Requires improvement

Norfolk and Suffolk NHS Foundation Trust

Mental health crisis services and health-based places of safety

Quality Report

Hellesdon Hospital
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Locations inspected

Location ID	Name of CQC registered location	Name of service (e.g. ward/ unit/team)	Postcode of service (ward/ unit/ team)
RMY01	Hellesdon Hospital	Health-based places of safety	NR6 5BE
RMY03	Northgate Hospital	Health-based places of safety	NR30 1BU
RMYWA	Fermoy Unit	Health-based places of safety	PE30 4ET
RMYX5	Wedgewood House	Health-based places of safety	IP33 2QZ
RMYX1	Woodlands	Health-based places of safety	IP4 5PD
RMY01	Trust Headquarters - Hellesdon Hospital	Crisis resolution and home treatment team (CRHT) (Central Norfolk)	NR6 5BE
RMY01	Trust Headquarters - Hellesdon Hospital	Single point of access team (Central)	NR6 5BE

Summary of findings

RMY01	Trust Headquarters - Hellesdon Hospital	Crisis resolution and home treatment team (CRHT) (West Norfolk)	PE30 4ET
RMY01	Trust Headquarters - Hellesdon Hospital	Crisis resolution and home treatment team (CRHT) (Great Yarmouth)	NR30 1BU
RMY01	Trust Headquarters - Hellesdon Hospital	Home treatment team East Suffolk	IP4 5PD
RMY01	Trust Headquarters - Hellesdon Hospital	Home treatment team West Suffolk	IP33 2QZ
RMY01	Trust Headquarters - Hellesdon Hospital	Access and assessment centre Suffolk	IP1 2GA
RMY01	Trust Headquarters - Hellesdon Hospital	Mental Health Acute Liaison James Paget Hospital	NR31 6LA
RMY01	Trust Headquarters - Hellesdon Hospital	Mental Health Acute Liaison Norfolk and Norwich University Hospital Liaison	NR4 7UY
RMY01	Trust Headquarters – Hellesdon Hospital	Mental Health Acute Liaison Queen Elizabeth Hospital	PE30 4ET
RMY01	Trust Headquarters – Hellesdon Hospital	Mental Health Acute Liaison West Suffolk Hospital	IP33 2QZ
RMY01	Trust Headquarters – Hellesdon Hospital	Mental Health Acute Liaison Ipswich Hospital	IP4 5PD

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

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

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

Summary of findings

Ratings

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

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

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

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

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

Summary of findings

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Summary of findings

Overall summary

We rated Crisis services and Health Based Place of Safety as 'requires improvement 'because:

- The last CQC inspection highlighted a number of concerns the trust was required to address. During this inspection we found improvements were still needed to ensure compliance with regulations in a number of areas, for example, compliance with mandatory training for some key subjects, staff receipt of supervision and appraisals, staff availability to support patients in the HBPoS at Fermoy, and compliance with key performance indicators and trust policy for assessment of emergency referrals within four hours.
- Some services had staffing shortages particularly at night. In some services all shifts were not covered at night and lone working practices could not always be followed. At the HBPoS Fermoy Unit, staff were not available to take responsibility for patients detained under section 136 by police and patients did not receive physical or physiological observations.
- Many staff were not in receipt of regular supervision and the trust has no effective oversight to monitor compliance at a local level. There were low levels of compliance with some key mandatory training. Not all staff had received an annual appraisal in line with the trust target and there were gaps in staff supervision across most teams.
- The trust continued to have no overarching operating procedure for crisis services that clearly defined key performance indicators (KPI) and targets for the services. Across most teams, team managers were not able to provide detailed KPI data, which affected their ability to monitor service performance effectively. Data provided by the trust for KPIs was unclear and inconsistent.
- Crisis services were not consistently meeting the trust target for response to emergency assessments. The response to crisis calls out of hours was inconsistent in one service. The crisis line for people not open to mental health services was not easily located on the internet, meaning people might not easily locate the contact number when needed.
- The length of time from admission to a health based place of safety to commencement of a mental health assessment was not always within the three hours target set by the trust and its partners and as recommended in the MHA Code of Practice.
- Environments in some interview rooms were not fit for purpose for assessing patients experiencing a mental health crisis. At the Fermoy Unit, staff managed the risk by remaining with patients while they were on site and for high risk patients, two staff were present.
- There was no alarm system in one crisis service and staff used personal attack alarms when seeing patients, which did not show their location if the alarm was activated.
- The storage of medication in one service did not meet best practice.

However:

- Improvements had been made to the environment of the health based places of safety. Ligature risk assessments had been completed and regularly reviewed.
- Risk assessments were completed for all patients and in most cases updated as the level of risk changed.
- Physical healthcare monitoring was taking place where needed. Overall, improvements had been made in the physical healthcare monitoring of patients in the health based places of safety.
- People told us staff treated them with respect, listened to them and were very professional and caring. They were involved in their care and treatment and were aware of their care plans. Most patients had care plans that considered all their circumstances and were centred on them as an individual.
- Staff communicated effectively with patients and were compassionate. Staff were very positive about team working and the mutual support they gave one another. They felt well supported by their immediate managers.

Summary of findings

Summary of findings

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

Are services safe?

Requires improvement 

We rated safe as **requires improvement** because:

- Some services had staffing shortages particularly at night. In some services all shifts were not covered at night and lone working practices could not always be followed.In one service one member of staff had to respond to telephone calls on the crisis line, make gatekeeping assessments for admission to the inpatient wards and assessments in the emergency department of the acute hospital. In another service, crisis staff had to work at times on the inpatient ward at night due to the ward's shortage of staff whilst providing a crisis service. The trust was required to review staffing levels, particularly out of hours, following our last inspection
- At the HBPoS Fermoy Unit, staff were not available to take responsibility for patients detained under section 136 by police. This is against the standards on the use of Section 136 of the Mental Health Act 1983 (England and Wales), The Royal College of Psychiatrists, July 2011. This was a requirement notice from the last inspection.
- Staff compliance with mandatory training across the services did not meet the trust target. In some teams, records showed very low compliance rates with some key training. This was a requirement notice from the last inspection.
- Environments in some interview rooms were not fit for purpose for assessing patients experiencing a mental health crisis.
- There was no alarm system in one crisis service and staff used personal attack alarms when seeing patients. Staff told us, and we observed, they would not know the location of the alarm if it were activated. This was a requirement notice from the last inspection. Staff managed the risk by remaining with patients and utilising two staff members when needed.
- Overall improvements in storage of medicines had been made since the last inspection but the storage of medication in one service still did not meet best practice. This was a requirement notice from the last inspection.

However:

- The trust had taken actions to improve the environment of the health based place of safety after our last inspection had identified issues.
- Ligature risk assessments had been completed and were regularly reviewed across the services we visited.

Summary of findings

- Improvements had been made to assessment of risk. Staff completed risk assessments for all patients and in most cases updated them as the level of risk changed. Risk assessments were completed for patients in a HBPoS.
- Incidents were reported and investigated. Staff had access to lessons learned via posters and team meetings. Staff gave examples learning from incidents to improve their practice. The trust had made improvements in the amount of medical staffing input since the last inspection. A consultant psychiatrist was in post in the service we had identified had a shortage of medical staffing.

Are services effective?

Requires improvement

We rated effective as **requires improvement** because:

- Not all staff had received an annual appraisal in line with the trust target. This was a requirement notice from the last inspection.
- The trust does not record supervision as a key performance indicator (KPI) and does not maintain central records of staff compliance. Records of supervision seen across most teams showed gaps in supervision for staff. This was a requirement notice from the last inspection.
- Staff at CRHT at Hellesdon Hospital had not completed care plans for patients in three out of nine records reviewed.
- Patients did not receive physical or physiological observations at the HBPoS at Fermoy as staff did not receive or support patients at this facility.

However:

- The needs of people who used the service were assessed and care was delivered in line with their individual care plans. Most patients had care plans that considered all their circumstances and were centred on them as an individual.
- People's physical health needs were considered and discussed at the point of assessment. Physical healthcare monitoring was taking place where needed .
- Overall, the trust had improved the physical healthcare monitoring of patients in HBPoS since the last inspection. Physiological observations and early warning score charts were completed for patients.
- Multi-disciplinary teams and inter-agency working were effective in supporting people who used the service. Teams had effective and well-structured handovers.
- Staff had a good understanding of the MHA and MCA.

Summary of findings

Are services caring?

Good

We rated caring as **good** because:

- Patients and relatives told us staff treated them with respect, listened to them and were very professional and caring. They showed good understanding of people's individual needs. They knew how to contact staff if they needed to.
- We observed staff treated people who used the service with respect and communicated effectively with them. They were compassionate and discussed options and future plans with the patient and where appropriate their relative. They showed the desire to provide high quality and responsive care.
- At the Fermoy Unit, we observed staff in the crisis service demonstrated good team working with their colleagues working on the acute admission ward to support each other to deliver safe care to patients, particularly when staffing levels did not meet the required establishment.
- Patients told us they were involved in their care and treatment and were aware of their care plans. Records showed most patients had been involved in planning their care and had either received or refused a copy of their care plan.
- Carers' assessments were offered to carers and carers' groups, including drop in sessions, were offered across the crisis services.
- Information was available for patients on access to advocacy.
- Patients at two HBPoS were able to give feedback on the service they received. Feedback was positive about their care whilst in the HBPoS.

Are services responsive to people's needs?

Requires improvement

We rated responsive as **requires improvement** because**:**

- The trust continued to have no overarching operating procedure for crisis services that clearly defined key performance indicators (KPI) and targets for the services. This was a requirement notice from the last inspection.
- Crisis services were not consistently meeting the trust target for response to emergency assessments. There were discrepancies between the trust's definition of an assessment following an emergency referral and practice. This was a requirement notice from the last inspection.
- The response to crisis calls out of hours was inconsistent in one service. When the staff member was out, after nine o'clock at night, the staff member was unable to answer a crisis call when they were completing an assessment or home treatment.

Summary of findings

- The crisis line for people not open to mental health services was not easily located on the internet, meaning people might not easily locate the contact number when needed.
- The length of time from admission to a HBPoS to commencement of a mental health assessment was not always within the three hours target set in the interagency protocol for section 136 of the MHA and as recommended in the MHA Code of Practice.

However:

- Crisis services took a proactive approach to engaging with people who found it difficult or were reluctant to engage with mental health services.
- Records and observation indicated patients were seen quickly for home treatment following assessment.
- People told us that appointments generally ran on time and they were kept informed if there were any unavoidable changes.
- Staff were aware of the complaints policy and supported patients to complain. People told us they knew how to complain. Outcomes of complaints were discussed in team meetings.

Are services well-led?

Inadequate

We rated well led as **inadequate** because:

- The last CQC inspection highlighted a number of concerns the trust was required to address. During this inspection, we found improvements were still needed to ensure compliance with regulations in a number of areas.
- Across most teams, team managers were not able to provide detailed KPI data on response times to referrals, caseloads and referral to assessment times, which affected their ability to monitor service performance effectively. Data provided by the trust for KPIs was unclear and inconsistent.
- Many staff were not in receipt of regular supervision and the trust has no effective oversight to monitor compliance at a local level. There were low levels of compliance with some key mandatory training.
- Staff generally had good morale but this was impacted in areas with staff shortages where staff felt that senior managers in the trust did not understand the pressures they were working under and the additional time they were working in order to keep the service going for patients.

Summary of findings

- As in our last inspection staff reported differences between operating procedures and staff structures in Norfolk and Suffolk which they said caused confusion for staff and patients.

However:

- Trust visions and values were evident in staff attitudes and engagement with patients.
- Staff were very positive about team working and the mutual support they gave one another. They felt well supported by their immediate managers.
- The trust is a signatory to an inter-agency protocol and regularly participates in a multi-agency group on the use of section 136 of the MHA. Staff reported good working relationships with those organisations.

Summary of findings

Information about the service

In Norfolk, there were three crisis resolution and home treatment teams (CRHT). They were based at Hellesdon hospital in Norwich, Northgate hospital in Great Yarmouth and Fermoy unit at Queen Elizabeth hospital in Kings Lynn. The teams' aim was to carry out emergency (four hour) assessments for adults who presented with a mental health need that required a specialist mental health service. Their primary function was to undertake an assessment of needs, whilst providing a range of short term treatment / therapies aimed at a quicker recovery for people who did not need long term care and treatment, and as an alternative to hospital admission. The teams were also gatekeepers so had the ability to admit patients to an inpatient unit if this was required. The teams operated 24 hours a day, 365 days a year.

The single point of access (SPoA) provided a single point of access for professional referrals to specialist mental health services across west and central Norfolk. Their function was to pass emergency (four hours) referrals to the CRHTs for assessment. Urgent (120 hours to assessment) and routine referrals (28 days to assessment) were sent to the appropriate service provided by the trust. The SPoA was based at Hellesdon hospital in Norwich.

In Suffolk the Access and Assessment Team (AAT) was the single point of access for all mental health referrals in Suffolk. The team had a number of sub teams. One of these teams was the Emergency Access and Assessment team (EAT) which responded to all emergency (four hours) and urgent (72 hours) referrals through screening, triage and face to face assessment. EAT was based at Mariner House in Ipswich and had satellite bases within the home treatment offices in Bury St. Edmunds and Ipswich. EAT operated 24 hours a day, 365 days a year.

There were two home treatment teams (HTT) in Suffolk. They were based at Wedgewood House at West Suffolk hospital in Bury St. Edmunds and Woodlands unit at Ipswich hospital in Ipswich. The teams provided a range of short term treatment / therapies aimed at a quicker recovery for people who did not need long term care and treatment, and as an alternative to hospital admission. The teams were also gatekeepers so had the ability to admit patients to an inpatient unit if this was required. The teams took referrals from AAT and the trust's integrated delivery teams.

The trust provided psychiatric liaison services to James Paget hospital in Great Yarmouth, Norfolk and Norwich University hospital in Norwich, Queen Elizabeth hospital in Kings Lynn, West Suffolk hospital in Bury St. Edmunds and Ipswich hospital in Ipswich.

There were five health based places of safety, often referred to as 'the section 136 suite' across Norfolk and Suffolk. They were based at Hellesdon hospital in Norwich, Northgate hospital in Great Yarmouth, Fermoy unit at Queen Elizabeth hospital in Kings Lynn, Wedgewood House at West Suffolk hospital in Bury St. Edmunds and Woodlands unit at Ipswich hospital in Ipswich.

A health based place of safety is a place where someone who may be suffering from a mental health problem can be taken by police officers, using section 136 of the Mental Health Act 1983, in order to be assessed by a team of mental health professionals. A health-based place of safety is also used when police have executed a warrant under section 135(1) of the Mental Health Act. It provides a safe place to carry out an assessment when required. A section 135(1) warrant is issued to police officers by the courts. It allows them to enter private premises to remove a person to a place of safety if there are concerns for their own, or others safety resulting from their mental state. An assessment under the Mental Health Act 1983 can then be arranged to assess whether they should be in hospital or be better supported at home.

The Norfolk and Suffolk NHS Foundation Trust was last inspected in July 2016 by the CQC and was rated overall as requires improvement. The mental health crisis service and health based place of safety core service was rated as requires improvement overall. The safe domain was rated as inadequate; the effective, responsive and well-led domains were rated as requires improvement. The caring domain was rated as good. During the inspection it was identified that :

Summary of findings

- The trust must address and improve compliance with monthly supervision for staff.
- The trust must ensure staff receive an annual appraisal in accordance with their own policy.
- The trust must ensure staff receive mandatory training in accordance with the trust policy.
- The trust must address the environmental concerns in the health-based places of safety (HBPoS).
- The trust must ensure that an overarching operating procedure clearly defines KPI response times for crisis services and clearly defines the way in which contact is made to patients.
- The trust must review their compliance with KPIs for response times to assessment in crisis services.
- The trust must ensure physical healthcare needs of patients admitted to HBPoS are addressed and recorded.
- The trust must ensure risk assessments for patients admitted to HBPoS are completed and recorded.
- The trust must address the provision of alarms available to staff in CRHT locations.
- The trust must review the out of hours staffing provision of crisis services.
- The trust must review staffing levels for CRHT at Fermoy.
- The trust must review the provision of medical input to the HTT in Suffolk (west) based at Wedgwood House and ensure face-to-face patient contact is recorded.
- The trust must ensure there are adequate staff to receive and support patients at the HBPoS at the Fermoy Unit.
- The trust should review the process to enable locality managers to be able to monitor their services against KPIs and have this information easily accessible.
- The trust should ensure environmental risk assessments are undertaken in psychiatric liaison services.
- The trust should ensure that medicines are stored within safe temperature ranges at all sites and that patient's medication is transported in a locked carrying case as per trust policy.

During this inspection we found improvements had been made in the environment of the health based place of safety, medical input to the HTT in Suffolk (west), risk assessments and addressing physical healthcare needs in the health based places of safety. The remaining issues identified in the last inspection still required improvement.

Our inspection team

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

Shadow Chair: Paul Devlin, Chair, Lincolnshire Partnership NHS Foundation Trust

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

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

The team that inspected the mental health crisis services and health-based places of safety consisted of one inspection manager, four inspectors, and four specialist advisors from a variety of professions, including a nurse, social worker, doctor and psychologist, and one expert by experience that had recent experience of using or caring for someone who uses the type of services we were inspecting.

Summary of findings

Why we carried out this inspection

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

How we carried out this inspection

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

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

Before the inspection visit, we reviewed information that we held about these services, asked a range of other organisations for information and sought feedback from patients at focus groups.

During the inspection visit, the inspection team:

- Visited the three crisis resolution and home treatment teams based at Hellesdon hospital in Norwich, Northgate hospital in Great Yarmouth and Fermoy unit at Queen Elizabeth hospital in Kings Lynn.
- Visited the home treatment teams based at Wedgewood House at West Suffolk hospital in Bury St. Edmunds and Woodlands unit at Ipswich hospital in Ipswich.
- Visited the single point of access (SPOA) based at Hellesdon hospital in Norwich and the Access and Assessment team (AAT) based at Mariner House in Ipswich.
- Visited the five health based places of safety (HBPoS) at Hellesdon hospital in Norwich, Northgate hospital in Great Yarmouth,Fermoy unit at Queen Elizabeth hospital in Kings Lynn, Wedgewood House at West Suffolk hospital in Bury St. Edmunds and Woodlands unit at Ipswich hospital in Ipswich.
- Visited the psychiatric liaison teams at James Paget hospital in Great Yarmouth, Queen Elizabeth hospital in Kings Lynn, West Suffolk hospital in Bury St. Edmunds and Ipswich hospital in Ipswich.
- Spoke with 13 people who used the service and five carers of people who used the service.
- Spoke with 88 staff members; including doctors, nurses, support workers, social workers, managers, administrators and approved mental health professionals.
- Attended and observed nine meetings of staff with people who used the service, with the prior permission of those involved.
- Attended and observed five handover meetings.
- Looked at 65 care records of people who used the services and 23 records for people who had been assessed in a HBPoS.
- Looked at 35 prescription charts for people who used the services.
- Carried out a specific check of the medication management in the teams that we visited.
- Looked at a range of policies, procedures and other documents relating to the running of the services.
- Completed an unannounced out of hours inspection of crisis services in Kings Lynn and Great Yarmouth on 25 July 2017.

Summary of findings

What people who use the provider's services say

- People were positive about the support provided to them and praised the staff. They told us staff treated them with respect, listened to them and were very professional and caring. They said they were involved in their care and treatment and were aware of their care plans.
- People told us that appointments generally ran on time and they were kept informed if there were any unavoidable changes. Some told us they saw different members of staff due to the nature of the service which meant they had to repeat information.
- People knew how to raise concerns and make a complaint. If needed.
- People who used the Health Based Place of Safety in Hellesdon hospital in Norwich and Wedgewood House in Bury St. Edmunds were able to give feedback on the service they received. They were positive about their care and said that they were offered refreshments.

Areas for improvement

Action the provider MUST take to improve

- The trust must improve compliance and recording of monthly supervision for staff in accordance with policy.
- The trust must ensure staff receive an annual appraisal in accordance with their policy.
- The trust must review and address the out of hours staffing provision of crisis services.
- The trust must review and address the staffing provision of Psychiatric Liaison Services.
- The trust must ensure that staff are available to receive and support patients detained under Section 136 of the Mental Health Act at the Fermoy Unit.
- The trust must ensure staff receive mandatory training in accordance with the trust policy.
- The trust must address the provision of alarms available to staff in CRHT at Fermoy.
- The trust must ensure that operating procedures clearly define KPI response times for crisis services and clearly defines the way in which contact is to be made to patients.
- The trust must review their compliance with KPIs for response times to assessment in crisis services.

Action the provider SHOULD take to improve

- The trust should ensure that accurate recording is maintained for the receipt and delivery of patient medication at the Fermoy Unit.
- The trust should ensure the crisis line for patients not known to the service is easily accessible on the trust website.
- The trust should ensure environmental risk assessments are undertaken and risk management plans developed in psychiatric liaison services.

Norfolk and Suffolk NHS Foundation Trust

Mental health crisis services and health-based places of safety

Detailed findings

Locations inspected

Name of service (e.g. ward/unit/team)	Name of CQC registered location
Health-based places of safety	Hellesdon Hospital
Health-based places of safety	Northgate Hospital
Health-based places of safety	Fermoy Unit
Health-based places of safety	Wedgewood House
Health-based places of safety	Woodlands
Crisis resolution and home treatment team (CRHT) (Central Norfolk)	Trust Headquarters - Hellesdon Hospital
Single point of access team (Central)	Trust Headquarters – Hellesdon Hospital
Crisis resolution and home treatment team (CRHT) (West Norfolk)	Trust Headquarters – Hellesdon Hospital
Crisis resolution and home treatment team (CRHT) (Great Yarmouth)	Trust Headquarters – Hellesdon Hospital
Home treatment team East Suffolk	Trust Headquarters – Hellesdon Hospital
Home treatment team West Suffolk	Trust Headquarters – Hellesdon Hospital
Access and assessment centre Suffolk	Trust Headquarters – Hellesdon Hospital
Mental Health Acute Liaison James Paget Hospital	Trust Headquarters – Hellesdon Hospital

Detailed findings

Mental Health Acute Liaison Norfolk and Norwich University Hospital Liaison	Trust Headquarters – Hellesdon Hospital
Mental Health Acute Liaison Queen Elizabeth Hospital	Trust Headquarters – Hellesdon Hospital
Mental Health Acute Liaison West Suffolk Hospital	Trust Headquarters – Hellesdon Hospital
Mental Health Acute Liaison Ipswich Hospital	Trust Headquarters – Hellesdon Hospital

Mental Health Act responsibilities

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

- The trust had taken actions to improve the environment of the health based place of safety after our last inspection had identified issues. However, there was no clock in the HBPoS at Wedgewood house to help avoid disorientation in time. There was no CCTV in the HBPoS at Woodlands to aid privacy and dignity for the patient. Patients could lie down in the HBPoSs; they had access to toilets, washing facilities and fresh air. A portable telephone was available and staff were able to make snacks and hot /cold drinks for patients.
- At the HBPoS Fermoy Unit, staff were not available to take responsibility for patients detained under section 136 by police.
- Most staff received training in the application of the MHA. Staff we spoke with were knowledgeable about the MHA and Code of Practice.
- We reviewed 23 records of patients who were assessed in a HBPoS. We found that the relevant legal documentation was completed appropriately.
- Information was displayed in the HBPoS about patients' rights and local services. Records showed patients were given oral and written information about their rights and the process of assessment.
- The Approved Mental Health Practitioner (AMHP) and doctor did not always attend within the three hours target set in the interagency protocol for section 136 of the MHA and as recommended in the MHA Code of Practice.
- The police were able to contact the HBPoS before the detained patient arrived at the HBPoS so that arrangements could be made for the person to be assessed as soon as possible People detained under S136 were usually transported to the HBPoS by police rather than by ambulance.
- The trust collected data to monitor practices with regard to section 136 and shared this at regular multi-agency meetings.

Mental Capacity Act and Deprivation of Liberty Safeguards

- Most staff received training in the application of the MCA. Information provided by the trust showed that at March 2017, 84% of staff in Crisis Services and HBPoS had received the mandatory training in the MCA. This did not meet the trust target of 90% attendance.
- Staff we spoke with were aware of the MCA and the implications this had for their clinical and professional practice.
- We looked at 65 care records and found capacity was being considered and assessed appropriately.

Requires improvement

Are services safe?

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

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

Our findings

Safe and clean environment

- Environmental risks found in our last inspection in the interview rooms at the CRHT at the Fermoy Unit in Kings Lynn remained. The rooms had ligature risks such as blinds with pulls and window handles. The furniture was not fixed down. There was only one door in and out. This door could be barricaded as the door opened inwards. Staff managed environmental risks by ensuring patients were always supervised whilst on site.
- At the Fermoy Unit, there was no alarm system and staff used personal attack alarms when seeing patients. Staff told us they would not know the location of the alarm if it was activated. During this inspection, a staff member accidentally activated the personal attack alarm. We observed staff had to search to find where the staff member was. This was a risk to both staff and patients.
- Improvements in the environment of the CRHT at Hellesdon hospital in Norwich had been made since our last inspection. Disabled facilities had been fitted. Pinpoint alarms had been made available for staff. Staff told us that these alarms were logged in and out each day and there were enough for all staff.
- Interview rooms in the HTT at Wedgewood House in Bury St. Edmunds, Woodlands unit at Ipswich hospital in Ipswich and CRHT at Northgate hospital in Great Yarmouth were fitted with alarms and/or staff had personal pinpoint alarms. Staff said that there was a quick response should an alarm be used.
- Ligature risk assessments had been completed and were regularly reviewed.
- The assessment room used by the psychiatric liaison service at Queen Elizabeth hospital in Kings Lynn had environmental risks if staff were assessing patients with risks of aggression.These risks were also identified in our last inspection. There was one assessment room which was also the emergency department's family room. The room had two exits but one was locked and staff did not have access to the key.There was lightweight furniture and CCTV did not cover all parts of the room. The CCTV monitors were in the nursing station but were not always monitored. The environmental risks were not on the trust register at the time of our last inspection and were still not on the risk register at the time of this inspection. We were not assured the trust were aware, or addressing, the potential risks to staff assessing patients within this facility.
- We assessed the physical environments of the HBPoS against the standards set out in: Standards on the use of Section 136 of the Mental Health Act 1983 (England and Wales), The Royal College of Psychiatrists, July 2011. Some improvements had been made since our last inspection.
- Ligature risks at the HBPoS at Northgate hospital in Great Yarmouth had been assessed and regularly reviewed. Furniture in the bathroom had been replaced and plans were in place to replace the toilet seat. There was a toilet brush in place, as in our last inspection, which could be used for self-harm or as a weapon. This was removed by staff during our visit. Since our last inspection specialist heavy furniture had been installed including a new bed and comfortable seating. Screening had been placed in the outside area leading to the HBPoS to improve privacy of patients on arrival. A door had been moved which meant that patients leaving the HBPoS via the adjoining ward did not have to pass through male bedroom areas.
- The HBPoS at Wedgewood House in Bury St Edmunds met the standards except there was no clock visible from any of the areas. There were no toilet and washing facilities in the room but there was a bathroom next door. The bedroom was used to seclude patients from the acute wards approximately once a month.
- The HBPoS at Woodlands in Ipswich met the standards except doors opened inwards; there was a blind spot when the shower room door is open. There were two electric sockets which staff told us could be isolated if needed.
- The HBPoS at Fermoy in Kings Lynn and Hellesdon in Norwich met the standards. CCTV was in use at Fermoy but there was no sign or information for patients to inform them of this.

Requires improvement

Are services safe?

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

- Of the five sites with a HBPoS, four scored above the trust average for cleanliness, condition appearance and maintenance, dementia friendly (where applicable) and for disability in the 2016 PLACE Assessments. The trust average score for cleanliness was 99% and 97% for condition appearance and maintenance. Northgate Hospital was below the trust average for both cleanliness and condition appearance and maintenance, scoring 96% and 94% respectively. The England average is 98% and 94.5%. The five HBPoS were clean and well maintained when we visited. PLACE assessments are self-assessments undertaken by teams of NHS and private/independent health care providers, and include at least 50 per cent members of the public (known as patient assessors). They focus on different aspects of the environment in which care is provided, as well as supporting non-clinical services.

Safe staffing

- From data provided by the trust prior to the inspection, crisis services and HBPoS working across Norfolk and Suffolk had a total of 177 substantive staff as of 31 March 2017. Between April 2016 and March 2017 a total of 15 substantive staff had left the service. As of 31 March 2017 these services had overall vacancy levels of 10% and 5% total permanent staff sickness. The qualified nurse vacancy rate was 21% (higher than the trust average of 12%) and the nursing assistant vacancy rate of -8%.
- From 1 April 2016 to 31 March 2017 crisis services and HBPoS had a total of 341 (2%) of qualified nursing shifts filled by bank staff and 803 (5%) filled by agency staff. For nursing assistant shifts there were 96 (1%) filled by bank staff and only one shift (0.01%) filled by agency staff. For qualified nursing shifts Access and Assessment (AAT) had the highest number (257) and proportion (55%) of shifts filled by bank staff. All of the qualified nursing shifts that were filled by agency staff were in AAT where there were 803 (15% of the total shifts in this team).
- The Emergency Assessment team (EAT), part of the AAT, had 25 posts for band six staff to provide the service. Staff vacancies meant that there was only 17.2 whole time equivalent staff in post, of which three were on long term sick leave. EAT was therefore working on only 14.2 members of staff. A risk relating to staffing was on the risk register and regular recruitment was underway. Staff told us that trust bank staff and agency staff that were familiar with the service and had experience of assessing a person in a mental health crisis were used to fill vacant shifts whenever possible. Staff had been offered overtime pay as an incentive to cover vacant shifts. Staff told us that despite these contingency plans some shifts could not be covered and at times only one member of staff was available to cover the whole of Suffolk at night. From data provided by the trust, 97 shifts in EAT were unfilled by regular, bank or agency staff between 19 June 2017 and 19 July 2017. There was only one member of staff working at night on three occasions during this period. Staff told us that due to the shortage of staff lone working practices could not always be followed. Staff were not always available to check the location of a lone worker and complete joint assessments.
- There were low staffing levels for the psychiatric liaison service at the Norfolk and Norwich hospital. Staff told us that the service aimed to have three band six staff on shift during the day and one at night and that the minimum level was two staff during the day and one at night. Managers told us night shifts could be difficult to cover and staff were unable to take a break. We reviewed staff rosters for the period 27 March 2017 to 16 July 2017. We found that out of the 140 days, at least one shift had not been covered on 126 days, and that of these, three shifts were not covered on 26 days. There had only been one nurse on shift on seven days.
- The last inspection identified low staffing levels for out of hours services in Great Yarmouth and in Kings Lynn. The CRHT at Northgate hospital in Great Yarmouth was fully staffed and staff told us an additional member of staff had been funded for the period of four o'clock in the afternoon to midnight to support the qualified member of staff and respond to the crisis help line. After midnight there was still one member of staff to respond to telephone calls on the crisis line, make gatekeeping assessment for admission to the inpatient wards and assessments in the emergency department of James Paget Hospital. The member of staff redirected the crisis calls to the inpatient ward when assessing a patient at the James Paget hospital.
- The CRHT at Fermoy Unit had agreed staffing levels of one band six staff member and one support worker at night. Staff told us over the previous two weeks band six members of psychiatric liaison had been working shifts

due to staff shortages within CRHT. The support worker on duty took the calls from the crisis line, delivered medication into the community and supported the inpatient wards when needed. Staff told us they had to pull over their car to take crisis calls in transit when delivering medication and when supporting the inpatient ward could not take the call until they are relieved of their observation duties.

- The trust block-booked agency staff during the day to maintain safe staffing levels at the CRHT at the Fermoy Unit. However, CRHT staff at Fermoy unit were also filling shifts on the inpatient wards when staffing levels were low. We reviewed the staff roster for the week commencing 24 July 2017 and saw CRHT staff had filled 11 shifts. We saw that two agency staff were booked to work for CRHT on 26 July 2017 but were needed to transfer to work on Churchill Ward (the acute admission ward). Low staffing levels on Churchill Ward were identified on the trust risk register.
- The HBPoS at Hellesdon hospital and Northgate hospital had a dedicated support worker and qualified nursing cover from the adjacent inpatient ward. The HBPoS at Wedgewood House and Woodlands were staffed from the adjacent wards but there were no dedicated staff. No staff were provided by the trust for the HBPoS at the Fermoy unit and the police had to stay with the patient until they were assessed under the MHA. This is against the standards on the use of Section 136 of the Mental Health Act 1983 (England and Wales), The Royal College of Psychiatrists, July 2011 and was identified in the last inspection. Staff told us that a business plan had been approved to re-site the HBPoS and provide dedicated staff.
- The trust had made improvements in the amount of medical staffing input to the CRHT in Wedgewood house in Bury St. Edmunds since the last inspection. A consultant psychiatrist was in post and was working well to support the multidisciplinary team.
- The trust supplied data prior to this inspection for staff compliance with mandatory training. However, the trust was unable to provide this data for the last 12 months and was only able to give the most recent three months' worth of data. As at 31 March 2017, the overall training compliance for crisis services and HBPoS was 83% against the trust target of 90%. There were 29 training courses that the trust classed as mandatory for crisis services and HBPoS, 19 out of the 29 courses had below target compliance of 90%. 12 courses were below 75% compliance, including Personal Safety (69%), Physical Intervention (69%), Fire Training (63%), Basic Life Support (58%), Intermediate Life Support (63%) and Suicide Prevention (63%). The last inspection identified the trust must ensure staff receive mandatory training in accordance with the trust policy.

Assessing and managing risk to patients and staff

- We reviewed 63 care records in crisis services. A risk assessment had been carried out at the point of assessment in all cases. The risk assessments were specific to the assessed needs of the patient. Staff updated these regularly in most cases as the patient's level of risk changed. Three out of the seven records reviewed in the HTT based at Woodlands in Ipswich had not been reviewed and were not up to date.
- From data provided by the trust prior to the inspection, 72% of staff in crisis services and HBPoS had completed mandatory training on Clinical Risk Assessment and Management.
- Risk levels for people who used the service were discussed at handover meetings in order to detect any increases and take prompt action. Staff demonstrated a good understanding of the needs and assessed risks of people who used the service.
- Improvements had been made in assessing risk for patients in the HBPoS since our last inspection. We reviewed 23 records for patients who had been assessed in a HBPoS. A risk assessment had been carried out for all patients. Trust staff and police officers had jointly completed and recorded a risk assessment to determine the need for continued police support at the HBPoS. This was not the case at the Fermoy unit where staff were not provided by the trust and the police had to stay with the patient until they were assessed.
- From data provided by the trust prior the inspection, crisis services and HBPoS had 18 incidents of restraint (on 13 different service users), between 1 April 2016 and 31 March 2017. There were three incidents of prone restraint which accounted for 18% of the restraint incidents. There were also two incidents which resulted

Requires improvement

Are services safe?

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

in rapid tranquilisation. The HBPoS at Woodlands had the most incidents of restraint with four (25%) across three different service users. There were no incidents of mechanical restraint.

- Personal safety protocols including lone working practice were used to reduce the risks to staff. Staff we spoke with were positive about the lone working practices except where shortage of staffing meant that these could not be followed.
- From data submitted by the trust prior to the inspection, 97% of staff in crisis services and HBPoS had received level one training in safeguarding adults and children. This was above the trust target. 87% of staff had received level 3 safeguarding children training. We spoke with 88 staff and they knew how to recognise and report a safeguarding concern. Observation of handovers and our review of case records showed that safeguarding concerns were identified, discussed and where appropriate reported. Staff were working with other agencies where appropriate such as multi agency public protection arrangements (MAPPA).
- The trust submitted their safeguarding referrals data for the period between 1 April 2016 and 31 March 2017. Crisis services and HBPoS made five adult safeguarding referrals. There were also 12 child safeguarding referrals to the local authority during this time; nine of these were from the Access and Assessment Team.
- Overall improvements in storage of medicines had been made since the last inspection. Medicines were stored securely when at CRHTs and HTTs when in transport. Staff from the CRHT at Fermoy unit ordered medicines from the trust pharmacy, and they were delivered to the clinic room for storage. Staff signed for the package on receipt from the pharmacy but records of storage at the clinic room through to delivery or administration to the patient were kept in a combination of systems including a paper log, the treatment chart and the computer care record, and there was no clear audit trail to account for individual packs of medicines.

Track record on safety

- Information provided by the trust showed staff had reported 22 serious incidents between 1 April 2016 and 31 March 2017 within crisis services and HBPoS. Of these 20 involved the unexpected death of a patient. The most common type of serious incident was 'apparent/actual/suspected self-inflicted harm meeting serious incident criteria' with 21 (95%) such incidents.
- The findings from the reviews of these incidents had been used to improve safety. Examples included introducing a joint visit protocol between the HTT and integrated delivery team in Ipswich, reflective practice to discuss ways of assessing risk and referring to the previous electronic patient record for historical information in the AAT and workshops run for staff in the CRHT based in Great Yarmouth on suicide prevention.

Reporting incidents and learning from when things go wrong

- Serious incidents and learning from them were discussed in reflective practice sessions and were a standard agenda item for discussion in team meetings and pathway meetings. Minutes of the meetings were shared with staff for future reference and for information for staff unable to attend the meeting. Posters with details of incidents and learning were placed around the services we visited.
- Staff we spoke with knew how to report incidents on the electronic system and were able to describe what should be reported. Managers showed us how they were able to review incidents and how they were sent investigation outcomes from across the trust to share with staff.
- Staff told us that they were de-briefed and supported after a serious incident.

Are services effective?

Requires improvement

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

Our findings

Assessment of needs and planning of care

- The needs of people who used the service were assessed and care was delivered in line with their individual care plans. We looked at 63 care records for people who used the service. Most had care plans that considered all aspects of the patient's circumstances, were centred on them as an individual and were regularly reviewed. The CRHT in Fermoy Unit Kings Lynn printed off all care plans for review and updating by the multidisciplinary team at handover. The HTT in Wedgewood House in Bury St Edmunds tracked risk and progress in care planning through their case management board and in handover. Care plans were comprehensive and developed collaboratively with the patient and where appropriate their family. However, three out of nine records had no care plan in the CRHT at Hellesdon hospital in Norwich. One out of seven care records had no care plan and five care plans did not consider all aspects of the patient's circumstances in the HTT in Ipswich.
- All information needed to deliver care was recorded on an electronic record system that operated across the trust. All staff involved in a person's care could access the system. Staff reported delays in accessing the electronic system at times in the psychiatric liaison service at Norfolk and Norwich hospital.

Best practice in treatment and care

- Data provided by the trust prior to this inspection showed crisis services and HBPoS had taken part in 13 audits over the period 1 April 2016 to 31 March 2017 that were directly related to their service.
- Staff followed NICE guidance when prescribing medication and conducted regular audits to ensure this.
- Staff in the crisis services gate kept all inpatient beds. They were involved in discharge planning from inpatient wards and considered whether home treatment was an appropriate option.
- Staff used health of the nation outcome scale (HoNOS) outcome measures and clustering tools to benchmark their service and to aid signposting to other services where appropriate.
- Patients had access to a range of psychological therapies such as cognitive behaviour therapy and anxiety management.
- Interventions included support for housing, employment and benefits and these issues were considered in most assessments and care plans. The CRHT in Hellesdon hospital in Norwich had two workers with specialist housing expertise and experience.
- Our review of 63 care records showed that people's physical health needs were considered and discussed at the point of assessment. Some specific care plans were put in place to ensure the person's physical health needs were met. Physical healthcare monitoring was taking place where needed with timely correspondence and discussion with the patient's GP.
- The trust had improved the physical healthcare monitoring of patients in HBPoS since the last inspection. We reviewed 23 records for patients assessed in HBPoS. Physiological observations and early warning score charts had been completed for all patients unless they refused this or the patient was in the HBPoS where no trust staff were allocated. One patient with identified tachycardia was assessed in the emergency department of the acute hospital

Skilled staff to deliver care

- The last inspection identified the trust must ensure staff receive an annual appraisal in accordance with their own policy. Data provided by the trust prior to this inspection showed as of March 2017 62% of permanent non-medical staff in crisis services and HBPoS had had an appraisal. This did not meet the trust target of 89%. All the teams, except the CRHT based at Hellesdon hospital in Norwich failed to meet this target. The lowest appraisal rate was in the HTT in Wedgewood House Bury St Edmunds with 5%. As of March 2017, the overall appraisal rate for permanent medical staff was 71%, against the trust target of 89%. The trust could not be sure that performance issues, training needs and developmental opportunities were identified and addressed with staff.
- The last inspection identified the trust must address and improve compliance with monthly supervision for staff. The trust was unable to provide the clinical supervision data for non-medical staff for the period 1 April 2016 to 31 March 2017. The trust advised that they

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Requires improvement

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will no longer keep central data on clinical supervision, leaving this to individual autonomous practitioners to maintain their own records as expected by their professional bodies.

- The trust introduced a new electronic system for recording supervision. We found that this had not been implemented fully and some staff were experiencing difficulty inputting data. Some managers had developed their own mechanisms for monitoring clinical supervision and appraisals and were able to share their data with us. The CRHT in Hellesdon in Norwich and psychiatric liaison service in Great Yarmouth were able to demonstrate 100% of staff had been regularly supervised. The HTT in Wedgewood House in Bury St Edmunds was able to demonstrate 85% of staff had been regularly supervised during the previous six months. The other services visited were not able to demonstrate their supervision rates and we observed some gaps in supervision. The trust could not be that staff received regular supervision or that performance issues were robustly monitored and addressed.
- CRHT and HTT consisted of a range of professional backgrounds including nursing, medical and occupational therapy. Teams were able to access psychological therapies for patients and case formulation.
- Staff were experienced and skilled. New staff had a period of induction before being included in the staff numbers on a shift. This included attending corporate and service induction and a period of shadowing experienced staff.

Multi-disciplinary and inter-agency team work

- Different professionals worked well together to assess and plan people's care and treatment. We observed good multidisciplinary team and multi-agency working. We spoke with 88 staff members who told us there was effective team working within the service.
- We attended and observed five handover meetings and found they were effective in sharing information about people and reviewing risks and progress in delivering their plan of care.
- Crisis service representatives attended regular pathway and interface meetings to communicate information and discuss patients' needs with other services within and outside the trust.
- We saw effective inter-agency working in assessing and supporting those people detained under S136 at the HBPoS. Staff reported good working relationships with the police and with local AMHPs.

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

- Not all staff received training in the application of the MHA. Information provided by the trust showed that at March 2017, 70% of staff in crisis services and HBPoS had received the mandatory training in the MHA. This did not meet the trust target of 90% attendance. The Hellesdon HBPoS (100%) and AAT (90%) were the only teams above this target compliance. The CRHT in Northgate, Great Yarmouth had the lowest compliance rate with 67% followed by CRHT in Hellesdon , Norwich with 68% and HHT in Wedgewood house Bury St Edmunds with 70%.
- Staff we spoke with were knowledgeable about the MHA and Code of Practice. Staff who worked within the HBPoS told us they had had specific training on section 136 of the MHA and were knowledgeable about their roles and responsibilities.
- We reviewed 23 records of patients who were assessed in a HBPoS. We found that the relevant legal documentation was completed appropriately.
- People detained under S136 were usually transported to the HBPoS by police rather than by ambulance. Only 1 patient out of the 23 records we reviewed was transported by ambulance to the HBPoS. Most documented reasons for this was delay in response by the ambulance service.
- People detained under section 136 were given oral and written information about their rights and the process of assessment. All but one record showed that patients had their rights explained to them when they arrived at the HBPoS. Written information was available in different languages and formats. AMHPs we spoke with told us that people detained under section 136 had had

Are services effective?

Requires improvement

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their rights explained to them. We reviewed 28 patient feedback forms from Hellesdon HBPoS and found that three patients had said they had had their rights explained to them.

- The police were able to contact the HBPoS before the detained patient arrived at the HBPoS so that arrangements could be made for the person to be assessed as soon as possible
- The trust collected data to monitor practices with regard to section 136 and shared this at regular multi agency meetings.

Good practice in applying the Mental Capacity Act

- Most staff received training in the application of the MCA. Information provided by the trust showed that at March 2017, 84% of staff in crisis services and HBPoS had received the mandatory training in the MCA. This did not meet the trust target of 90% attendance. The HHT in Ipswich (90%) and AAT (92%) were the only teams who met the target. The HHT in Wedgewood house Bury St Edmunds had the lowest compliance rate with 60% and the CRHT in Northgate great Yarmouth had a compliance rate of 67%.
- Staff we spoke with were aware of the MCA and the implications this had for their clinical and professional practice.
- We looked at 65 care records and found capacity was being considered and assessed appropriately.

Good

Are services caring?

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

Our findings

Kindness, dignity, respect and support

- We spoke with 13 patients and five relatives of people who used the crisis service. All were very positive about how staff behaved towards them. Patients told us staff treated them with respect, listened to them and were very professional and caring. Carers told us they knew how to contact staff if they needed to and most felt involved in their relatives care.
- We attended and observed nine visits/assessments by staff to people who used the service and observed telephone based assessments of people. Staff treated people who used the service with respect and communicated effectively with them. They were compassionate and discussed options and future plans with the patient and where appropriate their relative. They showed the desire to provide high quality and responsive care.
- When staff discussed people who used the service in handover meetings or with us, they discussed them in a respectful manner and showed a good understanding of their individual needs. They were aware of the requirement to maintain confidentiality.
- Data provided by the trust prior to the inspection for PLACE assessments related to privacy, dignity and wellbeing for HBPoS showed Wedgewood (92.2 %,) Woodlands (90.7%) and Hellesdon (91%) were above both trust average of 89.9% and the England average of 89.7%. The Fermoy Unit (81.5%) and Northgate Hospital (83.1%) scored worse than the trust and England average.

The involvement of people in the care that they receive

- Patients told us they were involved in their care and treatment and were aware of their care plans.
- We reviewed 65 care records and found most patients had been involved in planning their care and had either received or refused a copy of their care plan. There was little or no evidence of patient involvement in 13 care plans. There was no evidence that seven patients had been given or offered a copy of their care plan.
- Carers' assessments were offered to carers, and carers' groups, including drop in sessions, were offered across the crisis services.
- Information was available for patients on access to advocacy.
- The trust scored 93% in the May 2017 friends and family test, with 5% of respondents reporting they would not recommend the trust. 88 out of a total of 122 respondents indicated they would be extremely likely to recommend, with 26 likely and 6 extremely unlikely to recommend.
- Patients at the HBPoS in Hellesdon and Wedgewood HBPoS were able to give feedback on the service they received through feedback forms to them after their discharge. We reviewed 28 patient feedback forms from Hellesdon HBPoS and found that patients were positive about their care whilst in the HBPoS. Patients said that they were offered refreshments and the process and any delays were explained to them.

Are services responsive to people's needs?

Requires improvement

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

Our findings

Access and discharge

- The trust continued to have no overarching operating procedure for crisis services that clearly defined key performance indicators (KPI) and targets for the services. We reviewed the operational policies for the crisis teams and found that there no specific KPI included in the operational policy for CRHT based in Hellesdon in Norwich, and the HTTs in Suffolk.This was a requirement notice from the last inspection.
- Crisis services were not consistently meeting the trust target for response to emergency assessments. The trust target for Norfolk and Waveney was for 95% of emergency assessments to be made within 4 hours. There was no target set for Suffolk. Information from the trust showed that from January 2017 to the end of June 2017, 300 out of 397 emergency patients across crisis services were assessed within four hours (76% of cases).
- There were discrepancies between the trust's definition of an assessment following an emergency referral and practice. Staff told us the KPI was met following telephone contact recorded on electronic record system. Our review of records showed that the target had been assessed as being met following telephone contact. However, the policy stated 'Emergency: assessment (defined as face to face or telephone contact in exceptional circumstances where clinically appropriate) and first intervention (defined as treatment, signposting or discharge) required within 4 hours of referral. It was, therefore, unclear how the trust accurately monitored or assured itself that staff prioritised face to face assessments over telephone contact.
- Crisis services took a proactive approach to engaging with people who found it difficult or were reluctant to engage with mental health services. This included re-engaging with people who did not attend their appointments.
- Our review of 65 records and observation of five handovers indicated patients were seen quickly for home treatment following assessment.
- We spoke with 13 patients and five relatives of patients. People told us that appointments generally ran on time and they were kept informed if there were any unavoidable changes. Some told us they saw different members of staff due to the nature of the service which meant they had to repeat information.
- The response to crisis calls out of hours was inconsistent in the CRHT at Hellesdon in Norwich. When the staff member was out, after nine o'clock at night, crisis calls were diverted to the CRHT mobile. The staff member was unable to answer the call when they were completing an assessment or home treatment.
- MIND were commissioned to provide a crisis line for people not open to mental health services.The MIND crisis line was not visible on the trust website under 'what to do in a crisis'. Information related to this line was not easily located on the internet, meaning people not open to services might not easily locate the contact number when needed.
- The HBPoS were open 24 hours a day, 7 days a week. Data provided by the trust prior to the inspection showed the HBPoSs had been used 730 times during the period from 1 April 2016 to 31 March 2017. There were thirteen occasions over the 12 month period when a patient was not able to access the health based place of safety because it was already in use. Between 13 June and 17 July 2017, data showed the trust had closed HBPoS facilities in Suffolk on three occasions due to shortage of staff. Staff had used one HBPoS to seclude a patient from the acute ward, meaning this facility was not available to receive patients for assessment under section 136 of the MHA. When this occurred, patients were diverted elsewhere in the trust. An alternative HBPoS could either involve a lengthy travel time away from the patient's home area or mean the place of safety would have to be in an emergency department in an acute hospital or in a police station.
- The trust provided data to show how long a patient would wait in a health based place of safety for a MHA. The average length of time from admission to commencement of a mental health assessment was 5.4 hours. Our review of 23 records of patients assessed in an HBPoS also showed the Approved Mental Health Practitioner and doctor did not always attend within the three hours target set in the interagency protocol for section 136 of the MHA and as recommended in the MHA Code of Practice.

Are services responsive to people's needs?

Requires improvement

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

The facilities promote recovery, comfort, dignity and confidentiality

- Information on local services and patients' rights were available in all services we visited including the HBPoSs.
- There was no clock in the HBPoS at Wedgewood house to help avoid disorientation in time. There was no CCTV in the HBPoS at Woodlands to aid privacy and dignity for the patient.
- Patients could lie down in the HBPoSs; they had access to toilets, washing facilities and fresh air. A portable telephone was available for patients.
- Staff were able to make snacks and hot /cold drinks for patients in the HBPoS. Meals could be requested from wards if required. Staff were able to access clean clothes and bedding for patients when needed.

Meeting the needs of all people who use the service

- Adjustments were made for people requiring disabled access. There were lifts in place and accessible toilets. Equipment was available to support patients with hearing impairment.
- Staff had access to translation services and interpreters to help assess and provide for the needs of people using the service.
- Information leaflets were available in languages spoken by the people who used the service.

Listening to and learning from concerns and complaints

- Poster and leaflets describing how to complain and the complaints process were displayed in patient waiting areas and given to patients by staff.
- We spoke with 13 patients and five relatives. All knew how to complain if needed.
- From data provided by the trust prior to the inspection, crisis services and HBPoS received 79 complaints with 21 fully upheld (27%) and seven partially upheld (23%) during the last 12 months (1 April 2016– 31 March 2017). One complaint was referred to the ombudsman, this was from the AAT and as of 31 March 2017, and was ongoing. AAT had the most complaints with 45 (57%), with 23 of these referring to 'all aspects of clinical treatment'. The HTT in Bury St Edmunds had the least complaints, with one (3%).
- Staff demonstrated awareness of the trust complaints policy and supported patients to raise concerns. We saw minutes of meetings where complaints and any lessons learned were discussed with staff.
- The trust provided data related to compliments received. Crisis Services and HBPoS received 16 compliments during the last 12 months (April 2016 – 31 March 2017). Six of these compliments were received in the HTT in Ipswich, four were from AAT and three were received in the CRHT Kings Lynn. Two of these compliments were from the CRHT in Norwich and the CRHT in Great Yarmouth received one compliment.

Are services well-led?

Inadequate

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

Our findings

Vision and values

- The trust's vision and values were evident in staff attitudes and engagement with patients. Staff we spoke with were aware of the trust's values and vision. These were displayed in the services we visited.
- Staff told us they had regular contact with their immediate managers and occasional contact with more senior managers.

Good governance

- The last CQC inspection highlighted a number of concerns the trust was required to address. During this inspection, we found improvements were still needed to ensure compliance with regulations in a number of areas; for example, compliance with mandatory training for some key subjects, staff receipt of supervision and appraisals, staff availability to support patients in the HBPoS at Fermoy and compliance with key performance indicators and trust policy for assessment of emergency referrals within four hours.
- Local governance meetings were taking place but across most teams, team managers were not able to provide detailed KPI data on response times to referrals, caseloads and referral to assessment times, which affected their ability to monitor service performance effectively. Data provided by the trust for KPIs was unclear and inconsistent.
- Many staff were not in receipt of regular supervision and the trust has no effective oversight to monitor compliance at a local level.
- There were low levels of compliance with some key mandatory training. Staff told us they were unable to access some training and some training was inaccessible due to the travelling distance.
- Staff reported incidents and received feedback at team meetings.
- Team managers across all mental health crisis services said they had effective administrative support and sufficient authority to carry out their roles. They told us that they could submit items to the risk register where appropriate.
- The trust is a signatory to an inter-agency protocol for the use of section 136 of the MHA which includes all relevant information from the MHA Code of Practice.
- The trust regularly participates in a multi-agency group with organisations involved in the operation of section 136 of the MHA. Staff reported good working relationships with those organisations.

Leadership, morale and staff engagement

- All staff we spoke with were very positive about team working and the mutual support they gave one another. We spoke with 88 staff members who told us they were well supported by managers at a local level who they said would get involved in daily clinical practice if needed
  Staff we spoke with knew how to use the whistleblowing process. We saw minutes of regular staff meetings where issues were discussed openly.
- Staff generally had good morale but this was impacted in areas with staff shortages where staff felt that senior managers in the trust did not understand the pressures they were working under and the additional time they were working in order to keep the service going for patients.
- As in our last inspection staff reported differences between operating procedures and staff structures in Norfolk and Suffolk which they said caused confusion for staff and patients.

Commitment to quality improvement and innovation

- The trust was working towards accreditation for the triangle of Care and working with the Queen Elizabeth Hospital for accreditation for the Psychiatric Liaison Accreditation Network.

This section is primarily information for the provider

Requirement notices

Action we have told the provider to take

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

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Treatment of disease, disorder or injury	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment • The trust had not ensured all staff had access to appropriate alarms to summon assistance in a timely manner This was a breach of Regulation 12

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Treatment of disease, disorder or injury	Regulation 18 HSCA (RA) Regulations 2014 Staffing • The trust had not ensured compliance with monthly supervision for staff. • The trust had not ensured staff received an annual appraisal in accordance with their own policy. • The trust had not ensured staff received mandatory training in accordance with the trust policy. • Staffing levels for the out of hours crisis service was not sufficient to ensure patient needs could be met in a timely manner. • Staff from the psychiatric liaison teams were not always available to assess patients presenting in crisis in the acute hospitals. • The trust had not ensured there were staff to receive and support patients at the HBPoS at the Fermoy Unit. This was a breach of Regulation 18

Regulated activity	Regulation

This section is primarily information for the provider

Requirement notices

Assessment or medical treatment for persons detained under the Mental Health Act 1983

Treatment of disease, disorder or injury

Regulation 17 HSCA (RA) Regulations 2014 Good governance

- The trust had not ensured that the operating procedures clearly defined KPI response times for crisis services or clearly defined the way in which contact needed to be made with patients.
- The trust was not compliant with KPIs for response times to assessment in crisis services.

This was a breach of Regulation 17