improvements made and shared learning. Stakeholders confirmed that following enhanced surveillance of student education that the trust offered a suitable learning environment for students. Junior doctors and consultants reported good training and supervision support from the trust.

Stakeholders confirmed they were aware of the quality improvement projects and the culture the trust was developing. However, they expected the trust to be more outward focused about the projects. For example, how they had decided them and the sustainability and impact of the projects.

Stakeholders reported the trust was not very open to outside review and there had been a reluctance to allow stakeholders to carry out quality visits. Stakeholders had been involved in trust internal quality and safety reviews. However, these did not always cover the areas they were concerned about.

Our findings

Staff took part in many national awards schemes. Staff had presented posters and papers at national conferences.

The trust has been awarded Caring Together's Carer Friendly Tick Award – Employers, in recognition of their work to identify and support staff who are carers. The electroconvulsive therapy suite had national accreditation.

Staff were aware of their contribution to cost improvement objectives. The trust finance strategy is linked to the trust strategic objectives. The finance strategy would be updated following the refresh of the trust strategy. The trust had a budget of £305 million.

There had been board development in relation to finance, promoting good understanding amongst the board members. The Trust's Director of Finance had been in post since July 2020 and had fulfilled the role on an interim basis from October 2017.

During April 2020 and March 2021 there was a change in the financial framework in response to the COVID-19 pandemic, with prospective and retrospective block adjustments replacing non-recurrent payments received in relation to Provider Sustainability Fund and Financial Recovery Fund in 2020/21. The changing framework makes it inappropriate to draw a conclusion about the trusts underlying financial performance since 2019/20.

At month six the trust had a £617k surplus, with lower expenditures primarily related to Mental Health Sustainability and Development Funding. Delivery between April and September 2021 was against an historically modest efficiency target of 0.28%.

The October to March 2022 plan delivered the required breakeven position. Recent insight, from NHS England regional finance oversight and latest Provider Finance Return (PFR) submission, suggested the trust are on track to deliver against this plan. A use of resources review did not take place as part of the 2021 inspection.

The trust leadership team had a high level of confidence in the chief finance officer and the assurance provided back through the finance reporting routes. The chief finance officer demonstrated strong grip on both finance and non-financial issues impacting the Trust. The chief finance officer demonstrated good collaboration with peers operating within their integrated care systems and fully recognises the increased challenges on the trust as part of the broader Norfolk and Waveney financial position.

The trust financial position remained positive in regard to targets and the trust expected to deliver its plan during 2021/22, including delivery of mandated mental health investment standard to satisfy parity of esteem. The trust gave a good account of embedded financial governance at board, committee, and divisional leadership levels

During the COVID-19 pandemic the trust had limited focus on cost improvements. The trust had prioritised quality and sustainability of services in meeting population needs. Ownership of the cost improvement agenda rested with the care groups, lead nurses and clinicians held a cost improvement summit the summer 2021. All ideas for delivering cost improvements were required to complete a quality impact assessment.

Cost improvement delivery had been strengthened with the introduction of a project management office (PMO,) but further work would be required to strengthen and prioritise cost improvement delivery going forward, as the finance framework and system envelopes became significantly more challenging. The PMO would be required to leverage opportunities to support increased delivery of system benefits.

Our findings

The Trust had an internal plan for cost improvements of £6.5m and delivered £5.4m. However, national templates for first half of 21/22 did not include cost improvements and therefore the trust could only report their achievement of £5.4m versus the second half target, which was £2.7m .

The 2021/22 April to September plan included a total of £2.4m of cost improvements which had been fully delivered. The draft September 2021 plan included a cost improvement target of £2.6m. The cost improvement plans exceeded the national requirement. However, it is expected there would be a step-increase in efficiencies required to be around 5% in 2022/23 and 2023/24.

Staff used data to drive improvement. Seven out of eight core services inspected reported most teams had access to the information they needed to provide safe and effective care and used that information to good effect.

Key to tables

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

Month Year = Date last rating published

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

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

Ratings for the whole trust

Safe	Effective	Caring	Responsive	Well-led	Overall
Inadequate ↓ Apr 2022	Inadequate ↓ Apr 2022	Good ➔➔ Apr 2022	Requires Improvement ➔➔ Apr 2022	Inadequate ↓ Apr 2022	Inadequate ↓ Apr 2022

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

Rating for mental health services

	Safe	Effective	Caring	Responsive	Well-led	Overall
Wards for older people with mental health problems	Requires Improvement ↓ Apr 2022	Requires Improvement ↓ Apr 2022	Good → ← Apr 2022	Requires Improvement ↓ Apr 2022	Requires Improvement ↓ Apr 2022	Requires Improvement ↓ Apr 2022
Forensic inpatient or secure wards	Requires improvement Nov 2018	Good Nov 2018	Good Nov 2018	Good Nov 2018	Good Nov 2018	Good Nov 2018
Child and adolescent mental health wards	Inadequate ↓↓ Apr 2022	Inadequate ↓↓↓ Apr 2022	Requires Improvement ↓↓ Apr 2022	Good ↓ Apr 2022	Requires Improvement ↓↓ Apr 2022	Inadequate ↓↓↓ Apr 2022
Long stay or rehabilitation mental health wards for working age adults	Inadequate ↓ Apr 2022	Requires Improvement ↓ Apr 2022	Good → ← Apr 2022	Good → ← Apr 2022	Requires Improvement → ← Apr 2022	Requires Improvement → ← Apr 2022
Community mental health services for people with a learning disability or autism	Good Jan 2020	Good Jan 2020	Good Jan 2020	Requires improvement Jan 2020	Good Jan 2020	Good Jan 2020
Community-based mental health services of adults of working age	Requires Improvement → ← Apr 2022	Inadequate ↓ Apr 2022	Good → ← Apr 2022	Inadequate ↓↓ Apr 2022	Inadequate ↓ Apr 2022	Inadequate ↓ Apr 2022
Wards for people with a learning disability or autism	Good ↑↑ Apr 2022	Good → ← Apr 2022	Good → ← Apr 2022	Good ↑ Apr 2022	Good → ← Apr 2022	Good ↑ Apr 2022
Community-based mental health services for older people	Good Jan 2020	Good Jan 2020	Good Jan 2020	Good Jan 2020	Good Jan 2020	Good Jan 2020
Specialist community mental health services for children and young people	Requires Improvement → ← Apr 2022	Requires Improvement → ← Apr 2022	Good ↑ Apr 2022	Requires Improvement ↑ Apr 2022	Requires Improvement ↑ Apr 2022	Requires Improvement ↑ Apr 2022
Mental health crisis services and health-based places of safety	Inadequate ↓ Apr 2022	Requires Improvement ↓ Apr 2022	Good → ← Apr 2022	Requires Improvement → ← Apr 2022	Requires Improvement → ← Apr 2022	Requires Improvement → ← Apr 2022
Acute wards for adults of working age and psychiatric intensive care units	Inadequate ↓ Apr 2022	Inadequate ↓ Apr 2022	Requires Improvement ↓ Apr 2022	Requires Improvement Apr 2022	Inadequate ↓ Apr 2022	Inadequate ↓ Apr 2022

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

Long stay or rehabilitation mental health wards for working age adults

Requires Improvement 

Is the service safe?

Inadequate 

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

Safe and clean care environments

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

Safety of the ward layout

Staff did not complete thorough risk assessments of the ward areas and did not remove or reduce all the risks they identified. Staff had not identified potential ligature anchor points including; fixed curtain tracks and curtains in patient bedrooms, and two fixed curtain tracks in the male corridor staircase in the risk assessment. Following our inspection, the trust updated the risk assessment, but this still did not include the two fixed curtain tracks in the male corridor staircase. This meant staff did not know about all the potential ligature anchor points and these risks had not been mitigated to keep patients safe. However, to increase the awareness of staff, following our inspection the trust told us it had implemented ligature risk awareness training for staff.

The trust had not taken action to reduce and remove ligature risks it had identified where it would have been reasonable and practicable to do so. Staff had identified exposed pipework in the risk assessment as a potential ligature anchor point and the trust had not taken any action to reduce or remove this ligature risk. Following our inspection, the trust told us it intended to conceal this pipework and a capital bid for funding was made to replace communal curtain and blind tracks with reduced ligature alternatives. At the factual accuracy stage, the trust told us that it had concealed high risk pipework in patient bedrooms, replaced fixed curtain rails with a collapsible alternative but they had not concealed all pipework in communal areas which continued to be ligature risks.

Staff could not observe patients in all parts of the ward. The ward consisted of central communal areas and separate male and female bedroom corridors that each had a kitchen, dining room and lounge. The male corridor had two floors. A staff member was allocated on floor walker duty to maintain presence of the central communal areas of the ward including the entrance.

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

Staff carried alarms but at the time of our inspection, patients did not have access to a nurse call system. Staff told us, and crisis plans, stated that patients were required to contact the staff office using their mobile phones. In an emergency or an incident, patients may not have been able to access or use a mobile phone to call for help. A telephone call would not be distinct to ensure an urgent response from staff. Staff also did not complete regular observations to check patients were safe and well. They completed observations at shift handovers and at midnight. This meant it could be up

to seven hours before staff may know that someone needed help. Patient bedrooms doors had no mechanism for staff to check patients were safe and well without opening the door. Following escalation of our concerns to the trust after the inspection, the trust told us it had implemented portable alarms for patients and was sourcing a permanent nurse call system.

Maintenance, cleanliness and infection control

Ward areas were clean, well-maintained and well-furnished. Staff had addressed the issues with timely maintenance work being carried out which met one of the actions of our most recent inspection. The 2019 Patient Led Assessment of the Care Environment for condition, appearance and maintenance score was 95% which was slightly below the national average.

Staff made sure cleaning records were up-to-date and the premises were clean. The ward had dedicated domestic staff. The 2019 Patient Led Assessment of the Care Environment for cleanliness score was 99% which was slightly better than the national average.

Staff followed infection control policy, including handwashing. Staff asked everyone to wash their hands on entering the service. Staff wore appropriate personal protective equipment (PPE) and the ward was equipped with hand sanitiser stations.

Seclusion room

The ward did not have a seclusion room.

Clinic room and equipment

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

Staff checked, maintained, and cleaned equipment. Equipment had been calibrated within the timescales following manufacturers' guidelines. The clinic room was fitted with a system that alerted staff if the room or fridge temperatures went outside of the recommended ranges.

Safe staffing

The service had enough nursing staff. However, the service did not have enough medical staff and staff were not up-to-date with all the basic training to keep people safe from avoidable harm.

Nursing staff

The service had enough nursing and support staff to keep patients safe.

The service had a low vacancy rate. The trust reported that the vacancy rate for this service was 3% which equated to a vacancy for a 0.75 whole time equivalent position.

Long stay or rehabilitation mental health wards for working age adults

The service consistently used bank and agency nurses. Between 1 November 2020 and 31 October 2021, the average percentage of shifts covered by bank or agency nurses was 6%.

The service consistently used bank and agency nursing assistants. Between 1 November 2020 and 31 October 2021, the average percentage of shifts covered by bank or agency support workers was high at 31%.

Managers limited their use of bank and agency staff and requested staff familiar with the service. The service mainly used bank staff that worked regular bank shifts. If shifts were not covered by regular staff, then NHS Professionals was used to fill shifts. The service only used one agency registered nurse who was familiar with the service. The trust held a daily safety huddle where staffing issues were discussed, and resources were deployed across the trust's services to maintain safety.

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

The service had a high turnover rate. The staff turnover rate for this service was 19%. This was higher than the 15% trust target staff turnover rate. However, this only represented 4.5 whole time equivalent staff leavers.

Managers supported staff who needed time off for ill health. Managers made reasonable adjustments and supported staff that returned to work.

Levels of sickness were high. The sickness rate for this service was 7%. This was higher than the trust target which was 5%. However, this included COVID-19 related sickness absences.

Managers accurately calculated and reviewed the number and grade of nurses, nursing assistants and healthcare assistants for each shift. The minimum staffing levels during the day was, two registered nurses and two support workers, and at night, was one registered nurse and two support workers.

The ward manager could adjust staffing levels according to the needs of the patients.

Patients had regular one-to-one sessions with their named nurse. Each patient had a primary team that consisted of a primary nurse, a secondary nurse, two rehabilitation workers and an occupational therapist.

Patients rarely had their escorted leave or activities cancelled, even when the service was short staffed. No section 17 (permission to leave the hospital) leave had been cancelled in the previous six months.

The service did not have enough staff on night shifts to carry out high level physical interventions safely. The minimum staffing level on night shifts was one registered nurse and two support workers. This would not be enough staff to carry out a high level restraint. However, staff had only used restraint twice in the previous 12 months and other services were situated close by and could assist in an incident.

Staff shared key information to keep patients safe when handing over their care to others.

Medical staff

Long stay or rehabilitation mental health wards for working age adults

The service did not have enough daytime medical cover. However, a doctor was available to go to the ward quickly in an emergency outside of hours. The service had one consultant psychiatrist for half a day per week when patient reviews took place. A locum junior doctor was shared between this service and another service. Dedicated daytime medical cover was below the standards set out by the Royal College of Psychiatry for rehabilitation services.

Managers made sure all locum staff had a full induction and understood the service before starting their shift. Locum doctors could access trust training.

Mandatory training

Not all staff had completed and kept up-to-date with their mandatory training. Six out of the 25 mandatory courses fell below the trust target of 85%. These were: basic life support training at 0%, physical intervention 44%, fire training classroom based 64%, display screen equipment and home working 72%, personal safety 78% and learning disabilities awareness 83%. This meant staff may not have all the skills and knowledge required to keep patients and themselves safe. However, basic life support training was only required for one doctor and all other staff had completed immediate life support training. The ward manager also told us that data for physical interventions included staff who were medically exempt from completing this training.

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

Although managers monitored mandatory training and staff could see their training records, this had not ensured staff were up-to-date with mandatory training.

Assessing and managing risk to patients and staff

Staff at this service did not assess and manage the risks to patients and staff safety well. Although, the service promoted a least restrictive environment to support patients in their rehabilitation and recovery, it was not always in line with expected standards and there were increased risks to patients' safety as a result. The ward staff did not participate in the provider's restrictive interventions reduction programme. However, staff followed best practice in anticipating, de-escalating and managing challenging behaviour. As a result, they used restraint only after attempts at de-escalation had failed and did not use seclusion.

Assessment of patient risk

Staff did not complete comprehensive patient risk assessments. All five patient records reviewed contained a risk assessment which did not include an assessment of the levels of patient risk. Although staff added incidents which had occurred to the risk assessment, they did not review the overall risk assessment, including reviewing levels of risk. Staff did not complete risk assessments for all patients who self-medicated, for access to the locked ward areas using the electronic wristbands or for therapies and activities.

Staff did not use a recognised risk assessment tool. The risk assessment tool in use was developed by the trust.

Management of patient risk

Staff knew patients and their associated risks well. However, due to the issues with risk assessments, staff may not know all the information about patient risk and may not be able to manage all risks.

Long stay or rehabilitation mental health wards for working age adults

Risk assessments did not contain clear risk management plans. None of the five patient records reviewed contained a risk management plan to outline what action was needed to manage and mitigate risks posed towards and from patients.

All patients, including detained patients, could leave the ward as it was open. The environment was sometimes challenging for staff to manage specific patient risks including those of detained patients who may try to leave the service without section 17 leave. There had been incidents of detained patients leaving the ward without official section 17 leave and staff had left the ward to follow the patient to try and ensure they were safe. This had left the ward below the safe staffing level. This meant it was essential the admission process ensured that patients offered rehabilitation at the service were suitable and prompt action was taken if there was any change in patients' suitability for the service.

When patients went out, including on section 17 leave, staff did not complete any risk assessment or assessment of patients' mental state. This meant opportunities to identify changes, support patients and manage risks may be missed.

Staff could not observe patients in all areas of the wards and did not follow good procedures to minimise risks where they could not easily observe patients. The ward did not follow the trust's patient observation policy and staff were only required to check patients were safe and well at shift handovers at 7am, 7pm and at midday and midnight. This meant patients may not be seen for up to seven hours. This was significantly longer than the standard set out in national guidelines which state that staff should check patients' welfare at least every 30 to 60 minutes. Patients had access to areas of the ward that contained risks, including potential ligature anchor points. At the time of our inspection, in the event of an emergency, patients did not have access to a nurse call alarm system to call for urgent help.

Staff did not search patients or their bedrooms. Patients were encouraged to hand in any risk items, including lighters, to minimise fire risks.

The service did not enforce a smoke-free policy. Patients smoked outside of the service's entrance.

Use of restrictive interventions

Levels of restrictive interventions were low. In the previous 12 months, there had been two incidents of restraint. There had not been any incidents of seclusion, long-term segregation, rapid tranquilisation or prone restraint.

Staff were not aware of, and therefore did not participate in, the trust's restrictive interventions reduction programme.

Staff made every attempt to avoid using restraint by using de-escalation techniques and restrained patients only when these failed and when necessary to keep the patient or others safe. The ward was working on implementing the Safewards interventions. Safewards is model of interventions and techniques that can be used which are aimed at reducing conflict and containment.

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

Safeguarding

Staff understood how to protect patients from abuse and the service worked well with other agencies to do so. Staff had training on how to recognise and report abuse and they knew how to apply it.

Staff received training on how to recognise and report abuse, appropriate for their role. Staff had not made any safeguarding referrals in the previous twelve months.

Staff kept up-to-date with their safeguarding training. All staff had completed either level one and level three safeguarding adults and children training.

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

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

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

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

Staff access to essential information

Staff did not always have easy access to clinical information, and it was not always easy for them to maintain high quality clinical records – whether paper-based or electronic.

Staff told us they could not always access information easily due to issues with the hardware, systems and inconsistency in where information was stored on the patient electronic record system. Staff had reported issues with the information systems internally. Some staff had intermittent issues in accessing the electronic prescribing and medicines system and the electronic patient record system. There were enough computers but some of the computers in use required upgrading. This had the potential to cause clinical risks if staff could not access essential information.

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

Records were stored securely.

Medicines management

The service used systems and processes to safely prescribe, administer, record and store medicines. Staff regularly reviewed the effects of medicines on each patient's mental and physical health. However, it was not always recorded whether doctors were reviewing the use of 'as and when required' medicines regularly. It was also not always indicated in which order 'as and when required' medicines should be offered.

Staff mostly followed systems and processes when safely prescribing, administering, recording and storing medicines. However, one patient was prescribed two anti-psychotic medicines to be taken 'as and when required', and it was not clear which medicines should be offered first and which should be offered second.

It was not always clear whether staff reviewed patients' medicines regularly and provided specific advice to patients and carers about their medicines. Two patients were regularly taking anti-psychotic medicines and one of these patients was also regularly taking a hypnotic which was prescribed to be taken 'as and when required'. Patient records did not show whether doctors were reviewing the use of 'as and when required' medicines to ensure this was appropriate.

Long stay or rehabilitation mental health wards for working age adults

Staff mostly stored and managed medicines and prescribing documents in line with the provider's policy. However, we found a liquid medicines which had not been labelled with an opened on date and a patient had a medicines in stock that was no longer prescribed. Staff addressed these issues immediately after we raised them on our inspection.

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

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

Decision making processes were in place to ensure people's behaviour was not controlled by excessive and inappropriate use of medicines. The prescribing and administration system in use had alerts to prompt staff to potential prescribing considerations including, high dose anti-psychotics.

Staff reviewed the effects of each patient's medicines on their physical health according to NICE guidance. Staff either completed monitoring or arranged for patients to attend specific clinics for testing and monitoring to be completed. For example, clozapine clinics.

Track record on safety

The service had a good track record on safety.

There had been no serious incidents, never events or adverse incidents in this service in the previous 12 months.

Reporting incidents and learning from when things go wrong

The service managed patient safety incidents well. Staff recognised incidents and reported them appropriately. When things went wrong, staff apologised and gave patients honest information and suitable support. However, staff provided mixed feedback about receiving information on lessons learned.

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

There had not been any serious incidents in this service in the previous twelve months.

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

Managers debriefed and supported staff after any significant incidents.

Staff provided mixed experiences of receiving feedback from investigation of incidents, including lessons learnt both internal and external to the service. Some staff could give examples of how things had changed as a result of incidents and other staff could not recall receiving information following incidents.

Is the service effective?

Requires Improvement 

Long stay or rehabilitation mental health wards for working age adults

Our rating of effective went down. We rated it as requires improvement.

Assessment of needs and planning of care

Staff assessed the physical and mental health of all patients on admission. They developed individual care plans which were reviewed regularly through multidisciplinary discussion and updated as needed. Care plans reflected patients' assessed needs, and were personalised, recovery-oriented but not always holistic.

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

Patients had their physical health assessed soon after admission and regularly reviewed during their time on the ward. Staff completed comprehensive physical health observations daily using the National Early Warning Score two.

Staff developed care plans for each patient that mostly met their mental and physical health needs. Care plans were personalised and recovery-orientated. However, they were not always holistic. Three of out of the five patient care records reviewed contained care plans which were not holistic. One of these care plans was brief and basic because it did not contain sufficient information relating to the patient and their needs and another care plan was not clear what therapy was being provided. Two out of the five care plans reviewed did not contain information relating to restrictions and Section 17 leave. However, we were assured patients were receiving holistic care because staff and patients described their care and treatment in detail, and we observed patients completing a range of therapies and activities.

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

Best practice in treatment and care

Staff provided a range of treatment and care for patients based on national guidance and best practice. This included support for self-care and the development of everyday living skills and meaningful occupation. Staff supported patients with their physical health and encouraged them to live healthier lives. They also participated in clinical audits and sometimes used ratings scales for severity and outcomes. However, patients had limited access to psychological therapies and there was no benchmarking or quality improvement initiatives.

Staff provided a range of care and treatment suitable for the patients in the service. These included medicines, activities, training and work opportunities intended to support people to acquire independent living skills. However, access to psychological therapies was limited.

Staff mostly delivered care in line with best practice and national guidance. We identified issues with patient observations not being completed in line with national guidelines. Staff only checked patients were safe and well at shift handovers at 7am, 7pm, midday and midnight which was significantly longer than the national standard of checking the welfare of patients at least every 30 to 60 minutes.

Staff identified patients' physical health needs and recorded them in their care plans.

Staff made sure patients had access to physical health care, including specialists as required. Staff supported patients to access primary care services and referred patients to secondary care services appropriately.

Long stay or rehabilitation mental health wards for working age adults

Staff met patients' dietary needs and assessed those needing specialist care for nutrition and hydration. Staff could give examples where they had made referrals to dieticians and implemented additional hydration monitoring for specific patients.

Staff helped patients live healthier lives by supporting them to take part in programmes or giving advice. They provided education and support to patients around healthy eating and encouraged patients to accept well person checks.

Staff used recognised rating scales to assess and record the severity of patients' conditions. However, there was inconsistent use of outcomes measures to assess progress in care and treatment or to evaluate the effectiveness of the service.

Staff took part in clinical audits. However, staff did not take part in any benchmarking or quality improvement initiatives.

Managers used results from audits to make improvements.

Skilled staff to deliver care

Managers made sure they had staff with the range of skills needed to provide high quality care. They supported staff with appraisals, supervision and opportunities to update and further develop their skills. Managers provided an induction programme for new staff. However, the ward team had limited access to medical staff and psychological therapies which meant there was not always access to the full range of specialists required to meet the needs of patients on the ward.

Although the service had access to a full range of specialists, access to medical staff and psychological therapies was limited. The service could access some psychological therapy sessions. However, there was no dedicated psychologist sessions and recruitment was ongoing for a dedicated clinical psychologist. This meant there was not always full access to all the specialists required to meet the needs of the patients on the ward, in line with best practice for rehabilitation services. However, the service had two dedicated occupational therapists who worked closely with nurses and support workers.

Managers ensured staff had the right skills, qualifications and experience to meet the needs of the patients in their care, including bank and agency staff. However, not all staff were up-to-date with all the mandatory training courses required.

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

Managers supported staff through regular, constructive appraisals of their work. Appraisal rates showed 97% of staff had received an appraisal of their performance in the previous 12 months.

Managers supported non-medical staff through regular, constructive clinical supervision of their work. Staff told us that they received regular managerial supervision and could access clinical supervision. Supervision rates showed 75% received regular managerial supervision and 81% received regular clinical supervision in the previous 12 months.

The locum junior doctor received regular clinical supervision from the consultant psychiatrist.

Managers made sure staff attended regular team meetings and gave information from those they could not attend. Team meetings took place monthly and staff had access to the minutes of meetings.

Long stay or rehabilitation mental health wards for working age adults

Managers identified any training needs their staff had and gave them the time and opportunity to develop their skills and knowledge. Staff had development plans. One support worker was being supported to complete assistant practitioner training.

Managers made sure staff received any specialist training for their role.

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

The service did not have any volunteers. Managers intended on recruiting a peer support worker in the service, but this was not yet in place at the time of the inspection.

Multi-disciplinary and interagency teamwork

Staff from different disciplines worked together as a team to benefit patients. They supported each other to make sure patients had no gaps in their care. They had effective working relationships with staff from services providing care following a patient's discharge. Staff engaged with them early in the patient's admission to plan discharge.

Staff held regular multidisciplinary meetings to discuss patients and improve their care. On Friday mornings, staff met to review patients' progress in their care and treatment.

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

Ward teams had effective working relationships with other teams in the organisation. However, staff told us it was more challenging to keep staff in some community teams involved with patients and they believed this was due to high community caseloads.

Ward teams had effective working relationships with external teams and organisations. Staff worked well with those who would provide support following a patient's discharge in the community.

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

Staff understood their roles and responsibilities under the Mental Health Act 1983 and the Mental Health Act Code of Practice and discharged these well. Managers made sure staff could explain patients' rights to them. However, staff were not up-to-date with training in the Mental Health Act and one patient record did not contain a record of discussion and evidence of patient consent to treatment.

Staff did not receive and did not keep up-to-date with training on the Mental Health Act and the Mental Health Act Code of Practice. The trust had made Mental Health Act training an annual training requirement in September 2021 and only 56% of eligible staff were up-to-date with this training. However, staff understood their roles and responsibilities under the Mental Health Act and could describe the Code of Practice guiding principles.

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

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

Long stay or rehabilitation mental health wards for working age adults

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

Patients had easy access to information about independent mental health advocacy and patients who lacked capacity were automatically referred to the service. Patients with capacity also had support from advocates.

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

Staff made sure patients could take section 17 leave when this was agreed with the Responsible Clinician.

Staff requested an opinion from a Second Opinion Appointed Doctor (SOAD) when they needed to. Two patients who did not have capacity to consent to treatment had a T3 certificate in place. A T3 certificate is written by a Second Opinion Appointed Doctor approving particular forms of medical treatment for detained patients who do not have capacity to consent or do not consent to their treatment.

One patient record did not contain evidence staff had discussed care and treatment with the patient and gained informed consent to support the Mental Health Act treatment (T2) certificate in place. A T2 certificate is a form completed by a doctor that states the particular medical treatments a detained patient with capacity has provided their consent to accept.

Staff found it difficult to locate copies of patients' detention papers and associated records in the electronic patient record system. This meant these may not be accessible for staff to access them when needed.

The ward was open rehabilitation and informal patients knew they could leave the ward freely.

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

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

Good practice in applying the Mental Capacity Act

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

Staff had a good understanding of the Mental Capacity Act and of at least the five principles. The trust had set up to March 2022 as a deadline for all staff to complete the updated training in the Mental Capacity Act.

There were no Deprivation of Liberty Safeguards applications made in the previous 12 months.

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

Long stay or rehabilitation mental health wards for working age adults

Staff knew where to get accurate advice on the Mental Capacity Act and Deprivation of Liberty Safeguards. Staff told us they had sought support previously in the trust when a Deprivation of Liberty Safeguards application was needed.

Staff gave patients all possible support to make specific decisions for themselves before deciding a patient did not have the capacity to do so.

Staff assessed and recorded capacity to consent clearly each time a patient needed to make an important decision. Patient records contained capacity assessments for time specific decisions that followed the principles of the Mental Capacity Act.

When staff assessed patients as not having capacity, they made decisions in the best interest of patients and considered the patient's wishes, feelings, culture and history.

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

Is the service caring?

Good 

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

Kindness, privacy, dignity, respect, compassion and support

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

Staff were discreet, respectful, and responsive when caring for patients. Staff gave patients help, emotional support and advice when they needed it. Patients provided positive feedback about how staff treated them. They told us they were friendly, listened to them and were interested in their wellbeing.

Staff supported patients to understand and manage their own care, treatment or condition.

Staff directed patients to other services and supported them to access those services if they needed help. This included accessing educational courses, the community and volunteering work.

Patients said staff treated them well and behaved kindly.

Staff understood and respected the individual needs of each patient.

Staff felt they could raise concerns about disrespectful, discriminatory or abusive behaviour or attitudes towards patients.

Staff followed policy to keep patient information confidential.

Long stay or rehabilitation mental health wards for working age adults

Involvement in care

Staff involved patients in care planning and risk assessment and actively sought their feedback on the quality of care provided. They ensured patients had easy access to independent advocates. However, patient records did not reflect patient views or involvement well.

Involvement of patients

Staff introduced patients to the ward and the services as part of their admission.

Staff involved patients and gave them access to their care planning and risk assessments through regular one-to-one meetings. However, patient records did not reflect patient views or patient involvement well. One out of the five records reviewed contained some patient views. Another record stated that a patient did not want to be involved in their care planning. Three other records did not contain any evidence of patient involvement.

Staff mostly made sure patients understood their care and treatment. However, one record relating to a detained patient did not contain evidence of discussion about treatment and evidence of informed consent to support a Mental Health Act treatment (T2) certificate written by a doctor for patient consent to treatment.

Staff involved patients in decisions about the service, when appropriate. Patient representatives were involved in the recruitment of staff.

Patients could give feedback on the service and their treatment and staff supported them to do this. There had been one response to the friends and family test between 1 April 2021 and 31 October 2021 and this stated they would be likely to recommend the service. Patients had regular community meetings.

Staff supported patients to make decisions on their care.

Staff made sure patients could access advocacy services.

Involvement of families and carers

Staff informed and involved families and carers appropriately.

Staff supported, informed and involved families or carers. Where patients' provided consent information was shared with families and carers. Staff worked well with carers and relatives to plan for patients' discharges and to manage home leave.

Staff helped families to give feedback on the service.

Carers had access to a carers group. However, this had not met for some time due to COVID-19 precautions limiting face to face meetings.

Long stay or rehabilitation mental health wards for working age adults

Is the service responsive?

Good ➔➔

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

Access and discharge

Staff planned and managed discharge as well as they could. They liaised well with services that would provide aftercare and were assertive in managing the discharge care pathway. As a result, patients did not have excessive lengths of stay. However, the service had delayed discharges due to the lack of suitable adult social care placements.

Staff had ensured the service had a clear operational policy that had been updated to include the admission criteria and to outline the service was a community open rehabilitation service. This met one of the actions from our most recent inspection.

Managers made sure bed occupancy did not go above 85%. The average bed occupancy over the previous 12 months was 85%. This meant it was likely that beds were available for patients living in the catchment area.

Managers regularly reviewed length of stay for patients to ensure they did not stay longer than they needed to. The average length of stay of current patients was 14 months. The shortest length of stay was six months and the longest length of stay was 21 months. This was in line with the service's operational policy that estimated lengths of stay should be between three months and two years.

The service had no out-of-area placements. The trust only provided one open rehabilitation mental health ward. If a patient required a specialist or more intensive rehabilitation hospital placement, then an alternative placement would be identified outside of the trust's services. The trust reported that no patients were being cared for out-of-area for this core service.

Managers and staff worked to make sure they did not discharge patients before they were ready.

When patients went on leave there was always a bed available when they returned.

Patients were moved between wards during their stay only when there were clear clinical reasons, or it was in the best interest of the patient.

Staff did not move or discharge patients at night or very early in the morning.

If a patient required more intensive care, the patient would be transferred to another ward. The location of this would depend on the trust's bed availability for acute mental health beds and psychiatric intensive care. Staff recalled one incident where a patient was transferred promptly to an acute mental health ward. In these cases, staff from this service would continue to provide in-reach support to the patient until a decision had been made about whether the patient would be transferred back to the rehabilitation service or discharged.

Long stay or rehabilitation mental health wards for working age adults

Staff supported patients prior to their admission and following their discharge for a limited period to support patients with transition.

Discharge and transfers of care

Managers monitored the number of delayed discharges. The trust reported there were three delayed discharges in the previous 12 months, two of these involved current patients. The delayed discharges from the service were due to issues with finding suitable adult social care placements.

Staff carefully planned patients' discharge and worked with care managers and coordinators to make sure this went well.

Staff supported patients when they were referred or transferred between services. Staff worked well with families and paid carers who would provide ongoing care following discharge to support patients transition into the community.

Facilities that promote comfort, dignity and privacy

The design, layout, and furnishings of the ward supported patients' treatment, privacy and dignity. Each patient had their own bedroom and could keep their personal belongings safe. There were quiet areas for privacy. Patients could make hot drinks and snacks at any time. When clinically appropriate, staff supported patients to self-cater. However, not all bedrooms had en-suite bathrooms and there were difficulties with patient access to the internet.

Each patient had their own bedroom, which they could personalise. Both female bedrooms and two male bedrooms had en-suite bathrooms. There were five male bedrooms that shared access to three communal bathrooms.

Patients had a secure place to store personal possessions. Patients' bedrooms automatically locked when the door was closed so people could not enter without a wrist band that had been permitted access.

Staff used a full range of rooms and equipment to support treatment and care. The ward had a large kitchen, dining room and lounge on both the male and female corridors. Centrally there was a communal lounge, two activity spaces and a meeting room.

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

Patients could make phone calls in private.

The service had an outside space that patients could access easily. The ward had surrounding gardens patients could access at any time.

Patients could make their own hot drinks and snacks. Patients required a wrist band with permitted access to go into the kitchen independently. If a patient did not have kitchen access, they would need to depend on staff to access hot drinks and snacks. However, a water cooler was available in the communal areas.

All patients were expected to self-cater using the food provided or food they had purchased. Once a week, staff supported patients to make a group meal for all patients. At times during the COVID-19 pandemic, staff had prepared food and served this using a catering trolley.

Long stay or rehabilitation mental health wards for working age adults

The 2019 Patient Led Assessments of the Care Environments for privacy dignity and wellbeing was 89%. This was slightly higher than the national average score.

Patients could not access internet in the service due to difficulties with connectivity. This meant that patients could not always use their own electronic devices fully.

Patients' engagement with the wider community

Staff supported patients with activities outside the service, such as work, education and family relationships.

Staff made sure patients had access to opportunities for education and work, and supported patients. The ward had activities daily seven days per week and patients had access to the recovery college courses. Staff supported patients to access education and volunteering opportunities.

Staff helped patients to stay in contact with families and carers.

Staff encouraged patients to develop and maintain relationships both in the service and the wider community.

Meeting the needs of all people who use the service

The service met the needs of all patients – including those with a protected characteristic. Staff helped patients with communication, advocacy and cultural and spiritual support. However, the service did not have a multi-faith room.

The service could support and make adjustments for disabled people and those with communication needs or other specific needs. Staff could make reasonable adjustments to meet disabled patients' needs. The 2019 Patient Led Assessment of the Care Environments score for disability was 83%. This was slightly higher than the national average.

Patients with dementia were not excluded from admission to the service. However, the service admission criteria outlined that patients must understand and agree to the concept of rehabilitation and to engage in the therapeutic process. This may be more difficult for patients with fluctuating or declining cognitive abilities. There was no patient led assessment of the care environments for dementia to assess how dementia friendly the care environment was. However, the trust provided wards for older people with mental health problems which may be more suitable to meet individual patients' needs. There were no patients with dementia staying at the service at the time of the inspection.

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

The service had information leaflets available in languages spoken by the patients and local community. Managers made sure staff and patients could get help from interpreters or signers when needed.

The service provided food and patients self-catered. This meant they could ensure their own dietary and cultural needs were met. Staff could refer patients to dieticians where needed. The 2019 Patient Led Assessment of the Care Environments for food score was 100%. This was above the national average.

Patients had access to spiritual, religious and cultural support. However, the service did not have a multi-faith room.

Long stay or rehabilitation mental health wards for working age adults

Listening to and learning from concerns and complaints

The service treated concerns and complaints seriously. They had not received any complaints in the previous 12 months.

The service had made improvements to the system for logging, reviewing and learning from local complaints which met one of the actions from our most recent inspection.

Patients knew how to complain or raise concerns.

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

Staff understood the policy on complaints and knew how to handle them. Patients could either raise a complaint or a concern informally, staff had 24 hours to provide a satisfactory response or the complaint progressed to a formal complaint investigation.

Managers investigated complaints and identified themes. Staff provided us with an example where a patient had complained over 12 months ago and details about how this had been resolved and the lessons learnt.

Staff protected patients who raised concerns or complaints from discrimination and harassment.

Staff knew how to acknowledge complaints and patients received feedback from managers after the investigation into their complaint.

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

The trust reported the service had not received any compliments in the previous 12 months. However, the service had positive messages and compliments displayed in the service from discharged patients.

Is the service well-led?

Requires Improvement 

Our rating of well-led stayed the same. We rated it as requires improvement.

Leadership

Senior leaders were not visible in the service and approachable for staff and patients. However, ward leaders had good understanding of the services they managed and were visible in the service and approachable for patients and staff. Ward leaders had the skills, knowledge and experience to perform their roles.

Ward leadership had been impacted by COVID-19 and in response to this the trust had introduced an additional band seven clinical nurse specialist to support ward management.

Long stay or rehabilitation mental health wards for working age adults

The service had had inconsistent leadership at modern matron level. However, the current modern matron that was recently appointed had visited the service and was starting to provide support to staff.

Staff had raised concerns about senior leaders not being visible or available to support the team and the service at team meetings over the two months prior to our inspection in August 2021 and September 2021.

Managers had access to leadership development training.

Vision and strategy

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

The trust's senior leadership team had successfully communicated the provider's vision and values to the frontline staff in this service. Most staff could recall the trust's values well.

Staff felt they could bring forward ideas that would develop the service and thought these were listened to.

Culture

Staff did not always feel fully respected, supported and valued by all levels in the trust. However, the trust promoted equality and diversity in daily work and provided opportunities for development and career progression. Staff could raise any concerns without fear.

Although staff reported the wider trust and senior leadership teams had started to support and value them and the service better, they felt they continued to feel under supported and undervalued. However, at ward level, staff felt they were highly respected, supported and valued by the ward management team and their colleagues.

Staff felt positive and proud about their work at the service and the support they provided to patients.

Staff felt they could raise concerns without fear of retribution. They were aware and knew how to use the whistle blowing policy and knew who the Freedom to Speak Up Guardian was. Staff team meetings showed staff were confident in raising concerns. The service had changed from an early and late day shift to a 12-hour day shift. Following staff raising concerns, managers planned to change back to an early and a late day shift to support staff wellbeing.

The team reported they worked well together to continue providing the service during challenging times of the COVID-19 pandemic.

Staff appraisals contained discussions about career development and progression and staff had personal development plans.

Although the service's sickness rate was higher than the trust target, it included COVID-19 related absence. As a precaution, the trust required staff to self-isolate when someone in their household or someone that they had been in close contact with had tested positive for COVID-19. At the time of our inspection this was above the recommended government guidance for staff that had received both COVID-19 vaccinations.

Staff had access to an occupational health service for support with physical and emotional health needs.

Long stay or rehabilitation mental health wards for working age adults

Governance

Our findings from the other key questions demonstrated that governance processes did not always operate effectively at team level and that performance and risks were not always managed well.

Governance systems and processes were not always effective. They had not identified and therefore had not addressed issues that affected the safety and quality of the service provided. This included poor quality of the risk assessments and risk management of ligature risks and patient risks. The service had not ensured it followed national guidance in relation to nurse call systems, patient observations and medical staff provision. There were also concerns in relation to the quality of patients' care plans and medical review of the use of some medicines.

The service had a clear framework of what must be discussed at ward level and at care group level to share information from incidents and alerts.

Management of risk, issues and performance

Staff collected and analysed data about outcomes and performance. However, there were no known risks on the risk register including issues that we identified during our inspection.

Managers and staff had access to data from systems to understand performance.

Staff maintained and had access to the risk register at ward and care group level. Staff at ward level could escalate concerns when required.

There were no items on the risk register in relation to this service. This included omission of the issues that we identified at our inspection in relation to patient and environmental risk assessment and management, implementation of national guidance and staff training.

The service had suitable plans for emergencies including outbreaks of COVID-19.

There were no cost improvement projects reported.

Information management

Teams did not always have quick and easy access to the information they needed to provide safe and effective care. However, managers had access to information they needed.

There were issues with computer hardware and some computers needed to be upgraded. Systems were not always reliable, there were intermittent issues in accessing the electronic prescribing and medicines system and the electronic patient record system. Staff did not always use the systems consistently to record and store information.

Information systems included confidentiality of patient records.

Managers had access to information to support them in their management role.

Staff made notifications to external bodies when needed.

Long stay or rehabilitation mental health wards for working age adults

Engagement

Managers engaged actively with staff, patients, carers and stakeholders.

Staff, patients and carers had access to up-to-date information about the service.

Patients and carers had opportunities to give feedback on the service they received. This was mainly through the friends and family test, community meetings and a carer's support group.

Managers and staff had access to the feedback from patients, carers and staff and used it to make improvements. Feedback was used by managers to make positive changes in the service.

Patients and carers were involved in developing the service. When any changes occurred, patients and where appropriate carers' views were sought.

Managers engaged with external stakeholders including commissioners and advocacy services. Staff had positive relationships with external agencies and advocacy services and communicated with them regularly.

Learning, continuous improvement and innovation

Staff did not engage actively in local and national quality improvement activities.

Although the trust used quality improvement methodologies, none of the staff in this service had participated and none of the quality improvement projects completed applied to this service.

The service had not participated in any research.

Staff were not participating in any national audits in this service.

The service did not participate in the accreditation scheme for inpatient standards for mental health services rehabilitation. However, staff had started to consider how the service was meeting the quality standards and they aspired for the service to become accredited.

Staff had implemented some of the Safewards interventions in the service.

Specialist community mental health services for children and young people

Requires Improvement ↑

Is the service safe?

Requires Improvement →←

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

Safe and clean environments

The management of the prevention and management of infection control had improved since the most recent inspection. All clinical premises where young people received care were safe, clean, well-equipped, well-furnished, well-maintained and fit for purpose.

Staff completed and regularly updated thorough risk assessments of all areas and removed or reduced any risks they identified. We looked at the environments of six locations where children and young people were seen, all had up to date environmental and ligature risk assessments completed.

All interview rooms had alarms or staff had personal alarms to summon help and staff were available to respond.

All areas were clean, well-maintained, well-furnished with bright, child friendly fixtures and fittings and were fit for purpose.

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

Staff always followed infection control guidelines, including handwashing. Staff maintained toy cleaning records to ensure infection control measures were met.

Staff made sure equipment was well-maintained, clean and in working order. We saw “I am clean stickers” were used appropriately.

Safe staffing

Staffing numbers and disciplines within teams had increased since the most recent inspection. The service had enough staff, who knew the young people and received basic training to keep them safe from avoidable harm. The number of young people on the caseload of the teams, and of individual members of staff, was not too high to prevent staff from giving each young person the time they needed.

Nursing staff

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

Specialist community mental health services for children and young people

The service had reducing vacancy rates, there were two band six, two band five, two cognitive behaviour therapist, two psychologist and three assistant practitioner vacancies across the six Norfolk teams. In Suffolk there were four band six and one assistant practitioner vacancies over the three teams.

The service had low use of bank or agency nurses.

The service had low turnover rates, the rate across the service was 2% against a trust target of 15%.

Managers supported staff who needed time off for ill health.

Levels of sickness were high at 14% against a trust target of 5%. Managers told us that sickness had increased due to the COVID-19 pandemic and they were working with HR colleagues to support staff back to work.

The number and grade of staff matched the provider's staffing plan.

Medical staff

The service had enough medical staff, however we were told that the Consultant Psychiatrist in the Suffolk locality was leaving, and a replacement doctor had not yet been appointed. We observed a meeting where the service medical lead and others discussed the interim cover plans and the longer-term recruitment plans.

There were no service locums in post during this inspection.

The service could get support from a psychiatrist quickly when they needed to, an on-call system was in place to ensure staff could access psychiatrists in a timely way.

Mandatory training

Staff had completed and kept up to date with their mandatory training. Overall compliance rates across the service was 85% against the trust target of 95%.

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

Managers monitored mandatory training and alerted staff when they needed to update their training.

Assessing and managing risk to young people and staff

Staff did not always assess and manage risks to young people and themselves. They responded promptly to sudden deterioration in a young persons' health. Staff followed good personal safety protocols.

Assessment of risk

Staff did not always complete risk assessments for each young person, using the trust combined risk assessment tool, and reviewed this regularly, including after any incident. We found 11 out of 34 records did not have updated risk assessments in place.

Specialist community mental health services for children and young people

Staff did not always recognise when to develop and use crisis plans and advanced decisions according to young peoples' need. We found 11 out of 34 records where crisis plans were absent.

Management of risk

Staff responded promptly to any sudden deterioration in a young person's health. We saw one example where a young person had self-harmed on the premises and staff had successfully resuscitated them and transferred them to the acute hospital where they made a full recovery.

Staff continually monitored young people on waiting lists for changes in their level of risk and responded when risk increased. We saw staff managing referrals effectively. Weekly allocation meetings for high intervention young people had the same clinician input, where possible for continuity, the meetings were minuted, daily safety huddle meetings were held, and staff reported all 18-week breaches to the trust via the incident management system.

Staff followed clear personal safety protocols, including for lone working.

Safeguarding

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

Staff received training on how to recognise and report abuse, appropriate for their role. Staff told us they could access the trust safeguarding lead easily and had very good relationships with the local authorities who provided bespoke training sessions on request.

Staff kept up-to-date with their level three safeguarding training, compliance rates across the service was 100%.

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

Staff across both grades and professions described how they recognised adults and children at risk of or suffering harm and worked with other agencies to protect them.

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

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

Staff access to essential information

Records were clear, up-to-date and easily available to all staff providing care.

Clinical notes were in electronic form and all staff could access them easily.

When young people transferred to a new team, there were no delays in staff accessing their records. We saw evidence of communication between teams both before and after young people were transferred.

Records were stored securely.

Medicines management

The service used systems and processes to safely prescribe, administer, record and store medicines. Staff regularly reviewed the effects of medicines on each young person's mental and physical health. However, we found out of date pregnancy and drug testing kits at 80 St Stephens Road.

Staff followed systems and processes when safely prescribing, administering, recording and storing medicines. We inspected four clinic rooms; one was currently dispensing medicines, we reviewed 11 prescription charts, all complied with the provider's medicines management policy.

Staff reviewed young peoples' medicines regularly and provided specific advice about their medicines.

Staff stored and managed medicines and prescribing documents in line with the provider's policy. However, we found out of date pregnancy and drug testing kits at 80 St Stephens Road.

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

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

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

Staff delivered care which met those set out by the National Institute for Clinical Excellence (NICE)

Track record on safety

The service had a good track record on safety.

Reporting incidents and learning from when things go wrong

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

Staff described how they identified incidents to report and how to report them.

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

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

Staff comprehensively described their responsibilities regarding the duty of candour. They were open and transparent and gave young people and families a full explanation when things went wrong.

Specialist community mental health services for children and young people

Managers debriefed and supported staff after any serious incident. Staff described the process of "hot and cold" debriefs, hot debriefs taking place as soon as possible after an incident occurring and cold, more detailed debriefs happening days after the incident.

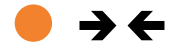
Managers investigated incidents thoroughly. Young people and their families were involved in these investigations.

Staff received feedback from investigation of incidents, both internal and external to the service. The feedback was given both face-to-face in team meetings and displayed on a governance notice board in the team base.

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

There was evidence that changes had been made as a result of feedback. We were told that letters to young people and their carers had been updated to include emergency support numbers at the top of the letter rather than at the end following feedback from the young people.

Is the service effective?

Requires Improvement 

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

Assessment of needs and planning of care

Staff did not always assess the health needs of all young people. They did not always work with young people and families and carers to develop individual care plans and did not always update them when needed. Care plans did not always reflect the assessed needs, were not always personalised, holistic and recovery oriented.

Staff did not always complete a comprehensive mental health assessment of each young person. We reviewed 34 care records, 20 of which had an up-to-date mental health assessment.

Staff told us how they had liaised with speech and language therapy services to increase their knowledge base. However, they did not always ensure that young people had a full physical health assessment and knew about any physical health problems. We found 11 out of the 34 care records did not have a physical health assessment.

Staff did not always develop a comprehensive care plan for each young person that met their mental and physical health needs, or regularly reviewed and updated care plans when needs changed. We reviewed 34 records, 20 of which were comprehensive, regularly reviewed, personalised, holistic and recovery orientated.

Best practice in treatment and care

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

Specialist community mental health services for children and young people

Staff provided a range of care and treatment suitable for the young people in the service. These included psychological, cognitive behavioural, family and play therapy along with educational sessions for young people and their carers, where appropriate.

Staff delivered care in line with best practice and national guidance.

Staff made sure young people had support for their physical health needs, either from their GP or community services. Managers told us there were regular interface meetings with primary and acute care providers.

Staff supported young people to live healthier lives by supporting them to take part in programmes or giving advice.

Staff used outcome measures and routine outcome measures to assess and record the severity of patient conditions and care and treatment outcomes. Examples of outcomes used were; The Revised Children's Anxiety and Depression Rating Scales for Social Phobia, panic disorder and generalised anxiety, Difficulties in Emotion Regulation Scale and Goal Based Outcomes.

Staff used technology to support young people. Appointments were offered either face-to-face or virtually. We were told about the "attend anywhere" initiative which young people can attend via zoom from the venue of their choice. The facility had a virtual monitored waiting room which staff can use to limit non-essential attendance at the meeting.

Staff took part in clinical audits, benchmarking and quality improvement initiatives. Managers told us about work that had been undertaken by staff in Norfolk with NHS Education and Improvement to look at the quality of outcome letters to young people and flow though the service. This was in the process of being shared across both the Norfolk and Suffolk teams.

Skilled staff to deliver care

The mental health teams for children and young people included or had access to the full range of specialists required to meet the needs of patients under their care. Managers made sure that staff had the range of skills needed to provide high quality care. Managers had improved compliance regarding staff receiving management supervision and appraisals and there were opportunities for staff to update and further develop their skills. Managers provided an induction programme for new staff. However, the trust failed to provide an accurate record for the uptake of clinical supervision.

The service had a full range of specialists to meet the needs of the young people.

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

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

Managers supported staff through regular, constructive appraisals of their work, compliance across the service was 94%.

Managers supported staff to access regular, constructive clinical supervision of their work. The trust failed to provide an accurate record for the uptake of clinical supervision. However, we saw evidence that managers were checking that staff were receiving clinical supervision as part of the line management supervision process.

Specialist community mental health services for children and young people

Managers made sure staff attended regular team meetings or gave information from those they could not attend.

Managers identified any training needs their staff had and gave them the time and opportunity to develop their skills and knowledge. Additional specialist training included, accredited mental health training, forensic child and adolescent training, autism diagnostic observation schedule and debrief training.

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

Multi-disciplinary and interagency teamwork

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

Staff held regular multi-disciplinary meetings to discuss young people and improve their care.

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

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

Staff had effective working relationships with external teams and organisations. We saw evidence of interface meetings with primary care, acute care, adult mental health, schools and recovery services.

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

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

Eighty two percent of staff received and kept up-to-date with training on the Mental Health Act and the Mental Health Act Code of Practice and could describe the Code of Practice guiding principles.

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

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

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

Patients had easy access to information about independent mental health advocacy.

For patients subject to a Community Treatment Order, staff completed all statutory records correctly.

Care plans clearly identified patients subject to the Mental Health Act and identified the Section 117 aftercare services they needed.

Specialist community mental health services for children and young people

Good practice in applying the Mental Capacity Act

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

Ninety four percent of staff received and kept up-to-date with training in the Mental Capacity Act and had a good understanding of at least the five principles.

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

Staff knew where to get accurate advice on Mental Capacity Act.

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

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

When staff assessed young people as not having capacity, they made decisions in the best interest of young people and considered the young persons' wishes, feelings, culture and history.

The service monitored how well it followed the Mental Capacity Act and made changes to practice when necessary.

Staff audited how they applied the Mental Capacity Act and identified and acted when they needed to make changes to improve.

Staff understood how to support children under 16 wishing to make their own decisions and applied the Gillick competency principles when necessary.

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

Is the service caring?

Good ↑

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

Kindness, privacy, dignity, respect, compassion and support

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

Specialist community mental health services for children and young people

Staff were discreet, respectful, and responsive when caring for young people.

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

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

Staff directed young people to other services and supported them to access those services if they needed help for example; local colleges and vocational opportunities.

Young people and their carers said staff treated them well and behaved kindly.

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

Staff felt that they could raise concerns about disrespectful, discriminatory or abusive behaviour or attitudes towards patients.

Staff followed policy to keep young peoples' information confidential.

Involvement in care

Staff involved young people in care planning and risk assessment and actively sought their feedback on the quality of care provided. They ensured that young people had easy access to independent advocates. Staff informed and involved families and carers appropriately.

Involvement of patients

Staff did not always involve young people or offer them access to their care plans. We reviewed 34 care records and found 13 young people had not been offered a copy.

Staff made sure young people understood their care and treatment, leaflets and care plans were available in easy read format.

Staff involved young people in decisions about the service, when appropriate. The person participation lead described several engagement sessions where young people and their families had been involved in developing the service.

Young people and their carers could give feedback on the service and their treatment and staff supported them to do this. Young people's involvement forums were established and run by the person participation lead.

Staff supported young people to make advanced decisions on their care.

Staff made sure young people could access advocacy services.

Involvement of families and carers

Staff supported, informed and involved families or carers, they were invited to assessment, intervention and multi-disciplinary meetings.

Specialist community mental health services for children and young people

Staff helped families to give feedback on the service. Suggestion and feedback boxes were situated in waiting rooms.

Staff did not always ensure carers had information on how to find the carer's assessment. Twelve out of the sixteen carers we spoke with had not been offered a carers assessment.

Is the service responsive?

Requires Improvement 

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

Access and waiting times

The service was not easy to access. Waiting lists were long, the trust reported a total referral to treatment rate as 93% against a target of 95%. There are a high number of active referrals, which grew from a low of 95 in August 2020 to 2,547 in July 2021.

There were 729 young people waiting more than 15 weeks for assessment and or allocation to a care coordinator or lead professional across Norfolk and Suffolk. The largest waits were in Central Norfolk Child and Adolescent and Youth Minor services at 105 respectively. Staff could not assess and treat young people who required urgent care promptly and those who did not require urgent care waited significantly to start treatment. Young people waiting for assessment were triaged by a senior clinician and were then rated red, amber or green according to risk. We saw evidence of the monitoring of young people in Norfolk and Suffolk. Those on the red waiting list for assessment and treatment were contacted on a weekly basis, those rated as amber were contacted every four weeks and those rated green were contacted three months. The service used a tracker log to oversee young people on the waiting list. Staff followed up young people who missed appointments. The service referral criteria did not exclude young people who would have benefitted from care.

The service ensured that young people, who would benefit from care from another agency, made a smooth transition. This included ensuring that transitions to adult mental health services took place without any disruption to the young person's care.

The service had clear criteria to describe which young people they would offer services to and offered patients a place on waiting lists.

Staff tried to engage with people who found it difficult, or were reluctant, to seek support from mental health services.

Staff tried to contact people who did not attend appointments and offer support.

Patients had some flexibility and choice in the appointment times and format available.

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

Appointments ran on time and staff informed patients when they did not.

Specialist community mental health services for children and young people

The service used systems to help them monitor waiting lists to support young people, each team held daily safety huddle meetings and received regular data to enable them to have oversight of the waiting lists and review the risk rating of young people.

Staff supported young people when they were referred, transferred between services, or needed physical health care.

The service followed national standards for transfer.

Facilities that promote comfort, dignity and privacy

Generally, the design, layout, and furnishings of treatment rooms supported young peoples' treatment, privacy and dignity. However, Thurlow House was an exception to this with a lack of a designated waiting area for children under 14 years old.

The service had a full range of rooms and equipment to support treatment and care.

Thurlow House did not have a designated waiting area for children under 14 years old. Clinicians met them in reception and escorted them to a room to wait for their appointment, this meant that if there was a delay a child and adult would share the same waiting area and potentially could be a safeguarding issue.

Interview rooms in the service had sound proofing to protect privacy and confidentiality.

Meeting the needs of all people who use the service

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

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

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

The service had a disengagement policy which set out how to manage young people who avoid contact with services, either intentionally or unintentionally over a period of time.

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

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

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

Listening to and learning from concerns and complaints

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

Specialist community mental health services for children and young people

Young people, relatives and carers knew how to complain or raise concerns. The service had six formal complaints in the 12 months prior to this inspection, which was below the trust average of 49 per month.

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

Managers investigated complaints and identified themes.

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

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

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

The service used compliments to learn, celebrate success and improve the quality of care. The people participation lead and staff had held several events whereby young people and their families shared their experiences, which led to improvements in care.

Is the service well-led?

Requires Improvement 

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

Leadership

Staff knew who the leaders were of the service and reported they were visible and approachable, not only to them but for patients too. Leaders had the skills, knowledge and experience to perform their roles. They had a good understanding of the services they managed and were visible in the service and approachable for patients and staff.

Staff said leaders were good and supported them in their day to day work. We observed that managers were visible in the service and knew the needs of the service and the young people in their care.

We spoke with the clinical leads as well as other members of the multi-disciplinary team and they confirmed development opportunities for career progression were available and were encouraged to take these up.

Vision and strategy

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

Staff said that the trust had invested in the service for young which had been positive, and they were proud to work for the service.

Specialist community mental health services for children and young people

Staff were clear about the transformation plans and strategy. Staff were able to articulate that the trust vision and values of "Positively, Respectfully, Together", where the trust aimed to ensure that people have the best possible experience of mental health care.

Staff were very motivated by and proud of the service. There were consistently high levels of constructive engagement with patients, carers and staff. Managers had developed their leadership skills and those of others, to ensure they were empowered to positive changes.

Culture

Staff felt respected, supported and valued. They said the trust promoted equality and diversity in daily work and provided opportunities for development and career progression. They could raise any concerns without fear. Staff told us they felt extremely respected, supported and valued. They said leaders promoted equality and diversity in daily work and provided opportunities for development, for example training and career progression, and they felt very proud to work in the service.

Governance

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

The managers had reviewed the audit schedule and implemented a comprehensive schedule that included the environment, Mental Health Act, Mental Capacity Act, care plans, medicines management, supervision, training and all aspects of the care and treatment given to patients. This audit schedule had started, and the managers said the findings would be shared in staff meetings and supervision to ensure outcomes were met and improvements made where needed.

Managers had systems in place to monitor waiting lists. However, they told us that the increased number of referrals to the service was leading to young people waiting excessively long to access care and treatment.

Management of risk, issues and performance

Managers told us the significant increase in referrals was having a negative impact within the teams, as waiting lists were very long. They had implemented systems to assess and manage risks however they said this was not sustainable in the long term.

Managers had good oversight of clinical practice and performance. There was a monthly meeting to look at key performance indicators and we saw actions where improvements had been implemented. There were Teams had access to the information they needed to provide safe and effective care and used that information to good effect.

Staff were able to add items to the local and the trust risk register if needed, the team had escalated the long waiting times to the executive team to include in the trust risk register.

The service had business continuity plans for emergencies for example, adverse weather or a flu outbreak.

Information management

Specialist community mental health services for children and young people

Staff collected analysed data about outcomes and performance and engaged actively in local and national quality improvement activities.

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

Access to equipment and information technology, including the telephone and patient record systems, worked well and helped to improve the quality of care.

Information governance systems included confidentiality of patient records.

Team managers had access to information to support them with their management role. This included information on the performance of the service, staffing and patient care.

Information was in an accessible format, and was timely, accurate and identified areas for improvement.

Staff made notifications to external bodies as needed.

Engagement

Managers worked closely with other local healthcare services and organisations such as schools, public health, local authority, voluntary and independent sector, to ensure there was an integrated local system that met the needs of children and young people living in the area. There were local protocols for joint working between agencies involved in the care of children and young people.

In the young person's Care Programme Approach meeting we observed, we saw how staff and managers worked with other local health and social care providers. All partners were engaged in working together to ensure the best outcomes for the patient and their family.

Learning, continuous improvement and innovation

Managers and staff spoke about how they learned continuously. Staff had twice weekly reflective practice sessions where they discussed care, incidents that had occurred and how they could learn from them. They also spoke about learning from what went well and how they could use that to improve working young people. Managers told us about work that had been undertaken by staff in Norfolk with NHS Education and Improvement to look at the quality of outcome letters to young people and flow though the service. This was in the process of being shared across the Norfolk and Suffolk teams.

Child and adolescent mental health wards

Inadequate ↓↓↓

Is the service safe?

Inadequate ↓↓

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

Safe and clean care environments

The ward was clean well-equipped, well-furnished, well-maintained and fit for purpose.

Safety of the ward layout

Staff completed and regularly updated thorough risk assessments of the ward area and removed or reduced any risks they identified.

Staff could observe patients in all parts of the ward. CCTV covered all blind spots.

There were no unaccounted-for ligature anchor points in the service. There was a ligature risk assessment most recently completed on 21 April 2021. Staff knew about any potential ligature anchor points and mitigated the risks to keep patients safe.

Staff knew about the blind spots and other high-risk areas on the unit. Staff referred to a ward heatmap displayed in the nursing office which highlighted potential high-risk areas on the ward.

The ward was well designed to accommodate both male and female patients without compromising mixed sex accommodation guidance.

Staff carried alarms which were regularly tested. Patients had access to nurse call alarms in their bedrooms and en-suite areas.

Maintenance, cleanliness and infection control

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

For the most recent Patient-Led Assessments of the Care Environment (PLACE) the location scored better than similar locations across England for condition, appearance and maintenance at 100%.

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

Staff followed infection control policy, including handwashing.

Seclusion room

The ward did not have a seclusion room. However, the ward did have a well laid out de-escalation area with lounge area, bedroom and toilet facilities.

Clinic room and equipment

The clinic room was fully equipped and tidy with accessible resuscitation equipment and emergency drugs that staff checked regularly. There were no temperatures recorded for the clinic room or medicine refrigerators, this meant medicines might not be stored at the correct temperature. However, cleaning records showed that staff checked, maintained, and cleaned all other equipment.

Safe staffing

While the service had enough nursing staff, the service relied heavily on known bank and agency staff. There was no permanent doctor and staff did not have adequate training to keep people safe from avoidable harm.

Nursing staff

While the service had enough nursing and support staff, the service relied heavily on bank and agency staff, most of whom were block booked and known to other staff and patients**.**

Since August 2021, when the new ward management team took over ward managers made sure all bank and agency staff had an induction and overview of the service before starting their shift. We saw evidence of this in the new staff induction folder.

The service had high vacancy rates at 18% overall, the trust target was 9%. This figure included 7% medical, 12% registered nurses and 5% support workers.

The service had high but reducing rates of bank and agency registered nurses. In January 2021, the service had 30% registered agency and bank nurses. In October 2021, this figure had reduced to 11%. The difference was due to successful recruitment of registered nurses.

The service had high and increasing rates of carer support workers. In January 2021, the service had 41% agency and bank support workers. In October 2021, this figure had increased to 66%. The increase was due to an increase in establishment numbers to meet patient needs.

The service had a turnover rate of 17%, the trust target was 15%. Managers explained most of their turnover was due to staff promotion or planned retirement.

Managers supported staff who needed time off for ill health. Levels of sickness was 7% and the trust target was 5%. However, this included COVID-19 related sickness absences

Managers calculated and reviewed the number and grade of nurses, and healthcare assistants for each shift. The establishment of nursing staff was two qualified nurses and three support workers on each of the three shifts per day. These numbers were supported by a ward manager or nurse in charge on each shift, plus a matron or senior nurse in the daytime.

The ward manager could adjust staffing levels according to the observation levels of the patients. Managers also acknowledged due to the acuity of the four patients they currently had, and the inexperience of some staff, they had temporarily increased the nursing establishment to eight staff in the daytime and ten staff at night-time. Managers had identified an increased number of incidents during the night shift and increased staffing at night-time accordingly.

Patients had regular one-to-one sessions with their named nurse or associate nurse. If neither were available, all patients had a support nurse allocated at the beginning of each shift and they were informed who this would be.

Patients rarely had their escorted leave, or activities cancelled, even when the service was short staffed. We saw care notes, school attendance records and activity sheets that showed when activities were cancelled or declined this was at the request of patients.

While the service had enough staff on each shift to carry out any physical interventions, not all these staff were trained in prevention and management of violence and aggression.

Staff shared key information to keep patients safe when handing over their care to others.

Medical staff

The service did not have a permanent child and adolescent mental health consultant psychiatrist, and the responsible clinician duties were covered by the trust's medical director. The trust was advertising for a replacement. However, there was a general practitioner with specialist interest in children and young people who provided two clinics per week on the ward. During out of hours, the service used the trust's out of hours on call doctors. Staff told us because the out of hours service were aware of their problems, they did not have to wait an undue amount of time for medical help to arrive. They also used the local accident and emergency service as required.

While managers could use locum doctors when they needed additional medical cover, they had not found this to be very reliable longer term.

When locums were used, managers made sure the locum staff had a full induction and understood the service before starting their shift.

Mandatory training

Staff were not up to date with their mandatory training. We were not assured of the actual training compliance as information provided on the ward told us it was 52% but the trust's compliance figure for this service was 79%. Eight out of nine staff we spoke with said they were not up to date with mandatory training.

Three out of the 20 mandatory courses for healthcare support workers fell below the trust target of 85%. These were information governance at 60%, Prevention and Management of Violence and Aggression (PMVA) at 31%, and safeguarding adults at 57%. Six out of the 25 mandatory courses for registered nurses fell below the trust target of 85%. These were counter fraud at 58%, immediate life support at 58%, information governance at 52%, learning disability at 50%, PMVA at 33% and safeguarding adults at 66%. Managers told us some course figures such as PMVA were low because face-to-face training during the COVID-19 pandemic had been limited. However, the trust was gradually introducing more courses to catch up with the backlog prioritising immediate life support, basic life support and PMVA.

Managers were aware some mandatory training fell short of the trust's required minimum level and told us about their plans to ensure all staff could access training as needed.

During our revisit to Dragonfly ward on 29 December 2021, we found mandatory training compliance had increased to 77% overall with an increase to 71% for information governance, 64% for PMVA and 67% for immediate Life support. Managers had prioritised training in life support and prevention of violence and aggression to maintain patient safety and all staff who had yet to complete their refresher training had booked to complete this by the end of February 2022.

Assessing and managing risk to patients and staff

While staff assessed patient risk and updated risk assessments following incidents, they did not always manage the risks to patients and themselves well. Although staff used restraint and rapid tranquilisation frequently, staff told us this was only after all attempts at de-escalation had failed.

Assessment of patient risk

We reviewed all four patient's risk assessments, positive behavioural support plans and risk management plans. Staff had completed these documents for each patient on admission, using a non-standardised but comprehensive risk assessment tool which was part of the electronic recording system they used. However, we could not be assured that staff reviewed this information regularly at all care and treatment reviews and after any incident because not all incidents had been reported.

Management of patient risk

Staff did not always intervene to prevent or reduce risks for patients. They failed to understand the individual needs of the patients, or the model of care used on the unit. This was evidenced in the number, frequency and types of incidents we reviewed, including physical aggression towards staff, self-harm and ligation, such as ligating to the point of causing themselves harm.

Staff had not always followed trust policies and procedures when they needed to search patients or their bedrooms or remove objects to keep the patients safe from harm. Examples such as patients hiding sharp objects to cut up clothes and curtains to make ligatures and hiding items to use as ligatures in their clothing or bedrooms.

Staff did not always respond to changes in risk in a timely manner leading to escalation of challenging behaviours posed by patients. For example, patients ligating several times in a short period of time to the point of causing themselves harm requiring hospital treatment without intervention from staff to prevent reoccurrence.

However, staff could observe patients in all areas of the ward and the environmental risk assessment showed the procedures staff followed to minimise risks where they could not easily observe patients. The ward had CCTV coverage in all communal areas.

Use of restrictive interventions

We were concerned the levels of restrictive intervention used on the ward were high. We could not be sure all physical restraint procedures were carried out correctly or safely. Data showed only 33% of registered nurses and 31% of healthcare support workers had completed mandatory PMVA physical intervention training. From 1 June 2021 to 31

October 2021 there had been 313 interventions. Of these 313 incidents, 23 had been recorded as prone restraints. From 11 August 2021 to 31 October 2021 there had been 43 incidents of rapid tranquilisation, involving eight different patients. Out of these 43 incidents, 23 were for one patient. Managers told us about the increase in restrictive intervention was primarily due to patient acuity.

Daily care notes indicated staff still made every attempt to avoid using restraint by using de-escalation techniques and restrained patients only when these failed and when necessary to keep the patient or others safe.

Staff failed to complete observation sheets correctly. We reviewed two weeks of observation sheets for three different patients. We found on two different patients records 15-minute observations were recorded as a one-hour block and staff failed to record what activities the patient was doing in a given time period. Three records showed that staff recorded specific incidents that had taken place, but the times did not match those of the closed circuit television. In addition, we found one observation failed to record a ligation incident for a patient on one-to-one observation.

Managers acknowledged these errors when we raised them during the inspection visit and assured us, they would put in place staff training on the use of therapeutic observations. However, we noted there was not a training course currently being offered to staff and agency staff as part of their mandatory training, role specific training or induction program.

Six of the nine staff we spoke with were not fully aware of the provider's restrictive interventions reduction program. This was despite documents suggesting staff participated in this program, Staff we spoke with did understand the Mental Capacity Act definition of restraint and believed they worked within in.

Staff followed National Institute for Health and Care Excellence (NICE) guidance when using rapid tranquilisation. Due to the acuity of the patients when distressed, the use of rapid tranquilisation was high.

Although staff had to use the de-escalation area for patient's seclusion, because this area had a bedroom and en-suite bathroom attached and staff kept clear seclusion records it met seclusion code of practice requirements.

While the service did not report any cases of long-term segregation, staff were aware of the trust's policies relating to long term segregation including guidance set out in the Mental Health Act Code of Practice.

Safeguarding

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

Staff received training on how to recognise and report abuse, appropriate for their role.

Staff kept up to date with their safeguarding children training. Data showed 89% of healthcare support workers and 83% of registered nurses were up to date with safeguarding children level 3.

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

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

Child and adolescent mental health wards

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

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

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

Staff access to essential information

Staff had easy access to clinical information, but while records were easy to maintain we found errors in their documentation of clinical observations and incident recording.

Patients electronic daily care notes were accessible to all staff including agency and bank staff and key information about patients likes, dislikes and trigger points was kept in a hard copy format in the nursing office.

Although the service used electronic patient records, staff told us for ease they all accessed some key information such as patients' formulations, positive behavioural support plans and activity timetables in paper format in folders in the nursing office and we found these were regularly updated.

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

Medicines management

Although the service had systems and processes in place to safely prescribe, record and store medicines, staff did not always administer medicines in a timely way. While staff regularly review the effects of medicines on each patient's mental and physical health, they did not always recognise the accumulative effects of sedative medicines.

Staff were not always following systems and processes when prescribing, administering, and storing medicines. Staff were not recording all the information required on the medicines charts all the time. Staff did not always follow current national practice to check patients had the correct medicines. Treatment certificates were not kept within the the electronic medicine charts, they were kept within Lorenzo patient record under the MHA tab. Interviews with staff did not assure us that checks were always made between the treatment certificate on the electronic data base and the medication administrated. Also there was no evidence showing how staff had provided specific medicines advice to patients.

Medicines charts and nurse audits showed staff did follow current national practice to check patients had the correct medicines. The service had reporting and escalation processes to ensure staff knew about safety alerts and incidents, so patients received their medicines safely.

While staff reviewed the side effects of each patient's medicines on their physical health in line with National Institute for Health and Care Excellence guidance, they did not appear to recognise the impact the sedating effect of the medicines could be having on daily function. We saw all the patients on the ward were prescribed Quetiapine of between 125 mgs and 300 mgs as a regular prescription and Promethazine 50 mgs 'as and when required'. While these doses were in line with British National Formulary (BNF) guidelines these medicines have a sedating effect, which was further

compounded as staff did not always administer the medicines at the prescribed times due to patient refusal. For example, patients not getting Quetiapine medicines until later in the evening meaning they were not waking until mid-morning. The impact of this disrupted medicines routine was that patients were not able to get ready to attend school or therapy sessions on time.

Track record on safety

Reporting incidents and learning from when things go wrong

The service did not manage patient safety incidents well. While staff recognised incidents and recorded them, staff were not always recording correct times on observation sheets, and electronic incident records. While managers investigated incidents and shared lessons learnt with the whole team, we did not see examples of how they had put any learning into practice. However, when things went wrong, staff apologised and gave patients honest information and suitable support.

We were not assured staff were rating incidents by their correct severity. For example, between 1 June 2021 to 31 October 2021 there had been a total 425 incidents recorded on the ward including incidents of restraint. These incidents included self-harm, ligation, absconding, physical and verbal violence to peers and staff, criminal damage to property, and severe headbanging. All incidents including those which had resulted in a degree of injury and requiring treatment at accident and emergency units had been rated as low severity.

The service did not have a specific policy and procedure in relation to headbanging to protect patients from serious injury, despite the electronic incident record showing incidents of this as a self-harming behaviour exhibited by some patients.

Staff we spoke with knew what incidents to report and how to report them. However, staff were not recording the correct time that incidents took place this meant that it was not possible to confirm what times the incidents actually took place. Whilst reviewing two serious incidents, the times shown on the daily care records, the closed circuit television footage, the incident form and the observation sheets did not align. We also found evidence of three incidents in the daily care notes that had not been reported on the electronic incident recording data base.

We found little evidence to show how changes had been made because of feedback and investigation into incidents. Although managers had plans for improvements and had identified the changes needed due to lessons learnt, they had not ensured the plans had been implemented. Managers cited having time away from ward duties, including physical attendance on the ward to support staff and responding to concerns with ward governance issues, was a barrier to following through their plans in a timely way.

The service had zero never events on the ward. Managers told us if they did have any of these events, they would share learning about them with their staff and across the trust. Managers shared learning with their staff about serious and relevant incidents that happened elsewhere, such as self-harm from plastic carrier bags, and ligation from poorly discarded face masks, and latex gloves.

Staff understood the duty of candour. They were open and transparent and gave patients and families a full explanation when things went wrong.

Managers had only recently reintroduced formal debrief and support for staff after any serious incident. This practice had diminished over the previous year and prior to the new management team taking up their posts.

Child and adolescent mental health wards

During our revisit to Dragonfly ward on 29 December 2021, we found from 6 November 2021 to 29 December 2021, there had been 39 incidents involving two patients. The majority of which were self-harm attempts. All incidents had been reported using the electronic reporting system, rated appropriately and reviewed by managers. Incidents were discussed at daily handover meetings and recorded using 'Situation, Background, Assessment and Recommendation' forms.

Is the service effective?

Inadequate 

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

Assessment of needs and planning of care

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

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

Psychologists worked with individual patients, their relatives and/or carers and wider team to produce detailed formulations for each patient.

Psychologists worked with individual patients to produce functional analysis and positive behaviour support plans that once completed were shared with the care team.

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

Staff developed a comprehensive care plan for each patient that met their mental and physical health needs.

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

Care plans were personalised, holistic and recovery orientated.

Best practice in treatment and care

The service offered a range of treatment and care for patients based on national guidance and best practice and used a recognised rating scales to assess and record severity and outcomes. However, not all staff had the required skills to deliver the range of treatments. Although we found all staff did ensure patients had good access to physical healthcare and supported them to live healthier lives.

The range of treatment and care offered by the unit included a bespoke educational program to meet individual patient's needs. This program was delivered by experienced educational facilitators who understood the learning needs of patients.

Child and adolescent mental health wards

Care and treatment was designed around a complex trauma care model, informed by dialectical behaviour therapy and unconditional positive regard. It aimed to help patients achieve better self-regulation and develop emotional intelligence. Both the education and treatment programs used recognised rating scales to assess and record patients' severity and clinical outcomes.

We found some staff lacked the skills or confidence to deliver the care and treatment program. The impact of this for patients were mixed messages around managing their distress and feelings to self-harm. A lack of adult guidance, structure and routine for patients resulted in poor boundary keeping which allowed the young people to take advantage of the situation they found themselves in. This resulted in an increase in incidents and lack of engagement in education, with the educators having to coax the young people out of bed.

Interviews with senior staff confirmed this was a service in transition and state of flux, after a difficult period of lockdown and loss of direction. As such many of the plans to address the staff skills shortages identified had not had time to be fully implemented.

Staff identified patients' physical health needs and recorded them in care plans. They made sure patients had access to physical health care, including specialists as required.

Staff met patients' dietary needs and assessed those needing specialist care for nutrition and hydration. Staff helped patients live healthier lives by supporting them to take part in programmes or giving advice.

Staff used technology such as whiteboard and visual cues to explain complex information and support patients.

Senior staff took part in clinical audits, benchmarking and quality improvement initiatives. However, managers did not always use results from audits to make improvements. An example was while recognising an increase in headbanging incidents, ward managers had not ensured there was a headbanging policy and guidance for staff to follow. This meant patients could sustain serious head injury.

Skilled staff to deliver care

The ward team did not include a full range of specialists required to meet all the needs of patients on the ward. Neither had managers made sure all staff had the range of skills needed to provide high quality care. Until very recently staff appraisals, and supervision compliance rates had been very low, and not all new staff and agency staff had received a full induction.

The service did not have a full range of specialists to meet the needs of the patients on the ward. The service did not have a family therapist, consultant psychiatrist or responsible clinician as well as an occupational therapist. The impact of this meant that complex family therapy work had ceased, although where focussed family therapy work was indicated the psychologist was able to provide this.

Medical cover occurred four days days a week. The responsible clinician was always available by mobile/MS teams. The medical director was covering the consultant psychiatrist and responsible clinician duties for two sessions per week. A speciality doctor attended for six sessions a week. He was supported two sessions per week by a general practitioner with an interest in young people's mental health issues.

The occupational therapy posts were being covered by a newly qualified fulltime occupational therapist supported by a very experienced band three occupational therapy assistant**.**

Child and adolescent mental health wards

Managers failed to ensure staff had the right skills, training and experience to meet the needs of patients in their care. The lack of role specific training, particularly around the model of care used on the ward, had been impacted due to the significant loss of regular and substantive staff and high use of agency staff. We saw the lack of this training resulted in patients receiving mixed messages about how staff should support them to manage their distress and urges to self-harm. This led to patients becoming frustrated and annoyed resulting in an increase of incidents. In addition, this impacted negatively on staff as there was poor team cohesion resulting in staff not effectively working together to reduce or manage patients self-harm behaviours and incidents on the unit.

During our visit to Dragonfly ward on 29 December 2021 the trust had implemented an action plan in November 2021 that set out specialist training for all staff including mentalisation therapy, trauma informed care, psychopharmacology and eating disorders. Staff members had already completed sessions on therapeutic relationships and boundaries, the Mental Health Act, care planning, and reducing restrictive interventions. Two staff members had also completed a session on autistic spectrum conditions which they were planning to deliver to the rest of the ward staff. The trust had also offered a two day leadership course to all staff on the ward with dates booked for January and February 2022.

There was a comprehensive corporate induction and local orientation program for the ward. We saw data confirming that 95% of staff had completed the corporate induction. However, we did not see how managers monitored completion and evaluation of role specific induction and ward orientation. Eight staff we spoke with said they had completed the corporate induction but only three could recall receiving a thorough orientation to the ward that they felt prepared them sufficiently to work there.

Managers were not supporting staff through regular, constructive appraisals or supervision of their work. Clinical supervision compliance rates at October 2021 was 46% and appraisal for the same period was 46%. Managers acknowledged that supervision and appraisal had been very poor in the months leading up to September 2021. One manager told us, and we saw evidence on the data base that for much of 2021 clinical supervision rates for are staff had been below 20%. Some managers explained their plans to improve supervision rates including the introduction of a new supervision structure and hierarchy, training to improve recording of supervision and a revised format for supervision that would include reflective practice sessions, and peer supervision.

During our revisit to Dragonfly ward on 29 December 2021, we found supervision compliance had increased to 89% and appraisal compliance had increased to 85%.

Non-clinical staff, members of the therapy team and doctors had their own supervision structures outside of the ward environment. This supervision was above 90%, though some staff such as the occupational therapy technician had to source professional supervision from an occupational therapist on another ward. Managers attempted to make sure staff could attend regular team meetings but acknowledged this was not always possible due to the demands of the ward and need to prioritise patient care. However, they did make sure all staff had access to minutes of team meetings and key messages were shared at shift handovers.

Managers knew the training needs of their staff, particularly specialist role specific training. They acknowledged they were still only in the early stages of putting together and deciding how to deliver a bespoke and comprehensive training program for all staff working on the ward.

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

Multi-disciplinary and interagency teamwork

Child and adolescent mental health wards

There was a lack of cohesiveness and understanding of different roles amongst the staff group. This led to patients receiving mixed messages from different staff. However, the teams worked well with other relevant teams within the organisation and with relevant services outside the organisation.

Not all staff were able to be part of regular multidisciplinary meetings to discuss patients and improve their care due to the demands of ward based clinical activity and the need to cover for absent colleagues and vacant posts.

However, staff did everything they could to make sure they shared information about patients and any changes in their care, including during handover meetings.

Ward teams had effective working relationships with other teams in the trust and external teams and organisations.

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

Staff understood their roles and responsibilities under the Mental Health Act 1983 and the Mental Health Act Code of Practice and discharged these well. Managers made sure that staff could explain patients' rights to them. However, not all patients understood what an independent mental health advocate was.

While the service had clear, accessible, relevant and up-to-date policies and procedures that reflected all relevant legislation and the Mental Health Act Code of Practice. Two patients we spoke with were not aware of what mental health advocacy was. The trust post inspection stated that all patients had been offered access to an independent advocate via the education provision to support access to a specialist unbiased source of information, when young people were offered an IMHA they declined. One young person did have an IMHA who had visited them.

Training for staff on the Mental Health Act and the Mental Health Act Code of Practice and could describe the Code of Practice guiding principles was 87%.

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

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

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

Daily care notes detailed when patients took section 17 leave (permission to leave the hospital) when this was agreed with the Responsible Clinician. Staff and patients told us this was rarely cancelled.

Staff requested an opinion from a Second Opinion Appointed Doctor (SOAD) when they needed to.

Staff stored copies of patients' detention papers and associated records correctly and staff could access them when needed.

Although all the young people on the ward at the time of our visit were detained under the Mental Health Act, occasionally the ward accepted non detained people. These people were known as informal patients. Signs in the communal lounge and on the exit, door explained that informal patients wanted to leave the ward, they could leave freely by asking one of the staff to open the door for them.

Child and adolescent mental health wards

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

Managers and staff made sure the service applied the Mental Health Act correctly by completing audits and discussing the findings with staff in the multi-disciplinary team meetings.

Good practice in applying the Mental Capacity Act

While staff tried to support patients to make decisions on their care for themselves. Not all staff understood how the trust policy on the Mental Capacity Act 2005 applied to young people aged 16 and 17, or how the principles of Gillick competence as they applied to patients under 16. However, staff did assess and record consent and capacity or competence clearly for patients who might have impaired mental capacity or competence.

Not all staff understood the principles of Gillick competency. Two staff we spoke with could not fully describe how Gillick competency applied to young people under 16 wishing to make their own decisions. Four staff we spoke with did not fully understand how the Mental Capacity Act applied to patients 16 to 18. However, all staff knew where to go to get information if they needed it.

Two of the four patients did not know about mental capacity advocacy.

On two medicines charts, staff had not recorded the young person's consent to treatment. 87% of staff had received and kept up to date with training in the Mental Capacity Act and staff we spoke with had a broad understanding of the five principles.

Staff gave patients support to make specific decisions for themselves before deciding a patient did not have the capacity to do so.

When staff assessed patients as not having capacity, they made decisions in the best interest of patients and considered the patient’s wishes, feelings, culture, and history.

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

Is the service caring?

Requires Improvement 

Our rating of caring went down. We rated it as requires improvement.

Kindness, privacy, dignity, respect, compassion, and support

Child and adolescent mental health wards

Most staff treated patients with compassion and kindness, and respected patient's privacy and dignity. However, patients told us that some staff, particularly agency, were not always kind or compassionate. Staff told us of one instance where a staff member had not respected a patient's confidentiality. Not all staff understood the individual needs of patients and as such were not always able to empower patients to understand and manage their own care, treatment or condition.

Most staff followed policy to keep patient information confidential. We were told of one incident where a staff member had shared care and treatment information with a patient's nearest relative against the wishes of the patient who was over 16 and deemed to have capacity. When questioned the staff member acknowledged the patient had verbally expressed her wish for ward staff to not share any information with her relatives, but the staff member felt justified on this occasion to involve parents. We reviewed all care records for the patient and were unable to find evidence that this wish had been recorded.

Patients felt staff did not know what they were doing or how to help them. Not all staff understood and respected the individual needs of each patient. Seven of the nine staff we spoke with said they sometimes struggled to understand all the needs of the patient group and particularly those patients with complex needs. This meant staff often felt deskilled and unable to support the patient effectively.

Patients told us most staff were discreet, respectful, and responsive when caring for them, but occasionally a staff member might say something unkind about their behaviours or responses to certain situations.

Staff gave patients help, emotional support and advice when they needed it, and support to understand and manage their own care treatment or condition. However, we found due to the lack of understanding of staff, and skills to work therapeutically with the patient group, this advice might be contradictory to what another staff member had said. This had potential to lead to incidents with patients becoming confused, frustrated, and angry about receiving mixed messages.

For the most recent Patient-Led Assessments of the Care Environment (PLACE) 2019, the location scored better than similar locations across England for privacy, dignity, and wellbeing at 95%. However, the service had seen significant changes to staffing, patient acuity and care modelling since this date.

Staff were able to direct patients to other services and supported them to access those services if they needed help. Staff felt they could raise concerns about disrespectful, discriminatory, or abusive behaviour or attitudes towards patients.

Involvement in care

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

Involvement of patients

Staff introduced patients to the ward and the services as part of their admission. Staff discussed individual risk behaviours with patients and together identified acceptable ways of managing their risks. This discussion resulted co-produced care planning and risk assessments.

Daily care notes showed how on admission staff made sure patients understood their care and treatment and found ways to communicate this with patients who had communication difficulties. Such as specialised mobile phone apps, visual information leaflets and previous patients' stories.

Staff involved patients in decisions about the service, when appropriate.

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

Staff supported patients to make decisions on their care.

While staff made sure patients could access general advocacy services, they had not made the young people aware of Independent Mental Health Act Advocates.

Involvement of families and carers

Staff informed and involved families and carers appropriately.

Staff supported, informed and involved families or carers, through regular telephone updates and invitations to care and treatment reviews, both on site and remotely. We saw ten feedback forms from families of previous patients and five commented on the effective communication with the ward staff. One form commented on the good written feedback the family had received after a care and treatment review meeting.

Staff helped families to give feedback on the service through regular feedback questionnaires and carers groups.

Staff gave carers information on how to find the carer's assessment.

Family and carers we spoke with confirmed they could also ask to speak with the ward social worker at any time during working hours. In a separate interview the social worker we spoke with explained that a lot of her daily work involved communication with family and carers and there was an active carers feedback forum.

Is the service responsive?

Good ↓

Our rating of responsive went down. We rated it as Good.

Access and discharge

The senior management team had decided to not admit any further patients to Dragonfly unit until the current cohort of patients had settled. They liaised well with services that would provide aftercare and were assertive in managing the discharge care pathway. As a result, patients did not have excessive lengths of stay and discharge was rarely delayed for other than a clinical reason.

Managers made sure bed occupancy did not go above 85%.

While there was a clear access and discharge policy, managers confirmed that in early 2021, due to a serious lack of CAMHs beds nationally, and because the ward at that time was settled and they had capacity, senior managers had agreed to deviate from the access criteria and accepted two urgent referrals that would not have met the referral criteria.

Managers regularly reviewed length of stay for patients to ensure they did not stay longer than they needed. The average length of stay was 10 weeks, the expected length of stay was between six and twelve weeks. The longest stay was for a current patient who had been on the ward for 19 weeks.

In October 2021 and as a direct result of the situation on the unit at the time, the senior management team had made the decision to discharge or transfer as many patients as possible to relieve pressure on the ward. This meant the service had two out-of-area placements. The plan was to bring these patients back into the service once the ward was more settled and new systems and process were in place.

When patients went on leave there was always a bed available when they returned.

Patients were moved between wards during their stay only when there were clear clinical reasons, or it was in the best interest of the patient.

Staff did not move or discharge patients at night or early in the morning.

However due to a national shortage of CAMHs in-patient beds, the service could not guarantee that a psychiatric intensive care bed was always available if a patient needed more intensive care, neither could they guarantee that if a bed was available this would be close to where the patient lived.

Discharge and transfers of care

The service had one delayed discharge between October 2020 and October 2021, which was for a total of 67 days. The delay was due to there being no suitable placement available for them to move to.

Staff carefully planned patients' discharge and worked with care managers and coordinators to make sure this went well.

Staff supported patients when they were referred or transferred between services and followed national standards for transfer.

Facilities that promote comfort, dignity, and privacy

The design, layout, and furnishings of the ward supported patients' treatment, privacy and dignity. Each patient had their own bedroom with an en-suite bathroom and could keep their personal belongings safe. There were quiet areas for privacy. The food was of good quality and patients could make hot drinks and snacks at any time usually under the supervision of staff and as their risk assessments indicated.

Each patient had their own bedroom, which they could personalise. We saw two bedrooms where patients had their own artwork and photographs in locked secure frames on the wall. All patients had their own duvet covers and pillowcases and where risk assessment allowed each patient had personal items on their desk and dressing tables. Patients had a secure place to store personal possessions.

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

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

Patients could make phone calls in private.

The service had an outside space that patients could access easily.

Patients could make their own hot drinks and snacks and were not dependent on staff.

The service offered a variety of decent quality food. For the most recent Patient-Led Assessments of the Care Environment (PLACE) 2019 the location scored the same as similar locations across England for quality and choice of food at 92%.

Patients' engagement with the wider community

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

Staff made sure patients had access to opportunities for education and prepared them for further education and work interviews and Ofsted had rated this school as outstanding. While maintaining compliance with national curriculum teachers recognised that some young people in their care faced educational challenges. To address this each young person was treated as an individual and teachers encouraged the young people to develop both academic and practical skills at a pace they could cope with and using formats that young people could respond to. In this way they prepared the young people for higher education or work opportunities. When appropriate teachers offered the young people interview coaching for jobs and higher education courses.

Staff helped patients to stay in contact with families and carers.

Staff encouraged patients to develop and maintain relationships both in the service and the wider community. Such as youth projects, sports clubs, and a community music project.

Meeting the needs of all people who use the service

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

The service could support and adjust for disabled people and those with communication needs or other specific needs. The unit was all on ground floor and was a recent purpose-built building that conformed to national accessibility standards with wide doorways, two adapted accessible bedrooms and level floors throughout. Signage was clear and not cluttered on walls.

Patients could access age-appropriate information on treatment, local services, their rights and how to complain. Staff could provide this information in other formats and languages on request.

Managers made sure staff and patients could get help from interpreters or signers when needed.

The service provided a variety of food to meet the dietary and cultural needs of individual patients.

Patients had access to spiritual, religious, and cultural support.

Listening to and learning from concerns and complaints

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

Patients, relatives and carers knew how to complain or raise concerns. Between 12 January 2021 and 27 September 2021, the service had received seven complaints. The data showed that four of these complaints were closed but did not indicate an outcome. Two complaints were still live, and a further one was waiting authorisation but again there was no information about the potential outcome.

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

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

While we saw that managers had investigated complaints, we did not see evidence of the outcomes of the complaints or any lessons learned.

Staff protected patients who raised concerns or complaints from discrimination and harassment.

Staff knew how to acknowledge complaints and patients received feedback from managers after the investigation into their complaint.

The service used compliments to learn, celebrate success and improve the quality of care. We saw a compliments board with numerus compliments displayed in the foyer to Dragonfly unit and in the communal corridor. Alongside the compliments the service displayed a 'you said, we did' information board.

Is the service well-led?

Requires Improvement ↓↓

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

Leadership

Leaders appeared to have the skills and experience to perform their roles. However, as a new team who had only been in place for between six weeks and two weeks, they were still developing an in depth understanding of the services they managed. Although all managers were visible in the service, some staff and patients said they were cautious about approaching them because they did not know how they might respond to complaints and challenge.

Child and adolescent mental health wards

Managers explained during the previous 12 to 15 months the service experienced significant deterioration for several reasons including COVID-19 restrictions, key staff leaving, admission of more complex patients, change of manager and staff sickness. The effect of this was that some governance systems and processes were stalled as managers were required to prioritise problems arising on the ward. The need to use high numbers of bank and agency staff was unsettling for permanent staff and patients and the lack of knowledge about the unit and needs of patients had led to disruption of ward routines and structures.

To address this deterioration senior management decided in October 2021 to voluntarily discharge as many patients as was safe to do so and suspend admission of new patients until the new management team had chance to re-establish what the ward had lost. At inspection, the 12-bed ward had only four patients all detained under section 3 of the Mental Health Act 1983 and who were all experiencing complex mental health issues and trauma.

During our revisit to Dragonfly ward on 29 December 2021, we found the ward occupancy had reduced to two patients and staff were continuing to work to find suitable placements for them.

Vision and strategy

Substantive staff knew the vision and strategy for the ward but not all staff, and particularly bank and agency staff fully understood how to apply the wards care and treatment model.

The model used was a complex trauma care model based on unconditional positive regard, and principles drawn from dialectical behaviour therapy including self-regulation and helping patients developed emotional literacy.

However, managers had not ensured staff received sufficient training and supervision to use the model effectively which led to confusion and anxiety for patients and lack of cohesion within the staff groups.

An action plan had been put in place in November 2021 that set out specialist training for all staff including mentalisation therapy, trauma informed care, psychopharmacology and eating disorders. The trust had paused appraisals during the pandemic in line with the Reducing the Burden guidance. During the pandemic times the trust had enhanced it trust wide and local monitoring through, safety huddles, listening sessions, reflective practice sessions, quality learning summits, wellbeing forums and IMT meetings.

During our revisit to Dragonfly ward on 29 December 2021, we found the trust had put in place a comprehensive training programme for all staff and this had commenced by the date of the follow up visit, with additional training booked between January 2022 and March 2022.

Culture

Staff said they did not always feel respected, supported, and valued by their managers, and while they could raise concerns with managers, they doubted much would be done to secure sustainable improvements. However, most staff agreed the trust promoted equality and diversity in daily work and provided opportunities for development and career progression.

Staff we spoke with referred to low staff morale, a lack of training and meaningful clinical support to enable them to do their jobs effectively. The culture showed managers and staff lack of control on the ward, specifically a lack of confidence to challenge unacceptable behaviours, maintain boundaries, and ward routines. Staff did not know how to

implement therapeutic observation. We saw how patients were refusing to get up for school, declining medicines and therapy sessions with little challenge or motivation from care staff. The impact was that patients developed poor sleep patterns and tiredness in the daytime so they could not get up in the mornings, concentrate on schoolwork or engage in all rehabilitation activities.

Governance

Governance systems and processes were not always effective. They had not identified and therefore had not addressed issues that affected the safety and quality of the service provided. This included audits, thematic review of incidents, and staff training and supervision. Our findings from the other key questions demonstrated that not all governance processes operated effectively at team level.

Managers acknowledged that since coming into post they had worked hard to review all the governance systems and processes for the ward and still had some work left to do before governance was at a standard they expected. We saw plans for a program of role specific training they wanted to introduce to all staff to improve their clinical skills and knowledge and subsequently their confidence. We saw a revised supervision hierarchy and the introduction of a new electronic supervision recording document. Managers explained that while supervision had risen from 19% in August 2021 to 46% in October 2021, they recognised there was still a lot more work to be done on this.

During our revisit to Dragonfly ward on 29 December 2021, we found supervision rates had improved to 89% and the training programme had commenced with additional training dates booked.

Following the initial inspection visit, the trust implemented an action plan that included daily assurance meetings between ward managers and members of the executive team. These took place from November 2021 to December 2021, when the calls were reduced to a weekly meeting with the executive team. The ward multi-disciplinary team continued to meet daily and held weekly calls with the East of England Provider Collaborative. However, as none of these meetings were minuted the trust could not evidence how they were assured the action plan was being met.

Management of risk, issues and performance

Management of risk was not always managed. While teams had access to the information, they needed to provide safe and effective care, managers had not ensured that all staff could use the information to good effect.

While care plans, risk management plans, activity plans and positive behavioural support plans were well written and accessible. Not all staff had the skills, training, understanding or experience to implement them. This led to confusion, anxiety and frustration for patients who were not always able to express themselves in a positive way. Staff did not always manage patients' frustration well or in a timely manner and this often led to more serious behaviours which often required varying levels of restraint to keep the patient and others safe.

Information management

While staff had easy access to information, they needed to provide safe care and treatment not all staff had the skills, knowledge, and confidence to deliver that treatment effectively or safely.

Managers were aware of this issue and had developed training plans to address this shortfall. However, they said they had not yet had enough time to deliver the training needed.

Managers had access to governance dashboards and meetings where information relating to the running of the service was made available.

Engagement

Managers engaged actively with other local health and social care providers to ensure that an integrated health and care system was commissioned and provided to meet the needs of the local population.

Managers from the service participated actively in the work of the local transforming care partnership.

While therapy staff engaged actively in local and national quality improvement activities, most of the nursing and care staff did not.

Managers held weekly calls with the East of England Provider Collaborative to discuss treatment and discharge planning.

Learning, continuous improvement and innovation

Learning from incidents was not always embedded into practice. Outcomes of investigations around incidents and complaints was not fully recorded and therefore not necessarily conveyed to staff to put into practice. Audits had not been robust or completed in a timely manner and so while issues might be known there was no formal investigation or thematic review and so any learning could not be implemented.

However, since September 2021 and under the new management team, this was improving. Managers were identifying and implementing lessons learnt and improvements but there had not been sufficient time for all these improvements to become embedded in practice.

Managers were ambitious for the service and told us given time and space they could bring the service back to where it was two years ago.

Mental health crisis services and health-based places of safety

Requires Improvement 

Is the service safe?

Inadequate 

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

Safe and clean environments

All clinical premises where patients received care were safe, clean, well-equipped, well-furnished, well-maintained and fit for purpose. The physical environment of the health-based places of safety met the requirements of the Mental Health Act Code of Practice.

Staff completed and regularly updated thorough risk assessments of all areas and removed or reduced any risks they identified. Patients were escorted to interview rooms and were not left alone.

All staff carried an alarm when using interview rooms, and other staff were available to respond.

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

Staff followed infection control guidelines, including handwashing. Staff wore face masks, had good access to personal protective equipment (PPE) and hand sanitiser gels.

Staff made sure equipment was well-maintained, clean and in working order.

Safe staffing

The service did not always have enough staff. Staff received basic training to keep people safe from avoidable harm, although some staff were not up-to-date. The number of patients on the caseload of the mental health crisis teams was not too high to prevent staff from giving each patient the time they needed.

Nursing staff

The service did not always have enough nursing and support staff to keep patients safe. Staffing varied across the teams. There were significant qualified nursing vacancies in the Great Yarmouth, East and West Suffolk teams: four, five and six respectively.

Staff in all the teams, apart from Norwich, were required to provide cover to the acute wards, the health-based place of safety and respond to alarms. Staff said this impacted them particularly at night because less staff were available across the site. On the night of the 8 November 2021, the two staff at the West Norfolk team had to escort a patient from the health-based place of safety to the emergency department. This meant there were no staff available for emergency assessments or to respond to patients who called the team in crisis. No system was in place for staff to know whether patients had tried to contact them, and staff we spoke with were concerned calls would be missed.

Mental health crisis services and health-based places of safety

On the day we visited, caseloads for each team ranged from 16 to 37. Great Yarmouth and West Norfolk were the lowest and East Suffolk was the highest. Staffing was enough to meet demand for that day and met with the team's minimum standards, apart from then West Suffolk team.

It was unclear from the staffing rotas we reviewed whether staff from across the crisis pathway were available to meet baseline staffing numbers. The West Suffolk team had six staff on duty instead of the required 8.5, for a caseload of 28. There was only one staff member rostered for duty on the nights of the 9 and 10 November 2021, instead of the required two. We reviewed the roster for the next three days and it did not meet the staff requirement of 8.5. Senior staff subsequently told us that additional staff could be sourced if needed and that only six staff were required. We were concerned that the trust did not have a clear system for recording staffing numbers or indicating where additional staff could be sourced from.

Managers limited their use of bank and agency staff and requested staff familiar with the service.

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

The service had low turnover rates. Turnover was below the trust target of 15%.

Managers supported staff who needed time off for ill health and sickness levels were within the trust target of 4.91% apart from the Norwich team, at 6%.

Managers used a recognised tool to calculate safe staffing levels. However, staff at West Norfolk were concerned that staffing did not always feel safe at night. West Norfolk was a stand-alone unit consisting of one acute mental health ward, the health-based place of safety and the crisis team. Staffing levels had been calculated as seven for the whole unit. Staff did not feel this was enough, especially if there was an incident on the ward and assistance was required. On the night of the 8 November 2021, the crisis staff escorted a patient to the emergency department, therefore were unavailable to assist, if required.

Medical staff

The service could not always get support from a psychiatrist quickly when they needed to. The service adopted different models of care across the five teams which impacted on the way medical staff were used. The West Norfolk and Norwich team utilised advanced nurse practitioners and non-medical prescribers to provide assessments, clinical oversight and prescribe and review medicines. Medical staff were available for consultation when required. The other three teams utilised medical staff to provide medical reviews, clinical oversight and worked in conjunction with non-medical prescribers to facilitate prescribing medicines.

However, the West Suffolk team had the equivalent of one day a week medical cover, which staff said was not enough and caused delays in patient treatment. This team did not have access to non-medical prescribers. Doctors said they were constantly prioritising tasks, and they could not be as responsive as they should be. This had not improved since our most recent inspection.

The East Suffolk team split their caseload between home treatment and crisis. The current consultant provision did not meet the needs of patients. The consultant was contracted to the home treatment team and did not input into the crisis element of the service. The consultant did not prescribe to patients in crisis. This meant that the crisis patients did not have access to support from a consultant.

The Great Yarmouth team had access to a consultant psychiatrist, however his time was split with the acute ward therefore he was not always readily available when required. Staff said this caused delays to patient treatment.

Locums were not available or used when teams needed additional support or to cover staff sickness or absence. The trust had tried to recruit to the vacant medical posts and obtain locums for the intervening period, but none were available to provide cover.

Mandatory training

Staff were required to complete and keep up-to-date with their mandatory training. Face-to-face training had been paused by the trust during the height of the COVID-19 pandemic, therefore staff had not been able to keep up-to-date with some of their training needs, such as Prevention and Management of Aggression (PMA) to manage challenging behaviour, manual handling, rapid tranquilisation and Intermediate Life Support (ILS). Three of the teams – North Norfolk, Norwich and Great Yarmouth were below 25% completion for Prevention and Management of Aggression. This meant there was potential for staff to injure themselves, patients or other staff if they were not up-to-date with physical restraint techniques.

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

Managers monitored mandatory training and alerted staff when they needed to update their training. All teams were below the trust target of 85% completion of mandatory training. The lowest achieving team was Great Yarmouth at 70%, and the highest achieving team was East Suffolk at 85%.

Assessing and managing risk to patients and staff

Staff assessed and managed risks to patients and themselves. They responded promptly to sudden deterioration in a patient's health. When necessary, staff working in the mental health crisis teams worked with patients and their families and carers to develop crisis plans. Staff followed good personal safety protocols.

Assessment of patient risk

Staff completed risk assessments for each patient on arrival, using a recognised tool, and reviewed this regularly, including after any incident. We reviewed 30 patient care records. They were completed thoroughly and were up-to-date.

We reviewed nine records in three health-based places of safety. Risk assessments were present and comprehensive.

Staff triaged patients when they were referred to the service. Staff used a comprehensive triage tool, which determined the level of urgency of the assessment. Emergency assessments were seen within four hours and urgent referrals within 72 hours, although staff told us assessments were generally sooner than the 72-hour target.

Staff could recognise when to develop and use crisis plans and advanced decisions according to patient need. We reviewed 30 crisis plans and care plans. Four were missing and not completed. However, 26 were completed to a good standard, were individualised and included information about patients preferred treatment choices.

Management of patient risk

Mental health crisis services and health-based places of safety

Staff responded promptly to any sudden deterioration in a patient's health and continually monitored patients on their caseloads for changes in level of risk and responded when risk increased. Staff were able to visit patients as often as required according to patient need. Staff discussed caseloads at least once daily, were flexible and adjusted visits depending on any changes to patients' risk or presentation.

Staff followed clear personal safety protocols, including for lone working. All teams followed the trust lone working policy and had procedures in place to ensure staff safety.

During the pandemic, staff continued to see patients face-to-face and followed the trust's COVID-19 procedures to keep themselves and patients safe.

However, we found one patient was able to self-harm in the health-based place of safety whilst being on nursing observations. This incident had been reviewed by senior management, but managers were unable to say how this had happened or whether lessons learned had been identified.

Safeguarding

Staff understood how to protect patients from abuse and the service worked well with other agencies to do so. Staff had some training on how to recognise and report abuse and they knew how to apply it.

Staff received training on how to recognise and report abuse, however the trust submitted data, which indicated that the mandatory training level for safeguarding was level one. This was not appropriate for their role or in line with national guidance. Clinical staff who work directly with patients should be trained to at least level two. or level three where clinical staff could potentially contribute to assessing, planning, intervening and evaluating the needs of a child or young person and parenting capacity where there are safeguarding/child protection concerns.

Staff kept up-to-date with their safeguarding training. Teams were 100% compliant with level one training for children and adults.

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

Staff knew how to recognise adults and children at risk of or suffering harm and worked with other agencies to protect them. They knew how to make a safeguarding referral and who to inform if they had concerns. The teams had made 53 safeguarding referrals from 2 November 2020 to 28 October 2021. Actions were appropriate and investigated when required.

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

Staff access to essential information

Staff working for the mental health crisis teams kept detailed records of patients' care and treatment. Records were clear, up-to-date and easily available to all staff providing care.

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

Mental health crisis services and health-based places of safety

When patients transferred to a new team, there were no delays in staff accessing their records. All trust staff used the same patient care record system.

Records were stored securely.

Medicines management

The service did not always use systems and processes to safely prescribe, administer, record and store medicines.

Staff did not always follow systems and processes to prescribe and administer medicines safely. At the most recent inspection, we found that systems and processes to safely administer and record medicines use did not always reflect local practice and staff did not always follow them.

At this inspection, we found safe systems and practices were followed in the Norfolk Crisis Resolution and Home Treatment team but there had been little or no improvement across East and West Suffolk.

The West Suffolk team had very limited clinical input or oversight of safe medicines processes. The policy and processes for safe prescribing were not followed. We found most patients were assessed remotely on an as required basis by a consultant and when patients required medicines urgently, the consultant would email a medicines order to staff. The service did not use prescription charts or the trust pharmacy service to prescribe or obtain medicines and therefore did not follow local policy. Staff gave a three-day pre-packed medicines supply to the patient. However, medicines orders by email did not follow policy or have the legal authority under the Human Medicines Regulations 2012 for the medicines to be dispensed, such as a prescriber signature.

Handheld prescription forms were used when a prescriber was available on site and an emergency dispensing procedure was used out of hours.

Staff did not always review each patient's medicines regularly. Staff did provide advice to patients and carers about their medicines. Regular multidisciplinary team meetings were held at the Norfolk and East Suffolk sites to review patients' medicines. However, we spoke to a doctor in the West Suffolk team who told us they did not routinely review any patients' medicines unless staff referred patients back to them. There was no pharmacist involvement at this site.

Staff completed medicines records accurately and kept them up-to-date. All the medicines records seen at Norfolk were completed, up-to-date and accurate. Staff at West Suffolk placed a copy of the medicines order and documented medicines supply on every patient record we reviewed.

Staff stored and managed all medicines and prescribing documents safely. Medicines and prescription stationary were stored securely. Medicines were checked regularly to make sure they were in date and suitable for use. At East Suffolk, prescription charts were audited monthly to check they were fully completed. Any issues were promptly escalated to prescribers to rectify.

Staff followed national practice to check patients had the correct medicines when they were admitted, or they moved between services. Staff had access to an electronic record of information created from patients GP records where they could check allergies and see what medicines patients were taking. However, at East Suffolk, documentation of the medical history on the front of the prescription chart was inconsistent. Therefore, we were not assured that staff always checked this before prescribing new treatment.

Mental health crisis services and health-based places of safety

We found poor communication to GP practices in West Suffolk. The medical team did not always communicate with the GP when prescriptions had been issued to patients or when medical assessments had taken place. Two patients had run out of medicines because the GP did not have an up-to-date record to continue their treatment.

At East Suffolk it was not always clear where and when the supply of medicines was coming from. Therefore, patients did not always receive their medicines on time or potentially had an increased quantity of medicines in their home. This was a concern for patients who were at risk of harming themselves. One patient had their sedating medicines reduced by the team, but staff had not taken the new dose to the patient, therefore the patient had obtained the original dose from the GP. The GP had not received communication to who would be arranging the supply. This was a risk to patient safety.

Staff learned from safety alerts and incidents to improve practice. Staff knew about safety alerts and medicines related concerns via monthly 'Medicines Safety' newsletters.

Staff understood the process to report incidents, and these were discussed locally in team meetings.

The service ensured people's behaviour was not controlled by excessive and inappropriate use of medicines.

Staff reviewed the effects of each patient's medicines on their physical health according to NICE guidance. In the Norfolk teams we found that patients physical health medicines were included on patients' medicines charts and physical health checks were routinely discussed by psychiatrists and pharmacists as part of their treatment. However, in East Suffolk, only mental health medicines were recorded on prescription charts with no record of any of their prescribed physical health medicines. It was therefore not clear whether patient's physical health needs were taken into consideration as part of their treatment.

Track record on safety

The service had recorded six patient deaths in the 12 months prior to inspection. They had been investigated and findings shared with relevant teams and other agencies.

Reporting incidents and learning from when things go wrong

The service managed patient safety incidents well. Staff recognised incidents and reported them appropriately. Managers investigated incidents but did not consistently share lessons learned with the whole team and the wider service. When things went wrong, staff apologised and gave patients honest information and suitable support.

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

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

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

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

Mental health crisis services and health-based places of safety

Managers did not always provide a debrief and support staff after any serious incident. Staff in the Great Yarmouth and West Suffolk team said they did not get a debrief and it was left to them to arrange their own support.

Managers investigated incidents thoroughly. Patients and their families were involved in these investigations.

A majority of staff received feedback from investigation of incidents, both internal and external to the service. At the most recent inspection we found staff in Great Yarmouth and West Suffolk teams did not routinely receive feedback about the outcomes or learning from incidents. At this inspection we found that feedback was shared in team meetings, although some staff we spoke with said they did not routinely know about lessons learned. The West Norfolk team however did not receive regular team meetings. However, staff were aware of changes made following feedback and investigation of incidents through supervision. The Norwich team received feedback from a range of sources such as safety huddles, group reflective practice, and was recorded in the comprehensive monthly governance report.

There was evidence changes had been made as a result of feedback. Some teams were able to give examples of changes to practice following serious incidents. For example, following the death of a patient, the West Norfolk team now ensured that a qualified nurse made the first visit to a patient following discharge from a ward. The Norwich team had implemented a dedicated telephone waiting system following feedback from patients who could not get through to the team when they were in a crisis. This ensured staff were aware of all patient calls waiting and could ensure resources were redeployed to meet the demand when needed. Managers audited the system to determine how effective they were, predict times of high demand to allocate enough resources and highlight areas of improvement.

Is the service effective?

Requires Improvement 

Our rating of effective went down. We rated it as requires improvement

Assessment of needs and planning of care

Staff assessed the mental health needs of all patients. Staff working for the mental health crisis teams worked with patients, families and carers to develop individual care plans and updated them when needed. Care plans reflected the assessed needs, were personalised, holistic and recovery oriented.

Staff completed a comprehensive mental health assessment of each patient. However, in the West Suffolk team, medical reviews were not always updated on the patient care records.

Staff made sure that patients had a physical health assessment and knew about any physical health problems.

Staff developed a comprehensive care plan for each patient that met their mental and physical health needs. Care plans were holistic.

Staff regularly reviewed and updated care plans when patients' needs changed. Staff updated care plans and crisis plans in safety huddles and multidisciplinary teams.

Mental health crisis services and health-based places of safety

We reviewed 30 patient care plans. We found 25 were completed to a good standard, were personalised, holistic and recovery orientated. They included patients' strengths and goals and were written in the patient voice. However, four were missing and one was not fully holistic.

At the most recent inspection, we found patient care records in the health-based places of safety were not all clear, up-to-date and easily available to all staff providing care. At this inspection we found documentation had improved. We reviewed nine patient care records for patients who had been assessed in the Norfolk health-based places of safety. They were detailed, contained a joint risk assessment, and the outcome and decision making of the assessment was clearly documented. However, three records did not contain a copy of the Approved Mental Health Professional report.

Best practice in treatment and care

Staff working for the mental health crisis teams did not consistently use recognised rating scales to assess and record severity and outcomes. Staff working for the crisis teams and in the health-based places of safety participated in clinical audit, benchmarking and quality improvement initiatives.

The trust had introduced a recognised rating scale the month prior to our inspection to assess and record severity and outcomes. It was too early to evaluate it's effectiveness. They participated in clinical audit, benchmarking and quality improvement initiatives.

Staff provided a range of care and treatment suitable for the patients in the service.

Staff delivered care in line with best practice and national guidance.

Staff made sure patients had support for their physical health needs, either from their GP or community services. Physical health champions were available in teams for consultation and advice.

Staff supported patients to live healthier lives by supporting them to take part in programmes or giving advice. Patients were given advice about stopping smoking and healthy eating.

Staff took part in clinical audits and quality improvement initiatives. Typical audits consisted of completion and quality of patient care notes and medicines prescription charts. Staff in the Great Yarmouth health-based place of safety participated in monthly audits of the patient care record to ensure completion, quality and the Mental Health Act Code of Practice was being adhered to.

Teams participated in quality improvement initiatives. The East Suffolk team were looking at ways they could redirect patients away from emergency departments. The West Norfolk team were looking at ways of improving their four-hour emergency referral target.

Managers used results from audits to make improvements. The results of the patient care note audits were shared with staff in team meetings and supervision.

Skilled staff to deliver care

Mental health crisis services and health-based places of safety

The mental health crisis teams included and most had access to the full range of specialists required to meet the needs of patients under their care. Managers made sure that staff had the range of skills needed to provide high quality care. They supported staff with appraisals, and opportunities to update and further develop their skills. Managers provided an induction programme for new staff. Staff did not always receive regular supervision.

Some teams had access to a full range of specialists to meet the needs of the patients. Teams consisted of a wide range of mental health professionals. However, patients did not have access to psychological therapies in the Great Yarmouth and East and West Suffolk teams. There was limited, if any, access to an occupational therapist across all teams.

Managers ensured staff had the right skills, qualifications and experience to meet the needs of the patients in their care, including bank and agency staff. Staff had a range of skills. Most teams had access to advanced clinical practitioners and non-medical practitioners. However, their availability varied across the teams. The Norwich team had the most and the West Suffolk team had none.

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

Managers supported staff through regular, constructive appraisals of their work. The trust target was 90%. Two teams did not meet this target; East Suffolk at 84% and West Suffolk at 54%.

Managers supported non-medical staff through regular, constructive clinical supervision of their work. From May 2021 to October 2021, the average team supervision completion rates varied. Great Yarmouth performed the best at 94% overall, and West Suffolk was the lowest performer at 51%. West Norfolk was at 64%, Norwich at 63% and East Suffolk at 59%.

Managers told us staff participated in peer supervision and reflective practice.

Managers made sure staff attended regular team meetings or gave information from those they could not attend. Most teams had regular team meetings to discuss team performance, lessons learned, changes to practice or trust policies and other business relevant for the local teams. However, the West Norfolk team did not have formal team meetings.

Managers identified any training needs their staff had and gave them the time and opportunity to develop their skills and knowledge and made sure staff received any specialist training for their role. Many staff had either attended or were participating in training such as non-medical prescribing, approved mental health practitioner training, and psychological therapies such as dialectical behaviour therapy and solution focused therapy. Developmental rotational posts were available for band five nurse, to gain experience across the acute pathway. Unqualified staff were able to train to become nursing associates or complete their nurse training.

However, staff in the Great Yarmouth team had been told by senior managers they could not attend specialist training which they requested, such as non-medical prescribing and approved mental health practitioner training.

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

Multi-disciplinary and interagency teamwork

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

Mental health crisis services and health-based places of safety

Staff held regular multi-disciplinary meetings to discuss patients and improve their care. Each morning, staff attended a safety huddle or handover to discuss the caseload and plan for the day. Patients progress was discussed, and treatment plans would be adapted depending on patient need or change to risk. In addition, all teams apart from the West Suffolk team held a weekly or twice weekly multi-disciplinary team meeting to discuss patients progress in more detail.

Staff made sure they shared clear information about patients and any changes in their care, including during transfer of care. There were effective handovers within teams, between internal and external teams and written information was easily accessible and updated.

Teams had effective working relationships with other teams in the organisation. Teams had interface meetings with other community teams, such as community mental health teams, the youth teams and primary care. Staff attended clinical meetings on the acute wards to facilitate early discharge. Managers liaised daily with their counterparts from the acute pathway to discuss staffing, discharges, admissions and any potential issues that required attention.

Teams had effective working relationships with external teams and organisations, such as the police, social services and drug services. The Norwich team engaged with the local university weekly to discuss current patients and any students who they were concerned about. The team were proactive in planning care and interventions before a referral was made.

Managers from the health-based places of safety attended multiagency meetings with partners, such as the police, ambulance, local authority and acute services. They discussed performance, highlighted issues regarding accessibility of the suites and assessments and any further areas for development. Managers engaged with partners well, and attendance was good.

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

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

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

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

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

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

Patients had easy access to information about independent mental health advocacy and staff could signpost them to the appropriate services.

Staff explained to each patient their rights under the Mental Health Act in a way that they could understand, repeated as necessary and recorded it clearly in the patient's notes each time. Patients had their rights read to them appropriately and in their own language when assessed in the health-based places of safety.

For patients subject to a Community Treatment Order, staff completed all statutory records correctly.

Mental health crisis services and health-based places of safety

Care plans clearly identified patients subject to the Mental Health Act and identified the Section 117 aftercare services they needed.

Staff completed regular audits to make sure they applied the Mental Health Act correctly. Staff in the Great Yarmouth health-based places of safety conducted a monthly audit, which included an audit of staff adherence to the Mental Health Act Code of Practice.

Good practice in applying the Mental Capacity Act

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

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

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

Staff knew where to get accurate advice on Mental Capacity Act.

Staff gave patients all possible support to make specific decisions for themselves before deciding a patient did not have the capacity to do so.

Staff assessed and recorded capacity to consent clearly.

When staff assessed patients as not having capacity, they made decisions in the best interest of patients and considered the patient's wishes, feelings, culture and history.

Is the service caring?

Good 

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

Kindness, privacy, dignity, respect, compassion and support

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

We spoke with 14 patients and two carers in Norfolk, one patient in the health-based places of safety and nine patients and four carers in Suffolk. Patients said staff were discreet, respectful, polite and responsive when caring for patients.

Staff gave patients help, emotional support and advice when they needed it.

Mental health crisis services and health-based places of safety

Staff supported patients to understand and manage their own care treatment or condition.

Staff directed patients to other services and supported them to access those services if they needed help.

Patients said staff treated them well and behaved kindly and they understood and respected the individual needs of each patient. Patients said that staff treated them as equals.

Staff felt that they could raise concerns about disrespectful, discriminatory or abusive behaviour or attitudes towards patients.

Staff followed policy to keep patient information confidential.

Involvement in care

Staff in the mental health crisis teams involved patients in care planning and risk assessment and actively sought their feedback on the quality of care provided. They ensured that patients had easy access to advocates when needed. Staff informed and involved families and carers appropriately.

Involvement of patients

Staff involved patients and gave them access to their care plans.

Staff made sure patients understood their care and treatment and patients said they always felt involved in decisions about their own care.

Patients could give feedback on the service and their treatment and staff supported them to do this. Patients told us they knew how to complain, and services asked for feedback through surveys and questionnaires. Patients also felt comfortable to provide feedback informally to staff who visited them.

Staff supported patients to make advanced decisions on their care. We saw this reflected in some patients' crisis and care plans.

Staff made sure patients could access advocacy services.

Involvement of families and carers

Staff informed and involved families and carers appropriately.

Staff supported, informed and involved families or carers. Carers told us their needs were considered by staff. The trust employed staff to work with carers in some of the teams.

Staff helped families to give feedback on the service.

Staff gave carers information on how to find the carer's assessment. We observed staff signposting carers support groups to a family member.

Mental health crisis services and health-based places of safety

Is the service responsive?

Requires Improvement 

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

Access and discharge

The mental health crisis service was available 24-hours a day although some teams were not always easily accessible. The referral criteria for the mental health crisis teams did not exclude patients who would have benefitted from care. Staff did not always assess and treat people promptly. Staff followed up people who missed appointments.

The service had clear criteria to describe which patients they would offer services to.

The trust set target times for seeing patients from referral to assessment. Staff triaged patients when they were referred to the service. Staff used a comprehensive triage tool, which determined the level of urgency of the assessment. Trust targets determined how quickly a patient would be assessed; emergency referrals within four hours, urgent referrals within 72 hours.

At the most recent inspection we found staff did not always see emergency referrals within the four-hour target. At this inspection we found most teams still did not meet the target. The trust target was 95%. For the months of September and October 2021, only two teams met the target; East Suffolk and Norwich. Most breaches were due to patient preference and requests to be seen outside the four-hour timeframe. The trust did not monitor the 72-hour target.

The teams had skilled staff although they were not always immediately available 24 hours a day, seven days a week.

The teams tried to respond quickly when patients called. Patients we spoke with said they could speak to the team when they needed to, but patients and staff said that some patients had sometimes faced difficulty getting through to teams on the telephone. West Suffolk told us staff were not always available to take telephone calls from patients in crisis, due to staff shortages.

The Norwich team had installed a dedicated telephone system, which ensured staff were aware of all patient calls waiting and could ensure resources were redeployed to meet the demand when needed. Managers audited the system to determine how effective they were, predict times of high demand to allocate enough resources and highlight areas of improvement. This had not been implemented by other teams.

On the night of the 8 November 2021, staff were not available in the West Norfolk team to respond to patients on the telephone because they had been reallocated to the health-based place of safety. Resources were not available to replace the staff.

The health-based place of safety was not always available. During September 2021, there were 44 occasions when the first-choice suite was not available. Some of these occasions were due to patients being admitted to the suite for non-section 136 reasons, such as an acute or CAMHS bed being unavailable. When we inspected, we were aware of three

recent occasions when patients had been admitted for several days; one occasion for 28 days. This meant that patients detained under a section 136 had to travel further to access a suite or had to wait for one to become free. This caused delays to treatment and created patient distress. Partner agencies such as the police and ambulance services had requested to the trust that the suites be protected for section 135/136 assessments only.

The team tried to engage with people who found it difficult, or were reluctant, to seek support from mental health services. Staff were flexible and could see patients in different settings or at different times of the day. Patients had choice in the appointment times available.

The team tried to contact people who did not attend appointments and offer support.

Staff worked hard to avoid cancelling appointments and when they had to, they gave patients clear explanations and offered new appointments as soon as possible. Staff mostly visited patients at home. Visits ran on time and staff informed patients when they did not.

Staff supported patients when they were referred, transferred between services, or needed physical health care. Staff attended joint visits with care co-ordinators, or key people involved in patients care when they were discharged from the service, to ensure continuity of care and provide a comprehensive handover. However, all teams described significant delays of allocation of care co-ordinators from community mental health teams. At times, patients were waiting up to six months, and staff across all teams said there had been times when patients had gone back into crisis whilst waiting. The West Norfolk team had created a separate holding list for these patients, which meant they contacted them weekly as a safe and well check. The holding list had been created to ensure patients had some support whilst awaiting a care co-ordinator, however it was not clear who held responsibility for the patients. Other teams discharged patients to the duty worker at the community mental health team, although they were not responsible for the patient's future care and treatment.

Facilities that promote comfort, dignity and privacy

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

The service had a full range of rooms and equipment to support treatment and care.

The were some small issues with the environment of the health-based places of safety. The North Norwich team had only one door for staff to enter the nursing office which was from the assessment suite. Staff had raised concerns that in the event of an incident, staff could not safely enter or leave the office. There had been a recent incident when a patient had gained access to the nursing office.

There was no clock for patients to see in the Great Yarmouth suite.

In the Norwich suite, staff had to cross the assessment suite to access the toilet. Staff raised concerns that this might not be safe to do so, in the event of an incident.

However, the suites provided toiletries and clothing and socks for patients.

Interview rooms in the service had sound proofing to protect privacy and confidentiality.

Mental health crisis services and health-based places of safety

Patients' engagement with the wider community

Staff supported patients with activities outside the service, such as work, education and family relationships.

Staff made sure patients had access to opportunities for education and work, and supported patients.

Staff helped patients to stay in contact with families and carers. Patients told us staff encouraged them with this.

Meeting the needs of all people who use the service

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

The service could support and make adjustments for disabled people and those with communication needs or other specific needs. Interview rooms at the team's sites were on the ground floor and easily accessible.

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

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

The service could produce information leaflets available in languages spoken by the patients and local community whenever required.

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

Listening to and learning from concerns and complaints

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

Patients, relatives and carers knew how to complain or raise concerns. There had been 61 complaints across the crisis services and health-based place of safety from 5 November 2020 to 29 October 2021. Common themes included; staff attitudes, unhappiness with the care provided and poor communication.

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

Managers investigated complaints and identified themes. We reviewed a selection of complaints and found these had been dealt with appropriately.

Staff protected patients who raised concerns or complaints from discrimination and harassment.

Staff knew how to acknowledge complaints and patients received feedback from managers after the investigation into their complaint.

The service used compliments to learn, celebrate success and improve the quality of care. There had been 90 compliments from 1 November 2020 to 31 October 2021 from patients, students and staff from other teams.

Mental health crisis services and health-based places of safety

Is the service well-led?

Requires Improvement 

Our rating of well-led stayed the same. We rated it as requires improvement.

Leadership

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

Staff were complimentary about their immediate managers and leaders. They were approachable, visible and supportive. Managers were knowledgeable and experienced.

The leadership in the Great Yarmouth team had recently changed as the manager had been seconded to a different team. A clinical lead from the team was acting up into that position.

Managers above team leader level were generally less visible. The majority of staff we spoke with did not feel that middle managers were responsive to their concerns and gave examples of them not communicating effectively with staff.

There had been several changes within middle management in the previous few weeks before we inspected in the North Norfolk team, although staff were confident that positive changes were now being made.

Managers could access leadership training and had the support to do their job.

Vision and strategy

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

Staff were aware of the trust's vision and values. This was promoted across the trust and they had access to this information through the trust intranet.

Some staff did not believe that senior managers promoted the trust values in the own actions and behaviours. For example, five staff told us of when they did not feel listened to, felt dismissed and not taken seriously, or did not get a response to concerns raised.

Culture

Staff did not always feel respected, supported and valued. However, they said the trust promoted equality and diversity in daily work and provided opportunities for development and career progression. They could raise any concerns without fear.

Mental health crisis services and health-based places of safety

Staff told us they did not like having to work on the acute wards and felt they did not have a choice. Staff expressed concerns about being left in charge, they did not enjoy working in that environment and were not being able to provide an effective service to their caseload as they were temporarily unavailable.

Over the previous 12 months, the two teams in Suffolk had merged to form a crisis home treatment team. Previously staff had worked in either crisis, or home treatment. This meant some staff had had to change their working pattern. Staff in the East Suffolk team were more positive about the merger and said it had been managed well. Some staff in the West Suffolk were not as positive and felt they had not been involved very much. They felt they were still working separately despite now being one merged team.

Morale varied, but the majority of staff we spoke with said morale was low across most teams. One example given was that staff had raised concern about the lack of medical availability in some teams for several months, but there had been no improvement, despite the trust trying to recruit medical staff. Morale was also low because staff were having to work on areas they were unfamiliar with such as the acute wards. Recent changes in the East Suffolk team meant that staff who used to work in the crisis team now had to work in the home treatment team and vice versa. This had caused some distress to staff due to changes to working patterns, so morale was low and staff said they felt 'stressed'.

Five staff felt "overlooked" and "insignificant", specifically in relation to working on the acute wards, and being denied further training opportunities.

Other staff were more positive. This was more evident in teams that had all members of the multidisciplinary team and staffing was more stable.

Staff felt they worked well as a team, patient care was their priority and they enjoyed working with patient group.

Governance

Our findings from the other key questions demonstrated that governance processes did not always operate effectively at team level and that performance and risk were not always managed well.

There was not a coherent crisis model of care across the trust. The teams worked differently from each other, even within their own County. For example, Norwich and West Norfolk utilised advanced nurse practitioners and non-medical prescribers for tasks traditionally performed by medical staff. The Great Yarmouth team did not do this. This meant some teams were at a disadvantage. Medical reviews and treatment were often delayed in the teams that did not have access to, or was limited, to medical staff.

Managers monitored key performance indicators, mandatory training, staff supervision and appraisals. When improvements were required, team managers were aware and had plans in place. In terms of objective data, the Norwich and East Suffolk team were performing the most effectively.

Health-based places of safety partners told us there was no overall system oversight for the suites. For example, the police had to contact five different managers, one from each care group to access a suite and determine whether it was available for use. This was time consuming and frustrating for the police. Partner agencies had asked the trust to make improvements regarding accessibility and provide a dedicated point of contact.

Management of risk, issues and performance

Mental health crisis services and health-based places of safety

Teams had access to the information they needed to provide safe and effective care and used that information to good effect. However, risks were not always escalated appropriately.

The West Norfolk and East and West Suffolk teams did not have items on the risk register, despite identified gaps in their staffing.

The Norwich team had contingency and capacity plans in place. For example, if they experienced a sudden increase in referrals, staff would be reassigned to provide assessments.

Information management

Staff collected analysed data about outcomes and performance and engaged actively in local and national quality improvement activities.

Managers and staff used key performance indicators to monitor their effectiveness, such as four-hour target for emergency referrals, gatekeeping for admission, and 72 hour follow up for patients discharged from the wards. Trust targets were 95% compliance. In September and October 2021, only two teams met the four-hour target. Three teams met the gatekeeping target; the manager in the East Suffolk team did not monitor this target, and the West Suffolk team was not compliant.

Engagement

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

There were multi-agency arrangements to agree and monitor the governance of the mental health crisis service and the health-based places of safety. Managers of the service met with partner agencies including the police, ambulance service, primary care and local acute medical services) to ensure that people in the area received help when they experienced a mental health crisis; regardless of the setting.

However, partners from the multi-agency meeting for the health-based places of safety reported they had experienced regular issues with the accessibility of the suites and that they were occupied by patients for a significant period. Despite raising this as an issue to the trust for several months, the situation had not improved. The multi-agency partners did not know if the incidents had been reviewed or lessons had been learnt. This had not been shared with the group.

Learning, continuous improvement and innovation

Some teams participated in quality improvement initiatives. For example, the West Norfolk team had discussed how to improve their four-hour targets and how to develop a better referral form for GPs at a recent away day.

The Norwich team had taken self-referrals from patients for the last 12 months. The team took the decision to do this following a review of patient cases that had shown taking a direct referral prevented delays in patient treatment and were beneficial for patients.

The Norwich team had participated in a thematic review with the Youth team regarding suicide in young people. This was in relation to a death within the team. The results were available for other teams and staff to see within the trust.

Wards for older people with mental health problems

Requires Improvement ↓

Is the service safe?

Requires Improvement ↓

Our rating of safe went down. We rated it as requires improvement.

Safe and clean care environments

The service did not carry out safe checks of the outdoor environment at Carlton Court Laurel ward. Sandringham and Reed wards did not comply with guidance on eliminating mixed sex accommodation. On Blickling ward there were potential ligature risks that had not been identified. However, wards were clean and well-equipped.

Safety of the ward layout

We inspected seven wards across four locations. Staff completed and regularly updated risk assessments of most of the ward areas, and a majority of the time removed or reduced any risks they identified. The risk assessments were risk rated and included a photograph of each risk. At Carlton Court Laurel ward, the large garden area had not been included in the risk assessment. Staff told us patients were always escorted when they accessed the garden.

Staff could not observe patients in all parts of the wards due to the layout of the buildings which were older buildings. However, patients were supported with enhanced observations and regular ward walks were completed by staff on the wards. Staff were positioned around the wards so they could observe patients. We saw curved mirrors had been placed in corridors. Most wards had closed circuit television camera (CCTV) monitoring which gave the staff an overview of all public areas.

Staff had easy access to alarms and patients had easy access to nurse call systems. We saw patients had access to push bar nurse call systems on the walls in bedrooms and sensors that were used at night-time.

At Julian Hospital Sandringham and Reed wards did not comply with guidance on eliminating mixed sex accommodation. On Sandringham a nine-bed mixed sex ward, a male patient stayed for three days during 30 October 2021 to 2 November 2021 with no additional measures in place to protect both female and male patients. Managers told us around four weeks previously two males stayed on the female ward. Bedrooms did not have full en-suite facilities which meant they would pass each other to access toilets and bathrooms. Managers for both these incidents did not consider patients risks, or additional measures and safeguards in place to protect female and male patients. Following the inspection, we urgently requested follow up information and action. The trust reviewed the level of risk for the mixed sex accommodation, which was not determined to be an urgent risk as the person who had been on the ward shortly prior to the inspection, had been moved from the female ward.

Post inspection the trust told us that In situations when male admissions increased staff would move a number of male patients on Sandringham Ward to the female corridor into three distinct ensuite bedrooms. In the event a male patient

would like to use the larger/supported bathrooms these will be accessed in the male allocated corridor Staff ensured that the males would not have to pass through areas used by patients of the opposite sex. All male patients in female corridor had fourly observations at night , and had movement sensors active at night to alert staff to movement. Staff were based in a 'night office' in the area at junction of male/female bedroom corridors

On a 13-bed female ward, Reed ward, we saw two male patients on the female ward. Staff told us they would accept male patients on the Reed ward with additional measures. Additional staffing levels, review of patient risk management and safeguards for female and male patients. We saw additional measures in place for both patients in their care records. Staff tried to keep male patients at the end of the corridor bedrooms away from female patients. However, we found a female bedroom in between two male bedrooms. On Reed wards, bedrooms were en-suite, so patients did not need to pass each other's rooms to access toilets.

Maintenance, cleanliness, and infection control

Ward areas were clean, well-maintained and well-furnished. Staff made sure cleaning records were up-to-date and the wards were clean. Staff followed infection control policy, including handwashing. Staff told us during the COVID-19 pandemic they had good access to personal protective equipment (PPE) and followed infection control procedures.

Families and carers said the wards were clean and comfortable and the décor was in good order. They said their relatives were able to find peace and quiet.

Clinic room and equipment

Clinic rooms were fully equipped, with accessible resuscitation equipment and emergency drugs that staff checked regularly. Medicines required in an emergency were available. They had a tamper evident seal to ensure they were safe. Staff were required to record weekly safety checks on medical gases, emergency medicines and equipment to ensure they were safe to use if needed in an emergency. However, on Abbeygate Laurel ward, we saw that staff had not checked the emergency medicines for a month prior to inspection and a medicines used for anaphylaxis (a severe life-threatening allergic reaction) was out of date. We raised this with staff to action immediately. Staff checked, maintained, and cleaned equipment.

Safe staffing

The service had high staffing vacancies and bank and agency usage on some wards. Staff mandatory compliance rates were low which impacted on keeping patients safe from harm and abuse.

Nursing staff

The service had high vacancies and bank/agency usage on some wards. Managers limited the use of bank and agency staff and where required requested staff familiar with the service. Managers made sure all bank and agency staff had a full induction and understood the service before starting their shift.

The trust staff vacancy target rate was 9%. The staff vacancy rates overall for this service were 14%. The highest vacancy rates were at Abbeygate Laurel ward at 29% followed by Blickling ward and Reed ward at 21%. The lowest vacancy rates were Beach ward at 1%. The trust did not provide us with a breakdown of staff vacancy rates for the different staff disciplines.

Wards for older people with mental health problems

The trust staff turnover target rate was 15%. The overall staff turnover rates for this service were 11%. The highest staff turnover rates were at Blickling ward at 37%, which consisted of seven staff, and lowest at Beach ward with nil staff turnover.

Some therapy staff told us they had difficulties providing a full range of care and therapy to patients and were frequently assigned to assist with patient observations or care tasks.

The trust provided bank staff and agency staff percentages which included nurse and care support workers across the service for October 2021. The core service had increased rates of bank staff and agency staff in September 2021. The ward with the highest use of bank and agency nurses were Willow ward 38% followed by Carlton Court Laurel ward 35%. Lowest use bank and agency nurses was Sandringham ward at 8%.

For care support workers, the highest use was Sandringham ward and Abbeygate Laurel ward were 62%. The lowest use of agency and bank care support workers were Blickling ward at 40%.

Managers accurately calculated and reviewed the number and grade of nurses, assistants' practitioners, and care support workers for each shift. The ward manager could adjust staffing levels according to the needs of the patients. Safe wards information was placed around the wards. Safety huddle took place in the morning to plan the ward day and consider if staff needed to be moved around the wards.

The trust target rates for staff sickness are 5%. The trust provided data from 1 October 2020 to 30 September 2021. The overall sickness rate for this service was 7%. The highest sickness levels were on Sandringham ward at 14% and the lowest were Beach ward at 4%. The trust's Datix incident reporting systems indicated there were 204 confirmed positive staff who worked in inpatient services. It was suggested there were under reporting of the extent of staff cases because of the then lack of available testing.

Staff sickness rates provided from managers on wards did not match with data provided by the trust. For example, manager's at Abbeygate Laurel and Maple wards told us staff absence was at 14%. Several staff were long-term sick. Staff sickness data from August 2021 showed both wards were at 8% sickness rates. At Carlton Court Laurel ward, seven staff were off on long-term sickness absence. Managers told us they had difficulty filling shifts due to patient's acuity. On Sandringham ward, sickness levels were 11% and four staff remained off work due to long-term sickness.

Patients had regular one-to-one sessions with their named nurse. We found on all wards escorted leave had been taking place regularly. Patients rarely had their escorted leave or activities cancelled, even when the service was short staffed.

The Blickling ward opened in March 2021, with a new ward manager and staff team, with some staff new to working in a hospital setting. The trust had recruited international nurses, with three nurses on Blickling ward on induction at the time of our inspection.

Families and carers when visiting the wards said there were plenty of staff around. They told us their relative was safe and their relatives experienced no aggression aimed at them.

Medical staff

The service had enough daytime and night-time medical cover and a doctor available to go to the wards quickly in an emergency. There was an on-call rota.

Wards for older people with mental health problems

Mandatory training

The trust staff mandatory and statutory training rate as of 14 October 2021 were 84% and below the 90% target. The staff training rate were low across the service at 79%. Most staff had not completed and kept up to date with their mandatory training. Not all training data on the ward managers dashboards were up-to-date or available. Abbeygate Laurel ward had the lowest compliance rates at 72% and the highest was Carlton Court Laurel ward at 85%. However, staff on all wards had gaps in their training. Managers across the service told us training compliance had been affected by the COVID-19 pandemic, staff pressures, staff sickness, patient acuity. Staff told us training had not been a priority.

The mandatory training programme met the needs of patients and staff. However, training rates were variable across wards. Mandatory training included physical intervention training, intermediate life support course, dementia, and manual handling. Managers monitored mandatory training and alerted staff when they needed to update their training. However, there were still gaps in mandatory training compliance.

Staff across the service told us they received Mental Health Act and Mental Capacity Act training, but training rates were low. Mental Capacity Act Training refresher training were every three years with compliance rate at 66% and annual Mental Health Act training compliance rate at 54%.

Following on from the onsite inspection visit, we requested the data from the trust for medicines management three yearly fresher. Overall training compliance rates were 67%, below the trusts 90% staff training rate. Beach ward had the highest rate at 74%. Abbeygate Laurel ward were lowest at 52%, there were four staff long-term sick and one staff on maternity leave.

On Blickling ward the manager's dashboard showed staff mandatory training rates were low at 67%. Data sent by the trust showed overall training rates for Blickling were 75%. Compliance rates were low for; Immediate Life Support (ILS) training annual refresher at 71%, physical intervention annual refresher at 55%, personal safety annual refresher at 58%. The ward manager had set aside training dates and training slots for staff to progress with their mandatory training. A training day was planned in November 2021 for care plan training.

Overall staff mandatory training rates for Abbeygate Laurel ward were low at 72%. Training compliance rates were low for: Infection control clinical annual refresher at 65%, personal safety annual refresher at 29% and physical intervention annual refresher at 26%.

Overall staff mandatory training rates for Sandringham ward were low at 77%. Training compliance rates were low for; Immediate Life Support (ILS) training at 68%, physical intervention annual refresher at 29%, infection control clinical annual refresher at 71% and personal safety annual refresher at 53%.

Overall staff mandatory training rates for Beach ward were low at 78%, although the ward managers dashboard showed the training compliance rates were at 72%. Compliance rates were low for: Immediate Life Support (ILS) training at 78%, physical intervention annual refresher at 51%, infection control clinical annual refresher at 71%, and personal safety annual refresher at 57%.

Overall staff mandatory training rates for Willows ward were low at 81%. Training compliance rates were low for: physical intervention annual refresher at 47%, infection control clinical annual refresher at 78% and personal safety annual refresher at 61%.

Wards for older people with mental health problems

Overall staff mandatory training rates for Reed ward were low at 83%, although the ward managers dashboard showed training compliance rates were at 77%. Compliance rates were low for: physical intervention annual refresher at 69% and infection control clinical annual refresher at 79%.

Overall staff mandatory training rates for Carlton Court Laurel ward were highest at 85%, although below the trust compliance target rate of 90%. Training compliance rates were low for: Immediate Life Support (ILS) training at 76%, physical intervention annual refresher at 66%, infection control clinical annual refresher at 77% and personal safety annual refresher at 66%.

Assessing and managing risk to patients and staff

Staff do not recognise risks, assess and manage risks to patients and themselves well. Staff followed best practice in anticipating, de-escalating and managing challenging behaviour. Staff used restraint and seclusion only after attempts at de-escalation had failed. The ward staff participated in the provider's restrictive interventions reduction programme.

Assessment of patient risk

Staff completed risk assessments for each patient on arrival, using a recognised tool. However, staff did not regularly update the risk assessments.

Management of patient risk

We reviewed 35 patient risk assessments across the service. We found two risk assessments at Blickling ward were not reviewed, following the ward procedures weekly red and green risk meetings. The weekly meetings allowed staff to review each patient's risks and rate them as red or green. For one patient, the risk assessment did not contain any information in relation to the management of violence and aggression towards self and others. Staff used restraint on 31 October 2021 as the patient did not respond to de-escalation techniques. There was no mention of physical health deterioration on the risk assessment and care plan. The patient's health deteriorated and was moved to hospital due to delirium and confusion; but the risk assessment was not reflective of the situation.

A second patient's risk assessment had not been updated weekly at the red and green risk meeting. The risk assessment was most recently updated on 15 October 2021. The patient was self-isolating in their bedroom and had minimal engagement with other patients. Records of Covid testing were located in individual patient records. Positive cases were reported through the electronic incident reporting system and escalated to the infection management team.

The risk assessment for one patient on Sandringham ward upon admission identified risks around sexualised behaviour towards staff. In addition, the need for two staff to support the patient with personal care. However, the risk assessment was not fully reflective of the risks.

One patient recently admitted to Sandringham ward told us their radio and television had been removed due to a risk of ligature. The patient's risk management plan showed they were of low suicidal risk. The ward matron immediately followed this up with the patient with a further review of the patients care and associated risks.

When we spoke with staff, they knew about the risks for each patient but did not always update the risk assessments.

Staff followed procedures to minimise risks where they could not easily observe patients.

Wards for older people with mental health problems

Use of restrictive interventions

Levels of restrictive interventions were low. Staff participated in the provider's restrictive interventions reduction programme which met best practice standards.

Staff applied blanket restrictions on patient's freedom only when justified.

Staff made every attempt to avoid using restraint by using de-escalation techniques and restrained patients only when these failed and when necessary to keep the patient or others safe.

Staff understood the Mental Capacity Act definition of restraint and worked within it. Staff followed National Institute for Health and Care Excellence (NICE) guidance when using rapid tranquilisation, which was rarely used.

Safeguarding

Staff safeguarding training rates were low across most wards. Staff understood how to protect patients from abuse and the service worked well with other agencies to do so. Staff had training on how to recognise and report abuse and they knew how to apply it.

Staff received safeguarding training on how to recognise and report abuse, appropriate for their role. However, the training uptake varied. Safeguarding training was mandatory, with annual and three yearly refresher adult and children training available. The adult safeguarding level 1 yearly training compliance rate were 90%. Wards with low compliance rates were Willows 89%, Abbeygate 86%, Blickling 81% and Sandringham 80%. The safeguarding adults three yearly refresher training overall compliance rate were at 81%. The wards with low compliance rates were Reed 63%, Beach 65%, Blickling 72%, Laurel 83%, and Abbeygate 86%.

Staff knew how to recognise adults and children at risk of or suffering harm and worked with other agencies to protect them. Staff followed clear procedures to keep children visiting the ward safe.

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

Staff access to essential information

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

Patient records were mainly comprehensive, and all staff could access them easily. Although the service used a combination of electronic and paper records, staff made sure they were up to date and complete. We saw at Carlton Court staff maintained high quality comprehensive patients' records. When patients transferred to a new team, there were no delays in staff accessing their records. Records were stored securely.

Medicines management

Staff did not always follow systems and processes when safely prescribing, administering, recording, and storing medicines.

Wards for older people with mental health problems

The trust had introduced an electronic prescribing and medicines administration system which had improved prescribing and recording of medicines administration. However, when we reviewed the medicines administration records, it was not always clear in what form medicines had been administered. This was particularly noted for patients being administered their medicines covertly. Covert administration is when medicines were administered in a disguised format without the knowledge or consent of the person receiving them.

Pharmacists provided detailed information for administering medicines covertly. However, the electronic prescribing and medicines administration system was not always updated to show how a patient should be administered their medicines. There was one example on Blickling ward and one on Willows ward where the form of medicines (e.g. tablet or liquid) was not prescribed. We were informed this decision was left to the nurse, however there was no record of what the patient was given or if staff had followed the advice provided by the pharmacist.

On Abbeygate Laurel ward, we saw that morning medicines were not always given to patients on time, and some were given at lunchtime. This meant that staff were sometimes delaying medicines due later in the day or giving them together, which may have an impact on a patient's health condition. For example, we saw one patient who had been given their morning and lunchtime diuretic (a medicines to help reduce salt and water from the body) at the same time. This could potentially cause a drop in blood pressure and lead to falls. We were told that this was due to staff shortages. It was not clear if the risks of delayed medicines administration for individual patient's had been discussed with either the prescriber or a pharmacist.

Patients' weights were not always recorded on medicines charts which was important to determine the correct dose of certain medicines. Out of 27 charts we reviewed, six did not have a patient weight recorded.

Medicine allergies or sensitivities were recorded on all medicine charts we reviewed. This ensured staff were alerted to prevent the prescribing and administration of medicines causing allergic reactions.

Medicines advice and supply from pharmacy were available five days a week. Staff knew the routes to obtain medicines out of hours, if required.

Staff reviewed patient's medicines regularly and provided specific advice to patients and carers about their medicines. Pharmacists reviewed patient's prescribed medicines. They attended multidisciplinary review meetings to discuss, advise and provide support to the decision-making processes for patients' medicines requirements.

The trust subscribed to 'Choice and Medicines' where information leaflets could be printed in different languages and formats for patients. However, we found not all staff were aware of this website and it was not used regularly.

Staff stored and managed all medicines and prescribing documents in line with the provider's policy. Medicines were stored securely in line with the providers policy and national guidance with access limited to authorised personnel only. FP10 prescription pads were stored securely with a system in place to track their use which is in line with national guidance.

Staff followed current national practice to check patients had the correct medicines. Medicines reconciliation, the process of ensuring that patients' current medicines were recorded, was carried out on admission. Doctors and pharmacy staff had access to patients' summary care records which was an electronic record of patients' medicines from their GP records. This helped to ensure that patients' medicines records were correct at the time of admission.

Pharmacists checked and reviewed patients' medicines whilst in hospital and ensured the medicines were correct at the point of discharge.

The service had systems to ensure staff knew about safety alerts and incidents, so patients received their medicines safely. Staff understood how to report a medicines incident or safety concerns following the trust's incident reporting policy. Staff told us they received 'Medicines Safety' updates about errors or incidents.

Decision making processes were in place to ensure people's behaviour was not controlled by excessive and inappropriate use of medicines. When a medicines was prescribed to be administered 'as and when required' there was information provided so that staff understood when it was needed. The need for these medicines were reviewed regularly during multidisciplinary team meetings.

When a medicine was administered to manage agitation or aggression (rapid tranquilisation), medicines were appropriately prescribed and checked. Staff we spoke with understood the requirements within the policy.

Staff could describe what they would do when someone refused their medicines and lacked mental capacity. There was a best interest process which followed the principles of the Mental Capacity Act. Where the need for covert administration of medicines was being considered we found that policies and procedures were followed. The decision-making process and an agreed management plan were documented in patients' records.

Staff reviewed the effects of each patient's medicines on their physical health according to NICE guidance. Pharmacists reviewed medicines prescribed for physical health and discussed any concerns at the multidisciplinary team meetings. Physical health nurses were available on most wards to ensure patients had their physical health checks carried out and this was recorded on the electronic system.

Most families and carers knew about the medicines their relative were taking if they wanted to.

Track record on safety

The service had a good track record on safety.

Reporting incidents and learning from when things go wrong

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

Staff knew what incidents to report and how to report them. Staff raised concerns and reported incidents and near misses in line with trust policy.

Managers shared learning about never events with their staff and across the trust.

Staff understood the duty of candour and gave patients and families a full explanation when things went wrong. Managers investigated incidents, gave feedback to staff and shared feedback from incidents outside the service. On Sandringham ward, there had been a patient death in 2020 and we found changes had been made in relation to patient do not resuscitate plans, strengthening work between inpatient and community teams, more multiple disciplinary team working, more involvement in patient meetings.

Wards for older people with mental health problems

However, we found one action from this death, staff trained in immediate life support, continued to be of concern with only 68% of staff trained at the time of the inspection.

There was evidence that changes had been made as a result of feedback. Staff met to discuss the feedback and look at improvements to patient care. Managers debriefed and supported staff after any serious incident.

There were 11 inpatients deaths due to the COVID- 19 pandemic. Staff told us they had received additional and regular support from the infection control team which included specialist infection control nurses.

Is the service effective?

Requires Improvement 

Our rating of effective went down. We rated it as requires improvement.

Assessment of needs and planning of care

Staff assessed the physical and mental health of all patients on admission. However, some care plans did not reflect patients current care needs. Staff developed individual care plans which were reviewed regularly through multidisciplinary discussion and updated as needed. Care plans were variable and reflected patients' assessed needs, and were personalised, holistic and recovery oriented.

Staff completed a mental health assessment of each patient either on admission or soon after. Patients had their physical health assessed soon after admission and most were regularly reviewed during their time on the ward. Staff regularly offered patients copies of their care plans.

We reviewed 35 care plans across wards and found them to be of a variable standard. Staff had generally developed personalised, holistic, and recovery-oriented care plans for patients that met their mental and physical health needs.

On Blickling ward, care plans were not of a high standard. We sampled six care plans, two care plans were incomplete and lacked vital information about patients' needs, for example crisis plan, safety plan and contingency plan. Staff told us the trust had launched recovery care plans from October 2021 with a training programme for staff. Staff at Blickling ward had already starting to use the new recovery care plans but not all staff had received the training. We were told a Blickling ward staff training day for recovery care plans was planned late November 2021.

On Abbeygate Laurel ward, care plans were of a variable standard. We sampled six care plans. One patient's care plan showed they had a grade two pressure sore that had developed to grade three but no detail in care records as to how the wound had worsened. We also saw inappropriate language was recorded to describe the patient's body parts. A second patient admitted 30 October 2021 had a care plan which was not completed.

However, on other wards, such as on Carlton Court Laurel ward, we sampled six care plans and found all six care plans were of a good standard, captured the life story and history of the patient, were comprehensive and included the patient's views, wishes and feelings.

Best practice in treatment and care

Wards for older people with mental health problems

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

Staff provided a range of care and treatment suitable for the patients in the service. Staff delivered care in line with best practice and national guidance.

Staff used recognised rating scales to assess and record the severity of patients' conditions and care and treatment outcomes for example, the national early warning score a tool which improves the detection and response to clinical deterioration in adult patients and improves patient outcomes. Therapy staff used the model of human occupation screening tool to gain an overview of the patients occupational functioning.

Staff used Waterlow assessment tools for assessing a patient's level of risk of developing a pressure ulcer. Staff followed a fall risk assessment tool to assess patients at risk of falls and recommend strategies to prevent falls and reduce the chance of injury.

On Reed ward, staff told us they used reminiscence interactive therapy activities digital therapy system which allowed patients to use apps, games and other leisure activities as part of their hospital recovery. Staff used this with patients on a one-to-one. For example, as part of reminiscence staff supported patients with simple games like virtual football and horse racing. In addition, staff used Aid Memoire a reminiscing tool that showed old fashioned television adverts and prompted responses, and discussion sometimes about patients' earlier lives.

Staff identified patients' physical health needs and recorded them in their care plans. Staff made sure patients had access to physical health care. Patients had access to tissue viability, falls and infection prevention and control specialists.

Patients had weekly access to a physical health nurse or a named nurse on the ward with physical health responsibilities.

Staff met patients' dietary needs and assessed those needing specialist care for nutrition and hydration. Staff could refer patients to other professionals, as their care needs required. These included dietetics, physiotherapy, speech, and language therapists. Staff helped patients live healthier lives by supporting them to take part in programmes or giving advice.

Staff took part in clinical audits, benchmarking, and quality improvement initiatives. The service took part in monthly audits; for example, falls assessment and care planning, medicines, emergency equipment, cleaning, and mattresses management.

Skilled staff to deliver care

The ward teams included, or had access to, the full range of specialists required to meet the needs of patients on the wards. Managers made sure they had staff with the range of skills needed to provide high quality care. However, managers had not provided staff with 12 monthly appraisals or regular supervision. Staff had opportunities to update and further develop their skills. Managers provided an induction programme for new staff.

Wards for older people with mental health problems

The service had access to a range of specialists to meet the needs of the patients on the ward. The service vacancy rates were 14% with the trust overall vacancy target rate at 9%. Each ward had staff vacancies and were actively recruiting to posts. Teams consisted of nurses, clinical support workers, assistant practitioners, occupational therapists, psychologists, doctors, and junior doctors. The wards were supported by social workers, physiotherapists, and physical health nurses. The trust employed activity coordinators who worked with the therapy team.

Two consultants were assigned to each ward. One consultant worked remotely across Reed and Beach wards.

Clinical team leaders (ward managers) were responsible to ensure staff had the right skills, qualifications, and experience to meet the needs of the patients in their care, including bank and agency staff. Managers gave each new member of staff a full induction to the service before they started work.

Not all staff had received 12 monthly appraisals or regular constructive management and clinical supervision. Managers told us working through the COVID-19 pandemic they had experienced overwhelming staffing pressures. Some staff told us they were on the "COVID-19 recovery stage now."

The trust appraisal target rate was 90%. The highest appraisal rates were at Carlton Court Laurel ward at 97% and the lowest rates were at Blickling ward at45%. However, most wards had low appraisal rates, such as Sandringham ward at 53%, Beach ward at 64%, Abbeygate Laurel ward at 69%, Willows ward at 76%, and Reed ward at 88%. Trust data showed for Laurel, Willows and Abbeygate Laurel wards two out of four medical staff (50%) had received appraisals.

The trust told us constructive management supervision deteriorated from a high of 79% in May 2021 to 65% in July 2021, below the target of 78%. This is a staged target with the aim of reaching 90% by the end of March 2022. We found variable rates across the service. For example, Carlton Court Laurel ward the rate was 54%, Blickling ward was 45%, Sandringham ward was 12%. Staff on Willows, Beach and Reed wards were unable to provide data on constructive management supervision. We asked the trust for this data but had not received any at the time of writing the report.

A new clinical supervision app was developed early in 2021 with a pilot group of 48 staff. Staff told us they had not received training in the new app. Training was being delivered through the centre for supervision training and development. The first cohort of staff commenced their training in June 2021, completing the course in October 2021 with all three groups fully trained by July 2022. The trust was asked to provide CQC with service clinical management supervision rates, but these were not provided. At Carlton Court Laurel ward, the ward manager told us clinical supervision dates were planned with staff in diaries with their named supervisor, but no records of the meetings were held on electronic systems. Other ward managers also told us clinical supervision were taking place with no records held.

Some therapy team staff told us they received appraisals and constructive management supervision with the ward manager and clinical management supervision with a senior therapy staff member of their choice.

Managers made sure staff attended regular team meetings or gave information from those they could not attend.

Two therapy team staff told us they preferred a senior therapy staff member to line manage them but were told by the trust this could not be facilitated.

Managers made sure staff received specialist training for their role.

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

Wards for older people with mental health problems

At Carlton Court Laurel ward, the trust had recruited, trained and supported volunteers to work in the large patient garden aligned to the ward. One volunteer in the garden area told us they had been an inpatient at the service and following on their recovery had volunteered to work in the garden.

Multi-disciplinary and interagency teamwork

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

Staff held regular multidisciplinary meetings to discuss patients and improve their care. There was regular discharge, and care programme approach meetings with patients and family carers. On Blickling ward we observed a virtual Section 117 meeting. Section 117 aftercare is a legal duty that is placed on health and social services to provide after care services for individuals who have been detained and comes in effect once the person has been discharged from the hospital. The meeting involved the patient, family members, ward doctor, nurse, the patient's social worker, and care home manager. Together the team discussed the patients potential return to the care home placement.

The service had social workers and discharge managers who supported the ward teams. The service had effective working relations with the community teams created in response to facilitate discharges from the wards.

Staff made sure they shared clear information about patients and any changes in their care, including during handover meetings. Ward teams had effective working relationships with other teams in the organisation for example the dementia intensive support team.

At Carlton House Laurel ward, we observed one staff handover. Staff shared key information to keep patients safe when handing over their care to others.

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

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

Staff were provided with annual Mental Health Act training with a 54% compliance rate. n. The trust told us the Mental Health Act training had changed from "once only" following a review of this by the trust's solicitor, legal services manager and Mental Capacity Act lead and Mental Health law lead. This was to ensure this legislative training was updated as the Act evolved and to incorporate any new case law. The Mental Health Act changed from "once only" to "yearly" from September 2021. The trust calculated 2,567 staff need time to complete the requirement so would not report on this as a trust until March 2022.

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

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

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

Wards for older people with mental health problems

Patients had easy access to information about independent mental health advocacy and patients who lacked capacity were automatically referred to the service.

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

On Blickling ward, care records showed not all patients could access section 17 leave (permission to leave the hospital) when this was agreed with the Responsible Clinician and/or with the Ministry of Justice. Following the inspection, the trust provided evidence of patients receiving Section 17 leave.

Staff requested an opinion from a Second Opinion Appointed Doctor when they needed to.

Staff stored copies of patients' detention papers and associated records correctly and staff could access them when needed.

Informal patients knew that they could leave the ward freely and the service displayed posters to tell them this.

Care plans included information about after-care services available for those patients who qualified for it under section 117 of the Mental Health Act. We observed a virtual Section 117 facilitated by the doctor involving the patient who remained in their bed throughout.

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

Good practice in applying the Mental Capacity Act

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

Staff received Mental Capacity Act refresher training every three years with a compliance rate at 66%. The trust told us the Mental Capacity Act training had changed from "once only" following a review of this by the trust's solicitor, legal services manager and Mental Capacity Act lead and Mental Health law lead. This was to ensure this legislative training was updated as the Act evolved and to incorporate any new case law. The Mental Health Act changed from "once only" to "yearly" from September 2021. The trust had calculated 2,567 staff need time to complete the requirement so would not report on this as a trust until March 2022.

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

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

Staff gave patients all possible support to make specific decisions for themselves before deciding a patient did not have the capacity to do so.

Staff assessed and recorded capacity to consent clearly each time a patient needed to make an important decision.

Wards for older people with mental health problems

When staff assessed patients as not having capacity, they made decisions in the best interest of patients and considered the patient's wishes, feelings, culture, and history.

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

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

Is the service caring?

Good 

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

Kindness, privacy, dignity, respect, compassion, and support

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

We spoke with 18 patients who told us they felt very well supported and staff and were kind, caring, and respectful. One patient recently admitted to Sandringham ward told us staff had told them there was no internet access. We fed this back to staff who immediately took action and arranged a guest internet pass and access to a ward laptop.

We observed and heard positive interactions between patients and staff across all wards we visited. Staff understood and respected the individual needs of each patient. Staff supported patients to understand and manage their own care treatment or condition.

Staff gave patients help, emotional support and advice when they needed it.

Staff felt that they could raise concerns about disrespectful, discriminatory or abusive behaviour or attitudes towards patients. Staff followed policy to keep patient information confidential.

We saw staff treated patients with compassion and kindness. We observed staff respected patient's privacy and dignity.

Involvement in care

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

Staff involved patients and gave them access to their care planning and risk assessments.

Staff introduced patients to the ward and the services as part of their admission. Each ward provided a patient booklet.

Wards for older people with mental health problems

Staff made sure patients understood their care and treatment and found ways to communicate with patients who had communication difficulties.

Patients could give feedback on the service and their treatment and staff supported them to do this. Patients could attend weekly mutual help meetings with therapy staff. Patient meeting notes we reviewed evidenced feedback from patients in relation to not liking staff wearing masks and appreciating the staff and activities provided.

On Sandringham ward, patients' feedback to staff, and events were organised to support patient's wellbeing and recovery. Staff told us about recent tea parties with themes, such as Wimbledon, Halloween and Remembrance Day 1940s. Patients told staff at mutual help meetings it was difficult as there was no shop on site to buy personal items such as; toiletries, sweets, socks, Christmas cards and birthday cards. Activity coordinators responded by organising a weekly pop up shop, with all items cost of £1.00 and non-profit making.

Staff supported patients to make decisions on their care. Staff made sure patients could access advocacy services.

Involvement of families and carers

Staff informed and involved families and carers appropriately.

We spoke with 13 families and carers. Some of the families and carers we spoke with told us the staff on the wards were respectful, polite, caring, and interested in their relatives. They were also responsive to their own needs of the relatives. Over half of the families and carers were involved with their relative's care plan and the discharge planning when it was appropriate. One person said they had spoken to the ward social worker. Families and carers told us that the diagnosis of their relative was worked out from information the relative told the ward staff.

When the weather was good, families and carers told us they were able to take their relative into the garden. All the patients were supported to maintain their relationships with their families and carers. Involvement from families and carers in care of their loved ones was clear in ward round notes.

Staff told us upon admission patients' relatives and carers were sent a welcome pack. There was a 72 hour follow up meeting with the patient's relatives and carers to keep them updated and involved.

Is the service responsive?

Requires Improvement 

Our rating of responsive went down. We rated it as requires improvement.

Access and discharge

Staff faced challenges to manage bed availability within the trust. A bed was available when needed. Discharge were delayed due to lack of available accommodation or suitable care packages. Patients were not moved between wards unless this was for their benefit.

Bed management

Wards for older people with mental health problems

The data provided by the trust for bed occupancy across this service from November 2020 to October 2021 were 89%. Managers regularly reviewed length of stay for patients to ensure they did not stay longer than they needed to. The average length of stay and out of area placements were requested during the inspection but not received from the trust. Managers and staff worked to make sure they did not discharge patients before they were ready.

When patients went on leave there was always a bed available when they returned. Patients were moved between wards during their stay only when there were clear clinical reasons, or it was in the best interest of the patient.

Staff did not move or discharge patients at night or very early in the morning. The psychiatric intensive care unit always had a bed available if a patient needed more intensive care and this was not far away from the patient's family and friends.

Discharge and transfers of care

The service had a total of 2,434 delayed discharges from October 2020 to September 2021. From October 2020 to September 2021, the lowest delayed discharges were in April 2021 with 60 delayed discharges and the highest in September 2021 with 348 bed days. The service had experienced significant pressures due to COVID-19 pandemic. Managers told us they are monitoring patient discharges and taking action.

There had been some delays on discharge due to suitability of placement. Staff carefully planned patients' discharge and worked closely with the community teams for discharges. Managers confirmed most patients go onto social care placements or community mental health teams. Ward social workers and the multidisciplinary team supported patients to prepare for discharge.

Staff supported patients when they were referred or transferred between services. The service followed national standards for transfer.

Facilities that promote comfort, dignity, and privacy

The design, layout, and furnishings of most wards supported patients' treatment, privacy, and dignity. Each patient had their own bedroom and could keep their personal belongings safe. However, there were not enough quiet areas for privacy. Patients could make hot drinks and snacks at any time.

The design, layout, and furnishings of most wards supported patients' treatment dignity and respect. Each patient had their own bedroom, with areas to keep their personal belongings safe. We saw areas for patients to store their belongings. Not all bedrooms included an en-suite shower or bath. Across services bedrooms varied some with full en-suite, hand basins, toilet and hand basins. There were enough communal bath and shower facilities available where patients did not have en-suite facilities.

We saw on Blickling ward the privacy film on some bedroom's door windows were peeling off. The ward manager told us this would be included on the ward works plan.

Staff used a full range of rooms and equipment to support treatment and care. The service had quiet areas and a room where patients could meet with visitors in private. Facilities included lounges and garden areas. There was a telephone on each ward and patients could make phone calls in private. Some patients had their own mobile phones.

Wards for older people with mental health problems

At Carlton Court Laurel ward, patients were receiving care and treatment for dementia. The ward lounge and dining areas were cramped and lacked space. The ward was not dementia friendly. The female lounge was small and used for storage and was the only visitor's room on the ward. We observed staff discretely assist two patients at lunch time in the corridor walkway near the ward door due to the lack of room. Staff told us when a patient was distressed in the communal areas, they had difficulty managing this, as other patients would see and hear another patient in distress and may become upset. We saw one patient shouting and staff redirect the patient away for privacy from the communal areas where other patients were seated.

Each ward had an outside space which patients could access easily. Patients could make their own hot drinks at the drinks station and access a range of snacks including fresh fruit and biscuits and were not dependent on staff. The service offered a variety of good quality food. Patients we spoke with told us they liked the meals on the wards. Most families and carers told us the food was good. Families and carers thought the hospital tried to encourage patients to eat healthy meals and exercise regularly.

Patients' engagement with the wider community

Staff supported patients with activities outside the service, such as work, education, and family relationships.

Staff made sure patients had access to opportunities for education and work, and supported patients. Staff helped patients to stay in contact with families and carers.

Staff encouraged patients to develop and maintain relationships both in the service and the wider community. Some patients at Julian Hospital visited the local coffee shop. Patients had trips out to local shops, garden centre, local beauty spots.

Some patients were involved in gardening projects, growing plants including fruit and vegetables. During the summer months, patients could eat their grown produce of spring onions, tomatoes.

A patient recently admitted to Sandringham ward told us they had no clothes to wear. We saw none in their bedroom cupboards and asked staff about this. Staff had been providing clothes for the interim and confirmed this had been discussed in the multiple disciplinary team meeting and a family member was visiting the next day with the agreement to bring additional clothing.

Meeting the needs of all people who use the service

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

The service could support and make adjustments for disabled people and those with communication needs or other specific needs. Carlton Laurel ward did not support disabled patients with sufficient space. Not all wards had adapted bedrooms for patients who needed accessible space.

Staff made sure patients could access information on treatment, local services, their rights and how to complain. We saw health and general information was accessible in different formats including easy read.

Patients had access to spiritual, religious and cultural support. Patients had access to the trust's chaplaincy service.

Wards for older people with mental health problems

Listening to and learning from concerns and complaints

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

We saw patients had regular mutual help meetings. They centred on how staff can support the patients during their stay on the ward.

Suggestion boxes could be found in the reception area at Carlton Court. The box was emptied on a weekly basis and collated by the trust's quality improvement team. They were then discussed within the senior leadership team for action, allocation and responses.

Patients, families and carers knew how to complain were confident that they could complain, however few had complained. The service clearly displayed information about how to raise a concern in patient areas. On some wards, a tablet mobile operating system with touchscreen display was available for friends and family feedback. We saw friends and family freepost envelopes with feedback cards.

Managers told us there had been no complaints received in the previous 12 months. Staff understood the policy on complaints and knew how to handle them. The service used compliments to learn, celebrate success and improve the quality of care.

Is the service well-led?

Requires Improvement 

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

Leadership

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

Managers had the right skills, knowledge, and experience to perform their roles. Three leaders were new to the service and worked with other experienced leaders. Some managers had undertaken leadership training modules. Managers had a good understanding of the services they managed.

Some ward managers told us that senior service managers were not always visible, approachable or that they felt listened to.

Managers and staff confirmed development opportunities for career progression were available and were encouraged to take these up.

Vision and strategy

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

Wards for older people with mental health problems

Those staff we asked knew the organisation's vision and values, and saw each ward had their vision and values prominently displayed. We saw evidence of the provider's vision and values in team meetings and business meeting minutes. Staff were able to articulate the philosophy of the wards.

Culture

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

Staff told us they enjoyed their work, but staff morale was mixed. Many staff talked about the relentless pressures on wards during the COVID-19 pandemic and felt exhausted. Not all staff felt valued and respected by senior service managers. Staff at ward level felt able to raise their concerns without fear of retribution.

Many staff on Blickling ward were complimentary about the ward manager and the open-door approach and that they felt listened to and valued.

Some managers told us they felt unable to raise concerns with senior service managers for fear of what may happen or lack of response. They felt they were not listened to or valued.

There appeared to be a good culture developed on wards and staff had a good understanding of the service they provided. Staff told us they promoted equality and diversity in their day-to-day work.

The service had been severely affected with high numbers of patients and staff testing COVID-19 positive during outbreaks in these areas. There were eleven inpatient deaths within 28 days of a positive test during 2020 and 2021. Staff told us they felt exhausted and unsure of what was expected of them next. Managers told us staff had risen to the challenge: they had developed strong teamwork, good support and had worked long days however the whole experience had been very challenging. Some staff were on restricted duties due to their own personal circumstances. Some staff told us they were on the COVID-19 recovery stage now. There were still pressures on the wards with one ward with nine pregnant staff.

Governance

Our findings from the other key questions demonstrated that governance processes were not effective at team level and that performance and risk were not managed well.

We saw some improvements in the service since the most recent inspection in 2018 around preventing and reduce risks associated with control and spread of infections, seek and acting on feedback and evaluating and improving the service.

Ligature reduction work on Blickling ward was an issue highlighted at our most recent inspection in 2018. We found the trust had failed to take action in relation to the ligature reduction work on Blickling ward at the time of this inspection. Following the inspection, the trust told us it had taken immediate follow up action to review ligature anchor points, with further works scheduled on the ward.

Patient risk assessments and care planning were not fully embedded across two wards.

Wards for older people with mental health problems

On Sandringham and Reed wards, eliminating single sex accommodation guidance had not been followed. The trust took immediate follow up action during the inspection to review patient care on Sandringham ward. Staff told us where male and female patients were mixed on the same wards were unsafe, and the frequency of this had become “business as usual.”

The trust had not ensured Carlton Court Laurel ward environment met dementia friendly guidance or promoted patients’ comfort, dignity, and privacy.

The trust did not ensure staff were up to date with mandatory training. For example, safeguarding adults, Mental Health Act and Mental Capacity Act, immediate life support training, physical intervention. This was despite learning from a previous patient death reflecting the important of immediate life support training.

The trust had not ensured staff received appraisals and regular constructive and clinical supervision.

The trust had systems and processes to prescribe and administer medicines safely. However, they were not always followed. Medicines were not always administered to patients at the prescribed time. The trust electronic prescribing and medicines administration system was not always updated with relevant information and therefore did not always reflect an up to date record of patient’s medicine requirements. Patients' weights were not always recorded on medicine charts.

We spoke with 13 families and carers. Most families and carers thought the hospital was well led. However, one relative thought the Blickling ward was not well led. They were not certain they had considered their relatives falls and were doubtful about any plans put in place to resolve this issue. They were also not happy with information they had received about their relative and their progress. Another family member told us there were lots of room for improvement. The ward communication skills were lacking and thought that they had to pull information from staff. They also felt the staff could answer the phone more promptly but said after several complaints’ things were improving.

Management of risk, issues, and performance

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

Effective multidisciplinary meetings across the service helped to reduce patient risks and keep patients and staff safe. Staff notified and shared information with external organisations. Staff were open and transparent and explained to patients when something went wrong. We saw staff had good rapport with patients.

Most staff were offered the opportunity to give feedback and input into service development. Staff did this through regular team meetings.

The trust provided information governance systems to measure key performance indicators and to gauge the performance of teams. However, on most wards, managers had difficulty locating key and current information. Where the CQC teams were provided data on site this frequently differed from the data provided by the trust.

Managers told us they had access to the risk register at ward level. Ward managers told us the most significant risks were staff recruitment and retention, safe wards, and ligature reduction plans.

Information management

Wards for older people with mental health problems

Staff engaged actively in local and national quality improvement activities.

Information governance systems included policy on confidentiality of patient records.

Managers had access to dashboards with information that supported them. However, we found some managers had difficulty access this information. It was unclear if the information was accurate.

Staff notified and shared information with external organisations when necessary, seeking patient consent when required to do so.

Managers from the service were active in the work of the local transforming care partnership, working across services and families and carers to agree and deliver local plans to improve services.

Engagement

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

Staff engaged in local and national improvements activities. The wards team reconfigured in response to the COVID-19 pandemic with isolation wards.

Learning, continuous improvement and innovation

Managers supported development of new student nurses. We spoke with one student, they said they felt welcomed and quickly made to feel part of the team. A group of 23 new nurses from India, Nigeria and the Philippines had started work at the trust as part of an NHS international recruitment project. We spoke with one international nurse who was enjoying work on the older people's wards

Community-based mental health services of adults of working age

Inadequate ↓

Is the service safe?

Requires Improvement →←

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

Safe and clean environment

Not all clinical premises where patients received care were safe, clean, well-equipped, well-furnished, and fit for purpose.

Staff had completed and updated environmental risk assessments regularly. However, not all managers and staff were aware of the outcomes of these assessments including identified risks and mitigations. Environmental risk assessments had been completed for all team bases. However, in one team, the environmental risk assessments were out of date. This was a concern raised following our most recent inspection. In Great Yarmouth staff showed us a copy of the premise's safety plan dated 18 February 2020 which was due for review February 2021 and the site-specific risk assessment dated 13 August 2020 which was due to be update August 2021. Neither document had received an update.

Staff had access to personal alarms and staff were available to respond.

All clinic rooms had the necessary equipment for patients to have thorough physical examinations.

Most areas were clean, well-furnished and fit for purpose. However, we found the community base in Kings Lynn had not been well maintained. There were missing ceiling tiles and stains on the ceiling as a result of water damage, and the décor required updating.

Staff had mostly ensured that cleaning records were up-to-date, and the premises were clean. However, in Norwich we found that the cleaning schedule had not been signed since September 2020.

Staff followed infection control guidelines, including handwashing. Managers had ensured personal protective equipment (PPE) was made available for patients and staff.

Staff had made sure most medical equipment was well maintained, clean and in working order. However, in Lowestoft there was no recorded evidence that equipment had been cleaned. This concern was previously raised during our most recent inspection.

Safe staffing

The service did not always have enough staff, to keep them safe from avoidable harm. The number of patients referred to the service for assessment and allocation, outreached demand preventing staff from giving each patient the time they needed.

Community-based mental health services of adults of working age

Nursing staff

Managers used a recognised tool to calculate safe staffing levels. However, the service did not always have enough nursing and support staff to provide good quality care and to keep all patients safe. One staff member told us there was "just not enough staff now, to cover the quantity of work". The number of staff available did not meet the number of referrals received by the service. Several staff members told us they did not feel safe. Managers had escalated concerns regarding staffing levels, which have been described on the trust's risk register in one team as being "excessive". The number of staff absences overall, exceeded the trust target of just under 5%. Out of 22 teams, 13 (59%) exceeded the trust target of just under 5%. The highest percentage of absences was over 20%. However, in nine out of 22 teams (41%) the percentage of absences were below the trust target.

The service had varying rates of bank and agency nurses across the service. The range of bank and agency usage over a 12-month period ranged from 120 hours to 3,358 hours per team. The mean average number of hours of bank and agency usage per team was 1,220 hours over a 12-month period, an average of 102 hours per month. In one team, managers were using bank and agency staff in the evenings and at weekend, to reduce numbers of patients awaiting initial assessment.

Managers had not always made arrangements to cover staff sickness and absence wherever possible. Staff told us they had written to the trust board regarding low levels of staffing. Managers told us this had led to a recruitment campaign, however not all vacancies could be recruited to.

Managers limited their use of bank and agency staff and requested staff familiar with the service.

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

The service had variable turnover rates. The average turnover rate for all teams was 13%, against a trust target of 15%. However, eight teams had a turnover rate higher than the trust target (15%). The highest turnover rate of 22% was reached in Kings Lynn and East Suffolk . The lowest turnover rate of zero was reached in one team.

Managers supported staff who needed time off for ill health. The average sickness levels from 1 October 2021 to end of November 2021 was six percent, which was above the trust target of 4.91%. These figures included staff who were off sick due to Covid-19. The highest team sickness level was 20%, however one team had reported no sickness.

Medical staff

The service did not always have enough medical staff. The number and grade of staff did not always match the provider's staffing plan.

There was no consultant psychiatrist in post in Great Yarmouth. As a result, patients on community treatment orders, had to be seen by consultants from other teams, which added to their workload. Medical staff in Suffolk told us that there were not enough Section 12 approved doctors.

Managers could use locums when they needed additional support or to cover staff sickness or absence. However, managers were not always able to find locum cover where required.

Managers made sure all locum staff had a full induction and understood the service.

The service could not always get support from a psychiatrist quickly when they needed to. In one team, staff access to a psychiatrist was only available on a Friday. In Great Yarmouth there was no consultant psychiatrist in post, however medical cover was provided by two speciality doctors.

Mandatory training

Staff had mostly completed and kept up-to-date with their mandatory training. The average mandatory training rate across all teams was 86%, against a trust target of 90%. The highest compliance level by team at the end of October 2021 was 100%. However, average training levels for seven courses fell below 75%. These included autism awareness (31%), counter fraud (15%), dementia awareness (8%), visual display equipment (58%), health, safety and welfare (15%), information governance (42%) and learning disability awareness (42%). The lowest mandatory training rate in a team was 13% for information governance and learning disability awareness where only 11 out of 26 teams achieving training levels of above 75%.

The mandatory training programme was generally comprehensive and met the needs of patients and staff. However, the mandatory training level rates for safeguarding adults and children provided by the trust was for level one training which did not meet national guidance for training staff in safeguarding. All non-clinical and clinical staff who have any contact with children, young people and/or parents and/or carers should be trained to level two, and those who could potentially contribute to assessing, planning, intervening and evaluating the needs of a child or young person and parenting capacity where there are safeguarding or child protection concerns, should be trained to level three.

Managers told us they monitored mandatory training and alerted staff when they needed to update their training. However, due to sickness associated with COVID-19 and staff vacancies, staff reported that they had been unable to be released to attend training.

Assessing and managing risk to patients and staff

Staff assessed and managed risks to patients and themselves as part of a combined core assessment. However, staff were not always able to respond promptly to sudden deterioration in a patient's health, due to poor staffing and high levels of demand. When necessary, staff worked with patients and their families and carers to develop crisis plans. Staff told us they monitored patients on waiting lists to detect and respond to increases in level of risk. However, we identified that not all patients on the waiting list were monitored in line with trust policy. Staff followed good personal safety protocols.

Assessment of patient risk

Staff completed a core assessment for patients which included a comprehensive assessment including a risk assessment. However, we found that staff did not undertake a physical health assessment as part of the initial assessment. Post inspection the trust informed us that 79% of the records contained a physical assessment which had improvement from 39% the last inspection.

Patients' risk levels were rated, depending on the outcome of the assessment. Staff rated patients' risk level as red (high risk), amber (medium risk) or green (low risk).

The trust's policy indicated that patients who had been rated red should be reviewed weekly, until an agreement between the patient and/or carer on what the frequency would be and the interventions that will be offered. The policy did not prescribe the frequency of contact for those rated amber and green. Methods, times and frequency were determined by the clinical team and patient based on "My Safety Plan" and "Crisis Plan"

During our inspection, ten patients in Kings Lynn were identified as not having been allocated a risk rating. This was addressed on the day of our inspection once we raised it with staff. We found evidence due to high demand and low capacity, staff were not always able to contact patients with the frequency outlined in trust policy. This meant we could not be assured staff knew the risks of patients on their caseloads or patients had their risks reviewed according to need. Concerns regarding the capacity of teams, was raised following our most recent inspection.

Staff had not completed a risk assessment for each patient. This was a continuing concern following our most recent inspection. Of the 35 records we reviewed, 76% had a completed risk assessment in place, and 71% of risk assessments had been reviewed regularly, including after any incident. One staff member told us due to the level of demand, she was not able to update risk assessments regularly due to time constraints.

Staff used a recognised risk assessment tool, which is part of the trust's electronic health record. Staff could recognise when to develop and use crisis plans and advanced decisions according to patient need, which were included in the patient's core assessment.

Management of patient risk

Staff had not always responded promptly to a sudden deterioration in a patient's health. This was mainly due to capacity within the teams. Staff had not always been able to monitor all patients on waiting lists for changes in their level of risk and responded when risk increased. This was due to the ongoing level of demand and staffing levels within the teams. We reviewed one patient record where a patient referred on 9 January 2021 was not seen until 4 November 2021. The outcome of the assessment was that the patient was to be allocated a care coordinator. However due a staff member leaving the team, the patient was placed on a waiting list for allocation.

A second patient was referred into a team at the end February 2021 due to suicidal thoughts. Staff undertook an assessment at the end of March 2021 and downgraded to an amber risk rating. However, there was no rationale given in the patient's records for the decision to reduce the patient's risk rating. There was no contact with the patient during the month of April 2021, and no contact between 25 May 2021 until early November 2021. Contact with the patient during this period should have been twice-weekly.

Staff followed clear personal safety protocols, including for lone working.

Safeguarding

Staff understood how to protect patients from abuse and the service worked well with other agencies to do so. Staff had some training on how to recognise and report abuse and they knew how to apply it.

Staff received training on how to recognise and report abuse, however the trust submitted data, which indicated that the mandatory training level for safeguarding was level one. This was not appropriate for their role or in line with national guidance. Staff working with young people and/or parents and carers should be trained to at least level two or level three where clinical staff could potentially contribute to assessing, planning, intervening and evaluating the needs of a child or young person and parenting capacity where there are safeguarding/child protection concerns.

Community-based mental health services of adults of working age

Staff mostly kept up-to-date with their safeguarding training. The average figures across the adult community mental health teams for adult safeguarding was 96% and safeguarding children was 97%. However, these figures were for level one safeguarding adults and children.

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

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

Staff knew how to make a safeguarding referral and who to inform if they had concerns. In the 12-month period 25 October 2020 to 25 October 2021, staff raised 136 safeguarding referrals. Of these, 70 were adult referrals, 44 were child referrals, two related to allegations against staff and two were referrals to the multi-agency risk assessment conferences (MARAC). The remaining referrals related to serious incidents. However, in four of the serious incident cases, managers identified that "safeguarding referrals and/or discussions with the Safeguarding Team were not made/had in a timely manner".

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

Staff access to essential information

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

Patient notes were mostly comprehensive, and all staff could access them easily. However, we found evidence staff had not always explained their rationale for their decisions in the patients' records. In one case, a referral had been downgraded from a red (high) risk rating to an amber (medium) risk rating. There was no rationale within the patient's records for the change in the patient's risk rating.

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

Records were stored securely.

Medicines management

Not all localities in this service used systems and processes to safely prescribe, administer, record and store medicines. Not all staff in all localities regularly reviewed the effects of medicines on each patient's mental and physical health. Some staff had not always conducted the required physical health checks in line with NICE (National Institute for Health and Care Excellence) guidance. This was a continuing concern following our most recent inspection.

Staff gave depot injections (slow-release form of medicines given into the muscle) on time and when it was due, and they recorded the site of administration each time. This is important as it reduces the risk of staff injecting the medicines in the same area on a patient's body which could cause skin disorders.

Community-based mental health services of adults of working age

Staff reviewed each patient's medicines regularly and provided advice to patients and carers about their medicines. Patients' medicines were reviewed regularly in multidisciplinary meetings. This included a six-month review for all patients prescribed a depot injection.

Any issues such as a potential delayed dose due to severe weather preventing a patient receiving their treatment would be immediately discussed and communicated with the patient to ensure they were informed of what action was being taken.

Staff completed medicines records accurately and kept them up-to-date. All prescription charts we saw were fully completed and accurate and this was audited monthly by staff.

Medicines and prescription charts were stored securely. However, at Walker Close, there was an excess of some patients' medicines, which had been delivered by an external company. We also saw in both Newmarket and Great Yarmouth, that adrenaline for anaphylaxis was available but was out of date. We raised these issues whilst onsite with staff to action immediately.

Staff followed national practice to check patients had the correct medicines when they were admitted, or they moved between services. Staff had access to patient's summary care records (SCR) which is an electronic record of patients' medicines from their GP records. This helped to ensure that patients' regular medicines could be checked prior to new medicines being prescribed so that they were safe.

Staff learned from safety alerts and incidents to improve practice. Staff knew about safety alerts and medicines related concerns via monthly 'Medicines Safety' newsletters. Staff understood the process to report incidents, and these were discussed locally in team meetings.

Staff had not always reviewed the effects of each patient's medicines on their physical health according to National Institute for Health and Care Excellence guidance. We saw evidence for some patients, there had been no physical health check undertaken when a patient's depot medicines had been changed. Some staff liaised with GPs and the team's physical health nurse to ensure patients had their physical health checks carried out regularly and this was recorded on the electronic system. However, in Waveney staff told us that there was a lack of clarity regarding who was responsible for patient's ongoing physical health checks. Staff followed systems and processes when safely prescribing, administering, recording and storing medicines.

Staff reviewed patients' medicines regularly and provided specific advice to patients and carers about their medicines. Staff stored and managed medicines and prescribing documents in line with the provider's policy. Staff followed current national practice to check patients had the correct medicines.

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

Decision making processes were in place to ensure people's behaviour was not controlled by excessive and inappropriate use of medicines. Staff reviewed the effects of each patient's medicines on their physical health according to National Institute for Health and Care Excellence guidance.

Track record on safety

Reporting incidents and learning from when things go wrong

Community-based mental health services of adults of working age

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

Staff knew what incidents to report and how to report them. Staff raised concerns and reported incidents and near misses in line with trust policy.

Staff reported serious incidents clearly and in line with trust policy. The trust reported that within the previous 12-month period, the service had reported 13 serious incidents, one of these related to self-neglect, ten related to community patient deaths and two related to mental health homicides. All serious incidents had been investigated and lessons learned identified. Managers held serious incident learning events on a monthly basis. The service had no never events.

Most staff understood the duty of candour. They were open and transparent and gave patients and families a full explanation if and when things went wrong. However, two staff members were not aware of the duty of candour requirements.

Managers debriefed and supported staff after any serious incident.

Managers investigated incidents thoroughly. Patients and their families were involved in these investigations.

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

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

There was evidence that some changes had been made as a result of feedback. Managers had reviewed the team structure as a result of a serious incident and had introduced dedicated staff to work with patient who had a serious mental illness.

Is the service effective?

Inadequate 

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

Assessment of needs and planning of care

Staff assessed the mental health needs of all patients but did not ensure all patients had a physical health assessment. They worked with patients and families and carers to develop individual care plans and updated them as needed. Care plans reflected the assessed needs, were personalised, holistic and recovery oriented.

Staff had completed a comprehensive core mental health assessment of each patient. This included full mental health assessment and an assessment of patient risk.

Community-based mental health services of adults of working age

Staff had not always made sure all patients had a full physical health assessment and knew about any physical health problems. Of the patient records we reviewed, only 26 out of 35 (79%) showed evidence a physical health assessment had taken place. Staff in Norwich staff told us they had to contact the patient's GP to ensure the ongoing monitoring of patient's physical health, as there was limited capacity in the team. In Great Yarmouth staff told us monitoring of patient's physical health had been a concern due to staff sickness and vacancies within the team.

Most staff developed a comprehensive care plan for each patient that met their mental and physical health needs. This was an improvement from our most recent inspection. Care plans were generally personalised, holistic and recovery orientated. Of the 35 patient records we reviewed, 84% had a comprehensive care plan in place. Staff reviewed and updated care plans when patients' needs changed. However, we found that four care plans reviewed were not up-to-date.

Best practice in treatment and care

Staff did not always provide a range of treatment and care for patients based on national guidance and best practice. Staff had not ensured all patients had good access to physical healthcare. Staff did not routinely use recognised rating scales to assess and record severity and outcomes. Staff participated in a limited number of clinical audits, not all of which had been conducted in line with the required frequency.

Staff provided a range of care and treatment suitable for the patients in the service. Due to waiting times for psychology, which was a concern identified during our most recent inspection, most staff were delivering low level psychological treatments including trauma informed therapy, which they had been trained to do.

Staff had not delivered all care in line with best practice and national guidance from relevant bodies such as National Institute for Health and Care Excellence . Some staff made sure patients had support for their physical health needs, either from their GP or community services. Of the patient records we reviewed, only 26 out of 35 (79%) showed evidence a physical health assessment had taken place.

Staff supported patients to live healthier lives by supporting them to take part in programmes or giving advice. We saw evidence that staff were referring patients to other agencies including MIND, and citizens advice.

We found little evidence nursing, and support staff were using recognised rating scales to assess and record the severity of patient conditions and care and treatment outcomes, they had been introduced but it was too soon to evaluate their effectiveness. Staff told us the main outcome measurement in use was the patient reported care plans which were measurable. However, psychology used a range of patient outcome measures. The trust had launched " My Recovery Plan" which includes Dialog+ scores which commenced at the end of October 2021, it was too soon to evaluate the impact of this.

Staff used technology to support patients. Staff had used technology in order to conduct assessments and ongoing monitoring of patients during the COVID-19 outbreak. Patients and carers attended virtual groups and most one to one intervention was done remotely.

Staff took part in a limited number of clinical audits, benchmarking and quality improvement initiatives. However, the trust provided data which evidenced audits were not always completed in line with the required frequency. One

example is the completion of a quality standard review, which was due to be completed monthly. The trust provided us with data which showed the audit had been completed only four times in Ipswich since April 2020. The same audit had only been completed five times since November 2020. Managers used results from a few clinical audits to make improvements.

Skilled staff to deliver care

The teams did not include or have access to the full range of specialists required to meet the needs of patients under their care. Managers made sure that staff had the range of skills needed to provide high quality care. Not all teams received regular supervision or appraisals. Managers provided an induction programme for new staff.

The service did not always have a full range of specialists to meet the needs of each patient. All teams did not have an occupational therapist (although this is not a requirement) or consultant psychiatrist. However, we note that there is currently no requirement for specific occupational therapist roles in Community Health Teams. In Norfolk, teams in place were not integrated with the local authority (there was no Section 75 arrangements for seconding social workers into teams), however one team had employed a social worker. In Suffolk, teams were integrated, so there were social workers in each team. However, we were informed the Section 75 arrangements in Suffolk were due to end in March 2022. We were informed this had created high levels of anxiety in staff teams, who were already under high levels of pressure.

Managers generally made sure staff had the right skills, qualifications and experience to meet the needs of the patients in their care, including bank and agency staff. Managers gave each new member of staff a full induction to the service before they started work. Induction is part of the trust's mandatory training.

Managers mostly supported staff through regular, constructive appraisals of their work. The trust provided data which showed that overall appraisal rate across the community teams was 79%. Nine teams achieved an appraisal rate above the trust target of 90%. The lowest appraisal rate achieved was 65%.

Managers supported most permanent medical staff to develop through yearly, constructive appraisals of their work. The trust reported an appraisal rate of 80% against a trust target of 90%. The lowest appraisal rate for medical staff by team was 50% and the highest was 100%.

We were not assured that all staff were in receipt of ongoing clinical supervision. Managers supported some non-medical staff through regular, constructive clinical supervision of their work. In Kings Lynn, the number of staff in receipt of local management supervision was 24%. At the time of reporting, despite several requests made to the trust, we had not received overall clinical supervision rates for medical and non-medical staff. Therefore, we were not assured that staff were in receipt of ongoing clinical supervision.

Managers made sure staff attended regular team meetings and gave information to those who could not attend.

Managers identified any training needs their staff had and gave most staff the time and opportunity to develop their skills and knowledge. Managers made sure most staff received any specialist training for their role. Staff told us that a range of training was available including cognitive behaviour, non-medical prescribing, specialist dementia and dialectic behavioural therapy. However, some staff told us current staffing levels made being released for attendance at training difficult.

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

Community-based mental health services of adults of working age

Multidisciplinary and interagency teamwork

Staff from different disciplines worked together as a team to benefit patients. They supported each other to make sure patients had no gaps in their care. The teams did not always have effective working relationships with other relevant teams within the organisation, however teams had effective working relationships with relevant services outside the organisation.

Staff held regular multidisciplinary meetings to discuss patients and improve their care. We saw evidence of daily and twice daily meetings to discuss patient caseloads and patient risks. In addition, all teams held a weekly multidisciplinary meeting.

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

Staff did not always have effective working relationships with other teams in the organisation. We were informed the clinical pathways between the community and other teams was at times disjointed. Staff told us they often experienced difficulties obtaining support from the crisis team and in finding an in-patient bed.

Staff had effective working relationships with external teams and organisations. We saw evidence of collaborative working with other teams and agencies. Staff had been seconded into some community teams from other agencies such as MIND, which is a mental health charity.

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

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

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

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

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

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

Patients had easy access to information about independent mental health advocacy.

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

For patients subject to a Community Treatment Order, staff completed all statutory records correctly. However, there was no consultant psychiatrist in Great Yarmouth. Consequently, consultant psychiatrists from other teams were acting as responsible clinician. The number of patients subject to a Community Treatment Order between 1 November 2021 and 31 October 2021 was 109. The number of patients subject to a Community Treatment Order during the 12-month period was 36%.

Community-based mental health services of adults of working age

Care plans clearly identified patients subject to the Mental Health Act and identified the Section 117 aftercare services they needed. However, we found that in Norwich patients' section 117 meetings were overdue.

Good practice in applying the Mental Capacity Act

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

Staff told us that they received and kept up-to-date with training in the Mental Capacity Act and had a good understanding of at least the five principles.

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

Staff knew where to get accurate advice on Mental Capacity Act.

Staff gave patients all possible support to make specific decisions for themselves before deciding a patient did not have the capacity to do so.

Staff assessed and recorded capacity to consent clearly each time a patient needed to make an important decision.

When staff assessed patients as not having capacity, they made decisions in the best interest of patients and considered the patient's wishes, feelings, culture and history.

The service monitored how well it followed the Mental Capacity Act and made changes to practice when necessary.

Is the service caring?

Good 

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

Kindness, privacy, dignity, respect, compassion and support

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

Most staff were discreet, respectful, and responsive when caring for patients. Nine out of 14 (64%) patients were positive about the care and treatment they had received. However, one patient told us that their care coordinator neither cared nor coordinated and that they didn't want her anymore.

Community-based mental health services of adults of working age

Staff gave patients help, emotional support and advice when they needed it. One patient stated that staff were "always positive, understanding, caring, will listen to you moan, will give you another idea if something isn't working". "'They are always on your side, give you a reality check that what your feeling is normal". "They're brilliant". However, one patient stated they had asked their care coordinator to do something for them over two weeks previously, which had still not been done.

Staff supported patients to understand and manage their own care treatment or condition.

Staff directed patients to other services and supported them to access those services if they needed help. We found evidence of cohesive working relationships with the voluntary sector, in order to assist patients with education and employment, and assistance with their finances.

Patients also had access to a recovery college in Lowestoft and Great Yarmouth, where they could develop a recovery plan based on needs identified at assessment.

Patients generally said staff treated them well and behaved kindly. However, two patients raised concerns regarding the level of support provided by staff.

Staff understood and respected the individual needs of each patient.

Staff felt they could raise concerns about disrespectful, discriminatory or abusive behaviour or attitudes towards patients and staff.

Staff followed policy to keep patient information confidential.

Involvement in care

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

Involvement of patients

Most staff involved patients and gave them access to their care plans. This had been helped via a move to an electronic patient centred care plan system. Out of the 35 care plans we reviewed, 84% of care plans evidenced that patients had been involved in the care planning process.

Staff made sure most patients understood their care and treatment and found ways to communicate with patients who had communication difficulties. However, one patient told us that they had been given medicines which had not been explained to them.

Staff involved patients in decisions about the service, when appropriate. The service had set up a service user and carers group which first met in January 2021. This group had produced a video and leaflet 'welcome to your community mental health team'.

Patients could give feedback on the service and their treatment and staff supported them to do this. The teams encouraged feedback via have your say, suggestion boxes, talk to us platform and via the friends and family test. During inspection we saw evidence of changes made as a result of patient feedback via 'You said, we did' posters.

Community-based mental health services of adults of working age

Staff supported patients to make advanced decisions on their care.

Staff made sure patients could access advocacy services.

Staff informed and involved families and carers appropriately.

Involvement of families and carers

Staff supported, informed and involved families or carers. The trust had a dedicated email address for carers and a carers section on the trust's website. The trust also produced monthly newsletters, of which we found printed copies in team bases.

Staff helped families to give feedback on the service. The trust had a dedicated email address for carers feedback, and feedback could also be given via complaints and compliments. Carers leads held virtual support groups, open to all carers in each locality. Details of these groups were advertised in the carer's newsletter and on the trust intranet.

Staff gave carers information on how to find the carer's assessment. The trust had appointed carers leads in each locality who provided one to one support for carers. Access details were provided in team bases, trust newsletter and internet site.

Is the service responsive?

Inadequate 🔴 ↓↓

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

Access and waiting times

The service was not easy to access. However, its referral criteria did not exclude patients who would have benefitted from care. Staff had not always been able to assess and treat patients who required urgent care promptly and patients who did not require urgent care had to wait to start treatment. Staff did not always follow up patients who missed appointments.

The service had clear criteria to describe which patients they would offer services to. However, during inspection, we were shown an outdated copy of a referral criteria November 2018. Due to current staffing levels, not all patients could be seen on receipt of referral. Managers had therefore introduced a waiting list for patients to be assessed and treated.

The service had not always met trust target times for seeing patients from referral to assessment and assessment to treatment. Staff reported high waiting times for initial assessment from referral. The trust reported that as of 11 November 2021, 1106 patients were awaiting initial assessment. The overall number of patients who had been waiting over 52 weeks for assessment was 14. The number of patients waiting treatment from assessment was 212. In Norwich four out of eight (50%) of patient records we reviewed indicated the patients had not been seen in a timely manner, in line with trust policy. Of the four patients not seen, two had gone into crisis, one patient was under the care of the crisis team and the other patient had been admitted to an in-patient ward.

Community-based mental health services of adults of working age

Staff had not always been able to see urgent referrals quickly and non-urgent referrals within the trust target time. The trust reported that as at the time of our inspection, the number of urgent patient referrals not yet assessed was 384. The longest wait for an assessment was over a year and one month. In Bury St. Edmunds staff told us that patients had to wait a number of months for a medical review.

Most staff tried to engage with people who found it difficult, or were reluctant, to seek support from mental health services. However current staffing levels had made this difficult. Most staff were aware of the trust policy for responding to patients who did not attend appointments or were reluctant, to seek support from mental health services.

Most staff tried to contact people who did not attend appointments and offer support.

Patients had limited flexibility and choice in the appointment times available. Staff worked hard to avoid cancelling appointments and when they had to, they gave patients clear explanations and offered new appointments as soon as possible. However, in Bury St. Edmunds we found that appointments had been cancelled" on a weekly basis". Staff reported that due to the number of patients on the waiting lists, there were delays in allocating new appointments. In Norwich staff told us the next available patient appointment was for February 2022. In addition, we heard that medical staff often had to cancel patient appointments in order to undertake a Mental Health Act assessment.

Appointments did not always run on time, however staff informed patients when they did not.

The service used systems to help them monitor waiting lists and support patients. Each team had an up-to-date list of patients awaiting assessment from referral, and allocation from assessment.

Staff supported some patients when they were referred, transferred between services, or needed physical health care. However, we found that staff had not always had capacity to provide the necessary support to patients. Staff also told us it had been difficult getting patients accepted by the crisis team, and access to beds was also difficult.

The service followed national standards for transfer.

The facilities promote comfort, dignity and privacy

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

The service had a full range of rooms and equipment to support treatment and care.

Interview rooms in the service had sound proofing to protect privacy and confidentiality.

Meeting the needs of all people who use the service

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

The service could support and make adjustments for people with disabilities, communication needs or other specific needs. The service had green light champions and there was a green light lead in the trust.

Staff made sure patients could access information on treatment, local service, their rights and how to complain. Leaflets and posters were visible in each of the team bases visited.

The service provided information in a variety of accessible formats so the patients could understand more easily. Staff had access to easy-to-read care plans where required.

The service had information leaflets which were available in languages spoken by the patients and local community. Staff told us that information could be accessed in any language.

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

Listening to and learning from concerns and complaints

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

Patients, relatives and carers knew how to complain or raise concerns. In the six-month period from 11 of February 2021 to 11 August 2021, the trust had received ten complaints. The highest number of complaints (three), related to patients' discharge.

Staff understood the policy on complaints and knew how to handle them. Staff knew how to acknowledge complaints and patients received feedback from managers after the investigation into their complaint. Managers investigated complaints and identified themes. In one team two managers were in the process of attending complaints training, with a plan that they would conduct peer reviews of team complaints. Staff protected patients who raised concerns or complaints from discrimination and harassment.

Patients received feedback from managers after the investigation into their complaint.

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

The service used compliments to learn, celebrate success and improve the quality of care. Between November 2020 and end of October 2021, the service received 165 compliments. The highest number 106 (64%) were from staff, 31 (19%) from patients and nine (five percent) from carers.

Is the service well-led?

Inadequate 

Our rating of well-led went down. We rated it as inadequate.

Leadership

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

Community-based mental health services of adults of working age

During our inspection we interviewed ten managers, most of who were experienced in their role. However, some managers were new in post and were in the process of gaining a fuller understanding of the services. All team managers interviewed were enthusiastic and committed to their role. Managers described significant increases in the number of referrals since the outbreak of COVID-19. All managers told us that demand for services, exceeded capacity. Managers had taken appropriate actions to ensure that staff caseloads were manageable, by ensuring that caseloads were between 30 to 35 cases. This was an improvement following our most recent inspection. However, there was an additional requirement for staff to monitor patients awaiting assessment and treatment. Teams held daily or twice daily meetings to discuss daily clinical and risk concerns.

Staff described all team mangers as being visible in the service and that they were approachable. Staff told us they would feel happy, in most cases, to raise issues directly with their manager. However, 13 out of 36 (36%) staff interviewed raised concerns regarding the visibility of senior managers above service level. This concern was raised by staff during our most recent inspection. Four members of staff described a "toxic culture" and two staff members spoke about pressures from directors. Two staff members raised concerns regarding poor communication above service management level, "where staff and doctors were not always listened to". One staff member told us there was "communication control" at senior manager level, therefore key messages were not being delivered to the board.

Vision and strategy

Most staff knew and understood the provider's vision and values and how they were applied to the work of their team.

The trust's senior leadership team had successfully communicated the provider's vision and values to the frontline staff in this service. Most staff interviewed knew of the trust's vision and strategy.

Managers had recently developed a psychology strategy. The aims of the strategy were to increase patient flow, access to psychological interventions, development of trauma informed care and improving services for patients with complex psychosis. The strategy focused also on the "evolving personality disorder strategy", improved meaningful involvement of patients and carers, staff support, outcome measurements and digitally enabled care.

Culture

Staff had not always felt respected, supported and valued. Staff told us that morale was poor and they did not feel supported by senior managers. However, they said the trust promoted equality and diversity in daily work and provided opportunities for development and career progression.

Staff said the support received from team managers was good. However, several staff told us they had not felt listened to by senior management. One staff member told us that staff opinions "are not listened to" and were not always welcomed. Five staff members told us senior managers were not visible in the service. One staff member said that "there is a problem with leadership". Four staff members described the culture as" toxic" and another staff member said that senior managers have their own agendas.

Some medical staff told us that their voice is not heard, and management do not take on board their clinical views. Another doctor told us they lacked autonomy. One staff member spoke of a "power struggle between medical and nursing staff". In one team we were told that there had been tension between nursing and medical staff. Managers recognised this as an issue and an external agency was working with the staff on team culture.

Community-based mental health services of adults of working age

Governance

Our findings from the other key questions demonstrated that governance processes were not operated effectively at team level and that performance and risk were managed well.

Senior managers were aware of the staffing difficulties within community teams, and the high numbers of patients awaiting assessment and treatment. Managers had escalated these concerns, and they had been included in the local and trust risk register. The escalation of concerns and addition of these onto the risk register had improved following our most recent inspection.

We found that the demand on clinical services outweighed capacity within the teams. Team managers and staff were actively trying to manage clinical risk. All teams had high waiting lists for assessment and allocation. Teams had introduced a RAG (red, amber, green) system to manage clinical risk of patients who were on a waiting list for assessment and allocation. However, due to the current level of demand, staff were not always able to review patients in a timely way or ensure that regular medical reviews and patients on waiting lists were always assessed in a timely manner.

Managers had not ensured that systems and processes for clinical management of patients was not consistent across community teams. This included assessment and management of patient's physical and health and use of outcome measures. Staff described experiencing ongoing barriers to obtaining support for patients in crisis out of hours. This included access to the crisis team and in-patient beds.

Staff across all teams told us that there had been limited visibility, oversight and support from senior managers. The trust had not taken adequate strategic actions to support clinical staff. During inspection we heard staff received a high number of referrals from primary care, which did not meet the service criteria. Closer working relationships with primary care could reduce the number of patients awaiting assessment, by signposting them to another service. This would reduce patient risk, improve patient satisfaction and reduce the level of demand on community teams.

Management of risk, issues and performance

Managers had ensured that systems and processes were in place in order to ensure that staff caseloads did not exceed 30 to 35 clients. This meant staff caseloads were generally manageable. However due to the high level of demand which had increased since the COVID-19 pandemic, demand had exceeded team capacity. We found that patient caseloads were high both for initial assessment and for initial treatment.

A risk rating was allocated to all patients awaiting allocation. The risk ratings rated red (high risk), amber (medium risk) and green (low risk). Staff were aware of the trust policy regarding the required frequency of contact with patients awaiting treatment. However due to the high level of demand staff were not always able to contact patients in line with the required frequency.

During inspection we found evidence that high risk patients were being contacted by junior staff. In Kings Lynn these staff were being supported by a senior clinician, however in Great Yarmouth we found no evidence of oversight, or assurance that staff had the skills and competencies for high-risk patients.

Information management

Community-based mental health services of adults of working age

Staff collected analysed data about outcomes and performance and engaged actively in local and national quality improvement activities.

Managers had access to information to support them in their management role. Managers collected and reviewed data about outcomes and performance and used this to report on key performance areas of the teams. Managers used information to oversee team performance. However, due to the level of demand and staffing levels, managers had limited capacity to address identified areas of concern.

Some staff reported that whilst they had access, information technology was slow and that there was poor internet connection.

Engagement

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

Managers had developed joint working relationships with a range of other key organisations including the third sector. Managers had arranged for some staff to be seconded into the team from other agencies. Managers engaged with external stakeholders including commissioners and advocacy services.

Staff, patients and carers had access to up-to-date information about the service. Patients and carers had opportunities to give feedback on the service they received. Managers and staff had access to the feedback from patients, carers and staff and there was evidence that staff acted on this feedback. Patients and carers were involved in developing the service, having recently developed videos and booklets 'welcome to your CMHT'.

Learning, continuous improvement and innovation

Medical staff were undertaking a project looking at how the service is delivered in order to streamline services. The trust held a staff recognition initiative which was called 'excellence in action'.

Psychology was in the process of developing a revised psychology strategy aimed at improving quality to improve clinical outcomes.

Wards for people with a learning disability or autism

Good ↑

Is the service safe?

Good ↑↑

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

Safe and clean care environments

The ward was safe, clean well-equipped, well-furnished, generally well-maintained and fit for purpose.

Since our previous inspection the bungalows had been refurbished and equipped and furnished and designed to meet the needs of people who live there. The bungalows were clean and generally well decorated. However, there was graffiti on one wall in the bungalow which was not occupied at the time of our inspection. Staff had reported this to estates to be repainted urgently.

Safety of the ward layout

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

Staff could observe patients in all parts of the wards. There were blind spots in the bedroom corridors, but the provider had installed mirrors to reduce these and staff used observation to further reduce any risks.

The ward complied with guidance on mixed sex accommodation. At the time of our inspection, there was one person admitted across two bungalows. There were three bedrooms in each bungalow. Staff said there had only been male patients admitted in the previous two years. Managers told us that as part of the learning disability transformation pathway there would only be three people admitted at any time to one bungalow. All bedrooms had en-suite facilities and there were separate lounges in each bungalow. Managers said that risk assessments would be completed before admitting people of mixed sex. The team leader had started some work on sexual safety in preparation for this to ensure risks would be reduced, and all staff would know how to reduce risks.

Staff knew about any potential ligature anchor points and mitigated the risks to keep people safe. Since the COVID-19 pandemic started personal protective equipment (PPE) had been stored in the emergency bag. Staff had identified this could mean that ligature cutters could not be quickly accessed. To reduce this risk staff had put a pouch on the outside of the emergency bag so these could be easily accessed.

Staff had easy access to alarms and people had easy access to nurse call systems. During the refurbishment of the bungalows, the provider had installed nurse call strips on bedroom, en-suite and bathroom walls that people could easily use to call for help when needed.

Maintenance, cleanliness and infection control

The bungalows were clean and generally well-maintained.

Wards for people with a learning disability or autism

The provider had completed a refurbishment programme since our previous inspection. The bungalows were generally well-furnished, staff showed us that some of the chairs were not washable as expected so they planned to return these to the manufacturer. In bungalow four there was graffiti on one wall which had been done by a person using the service and the wall needed repainting. There were no people staying in the bungalow at the time of our inspection. Staff had reported this urgently to the estates department and the ward manager assured us they were chasing this up.

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

Staff followed infection control policy, including handwashing. Staff followed local and government guidance for COVID-19. Staff did regular tests to ensure they did not have COVID-19 before coming to work. We observed staff regularly changing masks and using hand sanitiser throughout the day. Masks and hand sanitiser were available at the entrance of each building and hand wash and sanitiser were available in all bathrooms and toilets.

Clinic room and equipment

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

Staff checked, maintained, and cleaned equipment. The provider had identified a fault on the defibrillator machines losing charge and had raised an alert to all staff about this. Staff at Walker Close were checking the charge on these machines every time they entered the clinic room to administer medicines or do other tasks in addition to the daily check by night staff.

Safe staffing

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

This included safeguarding, managing violence and aggression, emergency first aid and intermediate life support.

Nursing staff

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

At the time of our inspection the service had six whole time equivalent vacancies. There were three healthcare assistant vacancies and three band five registered nurse vacancies. Due to the low number of patients and the proposed transformation to having a maximum of three beds this was manageable and safe. A band six post had been advertised and was being recruited to at the time of the inspection. There were five staff on each shift day and night which meant that if a patient needed to be admitted there would be enough staff to safely manage this. The service had low and reducing rates of bank and agency nurses and nursing assistants.

Managers limited their use of bank staff and requested staff familiar with the service. Managers made sure all bank staff had a full induction and understood the service before starting their shift.

The service had a turnover rate of 18% on 31 October 2021 which was higher than the trust target of 15%, this was due to the transformation of the service and changes in job roles.

Wards for people with a learning disability or autism

Managers supported staff who needed time off for ill health. However, levels of sickness were reported by the trust to be high. The trust reported for this service between 1 October 2020 and 30 September 2021, the sickness rate was 15% against the trust target of 4%. This included absences for COVID-19.

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

People had regular one-to-one sessions with their named nurse. People rarely had their escorted leave or activities cancelled, even when the service was short staffed.

The service had enough staff on each shift to carry out any physical interventions safely.

Staff shared key information to keep people safe when handing over their care to others. We observed the handover from the early to late shift on 2 November 2021. Staff handed over information about the person from the week before, so all staff had updated knowledge about the person.

Medical staff

The service had enough day and night medical cover and a doctor available to go to the ward quickly in an emergency.

The consultant and speciality doctor were locums but had worked there for two years. The consultant was leaving the service and the provider had advertised the post, but this had not been filled at the time of our inspection. This was to be covered by a locum in the interim. Managers made sure all locum staff had a full induction and understood the service before starting their shift.

Mandatory training

Staff had completed and kept up-to-date with their mandatory training.

At the time of our inspection, 79% of staff had completed their mandatory training. This was due to training in managing violence and aggression and intermediate life support being delayed during COVID-19 pandemic and three new staff starting. However, the ward manager said all staff were now booked to attend, and we saw evidence of this so it would be 100%. The mandatory training programme was comprehensive and met the needs of people using the service and staff. The training included training in supporting people with a learning disability and autistic people. Managers monitored mandatory training and alerted staff when they needed to update their training.

Assessing and managing risk to patients and staff

Staff assessed and managed risks to people and themselves well. They achieved the right balance between maintaining safety and providing the least restrictive environment possible to support peoples' recovery.

Staff showed us how they had supported a person to be able to use crockery again which was restricted on admission due to their risk.

Wards for people with a learning disability or autism

Staff had the skills to develop and implement good positive behaviour support plans and followed best practice in anticipating, de-escalating and managing challenging behaviour. As a result, they used restraint only after attempts at de-escalation had failed. The ward staff participated in the provider's restrictive interventions reduction programme.

Assessment of patient risk

Staff completed risk assessments for each person on admission, using the combined risk assessment tool, which was a recognised tool. Staff reviewed this regularly, including after any incident. The combined risk assessment was used in the community also so that when a person needed to be admitted all the information about their risks in the community were included and available for staff.

Management of patient risk

Staff knew about any risks to each person and acted to prevent or reduce risks.

Each person had a combined risk assessment. This was for the person when living in the community and then updated when admitted to the specific risks of the environment at Walker Close. Staff identified and responded to any changes in risks to, or posed by, people using the service. Staff completed thorough risk assessments if a person had epilepsy using specialist advice from epilepsy nurses.

Staff could observe people in all areas using mirrors in the bedroom corridors to reduce the blind spots and use of observation to minimise risks. These were placed to ensure that blind spots were minimised.

Staff followed trust policies and procedures when they needed to search people or their bedrooms to keep them safe from harm. Staff discussed in handovers and review meetings how they could ensure that blanket restrictions were reduced and did not search people or their bedrooms unless there was a risk.

Use of restrictive interventions

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

The provider trained staff in positive behaviour support and each person had a positive behaviour support plan. The specialist nurse allocated protected time for staff to hold sessions in positive behaviour support once a week. Staff said they found this a useful reflective time to consider how their actions and behaviour may affect people and how they needed to adapt to each individual need.

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

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

Staff followed National Institute for Care and Excellence (NICE) guidance when using rapid tranquilisation.

Safeguarding

Wards for people with a learning disability or autism

Staff understood how to protect people from abuse and the service worked well with other agencies to do so.

Staff had training on how to recognise and report abuse and they knew how to apply it.

Staff received training on how to recognise and report abuse, appropriate for their role and kept up-to-date with their safeguarding training.

Staff knew how to recognise adults and children at risk of or suffering harm and worked with other agencies to protect them. Staff knew how to make a safeguarding referral and who to inform if they had concerns.

Staff access to essential information

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

Most of the records were electronic but some easy read information was in paper format.

People's notes were comprehensive, and all staff could access them easily. This was an improvement from our most recent inspection.

When a person transferred to a new team, there were no delays in staff accessing their records as all the teams worked together and the person's information was available to community and inpatient staff. Staff stored records securely.

Medicines management

The service used systems and processes to safely prescribe, administer, record and store medicines. Staff regularly reviewed the effects of medicines on each person's mental and physical health.Decision making processes were in place to ensure people's behaviour was not controlled by excessive and inappropriate use of medicines.

They knew about and worked towards achieving the aims of STOMP (stopping over-medicines of people with a learning disability, autism or both). Staff gave us examples of how they had done this to improve the person's quality of life whilst ensuring the safety of the person and staff.

Staff followed systems and processes when safely prescribing, administering, recording and storing medicines. Staff reviewed peoples' medicines regularly and provided specific advice to people and carers about their medicines.

Staff stored and managed medicines and prescribing documents in line with the provider's policy. Staff followed current national practice to check people had the correct medicines.

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

Staff reviewed the effects of each person's medicines on their physical health according to National Institute for Care and Excellence (NICE) guidance. People's records showed that staff had completed physical health observations and monitoring as required.

Wards for people with a learning disability or autism

Track record on safety

The service had a good track record on safety.

There were no serious incidents reported for this core service.

Reporting incidents and learning from when things go wrong

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

Staff knew what incidents to report and how to report them. Staff raised concerns and reported incidents and near misses in line with trust policy.

The service had no never events.

Staff understood the duty of candour. They said they would be open and transparent and give people and their families a full explanation if things went wrong. A relative told us how staff had kept them informed throughout their relatives stay and shared all information with them that their relative agreed to.

Managers debriefed and supported staff after any serious incident. Staff had opportunity to attend three protected time sessions a week, two of which were reflective practice. However, staff said in addition to these they had a debrief after any incident.

Staff received feedback from investigation of incidents, both internal and external to the service. Managers shared learning with their staff about never events that happened elsewhere. The manager said they were concerned about the isolation of Walker Close to the rest of the trust. They had involved them in 'safety huddles' with other trust departments and ensured they received learning updates from across the trust to keep them updated. Staff met to discuss the feedback and look at improvements to care of people using the service.

Managers and staff were aware of the Learning from Deaths Mortality Review (LeDeR) Programme. Managers and staff supported the review process and changes made from any learning shared. There were no current reviews for this service.

Is the service effective?

Good 

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

Assessment of needs and planning of care

Wards for people with a learning disability or autism

Staff undertook functional assessments when assessing people's needs. They worked with people and with families and carers to develop individual care and support plans and updated them as needed. Care plans reflected the assessed needs, were personalised, holistic and strengths based.

Staff developed a comprehensive care plan for each person that met their mental and physical health needs. Staff completed a comprehensive mental health assessment of each person either on admission or soon after. Staff assessed peoples' physical health soon after admission and regularly reviewed this during their time on the ward.

Staff regularly reviewed and updated care plans and positive behaviour support plans when peoples' needs changed. Positive behaviour support plans were present and supported by a comprehensive assessment.

Care plans were personalised, holistic and strengths based. Staff were able to tell us about the person's strengths, their likes and dislikes and how they behaved when they were well. This showed they had got to know the person well and were interested in them as a person and not just focused on their behaviour when they were unwell.

Best practice in treatment and care

Staff provided a range of treatment and care for people based on national guidance and best practice. This included access to psychological therapies, support for self-care and the development of everyday living skills and meaningful occupation. Staff supported people with their physical health and encouraged them to live healthier lives.

Staff used recognised rating scales to assess and record the severity of peoples' conditions and care and treatment outcomes. They also participated in clinical audit, benchmarking and quality improvement initiatives. There was a project ongoing to improve the quality of handovers so that all staff present could see on the screen the persons risks rather than the staff member handing over reading these out. Staff said this had improved their knowledge of individual risk.

Staff provided a range of care and treatment suitable for the people in the service. This included psychological therapies appropriate and adapted to the individual and art psychotherapies.

Staff understood people's positive behavioural support plans and provided the care and support which had been identified. A specialist positive behaviour support nurse worked with the team and supported a weekly staff protective time session.

Staff made sure people had access to physical health care, including specialists as required. We saw that staff referred people to specialist physical healthcare doctors when needed.

Staff met peoples' dietary needs and assessed those needing specialist care for nutrition and hydration. Staff completed nutrition assessments on admission and updated them as needed. If these showed food and fluid records were needed, these were completed.

Staff helped people live healthier lives by supporting them to take part in programmes or giving advice. Staff supported people in giving up smoking and gave them advice in a format that they could understand.

Wards for people with a learning disability or autism

Staff took part in clinical audits, benchmarking and quality improvement initiatives. Staff were leading a red to green quality improvement project to ensure effective discharge planning for people. Staff were also involved in 'Safewards' (a model which aims to make wards safer places for staff and people) and were developing ways to adapt the model for people living with a learning disability and autistic people.

Managers used results from audits to make improvements. The manager had revised the audit schedule which was robust and included all areas of care provided.

Skilled staff to deliver care

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

The service had access to a full range of specialists to meet the needs of the people on the ward. However, there was not an occupational therapist appointed but this post had been advertised. An activity coordinator worked at Walker Close full time. The service was being reorganised as part of the transformation process so it was clear whether another occupational therapist would be needed for the inpatient service. This was covered by the community occupational therapist if needed.

Managers ensured staff had the right skills, qualifications and experience to meet the needs of the people in their care, including bank staff. Managers gave each new member of staff a full induction to the service before they started work.

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

Managers made sure staff attended regular team meetings or gave information from those they could not attend. Staff, including night staff, told us they could attend the protected time sessions held on Monday, Wednesday and Friday each week. On Monday these were learning sessions and on Wednesday and Friday were reflective practice sessions.

Managers identified any training needs their staff had and gave them the time and opportunity to develop their skills and knowledge. Managers made sure staff received any specialist training for their role.

Managers recognised poor performance, could identify the reasons and dealt with these. Managers told us they had responded to allegations made by staff promptly and resolved the situation.

Multidisciplinary and interagency teamwork

Staff from different disciplines worked together as a team to benefit people who used the service. They supported each other to make sure people had no gaps in their care. The ward team had effective working relationships with staff from services that would provide aftercare following the person's discharge and engaged with them early on in the person's admission to plan discharge.

Staff held regular multidisciplinary meetings to discuss people and improve their care. We observed a person's Care Programme Approach meeting with their consent. This was held via a video call and included a full team including community teams within the trust and from social services.

Wards for people with a learning disability or autism

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

The ward team had effective working relationships with other teams in the organisation and effective working relationships with external teams and organisations.

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

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

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

Staff had access to support and advice on implementing the Mental Health Act and its Code of Practice. Staff knew who their Mental Health Act administrators were and when to ask them for support.

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

People had easy access to information about independent mental health advocacy and people who lacked capacity were automatically referred to the service. This was in accessible formats to the people using the service to help them understand.

Staff explained to each person their rights under the Mental Health Act in a way that they could understand, repeated as necessary and recorded it clearly in the people's notes each time. Staff told us how they adapted the information about rights to the needs of the individual to help them understand.

Staff made sure people could take section 17 leave (permission to leave the hospital) when this was agreed with the Responsible Clinician. This was discussed in detail during the person's Care Programme Approach meeting and a clear plan put in place that was to be reviewed weekly.

Staff requested an opinion from a Second Opinion Appointed Doctor (SOAD) when they needed to.

Staff stored copies of peoples' detention papers and associated records correctly and staff could access them when needed.

Informal patients knew that they could leave the ward freely and the service displayed posters to tell them this.

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

Good practice in applying the Mental Capacity Act

Wards for people with a learning disability or autism

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

Staff received and kept up to date with training in the Mental Capacity Act and had a good understanding of at least the five principles. Staff knew where to get accurate advice on the Mental Capacity Act and Deprivation of Liberty Safeguards.

Staff gave people all possible support to make specific decisions for themselves before deciding a person did not have the capacity to do so. They made sure they used the time when the person was alert, comfortable and at a convenient time for them to maximise their capacity.

Staff assessed and recorded capacity to consent clearly each time a person needed to make an important decision. When staff assessed people as not having capacity, they made decisions in the best interest of the person and considered the person's wishes, feelings, culture and history.

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

Is the service caring?

Good 

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

Kindness, privacy, dignity, respect, compassion and support

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

Staff were discreet, respectful, and responsive when caring for people. Staff gave people help, emotional support and advice when they needed it.

Staff supported people to understand and manage their own care treatment or condition. They did this in a way the person could understand and took time to prepare how best they could communicate to a person the outcome of their review meeting.

People said staff treated them well and behaved kindly. Staff had monthly development days and sometimes used these to reflect on one person as an 'About Me' day. They looked at everything about the person, their strengths, needs, likes and dislikes and how they could best support them.

Wards for people with a learning disability or autism

Staff understood and respected the individual needs of each person. We observed in the Care Programme Approach meeting and during the handover meeting that staff spoke about the person in a respectful way and with empathy. Staff understood what helped the person and how they might respond to different situations and sought ways to change their behaviours to respond positively to the person.

Staff felt that they could raise concerns about disrespectful, discriminatory or abusive behaviour or attitudes towards people.

Staff followed policy to keep people's information confidential.

Involvement in care

Staff involved people in care planning and risk assessment and actively sought their feedback on the quality of care provided.

They offered people a copy of their care plan and this was in a format they could understand. Staff spent time discussing how to explain the outcome of the meeting to the person in a way they could understand.

Staff ensured people had easy access to independent advocates. The advocate said all people were referred to them and staff were responsive when they gave them feedback from people and were listened to.

Involvement of patients

Staff introduced people to the ward and the services as part of their admission.

Staff had recently produced a document to help introduce people to Walker Close which was in an easy read format using pictures and photographs.

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

Staff made sure people understood their care and treatment and found ways to communicate with people who had communication difficulties. Staff told us they had access to a number of communication methods such as Makaton, Widget and easy read information but they always looked at the best way to communicate with the individual and adapted the tools as needed.

Staff involved people in decisions about the service, when appropriate. There were monthly meetings with people who used the service and staff gave us examples of decisions to purchase a vehicle for the service that people could go out in and to provide water dispensers so people could have a drink when they wanted was as a result of their feedback.

People gave feedback on the service and their treatment and staff supported them to do this.

Staff supported people to make decisions on their care. Staff did this in a way based on the individual's needs and risks and helped them to communicate their decisions using a variety of communication tools.

Wards for people with a learning disability or autism

Staff made sure people could access advocacy services. The advocate told us any feedback they gave to staff from people was always listened to. They said staff always made sure that if possible, action was taken to make changes to the service based on feedback from people who use the service.

Involvement of families and carers

Staff informed and involved families and carers appropriately.

A relative told us all staff had involved them in their relative's care, and they were always invited to any meetings about their relative if they agreed to this. They said they could visit at any time unannounced and were always made to feel welcome by the staff.

Staff helped families to give feedback on the service.

Staff gave carers information on how to find the carer's assessment.

Is the service responsive?

Good  

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

Access and discharge

Staff planned and managed discharge well. They liaised well with services that would provide aftercare and were assertive in managing the discharge care pathway. As a result, people did not have excessive lengths of stay and discharge was rarely delayed for other than a clinical reason.

Bed management

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

The service had no out-of-area placements. People were placed at Walker Close from Suffolk and were in contact with their local community learning disability team.

Managers and staff worked to make sure they did not discharge people before they were ready.

When people went on leave there was always a bed available when they returned.

People were moved between wards during their stay only when there were clear clinical reasons, or it was in the best interest of the person. There was no evidence that people had been moved between bungalows unless it was in the persons best interests.

Staff did not move or discharge people at night or very early in the morning. The community teams worked with staff at Walker Close so that if a person was admitted this was planned.

Wards for people with a learning disability or autism

Discharge and transfers of care

The service had no delayed discharges in the past year.

Staff carefully planned peoples' discharge and worked with care managers and coordinators to make sure this went well. We observed in the persons Care Programme Approach meeting the detailed discussion about planning the person's discharge from the ward.

Staff supported people when they were referred or transferred between services. The ward team worked with staff from the community team and the intensive support team to ensure the person would be fully supported in the community following discharge.

Facilities that promote comfort, dignity and privacy

The design, layout, and furnishings of the ward supported peoples' treatment, privacy and dignity.

Each person had their own bedroom with an en-suite bathroom and could keep their personal belongings safe. There were quiet areas for privacy. The food was of good quality and people could make hot drinks and snacks at any time.

Each person had their own bedroom, which they could personalise. People had a secure place to store personal possessions.

Staff used a full range of rooms and equipment to support treatment and care. The service had quiet areas. People could make phone calls in private or use their own mobile phones.

The service had a courtyard that people could access easily. People had a wrist band that they could use to open doors to the courtyard and their bedroom following individual risk assessment. People could not access the garden without staff support unless their individual risk assessment stated it was safe to do so. There were always staff available to support people to access the garden.

People could make their own hot drinks and snacks if their individual risk assessment stated it was safe to do so, however staff were always available to support people with this. People could get a drink at any time from the water dispensers. We observed in the person's review meeting staff discussed in detail how to support the person to make their own drinks and snacks to increase their independence skills.

The service offered a variety of good quality food. This was based on the person's likes and dislikes and dietary needs.

Patients' engagement with the wider community

Staff supported people with activities outside the service and helped people to stay in contact with their families and carers.

Staff encouraged people to develop and maintain relationships both in the service and the wider community. Staff told us how a person had been able to reengage with friends in the local community soon after going on escorted leave from the hospital and how this had improved the person's wellbeing.

Wards for people with a learning disability or autism

Meeting the needs of all people who use the service

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

The service could support and make adjustments for disabled people and those with communication needs or other specific needs. There were two bedrooms in each bungalow that had beds which could be adjusted to enable staff to support a person getting in and out of bed. Corridors were wide enough to support use by a person using a wheelchair. The bungalows were ground floor and there were no steps leading from the entrance or to the garden or courtyard. Managers spoke about a quality improvement that was ongoing looking at adapting the service to people with a learning disability who are also living with dementia. There were no people living with dementia at the service at the time of inspection.

Staff made sure people could access information on treatment, local service, their rights and how to complain. Staff had access to several communication tools and adapted all information to the needs of individuals. The service had information leaflets available in languages spoken by the people using the service and local community. Managers made sure staff and people could get help from interpreters or signers when needed.

The service provided a variety of food to meet the dietary and cultural needs of individuals.

People had access to spiritual, religious and cultural support.

Listening to and learning from concerns and complaints

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

People, relatives and carers knew how to complain or raise concerns. Staff provided information about this in an easy read format and in a way each person could understand.

Staff understood the policy on complaints and knew how to handle them. They said they always listened to what people said and looked at how they resolve any complaints as soon as possible.

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

The service used compliments to learn, celebrate success and improve the quality of care. Staff told us they had used one of their protected time sessions to reflect on learning from a person who was admitted and successfully discharged which went well. They thought it was important to not only review lessons learned from complaints but also from compliments.

Is the service well-led?

Good 

Our rating of well-led stayed the same. We rated it as good.

Wards for people with a learning disability or autism

Leadership

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

The manager had recently started working at the service in a temporary role while the manager post was being recruited to. Staff said leaders were good and supported them in their day-to-day work. We observed managers were visible in the service and knew the needs of the service and the people using the service in their care.

Vision and strategy

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

Staff said the trust had invested in the service for people with a learning disability and autistic people which had been positive, and they were proud to work for the service.

Staff were clear about the transformation plans and strategy. They knew the aim was for a service that supported the person where they were, either in the community or if needs be on the ward. Staff knew the service was based on the individual person's needs and how best to meet that.

Culture

Staff felt respected, supported and valued.

They said the trust promoted equality and diversity in daily work and provided opportunities for development and career progression. They could raise any concerns without fear. Managers told of a recent situation raised by staff and showed that they acted on this quickly to ensure staff were listened to and people were safe.

Governance

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

The manager had reviewed the audit schedule and implemented a comprehensive schedule that included the environment, Mental Health Act, Mental Capacity Act, care plans, medicines management, supervision, training and all aspects of the care and treatment given to people. This audit schedule had started, and the manager said the findings would be shared in staff meetings and supervision to ensure outcomes are met and improvements made where needed.

Management of risk, issues and performance

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

Staff completed weekly audits and the findings from these were discussed in team meetings and monthly governance meetings.

Staff were able to add items to the local and the trust risk register if needed. Managers were aware of what the risk to their service were and how they took action to reduce these.

Information management

Staff collected analysed data about outcomes and performance and engaged actively in local and national quality improvement activities.

Staff told us about several quality improvement projects they were involved in including sexual safety, Red to Green promoting patients discharge and use of safety huddles.

Engagement

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

In the patients Care Programme Approach meeting we observed we saw how staff and managers worked with other local health and social care providers. All partners were engaged in working together to ensure the best outcomes for the people using the service and their family.

Learning, continuous improvement and innovation

Managers and staff spoke about how they learn continuously. Staff had twice weekly reflective practice sessions where they discussed care of people using the service, incidents that had occurred and how they could learn from them. They also spoke about learning from what went well and how they could use that to improve working with other people.

Managers and staff spoke about the transformation programme for the service for people with a learning disability and autistic people. The future model of the service was to have a service that moved with the person and was seamless. This meant that if the person needed to be an inpatient for a period of time, they would know staff as they would be part of the team that supported them in the community.

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

Inadequate ↓

Is the service safe?

Inadequate ↓

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

Safe and clean care environments

Not all wards were safe and fit for purpose. However, most wards were clean, well equipped, well-furnished and well maintained. Staff were not ensuring areas used for seclusion were safe for patients. Staff did not always complete comprehensive ligature risk assessments.

Safety of the ward layout

Staff did not always update environmental risk assessments of all ward areas or remove risks they had identified. On Great Yarmouth acute ward, staff had not updated the ward ligature risk assessment to include ligature items in patients' bedrooms. When we inspected, not all staff from Great Yarmouth acute ward knew where the ligature risk assessment was stored. We found this ligature risk assessment was not user-friendly in order for staff to easily identify ligature points and how to manage those risks. We raised this with the ward manager, who told us that due to staff shortages and lack of available time, the risk assessment had not been fully updated.

We revisited Great Yarmouth acute ward and Glaven ward on the 29 December 2021. During this visit we found ligature risk assessments had been updated and identified all ligature risks on the wards. Great Yarmouth ward ligature risk assessment was updated on 3 December 2021 and the risk assessment on Glaven ward was updated on 13 December 2021, including Christmas decorations. The trust had a programme of monthly ligature risk assessment reviews. The trust monitored reviews and alerted ward mangers if reviews were not completed.

All other wards had an updated ligature risk assessment in place that was regularly reviewed, and staff on other wards knew about any potential ligature anchor points and mitigated the risks to keep patients safe.

Staff did not always adhere to guidance on mixed sex accommodation. On Great Yarmouth acute ward, due to lack of available beds, staff would admit patients onto the acute ward and place them in the 136 suite which would normally be used for patients detained under section 136 of the Mental Health Act 1983. To prevent the door from locking on this suite, and therefore secluding the patient, when we inspected staff told us they left a towel in the doorframe to prevent the door from closing. The 136 suite was positioned next to a male corridor, therefore when female patients were in the 136 suite with the door wedged open with a towel, the patient's dignity and safety was not protected. Managers told us they tried to mitigate this risk by placing the patient in the 136 suite on hourly observations. However, this did not eliminate the risk of dignity and safety to the patient.

Staff had easy access to alarms and patients had easy access to nurse call systems. Managers recently addressed an incident in which staff were turning off the alarm in the main office when they were unable to identify the location of the alarm on the ward. Although there was no evidence to suggest an incident had been missed due to this, staff not responding to alarms posed a serious risk to patient safety.

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

Maintenance, cleanliness and infection control

The majority of ward areas were clean, well maintained, well-furnished and fit for purpose. Staff made sure cleaning records were up-to-date. However, the environment on Lark ward required updating and re-decoration. The trust had a refurbishment plan in progress and staff engaged patients to reduce damage to ward decoration and furniture. On Glaven ward, during our on-site inspection we observed unpleasant odours due to issues relating to drains and sinks. The trust mitigated the risk of Legionella in the water supply via a planned preventive maintenance schedule, to prevent vulnerable patients developing Legionnaires disease.

Staff told us Patient-Led Assessments of the Care Environment (PLACE) , had been suspended due to the COVID-19 pandemic. However, in 2019 the trust had received a score of 99% for cleanliness.

The majority of staff adhered to infection prevention control procedures and followed the provider's infection control policy, including handwashing and wearing face masks. However, staff on Southgate ward were not all routinely bare below the elbow. Staff were not up-to-date with Infection Prevention Control (IPC) training, only 52% of staff on Samphire ward and 54% of staff on Thurne ward had completed IPC training.

Seclusion room

Seclusion rooms allowed clear observation and two-way communication. They had a toilet and a clock. However, there was no seclusion room on Glaven ward and staff were secluding patients in their bedrooms if there was no other seclusion room available on another ward. Staff were not ensuring appropriate safeguards were in place when secluding patients in their bedrooms, including failing to search the room prior to seclusion in order to remove items that may have posed a risk to patients. Staff were not recording if they offered patients the opportunity to use a toilet when secluded in their bedroom as rooms did not have en-suites. Managers were unable to confirm if patients had been unlocked from their bedrooms to use the toilet as this was not recorded.

We revisited Glaven ward on 29 December 2021. We found staff had introduced a seclusion folder that contained a non-designated seclusion room risk assessment for staff to complete prior to secluding a patient in their bedroom. This would be used to identify any potential risks and remove them prior to using a non-designated seclusion room. The folder also contained all necessary paperwork for staff to complete during seclusion. There had been no episodes of seclusion since the previous visit, so we were unable to review completed documentation.

Clinic room and equipment

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

Staff checked, maintained, and cleaned equipment.

Safe staffing

The service was staffed by at lease one nurse and support staff and not all staff received basic training to keep people safe from avoidable harm.

Nursing staff

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

The trust calculated and reviewed the number and grade of nurses, nursing assistants and healthcare assistants for each shift and completed an independent audit to ensure the set staffing levels were accurately calculated. In response to the COVID-19 pandemic the trust had reviewed staffing levels in consultation with lead nurses and benchmarked staffing with other similar units. The review identified a safest staffing level that maintained safe staffing numbers but, where necessary, allowed wards to be staffed by only one registered nurse. Whenever possible the trust continued to facilitate agreed safe staffing levels with the presence of two registered nurses. The trust's analysis of rosters between September 2021 and November 2021 demonstrated that all shifts had been staffed by at least one registered nurse and 79% of acute wards shifts had been staffed by two or more registered nurses. The ward recording the lowest coverage by two or more registered nurses was Lark with only 56% coverage. Nurses told us that working alone was challenging because of the multitude of tasks they had responsibility to complete each shift.

The trust provided records of actual staffing of wards between September 2021 and November 2021. Records supported the trust's position that all shifts during this period had been staffed by at least registered nurse. Our review showed the majority of shift during this period were sufficiently staffed and met planned safer staffing levels. However, we did see occasions where shifts were staffed below the trust's safer staffing requirements. Our review identified a total of 41 during this three month period. For example, staffing records showed Glaven ward early shift on 2 October 2021 had four staff, one below the requirement. In the same period, staffing records frequently demonstrated staffing above the trust's safer staffing requirement. Staff reported this happened for a number of reasons including to meet the needs of prescribed high level observations or to support the needs of patients required to self-isolate as part of COVID-19 requirements when first admitted.

The trust regularly used bank and agency staff to cover shifts across all wards. The trust deployed bank or agency staff to maintain safer staffing levels and meet additional staffing requirements. For example, to meet the needs of patients prescribed high level observations. Wherever possible the trust deployed bank or agency staff that were familiar with wards. The trust identified that many of it's own staff worked additional shifts through the bank or NHS professional. We were also given examples where agency staff worked regularly to cover long-term sickness or absences. During October 2021, 74% of staff on Avocet were bank or agency staff. However, the trust reported that 48% of the total bank or agency use was provided by staff that worked regularly on the ward.

The trust required ward managers, clinical nurse specialists and matrons to complete clinical shifts on their ward. Ward managers and clinical nurse specialists completed two shifts a week, and the matron completed two shifts a month. When completing clinical shifts they were counted in ward staffing numbers. However, we saw one example where a manager had contributed clinical shifts more frequently in a week to ensure safe staffing.

Wards were also supported by a number of multidisciplinary staff who were supernumerary to ward staffing. This included occupational therapy staff, physical health nurses an activity staff

Staffing of Samphire and Great Yarmouth acute ward was integrated with the local crisis resolution and home treatment teams (CRHT). The trust recognised both wards were standalone and unsupported by other inpatient services. Integrated staffing allowed staff from the CRHT's to support safe staffing of these wards. Ward and CRHT staff worked closely and shared the same mandatory training requirements. Before supporting wards, CRHT staff received handover information to support their work with patients and guidance was available from senior ward staff. When CRHT staff supported wards to meet safe staffing, this was recorded as an incident.

A manager told us staffing records were not always accurate as staff could be moved between wards during a shift. Staff met during safety huddles to review staffing levels across units and make changes to meet the needs of patients.

Huddles provided oversight of staff movements and wherever possible staff updated records to reflect this. However, the trust's analysis of rosters between September 2021 and November 2021 showed rosters had not always accurately evidenced staffing of individual shifts. In response, the trust planned to cleanse and simplify staffing records and processes.

Staff reported low staffing levels as incidents. For example, on Great Yarmouth acute ward, there were 25 incident reports of low staffing levels between May and October 2021. However, the ward manager confirmed staff were not always reporting low staffing levels as incidents as they did not always have time to do this. Incident reports for this ward confirmed staff had closed off the communal area to patients, as there were not enough staff to safely keep the area open or complete general observations of patients.

Low staffing levels were often highlighted in team meeting minutes and patient community meetings. Patients on Southgate and Northgate wards told us they felt the impact of the ward being short staffed. Managers on Great Yarmouth acute ward told us about the impact of low staffing levels on patient one to one time with staff and the impact on managerial tasks, such as audits not always being completed due to staffing pressures.

Vacancy rates varied between wards, with Northgate ward holding the highest vacancy rates for both nurses and healthcare support workers at 28% and Great Yarmouth acute ward the lowest at 8%. The overall vacancy rate for both nurses and healthcare support workers on acute wards was 22%.The overall vacancy rate captured the recent addition of seven wholetime equivalent healthcare support worker roles. This had been agreed in response to increased acuity across the service. Managers told us of difficulties in recruiting staff nurses, despite rolling recruitment adverts and an international recruiting scheme.

Turnover rates also varied between wards, with the highest turnover on Lark ward which was 37% and the lowest turnover rate on Glaven ward at 4%. The overall turnover rate was 19% across acute wards at the trust.

Levels of sickness were above the trust target of 4.9%, as the average sickness rate for all acute wards over the previous 12 months was 7%.

Patients did not have regular one to one sessions with their named nurse. Patient records demonstrated a lack of one to one sessions recorded in patient notes and staff informed us that one to one time was often affected by the number of patients on enhanced observation levels on each ward.

Patients rarely had their escorted leave cancelled, even when the service was short staffed.

The service did not always have enough staff on each shift to carry out physical interventions safely. We reviewed two incidents in which police were called due to wards not having enough staff trained in restraint on shift. One incident related to staff not being able to safety administer intramuscular medicines, due to the need to restrain the patient. The other incident related to lack of available staff trained in restraint to restrain a patient in the 136 suite.

Medical staff

The service had enough daytime and night-time medical cover and a doctor available to go to the ward quickly in an emergency. However, wards at Hellesdon Hospital had reduced medical cover as outlined in the trust's governance meeting. There was one consultant vacancy and one Associate Specialty Doctor vacancy for Thurne ward. Four recent incident reports were submitted to raise this concern. The trust confirmed they were using consultants from other wards to cover these vacancies and were continuing with recruitment campaigns to attract people into this role.

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

Mandatory training

Staff had not kept up-to-date with their mandatory training, including restraint training, Infection Prevention and Control and induction training. Across all wards, only 74% of staff were up-to-date with their mandatory training and on Avocet ward only 59% of staff were up-to-date with their mandatory training. Overall, only 45% of staff working across acute wards were-up-to date with their training in the use of restraint.

Staff were not up-to-date with their restraint training. For example, on Avocet ward, only 8% of staff were in date with this training, 21% on Great Yarmouth acute ward, 37% on Samphire ward, 42% on Glaven ward and 46% on Thurne and Northgate wards. Managers told us that staff would be booked to complete face to face restraint training through November 2021 to January 2022. We reviewed three patient restraint incidents to check that staff restraining patients were in date with their training. In two out of three incidents, not all staff were in date with their training. For one incident, two staff were out of date and for the other incident, one staff member was out of date. Staff restraining patients without the appropriate training may risk causing serious harm to patients or other staff.

Assessing and managing risk to patients and staff

Staff did not always assess and manage risks to patients and themselves well. However, in most cases staff followed best practice in anticipating, de-escalating and managing challenging behaviour and used restraint and seclusion only after attempts at de-escalation had failed.

Assessment of patient risk

Most staff completed risk assessments for each patient on admission. However, staff did not always review patient risk assessments at appropriate times, such as after an incident or a change in a patient's level of risk. On Great Yarmouth acute ward, staff were not completing risk assessments on admission in a timely manner as some patients were waiting for up to a week.

Staff used a daily situational risk assessment tool on wards to capture any change to patient risk levels during the day. Despite this tool being used regularly, staff were not always updating the patients full risk assessment on their clinical notes with changes to patient risk. This risks not all ward staff being aware of a change to a patient's level of risk.

We revisited Great Yarmouth ward and Glaven ward on 29 December 2021. We reviewed 10 patient records on Great Yarmouth ward and four patient records on Glaven ward. We found risk assessments had been updated regularly in line with the trust policy. We found staff had updated risk assessments following incidents and when there was a change of risk. However, we found that one patient who was a new admission, did not have an up-to-date risk summary in the care records.

Management of patient risk

Staff did not always act to prevent or reduce risks or respond to changes in risks to, or posed by, patients. Staff on Great Yarmouth acute ward repeatedly let a detained patient leave the ward on at least three occasions due to the risk the patient posed of aggressive behaviour, as staff felt unable to safely manage the patient on the ward. The patient was reported as 'absent without leave' as the patient did not have Section 17 leave (planned community leave from hospital requiring authorisation) prior to staff releasing the patient from the ward. Due to the patient being absent from the ward and their whereabouts unknown, staff contacted the police to look for patient and return the patient to the ward. Staff did not follow the patient's care plan when managing the patient's aggression. The patients care plan detailed the use of

key interventions and strategies to support the patient to manage his aggression or when he presented as a risk to others. Staff had not attempted to use these interventions, prior to letting the patient leave the ward and in order to maintain the patient's safety. Staff had not updated the patient's risk assessment with these incidents. The practice of letting the detained patient leave the ward was not recorded as an appropriate intervention to use in the patients care plan, when the patient was aggressive. Staff had also not completed a review of the patient's observation levels when the patient returned to the ward, despite this being a requirement of the patients care plan.

Staff did not always follow trust policies and procedures when they needed to search patients or their bedrooms to keep them safe from harm. Staff on Glaven ward did not always search patients, or place a patient on enhanced observations, if they suspected the patient had a restricted item on them on the ward.

Not all wards had informed staff, visitors and patients of what constituted restricted items on the ward, for example, risk items which may be used to cause harm. On Glaven and Great Yarmouth acute ward, there were no signs displayed on the ward to inform people of what items were restricted and managers confirmed visitor searches did not always take place. Staff meeting minutes and incident reports confirmed restricted items were brought onto these wards. This posed a significant risk to patients' safety. However, all staff across the trust were restricting the use of plastic bags onto the wards as the result of a recommendation from a coroner's inquest from a Serious Incident.

Staff did not always follow trust policies and procedures, or national guidance for example the National Institute for Health and Care Excellence violence and aggression, when they needed to observe patients to keep them safe from harm. We reviewed CCTV footage of how staff were completing enhanced patient observations and reviewed patient observation records to check patients were being observed as per their care plans and within trust policy and national guidance. On Great Yarmouth acute ward, we reviewed two patient's observation records across a two-day period, for patients on level three arms reach observations. We found two gaps in records, of five hours each, highlighting staff were not observing this patient for that time period. We raised this with the ward manager who could not account for this gap in observations. Of these observation records, none had been checked or signed off by a manager, which was required in line with the trust's policy. Staff meeting minutes also confirmed there had been large gaps in patient observation paperwork, yet no action had been set from this meeting to address this concern. Staff had also not recorded times, dates, room numbers and the rationale for observations. Staff not observing patients as clinically directed via patient risk assessments and care plans posed a significant risk to patient safety. We revisited Great Yarmouth ward on 29 December 2021. We reviewed the observation records from the previous month for three patients and found they had been completed appropriately in line with the trust policy and there were no gaps in the records.

Staff on other wards including Southgate, Poppy, and Avocet ward, were observing patients for up to three hours, which was over the two-hour guideline within the National Institute for Health and Care Excellence recommendations and within the trust's observation policy. Staff told us this was due to the ward being short staffed. Staff on Poppy ward were observing patients at predictable time intervals, such as exactly every 15 or 60 minutes which was not best practice to protect patients from harm to themselves.

Staff on Glaven ward were not completing or recording food and fluid monitoring for a patient who was admitted to the ward with concerns they were not eating or drinking. The patient's observation records had gaps in recording and despite the patient self-harming and being admitted to Accident and Emergency on two consecutive occasions, the patient's observation levels were not amended until the third instance of self-harm, to reflect the level of risk. Staff on this ward were also not accurately documenting the time they observed the patient, their name or providing details of the patient's presentation when they completed their observation. During our revisit on 29 December to Glaven ward we reviewed the diet and nutrition chart for one patient whose diet and nutrition required monitoring. We found that staff had completed these appropriately.

We raised these concerns with the trust, who informed us of an ongoing quality improvement initiative relating to patient observations and that they were currently implementing a new patient observation policy to focus on patient engagement and patient privacy and dignity.

Use of restrictive interventions

Levels of restrictive interventions for seclusion and restraint were stable across a 12-month period, except for levels of prone restraint which had increased in the months of September and October 2021. For example, on Avocet ward in October 2021, there were 18 instances of prone restraint compared to just one instance in August 2021. On Southgate ward there were nine instances of prone restraint in September and a further nine in October 2021, compared to just two instances in August 2021.

The use of rapid tranquilisation had also increased in September and October 2021 to 90 and 94 instances across all wards, compared to 52 instances in August 2021. Staff did not always follow National Institute for Health and Care Excellence guidance when using rapid tranquilisation. We found staff were not always completing physical health observation checks on patients following administering the medicines. During our revisit on 29 December 2021, we reviewed four incidents of rapid tranquilisation to check staff had completed subsequent physical health observations. We found staff had completed physical health observations in line with the trust policy and had documented when the patient had refused to have physical health observations completed.

Staff were not recording, reviewing, and appropriately justifying all blanket restrictions on wards. For example, on Great Yarmouth acute ward we found signs stating that patients could only have one takeaway per week. When we asked to see the ward's blanket restriction register to check how this was reviewed, staff showed us a blank register. This was against the trust's policy, which stated that blanket restrictions should be monitored and reviewed.

We reviewed a random selection of restraint incidents on CCTV to assess if staff were proportionately restraining patients as a last resort and using de-escalation techniques prior to restraining a patient. Staff restrained patients proportionately and we saw evidence that staff were using de-escalation techniques. However, one incident showed staff did not always act to prevent patient on patient incidents re-occurring, requiring restraint to be used to intervene in re-occurring incidents. We observed three successive patient on patient incidents relating to the same patients, in which staff did not act to debrief, engage or monitor patients following each incident, resulting in the patients becoming aggressive to one another three times and undergoing restraint.

When a patient was placed in seclusion, staff did not always keep clear records or follow best practice guidelines. Glaven ward and Great Yarmouth acute ward staff were not always accurately recording start and end times of seclusions or recording if they were removing risk items from patient bedrooms when secluding patients in their rooms. Staff failed to record how they were ensuring patients had access to the toilet when secluding patients in bedrooms without toilets. Not all medical reviews were taking place following seclusion, as highlighted within the ward's audits

During our revisit on 29 December 2021, we reviewed the seclusion records for two patients on Great Yarmouth ward. We found that all medical reviews were completed in line with the trust policy and that staff had completed all seclusion documentation appropriately. There had not been any incidents of seclusion on Glaven ward since the previous inspection.

There was only one instance of long-term segregation in the previous 12 months.

Safeguarding

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

Staff understood how to protect patients from abuse and the service worked well with other agencies to do so. Staff had training on how to recognise and report abuse and they knew how to apply it.

Staff received training on how to recognise and report abuse, appropriate for their role. Staff kept up-to-date with their safeguarding training.

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

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

Of the wards we asked, managers stated that children were not able to visit patients on the ward. However, there were rooms off the ward whereby visitors, including children, could see patients.

Staff knew how to make a safeguarding referral and who to inform if they had concerns. However, not all staff on Glaven and Great Yarmouth acute ward were familiar with where to find a record of completed safeguarding referrals made by staff. We highlighted a child safeguarding concern to the ward manager on Glaven ward, who was not immediately aware if a referral had been completed. Following further investigation, managers were able to confirm that a safeguarding referral had been completed by an external agency and not the ward staff. However, this information had not been updated within the patient's risk assessment, handover documentation or care plans. During our revisit on 29 December 2021, we reviewed the incident records of 14 patients on Glaven ward and Great Yarmouth acute ward. We found that all potential safeguarding referrals had been reported and recorded appropriately.

Staff access to essential information

Not all staff had easy access to clinical information, resulting in incomplete clinical records. Staff were not always updating clinical records with key information required in order to safely support patients.

Permanent staff working for the trust had access to clinical information via an electronic recording system. Agency staff reported they did not have access to electronic systems to record patient notes, therefore they had to ask other ward staff to complete entries for them. Meeting minutes which we reviewed confirmed this, stating that gaps in recording occurred due to agency staff not always having access to the appropriate system.

Medical staff raised a concern they did not have access to essential information for their role, such as rates of rapid tranquilisation, seclusion or restraint.

Records were stored securely. However, some staff were unclear where key documents were stored, such as observation records and seclusion logs. For example, not all staff from Glaven ward and Great Yarmouth acute knew where to access the trusts electronic seclusion log.

Patient notes were not always completed comprehensively or updated with relevant risks, incidents or key information required to provide individual care for patients. For example, risk assessments did not highlight recent violent or aggressive behaviours, physical health checks were not always recorded, and patient observation records lacked key details such as times, patient presentation and food or fluid monitoring.

Medicines management

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

The service had systems and processes to prescribe and administer medicines safely, however they were not always followed. Staff did not always review the effects of medicines on each patient's mental and physical health.

Staff did not always follow systems and processes when safely prescribing, administering, recording and storing medicines. The trust had introduced an electronic prescribing and medicines administration system (EPMA) which had improved the prescribing and recording of medicines administration. However, it was not always updated with relevant information and did not always reflect an up-to-date record of patient's medicines requirements. For example, two patients EPMA records indicated they were overdue a medicines review, with one review recorded as overdue since July 2021. We were shown separate medical notes that documented the reviews had taken place, however the EPMA system had not been updated.

When staff gave depot injections to patients, a slow-release form of medicine given into the muscle, they did not always record the site of administration. This meant there was a risk of staff injecting a depot medicine into the same area of the body as the previous time, which could cause skin disorders.

Medicine allergies or sensitivities were recorded on all medicine charts seen. This ensured staff were alerted to prevent the prescribing and administration of medicines causing allergic reactions.

Out of 12 medicine charts we reviewed; none recorded a patient's weight which is important to determine the correct dose of certain medicines.

Medicine advice and supply from pharmacy were available five days a week. Staff knew the routes to obtain medicines out of hours if required.

Staff reviewed patient's medicines regularly and patients and carers were involved in decisions where appropriate. Patient feedback was mixed about appropriate advice on their medicines being given to them. Patients on Great Yarmouth acute ward did not always feel they had enough information about their medicines. However, we spoke with one patient on Lark Ward who told us they understood what their medicines was for. The patient also told us they had been involved in making decisions to find a medicine which worked well for them. Patients were able to speak to a member of the pharmacy team about their medicines.

Staff stored and managed e-medicines and prescribing documents in line with the trust's policy. Medicines required in an emergency was available. Staff recorded weekly safety checks on medical gases, emergency medicines and equipment to ensure they were safe to use if needed in an emergency.

Staff did not always follow current national practice to check patients had the correct medicines. Mental Health Act (MHA) certificates are legal documents which describe the medicines doctors are allowed to prescribe to patients after they had been detained. However, these were not always easily accessible, and staff did not always check this prior to every administration. For example, on Yare ward we saw two patients were prescribed medicines which were not documented on their MHA certificates. This meant staff could not be assured that all mental health medicines they were administering were covered legally.

Staff checked the medicines that patients were taking on admission (medicines reconciliation). This was documented on the electronic prescribing system by pharmacy staff and any discrepancies promptly communicated with medical staff.

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

The service had systems to ensure staff knew about safety alerts and incidents, so patients received their medicines safely. Senior ward staff knew about safety alerts and medicines related concerns via monthly "medicines safety newsletters". Staff understood the process to report medical incidents, and these were discussed locally in team meetings. We saw evidence of investigations taking place when medicines incidents had occurred.

Staff did not always use decision making processes to ensure people's behaviour was not controlled by excessive and inappropriate use of medicines. On Samphire ward we saw that patients were often being given 'as and when required' sedating medicines by night staff without documenting a reason. This had not been reviewed by medical staff. This was a concern as sedating medicines had the potential to cause dependence. We raised this with senior ward and medical staff, who told us immediate action would be taken.

On other wards we saw that staff understood when 'as and when required' medicine was needed. The need for this medicines were reviewed regularly during multidisciplinary team meetings.

Staff reviewed the effects of each patient's medicines on their physical health according to National Institute for Health and Care Excellence guidance. Patients who were on other physical health medicines such as for diabetes were monitored appropriately.

Track record on safety

Staff reported serious incidents clearly and in line with trust policy. Within the previous 12 months, there had been eight serious incidents across acute wards, including two inpatient deaths.

The service had not recorded any never events on any wards.

Reporting incidents and learning from when things go wrong

Staff were not always reporting incidents appropriately. Managers did not investigate all incidents. However, we saw evidence that some lessons learned were shared with staff teams.

Staff did not always know what incidents to report and how to report them in line with trust policy. On Glaven ward, we found incident reports which did not accurately detail incidents in which staff had restrained patients. On Great Yarmouth acute ward, staff were also not reporting restraint incidents accurately, such as including how long they were restraining patients in prone position. Staff were not reporting incidents of seclusion on the trust's incident reporting system nor were they accurately recording what actions they had taken as a result of the incident. For example, referring a safeguarding incident to the local safeguarding authority. Managers were aware of this and told us staff do not often have the time to record such incidents on Datix due to low staffing levels on the ward. Managers noted staff would always raise concerns during daily safety huddles so that appropriate actions could be taken at the time. During our revisit to Glaven ward and Great Yarmouth ward on 29 December 2021 we reviewed 15 incident reports relating to restraint. Staff completed most reports accurately and appropriately, however we found two incident reports continued to lack detail such as type of restraint used with a patient.

Staff understood the duty of candour. They were open and transparent and gave patients and families a full explanation when things went wrong.

Managers debriefed and supported staff after any serious incident.

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

Managers did not always review or investigate incidents within trust timescales. On Great Yarmouth acute ward, out of 163 open incidents, 161 had not been reviewed by manager within one month of reporting. We reviewed these overdue incidents and found 11 incidents had been reported in June 2021 and 52 incidents in July 2021 but had not yet been reviewed by a manager. The overdue incidents we reviewed related to self-harm, sexual safety and incidents involving restricted items on the ward. We raised this with the ward manager who told us they often did not have time to review the incidents due to low staffing levels as managers were regularly used to work in the clinical ward staffing figures for the day. During our revisit to Great Yarmouth ward on 29 December 2021, we found three out of 15 incident reports were open awaiting review and four were under investigation. However, these incidents had occurred within the previous week, and the timeframe for a manager review was within the trust's key performance indicators.

For incident reports that had been reviewed by a manager, staff received feedback from the investigation of incidents, both internal and external to the service. Staff met to discuss the feedback and looked at improvements to patient care. Managers fed back learning from incidents in team meetings, safety huddles and lessons learned meetings. However, as incidents on Great Yarmouth acute ward were not always reviewed in a timely manner, we were not assured staff always received this feedback in a timely manner, limiting the effectiveness of this process.

There was evidence that actions had been taken as a result of feedback. For example, all wards were now using paper bags rather than plastic bags, following a recent serious incident relating to the use of plastic bags. However, staff from Glaven ward and Great Yarmouth acute ward did not display information about restricted items on and did not always search patients and visitors for restricted items. Overdue incidents on Great Yarmouth ward included a self-harm incident involving a pipe cleaner. As this incident had not been reviewed or actions set by managers, we were not assured all appropriate actions had been made to keep patients safe from harm. We raised this with the trust, who confirmed all outstanding incident reports had now been reviewed by a manager.

Is the service effective?

Inadequate  

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

Assessment of needs and planning of care

Staff assessed patient's mental health on admission, but physical health assessments were not always completed at the same time. Staff were not consistently developing individual care plans or updating them as needed. Care plans did not always reflect patients' assessed needs, and were not always personalised, holistic or recovery-oriented.

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

Patients did not always have their physical health assessed on admission or regularly reviewed during their time on the ward. We found 19 out of 22 records we reviewed for physical health assessments on admission, had an assessment in place on admission. On Glaven ward, two out of five patients had no evidence of ongoing physical health monitoring and on Great Yarmouth ward, we saw evidence that patients had declined physical health checks, but these were not followed up to check if patients wanted another one. Managers were completing regular audits of physical health assessments and ongoing monitoring, which highlighted similar findings. For example, in August 2021, only 63% of

patients received a physical health check upon admission and on Poppy ward during August 2021, staff had not completed physical health monitoring for 10 out of 17 patients. Audits also highlighted staff were not always taking action when patients showed early signs of physical deterioration. Despite the findings from these audits, we continued to find omissions in recording of physical health assessments or ongoing monitoring.

Staff did not always develop comprehensive care plans for patients that met their mental and physical health needs. Staff were not always highlighting patient risks on care plans, in order to safely support the patient. Care plans were not always personalised, holistic and recovery-orientated. However, care plans at Woodlands in Suffolk included the patient's voice and patient strengths.

Staff were completing regular audits of patient care plans, which highlighted that care plans did not always address the patient's needs as identified in their assessment, including physical health needs and safety plans. Managers told us they were working with staff to address issues identified via audits. Despite Lark ward demonstrating an improvement in these areas in September 2021, other wards did not demonstrate consistent improvement over the course of the audits.

Staff did not always review and update care plans when patients' needs changed. However, staff were regularly completing audits to review this, and told us this was an ongoing quality improvement initiative. Staff spoke about recent changes to a new care plan format which enabled them to make the care plans more patient focused.

Best practice in treatment and care

Staff provided a range of treatment and care for patients based on national guidance and best practice. Staff did not always ensure patients physical health needs were monitored or recorded. Staff did not consistently use recognised rating scales to assess and record severity and outcomes or consistently participate in clinical audits.

Staff provided a range of care and treatment suitable for the patients in the service.

Staff on most wards delivered care in line with best practice and national guidance.

Patients reported activities were limited across all wards, despite the trust's recent improvement project to increase activities available at weekends and during evenings. Staff used a daily planner to allocate individual staff to offer daily support to patients and each ward had an activity timetable. However, staff reported they often did not have the time to provide this. Staff also informed us patient activities could be cancelled if the ward is short staffed and patient community meeting minutes confirmed this.

Staff at Wedgewood House recently completed an audit to ascertain how often patients were receiving one to one sessions. In August 2021, this was 65%, however the target was 90%. Staff on Glaven, Yare and Lark wards confirmed Occupational Therapists can offer one to one sessions through individual assessment. We saw evidence of positive one to one engagement between an Occupational Therapist and a patient, involving a one to one to address hoarding behaviours and to prepare for discharge.

Staff on Northgate ward were not always recording physical health monitoring in patient notes, despite inspectors observing staff completing physical health monitoring on the wards.

Staff met patient's dietary needs and assessed those needing specialist care for nutrition and hydration. However, managers on Great Yarmouth acute ward informed us patients did not currently have access to a dietician.

Staff helped patients live healthier lives by supporting them to take part in programmes or giving advice. However, not all wards had implemented the trust's smoke free policy. Managers told us this was due to delays caused by COVID-19. Wards provided smoking cessation support for patients.

The use of recognised rating scales to assess and record the severity of patients' conditions and care and treatment outcomes was inconsistent across wards. Staff in Wedgewood House in Suffolk told us they were not using structured outcome tools to record or monitor clinical outcomes.

Staff were not routinely using technology to support patients, with the exception of the use of iPads for patients to remain in contact with family members during the COVID-19 pandemic.

Staff took part in clinical audits, benchmarking and quality improvement initiatives. However, the type of audits undertaken differed between individual wards and certain audits were not always completed. For example, on Samphire ward, daily and/or weekly audits such therapeutic observations, physical health and seclusion audits were not always completed as only one record was provided to evidence these audits. Medical audits were not always undertaken, which meant that missing information relevant for prescribing medicines was not always identified. The trust was due to conduct a 'least restrictive' audit to review the use of restrictive interventions on patients, however this was currently on hold due to capacity concerns.

There was evidence managers used results from some audits to make changes and challenge poor practice, such as increasing contact with carers and relatives. However, ward level audits also demonstrated there was a lack of consistent improvement over time. For example, seclusion audits demonstrated staff were not always adhering to appropriate seclusion safeguards over the previous six months and over the same time period care plan audits demonstrated staff were not consistently creating holistic, recovery-centred and up-to-date care plans.

Skilled staff to deliver care

Most ward teams included, or had access to, the full range of specialists required to meet the needs of patients on the ward, with the exception of Great Yarmouth acute ward. Managers did not ensure staff had the range of skills needed to provide high quality care. Managers did not consistently support staff with appraisals or supervisions. Managers did not ensure all new staff were provided with induction training.

Most ward teams had a full range of specialists to meet the needs of the patients on the ward. However, managers on Great Yarmouth acute ward informed us that patients do not currently have access to a dietician or access to Speech and Language Therapists. The ward manager confirmed this was a gap in treatment for patients on this ward.

Managers did not ensure staff had the right skills, qualifications and experience to meet the needs of the patients in their care, including bank and agency staff. Managers had not ensured that all staff were trained in the use of restraint, therefore staff did not have the right skills to meet the needs and risks of patients. Managers had not ensured all staff were provided with clinical supervision and staff were not always provided with an induction.

Managers told us they offered each new member of staff a full induction to the service before they started work such as shadowing more experienced staff on the ward and being shown key risk information via a ward tour and explanation. However, not all new staff had completed their induction training. On Southgate ward, only 50% of staff had completed their induction training and on Avocet ward, 66%. Staff not receiving the appropriate training when they start in their

role, may put patients at risk of harm, as staff may not be following correct policies, procedures and safeguards. We found not all ward managers had a handover prior to starting work, this meant they were not always aware of key risks and performance areas. Bank and agency staff did not have access to the patient clinical records system, resulting in a lack of knowledge about patient specific risks and care needs.

Managers were not always supporting permanent non-medical staff to develop through yearly, constructive appraisals of their work. Appraisal rates on Thurne ward were 45% and 47% on Southgate ward. However, on Lark ward, 100% of staff had an annual appraisal and 93% of staff on Samphire ward.

Managers supported permanent medical staff to develop through yearly, constructive appraisals of their work.

Managers did not always support staff through regular, constructive clinical supervision of their work. Clinical supervision rates for Glaven ward were 4% during October 2021 and 7% for Great Yarmouth acute ward. However, on Lark and Poppy ward, 80% of staff had supervision during October 2021.

Managers facilitated team meetings and staff safety huddles which reviewed key daily updates and changes to patient risk levels. Staff told us weekly team meetings were sometimes cancelled due to staffing levels, particularly on Thurne, Glaven, Southgate and Great Yarmouth acute wards. Southgate ward should have been holding weekly meetings, however there had only been six full team meetings in the last nine months. Lark ward held a standalone meeting to discuss lessons learned from incidents.

As managers were not always completing supervisions with staff, we could not be assured that managers were identifying training needs of their staff. However, staff were able to request specialist training for their role.

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

Multi-disciplinary and interagency teamwork

Staff from different disciplines worked together as a team to benefit patients. The ward teams had effective working relationships with other relevant teams within the organisation and with relevant services outside the organisation.

Staff held regular multidisciplinary meetings to discuss patients and improve their care.

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

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

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

Staff understood their roles and responsibilities under the Mental Health Act 1983 and the Mental Health Act Code of Practice and discharged these well. However, not all staff completed training on the Mental Health Act and the Mental Health Act Code of Practice.

Not all staff completed training on the Mental Health Act and the Mental Health Act Code of Practice. Overall, only 52% of staff across all acute wards had complete this training.

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

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

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

Patients had easy access to information about independent mental health advocacy.

Staff made sure patients could take section 17 leave (permission to leave the hospital) when this was agreed with the Responsible Clinician and/or with the Ministry of Justice.

Staff stored copies of patients' detention papers and associated records correctly and staff could access them when needed.

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

Wards did not always display posters to let informal patients know they could leave the ward freely. However, informal patients that we spoke with knew they could leave the ward and staff were informing informal patients on admission they were able to leave the ward.

Good practice in applying the Mental Capacity Act

Staff supported patients to make decisions on their care for themselves. They understood the trust policy on the Mental Capacity Act 2005 and assessed and recorded capacity clearly for patients who might have impaired mental capacity. However, not all staff were up-to-date with their training on the Mental Capacity Act.

Staff did not keep up-to-date with training in the Mental Capacity Act. Overall, only 65% of staff were up-to-date with this training.

There were 188 deprivations of liberty safeguards applications made in the previous 12 months.

Staff knew where to get accurate advice on the Mental Capacity Act and deprivation of liberty safeguards.

Staff gave patients all possible support to make specific decisions for themselves before deciding a patient did not have the capacity to do so.

Staff assessed and recorded capacity to consent clearly each time a patient needed to make an important decision.

When staff assessed patients as not having capacity, they made decisions in the best interest of patients and considered the patient's wishes, feelings, culture and history.

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

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

Is the service caring?

Requires Improvement ↓

Our rating of caring went down. We rated it as requires improvement.

Kindness, privacy, dignity, respect, compassion and support

Most staff treated patients with compassion and kindness. However, not all staff respected patients' privacy and dignity.

Staff gave patients emotional support and advice when they needed it. On Great Yarmouth acute ward, we observed staff supporting patients with upcoming mental health tribunals and following periods of distressed behaviour.

Staff directed patients to other services and supported them to access those services if they needed help.

Most staff were discreet, respectful, and responsive when caring for patients. However, staff on Great Yarmouth acute ward were not always responsive when responding to patient's needs. We observed a patient knocking on the ward office window over a prolonged period of time, yet staff did not always respond to the patient. Patients also stated during a community meeting, that staff did not always respond to them when they needed something and knocked on the office door. Community meeting minutes for this ward also highlighted that patients did not like staff knocking on their bedroom door and walking straight in, rather than waiting for them to respond in non-emergencies. However, we observed staff continuing to do this on this ward.

We found staff did not always treat patients with dignity on Great Yarmouth acute ward, due to wedging open the door of the 136 suite with a towel, leaving the patient's safety and dignity at risk.

Patients we spoke to during this inspection told us staff treated them well and behaved kindly, with the exception of one patient on Southgate ward and one carer on Glaven ward, who informed us staff had made inappropriate jokes about them and were rude over the telephone.

Staff felt they could raise concerns about disrespectful, discriminatory or abusive behaviour or attitudes towards patients.

Staff followed the provider's policy to keep patient information confidential.

Involvement in care

Staff did not always involve patients in care planning or risk assessment. Staff sought feedback on the quality of care provided, although concerns were not always taken forward. However, we found staff ensured patients had easy access to independent advocates.

Involvement of patients

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

Not all wards were providing patients with an introduction to the ward as part of their admission. Three patients on Glaven ward told us they had not been provided with an information pack on admission or shown around when they arrived at the ward. Patients on Great Yarmouth acute ward reported they did not have an induction to the ward in their community meeting. Staff completed audits of patient admission processes to check the correct procedures had been followed and information provided. On Great Yarmouth acute wards, the audits highlighted that 12 out of 13 admissions had not been provided with information relating to medicines and physical health. Another audit recorded the date the patient was provided with their relevant admission information, was prior to patient's admission date. We were therefore not assured that audits of admission processes were effective, or that patients were receiving all relevant information when they arrived at this ward. However, we found all other wards were providing patients and carers with admission information packs and they were shown around the ward.

Patient views were mixed as to whether staff involved them in their care. Two patients on Southgate ward, four patients on Northgate ward and one patient on Glaven ward did not feel involved within their own care. Patients regularly told ward staff in their community meetings they did not feel involved in their care, that they wanted to be more involved in care planning and have more information about their medicines. Staff had not set actions from community meetings to address these concerns. Staff completed audits to assess if patients were involved within their care plans, which confirmed our finding that staff were not always collaborating with patients when completing their care plan. For example, on Glaven ward, four out of 16 care plans did not have any evidence of collaboration. Our findings from other key questions also highlighted that care plans lacked personalisation and patient voice.

Most patients reported they could access their care plan if they asked staff. However, care records demonstrated that patients were not always offered a care plan when these were completed. Staff completed audits on whether patients were offered care plans, which confirmed patients were not always offered a care plan. However, staff at Wedgewood House told us they would complete weekly walk-arounds in which they would offer patients copies of their care plans.

Patients from all wards told us they did not feel involved regarding decisions relating to the running of the service. However, we observed patients on Lark and Glaven wards involved in the re-decoration of the wards. Staff told us patients could become 'service user representatives' and that patients were involved in recruitment processes and attended interview panels.

The trust employed patient participation leads who were employed to improve communication between patients and the trust. We saw evidence that patient and carer views on the new inpatient facilities at Hellesdon hospital had been sought.

Patients could give feedback on the service about their treatment and staff supported them to do this. Staff held community meetings on all wards to ensure patients could feedback about their treatment and the service. However, it was not always clear how concerns raised by patients at the meetings were followed up. Consecutive meetings often highlighted the same problems, such as patients not feeling involved in their care. Managers told us concerns were fed into team meetings, however managers also told us that both community meetings and team meetings were cancelled on occasion due to staffing shortages. We were therefore not assured all patients had frequent opportunities to provide feedback on their care, and staff were taking action with concerns raised.

Staff made sure patients could access advocacy services, including independent mental health advocates.

Involvement of families and carers

Not all families and carers felt that staff informed and involved them within patient care.

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

Feedback as to whether staff supported, informed and involved families or carers was mixed. Patients and carers felt involved in their relative's care and treatment on Avocet and Lark wards. We saw evidence that staff were providing relative and/or carer information packs on Avocet, Poppy and Lark wards. Staff on Southgate ward informed us they ran weekly carer clinics which were generally well attended, and all wards regularly completed audits on carer contact to ensure these were regular and of good quality. However, on Southgate, Northgate and Glaven wards, patients did not feel carers were always involved in their care and treatment. Carers with relatives from these wards, also confirmed they did not always feel informed about their relative's care and treatment and did not receive information when their relative was admitted to the ward.

Is the service responsive?

Requires Improvement

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

Access and discharge

Staff faced challenges to manage bed availability within the trust. A bed was not always available when needed. Discharge was often delayed due to lack of available accommodation or suitable care packages. However, we found patients were not moved between wards unless this was for their benefit.

Bed management

Bed occupancy for the previous 12 month period was 96% and managers told us of challenges of bed availability due to a high demand for beds.

Managers regularly reviewed the length of stay for patients to ensure they did not stay longer than they needed to. However, managers reported longer lengths of stay for patients at Hellesdon hospital due to a lack of local residential or supportive accommodation options. Managers were working with local services to try and resolve this.

The service had high levels of out of area placements. For the previous 12 months, there were 113 out of area placements. The trust told us out of area placements had decreased despite seeing increased demand for the service and acuity. Bed management and looking after people locally was a key priority for the trust.

Managers and staff worked to make sure they did not discharge patients before they were ready.

Managers were carrying out risk assessments of patients to offer home leave prior to discharge and using the available bed for an alternative patient. Managers told us safety plans were in place for individuals on home leave in case they needed to return early, and this was monitored in daily operational huddles.

Bed occupancy rates on Great Yarmouth acute ward were over 100% for the months of April, June, July, August, September and October 2021 as managers were using beds for patients on leave, for alternative patients. This risked the bed not being available for the patient if they returned from leave. Managers reported this was occurring due to the high demand for beds.

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

Patients were moved between wards only when there were clear clinical reasons, or it was in the best interest of the patient.

Staff did not move or discharge patients at night or very early in the morning.

The PICU did not always have a bed available if a patient needed more intensive care. Staff felt that patient acuity levels had increased on the acute wards and felt they were managing more complex patients. The trust had recently closed Rollesby ward, one of two PICU wards across the trust, for refurbishment.

Discharge and transfers of care

The service had 4,986 instances of patients with a delayed discharges or transfer of care in the previous 12 months. Managers monitored these delays and the trust informed us that the majority of these were due to issues with securing suitable housing or care packages, resulting in patients staying in hospital for longer. The trust informed us they were working with social care and district housing to increase accommodation options for patients.

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

Staff supported patients when they were referred or transferred between services.

Facilities that promote comfort, dignity and privacy

The design, layout, and furnishings of the wards did not always support patients' treatment, privacy and dignity. Each patient had their own bedroom and could keep their personal belongings safe. There were quiet areas for privacy. The food was of good quality however patients could make hot drinks and snacks at any time.

Each patient had their own bedroom, which they could personalise.

Patients on most wards had a secure place to store personal possessions. A patient on Glaven ward told us they did not have a secure place to store their own personal coffee, which was kept in the ward office.

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

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

Patients could make phone calls in private.

Furnishings on most wards were in good condition, however there was a high level of damage to furniture on Lark ward. Managers told us this furniture would be replaced.

Each ward had an outside space that patients could access easily. However, the outside space on the male ward, Poppy, was overlooked by the female ward, Avocet. Similarly, the outside space on the female ward was overlooked by large windows on the male ward. This created a lack of privacy for both wards as males could see into the female ward and females could see into the male courtyard. The trust informed us they had purchased reflective screens to be applied onto the windows so that patients could not see between wards.

Patients could not always make their own hot drinks and snacks as they were dependent on staff. Drinks and snacks trolleys were risk assessed on most wards resulting in patients having to ask staff for a hot drink or snack. On Northgate ward, two patients told us the snacks and drinks trolley was frequently broken and would take a long time to get replaced. Another patient on Southgate ward told us they were unable to make coffee as he had to request this from the ward office each time.

The service offered a variety of good quality food.

Patients' engagement with the wider community

Staff told us that since the COVID-19 pandemic, patient engagement with activities in the wider community had decreased but there were plans to increase this again. However, at the time of the inspection, this was yet to happen.

Meeting the needs of all people who use the service

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

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

Staff made sure patients could access information on treatment, local services, their rights and how to complain. We saw evidence that patients had their rights explained to them and this information was on notice boards for each ward. However, patients on Great Yarmouth acute ward and patients at Wedgewood House did not always feel they had enough information on their rights provided during admission to the ward.

The service had information leaflets available in languages spoken by the patients and local community.

The trust subscribed to 'choice and medicines' where information leaflets regarding medicines could be printed in different languages and formats for patients. However, not all staff were aware of this website and it was not used regularly.

Managers made sure staff and patients could get help from interpreters or signers when needed.

The service provided a variety of food to meet the dietary and cultural needs of individual patients.

Patients had access to spiritual, religious and cultural support.

Listening to and learning from concerns and complaints

The service did not always investigate complaints within appropriate timescales resulting in delays to learning or recommendations from complaints being shared with staff teams.

Patients, relatives and carers knew how to complain or raise concerns.

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

Not all staff understood the policy on complaints or knew how to handle them. Staff we spoke to were unsure if there was an informal complaints process on the wards, however, were aware that a separate complaints team handled formal complaints. The staff on Great Yarmouth acute ward was not aware of how patients complained or how many recent complaints had been made.

Patients received feedback from managers after the investigation into their complaint. However, one complaint response on Lark ward did not fully respond to a patient's needs. The details of the complaint demonstrated the patient was extremely distressed, and although the patient had been discharged from the ward, staff did not make an attempt to check on the immediate safety of the patient or refer the patient to an appropriate alterative service.

Managers were not investigating complaints within the trust timescale of 30 days. For Great Yarmouth acute ward, there were 12 complaints outstanding for review in September 2021. Out of these 12, one had been overdue since June 2019 and another one since February 2020. For Lark ward, the average number of days it took staff to respond and close a complaint was 81 days. For complaints at Wedgewood House, it was not clear when responses should have been due, or when a response had been issued, therefore we were not assured these were within the Trust timescale of 30 days.

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

Is the service well-led?

Inadequate 

Our rating of well-led went down. We rated it as inadequate.

Leadership

Not all leaders had the skills, knowledge and experience to perform their roles. The ward manager on Great Yarmouth acute ward did not demonstrate a good understanding of the service they managed. However, ward managers and matrons were visible in the service and approachable for patients and staff.

Most leaders had the skills, knowledge and experience to perform their roles and had a good understanding of the services they managed. However, not all ward managers were able to explain how their team were working to provide high quality care. For example, the ward manager on Great Yarmouth acute ward did not have oversight of key areas of the ward such as complaints, restrictive interventions, patient observations, training compliance, incidents, staff supervision, audits or how these fed into the overall governance structure of the care group. and as these areas were not being routinely reviewed by the ward manager, and there was a lack of awareness of how the ward was performing in these areas, we were not assured that managers had a full understanding of these areas of the service in order to provide high quality care. Staff on Great Yarmouth acute ward were not aware of all ligature points and were not protecting the dignity of patients within the 136 suite, as they were using a towel to hold open the door. Managers had not addressed these concerns.

Our findings from other key questions demonstrated that managers were not providing clinical supervision to staff or ensuring staff had adequate training in order to perform their roles. Therefore, we were not assured that managers were enabling staff to provide high quality care to patients as these procedures for staff to develop and learn were not occurring.

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

Leaders, such as ward managers and matrons, were visible and approachable for patients and staff. However, four staff told us senior leaders in the trust were not visible on the acute inpatient wards. Pharmacy staff also reported the chief pharmacist had not been seen in approximately two years and they were unaware of what strategy they should be working towards.

Leadership development opportunities were available, including opportunities for staff below team manager level.

Vision and strategy

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

Staff knew and understood the trust's vision and values and how they were applied in the work of their team.

The trust's senior leadership team had successfully communicated the provider's vision and values to the frontline staff.

Most staff had the opportunity to contribute to discussions about the strategy for their service, especially where the service was changing. However, therapeutic and medical staff did not feel involved in the trust's strategy and reported they were not involved in the longer-term strategy of the trust.

Culture

Staff felt respected, supported and valued. However not all staff felt the trust promoted equality and diversity in their daily work. Staff felt the trust provided opportunities for development and career progression. They could raise any concerns without fear.

Staff felt respected, supported and valued.

Staff felt positive and proud about working for the trust and their team. However, seven staff reported feeling burnt out due to high workloads, staffing pressures and increased patient acuity.

Staff felt able to raise concerns without fear of retribution.

Staff knew how to use the whistle-blowing process and about the role of the Speak Up Guardian.

Managers dealt with poor staff performance when needed.

Teams worked well together and where there were difficulties, managers dealt with them appropriately.

Not all staff were offered appraisals to review their performance or support conversations about their career development.

We saw evidence that the trust held a comprehensive equality and diversity strategy. However, not all staff felt equality and diversity was promoted in their day to day work. One staff member who had been recruited overseas, reported that no one had completed any cultural adaption work with them, they were left to find their own accommodation and felt the trust did not support a zero tolerance to racial remarks from patients.

Staff had access to support for their own physical and emotional health needs through an occupational health service.

Governance

Our findings from the other key questions demonstrated governance processes were not always operating effectively at team level. Some staff collected and analysed data about outcomes and performance and engaged actively in local quality improvement activities. However, quality improvement processes were ineffective at demonstrating consistent improvements in patient safety and quality of care.

Our findings from the other key questions demonstrated serious quality concerns relating to patient care, highlighting that governance processes were not operating effectively. For example, managers had not identified and addressed concerns in relation to seclusion, ligature risks, gaps in patient observation records, inappropriate use of the 136 suite or lack of adherence to patient care plans and risk assessments when managing aggressive behaviours. Patients were left at risk of harm and lack of dignity due to these ongoing practices. Managers had also not addressed ongoing concerns in relation to lack of staff supervision and completion of mandatory training. Other processes which could be used to improve the quality of care to patients, such as the reviewing of incidents and sharing of appropriate learning, was not always taking place. In particular, on Great Yarmouth ward, we found 161 incidents which had not been reviewed by a manager of which some of these incidents related to risks to patient safety. By not ensuring their review, actions and learning had not been immediately shared with staff, which risked the incident of occurring again.

There was evidence staff had implemented recommendations from reviews of deaths, incidents, complaints and safeguarding alerts at a ward level. However, not all recommendations from serious incidents had been implemented within appropriate timeframes on Great Yarmouth acute ward and Glaven ward. For Great Yarmouth acute ward, in August 2021 there were 12 overdue recommendations that required implementation from the result of serious incidents, these ranged from 51 days overdue to 446 days overdue.

Staff undertook or participated in local clinical audits. However, audits on some wards were not always completed, such as safeguarding and care plan audits. Managers told us this was because of low staffing levels. Staff were provided with feedback from audits within meetings, via email and were offered training following managers identifying training gaps. However, we were not assured staff were always acting on the results of all audits as there was a lack of consistent improvement within certain audits over a period of time. For example, audits relating to patient care plans and physical heath monitoring highlighted staff were not always completing comprehensive care plans or escalating physical health concerns and we continued to identify these concerns during our inspection. Therefore, the audits were not always sufficient to improve quality or patient safety.

Staff were not always completing medicines audits on Samphire ward to review patients on high doses of antipsychotic medicines. This was a concern as we found patients were often prescribed high levels of ‘as and when required’ medicines on this ward. Audits on the Electronic Prescribing and Medicines Administration System (EPMA) system were not always undertaken. This meant that missing information relevant for prescribing medicines was not always identified. For example, on Waveney ward there had been no EPMA audit undertaken for over six weeks.

There was a clear framework of what must be discussed at a ward, team or directorate level in team meetings to ensure that essential information, such as learning from incidents and complaints, was shared and discussed. However, despite this framework, our findings from other key questions highlighted not all wards were using such information to learn and improve quality.

Staff understood the arrangements for working with other teams, both within the provider and external, to meet the needs of the patients.

Management of risk, issues and performance

Staff maintained and had access to the risk register at ward or directorate level. Staff at ward level could escalate concerns when required. However, not all risks were recorded on ward risk registers such as ligature risks, gaps in observation records, low supervision and training rates and incidents left without management review. If managers are not identifying or recording appropriate risks, then solutions to mitigate the risk may not be found, leaving patients at risk of harm.

Our findings from other key questions identified that managers had not identified all risks that were present on the wards. For example, managers had not identified the dignity issues posed by use of a towel in the door of the 136 suite or identified all environmental risks such as ligature points.

The service had plans for emergencies – for example, adverse weather or a flu outbreak.

Information management

Not all staff had access to the information they needed to provide safe and effective care and staff reported having limited time due to staffing pressures to review key information.

The service used systems to collect data from wards and directorates that were not over-burdensome for frontline staff. However, not all bank and agency staff had access to systems to record and collect data, despite high rates of use of such staff.

Information governance systems included confidentiality of patient records.

Team managers had access to information to support them with their management role. This included information on the performance of the service, staffing and patient care. However, one ward manager told us they did not often have time to access the system to support them in their management role, due to low staffing levels and frequently completing clinical duties rather than managerial duties.

Engagement

Most staff and patients had access to up-to-date information about the work of the trust and the services they provided – for example, through the intranet, bulletins and newsletters. However, relatives of patients from Southgate, Northgate and Glaven told us they did not receive information on the ward such as how to provide feedback on the service that their relative received.

We saw evidence that patients had opportunities to give feedback on the service they received in ward community meetings throughout August to September 2021. However, not all patients we spoke to felt they had opportunities to provide feedback. Ward managers confirmed community meetings had recently not always been taking place due to low staffing levels on the wards. Community meeting minutes did not always set actions to address concerns raised by patients.

Learning, continuous improvement and innovation

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

Managers considered opportunities for improvements, used quality improvement methods and we saw evidence this led to changes across the wards. However, our findings from other key lines of enquiry highlighted that not all recommendations from serious incidents had been implemented, audits did not always demonstrate a consistent level of improvement and ward incidents were not always reviewed to check for learning and shared with staff. Therefore, despite governance processes initiating some changes and improvements, this process needed further work in order for staff to learn and improve across all areas.

The trust actively sought to participate in national improvement and innovation projects, such as the national quality improvement collaborative focused on sexual safety (the right to be safe from sexual harm and to feel safe and supported on a ward).