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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Norwich
NR6 5BE
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Website: www.nsft.nhs.uk

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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 |
| RMYNR | Wedgwood House | Health-based places of safety | IP33 2QZ |
| RMYNG | Woodlands | Health-based places of safety | IP4 5PD |
| RMY01 | Hellesdon Hospital | Crisis resolution and home treatment team (CRHT) (Central Norfolk) | NR6 5BE |
| RMY01 | Hellesdon Hospital | Access and focused intervention service | NR30 1BU |

# Summary of findings

| | | | |
|---|---|---|---|
| RMY01 | Hellesdon Hospital | Single point of access team (Central) | NR6 5BE |
| RMY01 | Hellesdon Hospital | Crisis resolution and home treatment team (CRHT) (West Norfolk) | PE30 4ET |
| RMY01 | Hellesdon Hospital | Crisis resolution and home treatment team (CRHT) (Great Yarmouth) | NR30 1BU |
| RMY01 | Hellesdon Hospital | Home treatment team East Suffolk | IP4 5PD |
| RMY01 | Hellesdon Hospital | Home treatment team West Suffolk | IP33 2QZ |
| RMY01 | Hellesdon Hospital | Access and assessment centre Suffolk | IP1 2GA |

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

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

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

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

# Summary of findings

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# Summary of findings

## Overall summary

**We rated crisis services and health based places of safety as requires improvement overall because**:

- Staff in Crisis resolution home treatment (CRHT) teams in Norfolk managed high volumes of referrals 24 hours a day. In three CRHT teams, caseloads exceeded the recommended number of 30 patients.
- The trust provided data that showed four patients from CRHT Hellesdon had delayed discharges as they were waiting allocation to a care co-ordinator in the community team. The trust did not consistently monitor delayed discharge information across all services.
- The psychiatric liaison services environments were not fit for purpose for assessing patients experiencing a mental health crisis.
- The CRHT teams had variable access to personal alarms when on duty.
- Staffing of the health-based place of safety (HBPoS) suites was managed in different ways across the trust. Specifically allocated staff managed some units and staff from acute wards staffed other suites when a patient was admitted. This reduced the staffing numbers on the acute service when they were needed to staff an admission to the suite.
- HBPoS at Northgate did not have risk assessments documented. Staff had not completed risk assessments in all 19 care records we reviewed.
- The environment in health-based places of safety was unsafe. Furniture was not fixed to the floor, it was light and could be thrown or picked up by patients. The rooms were not clean and the ligature environment risk assessment did not identify risks we found.
- Medication was not stored, managed or transported as required by best practice in two CRHT teams.
- Staff were not receiving clinical and managerial supervision regularly across the core service.
- Appraisal rates for staff did not meet the trust compliance target.
- Staff mandatory training did not meet the trust compliance target.
- The reading of Mental Health Act rights to patients was poor at the HBPoS suite in Northgate hospital. Only six out of 19 patients who had used the suite had been read their rights, and had been recorded in the patient record.
- Staff had not completed or recorded physical healthcare checks for patients in all 19 care records reviewed at Northgate HBPoS.
- Members of the public did not know crisis telephone numbers. Staff re-directed the crisis calls to the acute ward at night in one service when staff from the crisis team were out of the office.
- The trust had no single service wide operational policy guidance for staff on how to meet targets for emergency (four hour), urgent (72 hour) or routine (28 day) referrals.
- Staff told us there were significant delays in an approved mental health professional (AMHP) attending HBPoS out of hours.
- There is no single service wide policy for crisis services from the trust. All localities managed their services using a local model.

However:

- We saw good evidence of lone working practices and the systems in place to manage this.
- CRHT at Northgate had a clean, alarmed unit.
- CRHT and home treatment teams (HTT) held effective team meetings.
- Care plans across the services were detailed, up to date and person centred.
- Staff recorded patient involvement in care plans.
- Staff we spoke with showed commitment to and passion for their job. We saw face-to-face interactions and telephone conversations with patients where staff showed compassion, empathy and knew their patients well.
- We observed team meetings that were patient centred. Discussions considered the involvement of carers and families.
- Staff told us they felt supported by their managers and felt managers were visible in the services. We observed core team leaders being supportive of their staff.

# Summary of findings

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

### Are services safe?

Inadequate

**We rated crisis services and health based places of safety as inadequate for safe because**:

- Staff in CRHT teams in Norfolk managed high volumes of referrals 24 hours a day. Caseloads were high. We observed at night, one staff member covered the crisis lines, assessments and home visits. Staff told us this had an impact on patient care.
- Environments in some psychiatric liaison services were not fit for purpose for assessing patients experiencing a mental health crisis.
- Staff working in CRHT teams had variable access to personal alarms when on duty. Some staff did not have alarms to wear.
- Staff compliance with mandatory training across the services did not meet the trust compliance target of 90%.
- Medication was not stored, managed or transported as required by best practice in two CRHT teams.
- Staff did not have access to anaphylaxis kits when administering depot injections, so did not follow guidelines for emergency treatment of anaphylactic reactions.
- The entrance to the HBPoS at Woodlands was clearly visible to the public, which reduced privacy and dignity of patients.
- Managers staffed the HBPoS suites in different ways across the trust. Specifically allocated staff staffed some suites and other suites were staffed from acute wards. As a result, staffing numbers were reduced on the acute service when a patient was admitted.
- The environment in some HBPoS was unsafe. In some suites, the furniture was not fixed to the floor, was light and could be thrown or picked up by patients. The rooms were not clean. The trust had not identified all ligature risks.
- HBPoS at Northgate did not have risk assessments documented. Staff had not completed risk assessments in all 19 care records we reviewed.
- At the HBPoS Fermoy Unit, staff told us, and records showed, that staff were not available to take responsibility for patients detained under section 136 by police.

However:

- We found risk assessments in crisis services were comprehensive and in date.
- The trust shared lessons learned from incidents and we saw posters and minutes of meetings in all services.

# Summary of findings

- We saw evidence of lone working practices and the systems in place to manage this.
- The CRHT at Northgate had a clean, alarmed unit with a number of rooms for staff use to see patients.
- Staff had access to administration support in CRHT teams.
- Medicines were stored securely and within safe temperature ranges in CRHT at the Fermoy Unit.

**Are services effective?**

**Requires improvement**

**We rated crisis services and health based places of safety as requires improvement for effective because**:

- Staff did not receive regular clinical and managerial supervision across this core service.
- Appraisal rates for staff did not meet the trust compliance figures.
- Staff told us the electronic patient record system was slow and patient records were difficult to find. We saw this when staff showed us the clinical records for patients.
- Managers completed audits but did not share these tasks with their team.
- Staff at Northgate CRHT were unable to access specialist training.
- Nurses in HTT's in east and west Suffolk provided most face to face input with patients. Other professions who provided clinical input with patients was more limited.
- The reading of Mental Health Act rights to patients was poor at the HBPoS in Northgate hospital. Staff recorded only six out of 19 patients had been read their rights.
- Staff did not complete or record physical healthcare checks in 19 care records for those admitted to the HBPoS suite at Northgate.

However:

- Care plans in place across the services were detailed, up to date and person centred.
- Hellesdon CRHT, access and focused intervention (AFI) team at Northgate hospital and the HTT at Woodlands employed nurses in specific roles to look after patients' physical healthcare needs.
- The HTT at Woodlands used outcome measures and clustering tools to benchmark their services and signpost patients onto other services.
- We saw evidence of staff who used National Institute for Health and Care Excellence (NICE) guidelines in CRHT Northgate Hospital.

# Summary of findings

- We observed effective team meetings held in all crisis services.
- All HBPoS suites had multi-agency meetings to review their services on a monthly basis.
- The AFI team had good working relationships with external agencies. Patients were efficiently signposted to the CRHT team and local services.
- Staff showed a good understanding of the Mental Capacity Act (MCA), the need to gain consent to treatment and where this should be documented.
- Staff showed a good understanding of the Mental Health Act (MHA) and how to apply its principles in practice with patients.

## Are services caring?

Good

**We rated crisis services and health based places of safety as good for caring because**:

- Staff recorded patient involvement in care plans.
- Staff we spoke with showed commitment to and passion for their job. We saw face-to-face interactions and telephone conversations with patients where staff showed care, empathy and knew their patients well.
- Staff demonstrated compassion in their interactions with patients.
- Patients we spoke with said that staff knew them well, even if they did not see the same member of staff all the time. Patients and carers told us the care they received was excellent.
- We observed team meetings that were patient centred. Discussions considered involvement of carers and families.
- One patient who had stayed at Wedgwood house HBPoS told us that staff had been caring and helpful.

## Are services responsive to people's needs?

Requires improvement

**We rated crisis services and health based places of safety as requires improvement for responsive because**:

- Staff reported they had difficulty moving patients onto community mental health teams. CRHT teams said they were reluctant to discharge patients from their caseloads until patients had been allocated permanent care co-ordinators.
- The trust provided data that showed four patients from CRHT Hellesdon had delayed discharges as they were waiting allocation to a care co-ordinator in the community team. The trust did not consistently monitor delayed discharge information across all services.

# Summary of findings

- Team leaders were not able to provide detailed KPI data on response times to referrals, caseloads and referral to assessment times. They were able to produce data on supervision and appraisal.
- The trust had no single service wide operational policy guidance for staff on how to meet targets for emergency (four hour), urgent (72 hour) or routine (28 day) referrals.
- CRHT teams and HTT did not meet their KPI targets in responding to emergency, urgent and routine referrals.
- Access to crisis services for members of the public was not well co-ordinated. Members of the public did not know crisis telephone numbers. This meant that if a member of the public was not known to crisis services, and they needed emergency, urgent or routine help for a mental health crisis they would telephone 111, wait to see their GP or attend A&E.
- The HTT in Suffolk did not have dedicated interview rooms to see patients. The rooms used were also used as the waiting room/family room and the ECT room.
- Staff told us there were significant delays in an approved mental health professional (AMHP) attending HBPoS out of hours.

However:

- Access and assessment teams (AAT) across Suffolk were responsive to emergency referrals.
- Psychiatric liaison services in Suffolk met their KPI targets for responding to emergency and urgent referrals.
- CRHT staff continued to hold patients on their caseloads whilst waiting for a permanent care co-ordinator in the community.
- The CRHT environment in Northgate hospital had a range of rooms for patient treatment. There was a range of MDT professionals within the team.
- Managers in Suffolk sent out feedback forms to relatives and carers so they could feedback about the care their family member had received.
- Liaison psychiatry in Suffolk offered a follow-up service to patients.
- The trust had fully implemented the streetcar triage in Suffolk, in co-operation with the police service. The trust had been piloting this at the time of the last inspection.

**Are services well-led?**

**We rated crisis services and health based places of safety as requires improvement for well-led because**:

**Requires improvement**

# Summary of findings

- The trust had no single service wide policy for crisis services. All localities managed their services using a local model.
- Team leaders 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. They were able to produce data on supervision and appraisal.
- Staff told us of a disconnect between services in Norfolk and Suffolk; and felt they worked for two different trusts.

**However:**

- Core team leaders worked in an integrated way with acute wards when a patient was admitted to an HBPoS.
- Core team leaders had overseen improvements to the environments in some HBPoS.
- Staff we spoke to told us their team leaders at local level were well respected and supportive. Staff morale was good in all services. Staff told us they felt positive about their roles.
- Managers led local governance meetings.
- Core team leaders recognised there were gaps in supervision, training and appraisals and had plans in place to address this.

# Summary of findings

## Information about the service

The mental health crisis services and health-based places of safety (HBPoS) were part of the mental health service delivered by Norfolk and Suffolk NHS Foundation Trust.

The crisis resolution and home treatment teams (CRHT) provided emergency (four hours) and urgent (72 hour) initial assessment and home treatment 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 based at the Hellesdon Hospital, Northgate Hospital and the Fermoy unit at Queen Elizabeth Hospital. They also provided psychiatric liaison services in Norfolk's acute physical healthcare NHS hospitals.

The access and focused intervention (AFI) service in Great Yarmouth provided triage services for referrals to crisis teams. Their function was to pass emergency referrals requiring assessment within four hours and urgent referrals requiring assessment within 72 hours to the CRHT team at Northgate. Routine referrals requiring input over 28 days or more would stay with the AFI team for treatment. This was considered a community service.

In Suffolk there were two home treatment teams (HTT), and one access and assessment team (AAT). In Norfolk, there was one access and assessment team. Their function was to provide emergency (four hours), urgent (72 hour) and routine (28 day) initial assessment and home treatment 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 HTT teams were based at Woodlands unit (East Suffolk) and Wedgwood house (West Suffolk) and the AAT was based at Mariner House, Ipswich. The AAT team in Norfolk was based at Hellesdon Hospital. The HTT in East Suffolk also provided psychiatric liaison services Suffolk's acute physical healthcare NHS hospital.

There were five health-based places of safety (HBPoS) across Norfolk and Suffolk. An HBPoS is a place where someone who may be suffering from a mental health problem can be taken, by police officers, using the Mental Health Act, in order to be assessed by a team of mental health professionals. The health-based places of safety were at Hellesdon Hospital, Fermoy Unit and Northgate hospital in Norfolk and at Wedgwood house and Woodlands in Suffolk.

The Norfolk and Suffolk NHS Foundation Trust was last inspected in October 2014 by the CQC and was rated as inadequate. As a result, the trust was placed into special measures. During the inspection it was identified that the trust:

- Must address the environmental health and safety concerns in the health-based places of safety.
- Must ensure all staff receive their mandatory training in accordance with the trust policy.
- Must review the provision of inpatient beds to ensure the needs of the local population are met.
- Must review their staff consultation process, address low morale of staff and ensure all staff receive an annual appraisal and regular management supervision.
- Should ensure a 'standard operating procedure' is introduced to manage effectively the interface between the various community services provided.
- Should ensure all call handlers receive specific mental health awareness training and the trust should promote their vision and values effectively.

During this inspection, we found that managers had addressed the majority of these issues.

# Summary of findings

## Our inspection team

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

**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 two inspection managers, four specialist advisors from a variety of professions including three mental health nurses, two social workers, and one expert by experience that had recent experience of using or caring from someone who uses the type of services we were inspecting.

## Why we carried out this inspection

We inspected this core service as part of our on-going 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.

During the inspection visit, the inspection team:

- Visited all five health-based places of safety and looked at the quality of the environment, and observed how staff cared for patients.
- Visited all three crisis and home treatment teams in Norfolk.
- Visited home treatment teams in Suffolk, and the access and focused intervention team and the access and assessment team in Norfolk.
- Attended a home visit with a home treatment team.
- Spoke with 11 patients who were using the services.
- Spoke with 25 managers of the services including senior managers and operational managers of the locality areas.
- Spoke with 85 other staff members; including doctors, nurses, occupational therapists, psychologists, modern matrons, social workers and administration staff.
- Attended and observed five hand-over meetings and three multi-disciplinary meetings.
- Spoke with five carers of patients who were using the services face to face or by telephone.
- Observed seven interactions taking place between staff and patients during the day and one at night.
- Reviewed 43 care records, 19 from a health-based place of safety (HBPoS).
- Carried out a specific check of the medication management across the sites and looked at 17 medication cards.
- Looked at a range of policies, procedures and other documents relating to the running of the service.
- Completed an unannounced out of hours inspection of crisis services in Norfolk and Suffolk on 27 and 28 July 2016.

# Summary of findings

## What people who use the provider's services say

People who used the crisis services told us that staff treated them in a caring way and that staff who provided care knew them well. People told us staff were respectful and polite and staff were interested in people's well-being. People using the service told us they would be able to access a member of staff quickly when needed. Carers who had relatives using the services told us they had been involved in their family member's care and staff provided them with information about the service.

People we spoke with, including carers, told us they knew how to make a complaint. Some carers who did raise a complaint told us the issue had been dealt with to their satisfaction.

One patient we spoke with who used an HBPoS told us staff had been caring and helpful.

## Good practice

The AFI team at Northgate hospital used innovative ways to manage the needs of their patients. The core team leader was involved in multi-agency working groups and had led the team to be able to deliver treatment in different ways to conventional home visits. An example of this was the 'early help hub' where patients' needs were discussed and multiple agencies could be involved. The core team leader made suggestions of how each agency could assist in the holistic treatment of the patient. Senior staff described this as a way to support them to support the service users. The staff group have together set up groups for patients to help meet their needs. Examples of this were 'stabilisation work' and the 'emotional regulation group'. This offered patients a variety of treatment options.

In Wedgwood House HTT, the psychology team held case formulation meetings, which all nursing staff attended. This allowed the team to discuss the patients' needs but also to manage the staff's understanding on the phases of change a patient may experience. Psychology staff also provided supervision for nursing staff.

At CRHT Northgate hospital, one staff member had a role of carers' lead. The carers' lead facilitated groups and drop in clinics for carers to attend. Guest speakers and events were organised for carers of those who used services. Twenty sessions had taken place since January 2016. One carer who had attended the carers group told us they felt listened to and supported and their relative using services felt involved in their care plan.

## Areas for improvement

**Action the provider MUST take to improve**

- 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.

# Summary of findings

- 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.

**Action the provider SHOULD take to improve**

- 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.

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 place of safety | Hellesdon Hospital |
| Health-based place of safety | Northgate Hospital |
| Health-based place of safety | Fermoy Unit |
| Health-based place of safety | Wedgwood House |
| Health-based place of safety | Woodlands |
| Crisis resolution and home treatment team (CRHT) (Central Norfolk) | Hellesdon Hospital |
| Access and focused intervention service | Northgate Hospital |
| Single point of access team (Central) | Hellesdon Hospital |
| Crisis resolution and home treatment team (CRHT) (West Norfolk) | Fermoy Unit |
| Crisis resolution and home treatment team (Great Yarmouth) | Northgate Hospital |
| Home treatment team East Suffolk | Woodlands |
| Home treatment team West Suffolk | Wedgwood House |
| Access and assessment centre Suffolk | Mariner House |

# Detailed findings

## Mental Health Act responsibilities

Relevant legal documentation was completed in the records we reviewed. Staff were clear about the procedure and process if a person required assessment under the Mental Health Act.

We observed staff interacting with a patient who attended a crisis centre, but was not known to the team. Staff showed a good understanding of the Mental Health Act (MHA) and how to apply its' principles in practice with patients. The team were fully aware of their responsibilities and ensured their actions complied with Mental Health Act responsibilities.

Compliance with staff mandatory training in the Mental Health Act ranged from 63% to 78%, which did not meet the trust compliance target.

Only six out of 19 care records we reviewed showed that patients who had used the HBPoS suite at Northgate hospital had been read their rights.

## Mental Capacity Act and Deprivation of Liberty Safeguards

We reviewed 43 care records. In crisis services, 50% of records showed patients had received information about their treatment from, for example, leaflets and discussion of treatment options. Only four records had documented a mental capacity assessment had taken place.

Staff that attended Mental Capacity Act 2005 (MCA) training were aware of their responsibilities under the Act. Training records showed that compliance with MCA training was between 54% and 80%. This did not meet the trust compliance target.

Training records showed that compliance for training in Deprivation of Liberty Safeguards (DoLS) ranged between 50% and 85%. This did not meet the trust compliance target.

Inadequate

# 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

- CRHT staff at the Fermoy Unit did not have alarms available to them. Staff told us they completed assessments on the wards in pairs. As a result, staff numbers were depleted for other activities. Staff told us they thought the alarm system did not work. We tested the alarm system and saw lights flashed, but the alarm could only be heard in some parts of the building. Staff were unaware this system was in place.
- The CRHT at Northgate had an ECG machine; however, the machine's calibration was out of date, which meant that readings might not be accurate. We informed senior staff of our concern. However, when we returned to the unit one week later, we found staff had not recalibrated the machine or made staff aware they should not use this equipment.
- At the HTT at Woodlands, staff did not have alarms to carry routinely but were able to access them if required. Unless staff knew the patients' risk well, staff were vulnerable.
- There was no ligature risk assessment at the CRHT in Hellesdon hospital. There were no pinpoint alarms for staff despite the need for them to respond to the acute wards and to attend the wards to assess in-patients. Staff reported they saw patients in the office areas to carry out assessments; there were no alarms in the office areas. Therefore, staff would be unable to call for help if needed when working with a patient in crisis who was high risk.
- At the HBPoS at Northgate hospital, the ligature environment risk assessment did not identify the risks we found. Furniture in the bathroom posed a ligature risk. There was a toilet brush in place, which could have been used as a weapon. We reported this to the modern matron.
- The HBPoS at Northgate hospital was not clean. The windowsill was stained with tea and coffee.
- The assessment room used by the psychiatric liaison team at Queen Elizabeth acute hospital was not safe for assessing patients. This room would have been difficult to exit if a patient prevented staff from leaving. This was not on the trust risk register.
- The HBPoS at Hellesdon, Woodlands, Northgate and Fermoy had furniture that was not fixed to the floor and could be picked up and thrown. Staff told us that some patients had done this at Hellesdon. However, HBPoS at Hellesdon had made some improvements to the suite. It was light and bright, with good private access away from public view. There was a walled patio area and food and drink facilities were available. The HBPoS at Northgate had made improvements to the suite, with a spacious lobby area, food and drink facilities and a private patio area.

### Safe staffing

- The trust set the core staffing levels for the service. Trust data showed the established level of registered nurses across the service was 57 whole time equivalent (WTE). At the time of the inspection there were five vacancies; 14% of the establishment. The established level of unqualified nurses was 98. The service had nine vacancies. The service with the highest number of vacancies was CRHT Hellesdon. However, we saw staffing at CRHT Fermoy had only 50% of staff in post. Three staff told us they were short staffed and one staff member told us they were unable to complete as much home treatment as they would have liked. This had an impact on patient care and patients did not see staff as frequently as they needed to. Senior staff held the rota which showed 27 unfilled band six nursing shifts during May 2016.
- There was one doctor in post at the HTT in Wedgwood House. This post was 0.5 WTE based in the HTT and 0.5 WTE post based in psychiatric liaison service at the acute NHS hospital. There were delays in the doctor conducting medical reviews. Qualified nurses confirmed this.
- There were low staffing levels for out of hours services at psychiatric liaison services, at Queen Elizabeth Hospital, James Paget Hospital and Ipswich hospital. At the Fermoy Unit, staff told us they travelled significant distances at night to deliver medication to patients and

Inadequate

# Are services safe?

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

carry out assessments. The AAT at Mariner House had two staff on each shift who managed all emergency and urgent assessments over a 24 hour period. Northgate CRHT provided one band six nurse to cover CRHT calls and psychiatric liaison services overnight, who worked alone. This affected the caseload volume for staff.

- A senior nurse at CRHT Fermoy told us that the psychiatric liaison services based at the Queen Elizabeth Hospital had three consecutive days in July when there were no staff in the liaison service and only one registered nurse in the CRHT at Fermoy to manage assessments and liaison. Timely completion of assessments were affected by insufficient staffing.
- At the HBPoS Fermoy Unit, staff told us, and records showed, that staff were not available to take responsibility for patients detained under section 136 by police.
- At CRHT Northgate Hospital, the operational policy, the staffing budget and the manager's files showed there were three staffing models showing different numbers of staff for the unit. The core team leader was unclear which staffing establishment was correct. However, we observed safe staffing numbers. The rota was up to date with the correct planned number of staff on duty. A review of the rota showed sickness was low and staffing numbers were consistently to plan.
- Support workers staffed the HBPoS at Hellesdon and there was limited registered nurse cover. The Clinical Commissioning Group (CCG) had approved funding for registered nurse posts, but because of problems with appointments, support workers were working in the service. We spoke to three staff who confirmed this.
- Wedgwood House HBPoS had additional staff from the acute wards to staff the suite. This meant when patients were admitted the acute service was not short staffed.
- Staff in CRHT teams in Norfolk managed high volumes of referrals 24 hours a day and caseloads were high. In three CRHT teams, since January, caseloads exceeded the trust recommended number of 30 patients in 41 of the 81 weeks.
- The trust had set on overall compliance rate for mandatory training of 90% to be achieved by September 2016. Training topics that fell below 80% were being addressed by the trust. Crisis services training compliance was 44%. Every location had training topics that fell below the 80 trust target. The lowest compliance with mandatory training was the HTT at Wedgwood house. Training topics not meeting compliance targets were basic life support, fire training, clinical manual handling, medicines management, Mental Capacity Act, Mental Health Act, full prevention and management of aggression, personal safety and rapid tranquilisation training. Therefore, compliance with key clinical skills topics was below the trust target.
- The trust told us that the sickness rate of permanent staff was 6%, which was higher than the trust wide total of 5%. The service with the lowest sickness rate was CRHT Fermoy and the highest was CRHT Northgate hospital.
- The trust told us that turnover figures for this service were at 35%. Bank staff covered 5% of shifts and agency staff covered 6% of shifts in a three-month period.

### Assessing and managing risk to patients and staff

- We saw 19 care records at the HBPoS at Northgate. No records had copies of the risk assessment.
- In crisis services, three out of 24 records did not have a risk assessment and seven did not have up to date risk assessments. However, the risk assessments we saw were robust, up to date and involved patients' views.
- Staff told us from across services they knew how to make a safeguarding alert and managers confirmed this. Examples of safeguarding documents in records we saw were completed accurately.
- The trust had lone working practices throughout the locations. Staff told us they felt safe when visiting patients. We saw various systems for staff to manage and monitor lone working, including white boards with staff contact details and whereabouts.
- In the CRHT at the Fermoy Unit there was no evidence of a pharmacist review of prescription charts. Staff indicated they had no knowledge of a clinical review of charts. Staff had access to lockable briefcases for transport of medication; however, staff did not use these. Staff at the CRHT at Northgate carried medication in an unlocked rucksack. This could put staff in both services at risk when carrying medication in the community. In the CRHT at Hellesdon staff did not keep records of any medication returned from patients for destruction. At the CRHT at the Fermoy unit no anaphylaxis kits were available for staff to use in the community when administering depot injections. This does not follow guidelines for emergency treatment of

Inadequate

# Are services safe?

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

anaphylactic reactions. At the CRHT Northgate and CRHT at Hellesdon staff did not monitor the room temperature where medication was stored, as required by best practice. Therefore, staff could not be sure medication had been stored at the correct temperatures to ensure their quality. However, we saw the medication at the CRHT at the Fermoy Unit and Hellesdon was named and stored in a locked cupboard and room, with corresponding medication charts. Staff ordered medication using the prescription chart and stored medication correctly. Staff completed appropriate documentation in the electronic patient record and on the patient prescription chart. An on call pharmacist was available for advice. We saw six prescription charts that had been written and reviewed by medical staff.

## Track record on safety

- The trust supplied data that showed there had been 15 incidents in the period 26 May 2015 to 18 May 2016. This included one incident where the incident is likely to result in significant future harm, nine self-inflicted harm, one relating to a pressure ulcer and four pending review. The trust supplied data that showed there had been 18 serious incidents in the period 15 January 2015 to 12 March 2016. One was due to potentially avoidable injury and 18 related to unexpected deaths. 9 of these are pending a review. 6 related to apparent, actual or suspected self-inflicted harm.

## Reporting incidents and learning from when things go wrong

- The trust placed posters around all locations giving details of recent trust incidents and the learning from those incidents. Senior staff held local governance meetings where lessons learned were shared. Staff kept minutes of these meetings for future reference. Managers held team meetings to share lessons learned and we saw minutes of these meetings. Staff knew how to record incidents in the electronic record system and managers were able to monitor this data. We observed managers reviewing their datix information. However, staff told us about an incident that occurred at the HBPoS at Woodlands. Senior staff did not consider it to have reached the threshold for reporting as a serious incident, despite a patient having absconded from the service. This decision may impact on learning from the incident to prevent recurrence.
- Staff at Wedgwood house and Woodlands told us they received debrief sessions if needed after incidents.

# 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

- We reviewed 24 care records in the crisis services. Nine records had no care plans. 15 care plans were completed, 10 were personalised and holistic and 13 patients had received a copy of their care plan. However, care plans were difficult to access on the electronic patient records system. We observed staff taking time to find care plans and risk assessments within the system. We observed nursing staff and administration staff finding care plans, risk assessments and documentation in different sections of the electronic records. This posed a risk that staff might not be able to access the correct information within a reasonable timescale. Staff reported and we saw that the system often froze.
- In the 15 care plans completed, up to date and clear care plans included crisis plans, showing triggers and interventions. Patients known to the service had been given the crisis telephone number to use in an emergency if their condition deteriorated. We saw this recorded in patients' notes.
- Some staff who worked in psychiatric liaison services out of hours did not have access to patient records at the acute hospital sites. Therefore, they needed to write up their notes when they returned to their base locations. Staff did not have quick access to risk assessments or mental health history. For example, at Northgate hospital the CRHT night worker needed to travel five miles between the CRHT office and St James Paget hospital in order to access the patient electronic note system. This might cause significant delays in assessments for patients.

### Best practice in treatment and care

- Psychology staff at Wedgwood House HTT did not have a clinical caseload and did not offer psychological interventions to patients. Psychology staff were involved in the supervision of staff and gave advice to nursing staff on managing patient's needs. However, the psychologist at Fermoy did not hold a caseload but did offer some psychological input to patients on a needs-led basis.
- At the CRHT Northgate, there was input from Citizens Advice Bureau where patients could access advice for benefits and employment support. Staff told us this was a very valuable resource. However, staff told us this input was ending and would not continue due to funding.
- At the CRHT at Hellesdon, staff told us they required the GP to have completed physical healthcare checks on patients before making a referral. Staff told us this was to reduce the number of inappropriate referrals to the service. However, this caused a risk of unnecessary delay before the CRHT accepted the referral. A physical healthcare examination had been completed for 13 out of 24 patients who used the service.
- Staff had not completed or recorded physical healthcare checks for patients in all 19 care records reviewed at Northgate HBPoS.
- We found no evidence of clinical staff participation in clinical audit across services. However, trust wide audits were completed and core team leaders had completed audits.
- Staff at the HTT at Woodlands used health of the nation outcome scale (HoNOS) outcome measure and clustering tools to benchmark their services and signpost patients onto other services. This reduced the impact on HTT caseloads. Service line reports showed core team leaders monitored mental health clustering of patients in their services.
- The consultant at CRHT Northgate hospital used up to date evidence-based practice and NICE guidelines. We saw evidence of the training the consultant had attended and during team meetings this knowledge was shared. The HTT at Wedgwood House used nationally recognised clinical assessments and staff received training on the use of assessment tools.

### Skilled staff to deliver care

- The trust employed a physical healthcare nurse at the CRHT at Hellesdon. The AFI team at Northgate employed a nurse prescriber and Wedgwood house employed a non-medical prescriber. Patients' physical healthcare needs were being reviewed which reduced reliance on local GP services. However, the non-medical prescriber at the HTT at Wedgwood house told us they had limited supervision from the consultant because of high demands on the consultant's workload. The consultant confirmed this.
- At Wedgwood House and Woodlands HTT, there was no occupational therapist, or social worker as part of the

# Are services effective?

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Multi-Disciplinary Team (MDT). At Fermoy CRHT, there was no occupational therapy provision. There were no psychology services at the AAT at Mariner House. Nurses in HTT's in east and west Suffolk provided most face to face input with patients. Other professions had some clinical input with patients.

- The trust expected all staff to attend an induction programme. All crisis teams, except CRHT Fermoy, met this target. CRHT Fermoy had 96% compliance and Mariner house had 98% compliance. Compliance with a workplace induction ranged from 75% to 98%. However, all crisis teams achieved 100% of staff completing care certificate training, except CRHT Fermoy.
- We saw 98 records relating to appraisal. Managers completed 42% of staff appraisals in the last year.
- Across the service between 33% and 43% of staff attended monthly supervision. Two teams, CRHT Northgate and AAT Mariner House, did not have records of supervision. This did not meet the trust policy for clinical supervision. The trust could not be sure that developmental opportunities or training needs were identified with staff.
- The staff at CRHT Northgate did not access regular training in specialist areas for their core service. Senior staff told us it was difficult to release staff for specialist training. Three staff we spoke with had not attended external specialist training courses since they had been in post, which ranged from 10 to 12 years.

### Multi-disciplinary and inter-agency team work

- The team at CRHT Northgate hospital consisted of nurses, occupational therapists, doctors, social workers and support workers. However, this was not consistent across crisis teams. Nurses in HTT's in east and west Suffolk provided most face to face input with patients. Other professions had some clinical input with patients.
- Staff attended handover meetings, where a number of professions were involved, and minutes of these meetings had clear actions for staff to carry out. Staff completed an MDT meeting book in several locations to record meetings and patient discussions. This enabled all staff to be aware of the patient's needs, even if they were not on shift when the meeting took place.
- In HBPoS, staff told us they attended monthly meetings between police, approved mental health practitioners (AMHPs), ambulance, solicitors and others. Across three HBPoS we saw minutes of a 'mental health operational steering group', an 'interagency meeting' and a 'Norfolk multi agency mental health monitoring group'. These showed multi-agency working, and documented items for discussion and follow up actions given to named staff. However, staff in west Suffolk had cancelled a number of meetings due to non-attendance by other agencies.
- We spoke with core team leaders at the AFI and CRHT at Northgate hospital and there was evidence of signposting patients between the two services. The Queen Elizabeth acute hospital at Kings Lynn had their own psychiatric liaison service and we saw evidence of joint working between this service and the CRHT at the Fermoy Unit.

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

- Staff compliance with mandatory training in the MHA ranged from 63% at the HTT at Wedgwood House to 78% at the AAT in Suffolk. The trust had set a target of 90% to be achieved by September 2016. The trust could not be sure all staff had sufficient training for their role.
- In the HBPoS at Northgate hospital, we reviewed 19 records. Staff recorded only six out of 19 patients had been read their rights under the MHA. It is a requirement under the MHA code of practice for staff to advise all detained patient of their rights when detained.
- In crisis services, staff had completed legal documentation appropriately in the records we reviewed. Staff were clear about the procedure to complete paperwork, how to make requests for MHA assessments, and the rights of patients during detention. We saw administrative support in services to assist clinical staff with loading detention paperwork into the electronic note system.
- Staff at the HBPoS at The Fermoy unit told us AMHPs required staff to find a bed for a patient prior to completing MHA recommendations for admission. This suggested that AMHPs were expecting to admit patients prior to completing their assessment and placed pressure on bed management staff to find beds that might not be required. Staff had secured beds for patients the day before our inspection, which were

# Are services effective?

**Requires improvement**

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subsequently not needed. We were concerned there might also be delays in MHA assessments being completed while beds were secured, placing patients at risk in the community.

### Good practice in applying the Mental Capacity Act

- The trust had a hospital wide policy for mental capacity act, which detailed the key principles of the Act, when capacity should be assessed, Deprivation of Liberty Safeguards, and guidance for staff on how to assess patients' capacity.
- Staff attended MCA training and were aware of their responsibilities under the Act. Staff compliance with mandatory training in the MCA ranged from 54% at the HTT at Wedgwood house to 80% at the AAT in Suffolk. The trust had set a target of 90% to be achieved by September 2016. The trust could not be sure all staff had sufficient training for their role.
- Staff told us they knew the principles when assessing capacity of patients. Staff told us they knew how to seek advice on capacity if they needed to.
- We reviewed 24 care records in crisis services; 50% of those records showed patients had received information about their treatment from, for example, leaflets and discussion of treatment options. Only four records had documented a mental capacity assessment had taken place.
- We did not see evidence of audit of mental capacity or consent to treatment.
- Staff compliance with mandatory training in DoLS ranged from 50% at the HTT at Wedgwood house to 85% at the CRHT at Northgate Hospital. The trust had set a target of 90% to be achieved by September 2016. The trust could not be sure all staff had sufficient training for their role.

Good

# Are services caring?

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

## Our findings

### Kindness, dignity, respect and support

- Staff showed compassion in their interactions with patients. We observed interactions between patients and staff and saw staff were respectful, kind and showed a caring attitude towards patients.
- Staff we spoke with showed commitment to and passion for their role. Staff showed compassion and empathy and knew their patients well.
- We spoke with five patients who said that staff knew them well, even if they did not see the same member of staff all the time. Patients told us the care they received was excellent. Carers we spoke with said staff were caring, included them in their relatives' care and they knew how to contact staff if they needed to. One patient we spoke with, who had used the service, told us the staff were "friendly and nice".
- The staff at the HTT at Woodlands, showed person centred and caring attitudes when talking to us about their patients. Staff involved families in the care of patients. For example, families and carers were invited to a monthly evening drop in at Woodlands where they could seek support from staff and others. Staff completed the friends and family test questionnaires when patients were discharged.
- One patient who used an HBPoS, told us staff had been caring and helpful.
- However, in the waiting area of the CRHT at Hellesdon, staff were overheard discussing patient details in the office. Therefore, confidentiality was not being maintained in an open area.

### The involvement of people in the care that they receive

- We reviewed 24 care plans in crisis services. There was no evidence of patient involvement in nine care plans. Five patients told us they had been actively involved in their care plans.
- At CRHT Northgate hospital, one staff member had the role of carers' lead. The carers' lead facilitated groups and drop in clinics where guest speakers and events were organised for carers of those who used services. Since January 2016, 20 sessions had taken place. One carer who had attended the carers group told us staff listened to them, offered them support and their relative felt involved in their care plan.
- We observed team meetings that were patient centred and discussions considered involvement of carers and families.
- We saw leaflets for patients on how to access advocacy services in most crisis services.
- We saw feedback forms given to patients and carers. We saw evidence of this in care records. This offered patients and carers the opportunity to give their view on the service they received. A staff member in the HTT at Wedgwood house ensured feedback forms were sent to patients on discharge.
- We saw posters about our inspection telling patients they had an opportunity to give feedback. Comment cards were available in reception areas of some services.

# 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 had no single service wide operational policy guidance on how to meet targets for emergency (four hour), urgent (72 hour) or routine (28 day) referrals. For example, staff were unclear if they needed to make contact with patients referred to them by telephone or face-to-face.
- The trust target time for emergency referrals to be contacted was four hours. The trust provided data that showed compliance with trust targets between January 2016 and June 2016. CRHT teams in Suffolk had 43 cases (7%) that did not meet this target. CRHT teams in Norfolk had 535 cases (93%) that did not meet this target. The AAT in Suffolk did not meet this target in four cases (17%).
- The trust target time for urgent referrals to be contacted was 72 hours. The AAT at Mariner House did not meet this target in 32% of cases over a three-month period.
- The trust target for routine referral to be contacted was 28 days. The AAT at Mariner house did not meet this target in 42% of cases over a three-month period.
- Psychiatric liaison services in Suffolk were responsive to targets set for responding to patients attending A&E services with a mental health crisis. Of those who attended A&E 99% of patients were seen within one hour and discharged within four hours. No patients stayed for longer than eight hours.
- Eighty-four per cent of inpatients at the acute hospital in Suffolk who had mental health needs were seen within one hour by psychiatric liaison services in emergency cases.
- Ninety per cent of inpatients at the acute hospital in Suffolk who had mental health needs and required an urgent assessment were seen within 14 hours.
- Team leaders in crisis services did not produce data on their compliance with key performance indicators (KPI) targets for emergency (four hour), urgent (72 hour) or routine (28 day) referrals. Staff told us this was since the implementation of a new electronic record system. Team leaders were unable to see how responsive their services were. In Suffolk, Clinical Commissioning Groups (CCGs) had implemented a remedial action plan (RAP) to address failings in meeting targets. One core team leader was able to find some compliance data with the help of an administrator.
- Staff reported they had difficulty discharging patients to the care of community mental health teams. CRHT teams said they were reluctant to discharge patients from their caseloads until patients had been allocated permanent care co-ordinators. The trust provided us with data that said four patients in CRHT Hellesdon had a delayed discharge due to a permanent care co-ordinator in the community team not being allocated. There was no mechanism to record or retrieve data to monitor discharges from HTT and CRHT to community teams where a permanent care co-ordinator was allocated. The trust did not supply delayed discharge data for CRHT Fermoy and Northgate hospital or data for delayed discharges back to the GP or wellbeing team. The trust did not consistently monitor delayed discharge information across all services. As a result, the trust was not able to measure the responsiveness of its provision; and staff might have large caseloads, consisting of new referrals and patients who remain on their caseload until discharge to community teams.
- Staff told us members of the public did not have access to the trust crisis line. If a member of the public was not known to crisis services and they needed help for a mental health crisis they would telephone 111, wait to see their GP or attend A&E. Those patients known to crisis services had access to the 'crisis line'. At night, in one service the telephone was re-directed to the acute ward if staff from the crisis team were out of the office with a patient or travelling to an appointment. This meant a patient might not speak to someone who knew him or her well. In other services, staff carried a mobile phone and, when they were unavailable, patients could leave a message. Staff told us they always contacted patients as soon as they were able.
- The Integrated Delivery Team (IDT) at Ipswich and Bury South transferred their phones for out of hours services to the crisis telephone line. One patient reported this went to answer machine. Two staff told us The Samaritans or Night Owl answered crisis calls for IDT patients. Therefore, crisis services, out of hours, were not responsive to patient need. However, staff documented crisis telephone numbers in patients' care records. Patients and carers told us they knew the crisis help line number to call if they needed it.

# Are services responsive to people's needs?

Requires improvement

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

- Staff told us they followed up their patients after discharge. The trust provided data which showed that 90% of patients in the month of June had follow up appointments with staff within seven days.
- We spoke to an AMHP at Hellesdon hospital who described some difficulty in accessing an ambulance to transport patients to the HBPoS. Data available showed that only 32% of patients admitted to the HBPoS were brought by ambulance as required by the MHA code of practice and trust policy. In most cases, police vehicles were used to transport patients to the HBPoS.
- We saw a triage meeting between a team of staff and a doctor at Hellesdon CRHT and this was responsive to the patient's needs. There was clear documentation and communication.

### The facilities promote recovery, comfort, dignity and confidentiality

- Staff at the HTT at Woodlands told us they assessed patients considered to be high risk on site, rather than in their own homes. However, the service did not have dedicated interview rooms to see patients. Staff saw patients in two rooms, both of which were unsuitable. One room was a multi-purpose room with tables and chairs, which were light enough to pick up and throw. The second room was a multi-faith room, which was very small with one entrance and exit. There were no alarms for staff to summon assistance in an emergency. Staff told us there were always two staff present for patient assessments.
- Northgate CRHT had a range of rooms for patients to use, including a kitchen, group and individual rooms, a family room and a multi-faith room. It was clean and tidy and all areas were alarmed. Staff had access to personal alarms.
- The entrance to HBPoS at Woodlands is open to view by the public. This compromised patients' privacy and dignity.
- The HBPoS at Hellesdon and Northgate hospital were able to admit one patient. This does not meet national standards. When a second patient was admitted to the suite, an alternative suite within the trust would need to be found.
- In psychiatric liaison services at Ipswich hospital there was no dedicated room for staff to see patients and there were no alarms in place for staff to call for help if needed. Staff had raised this and it was reported the trust risk register.
- All crisis services had a range of leaflets available for patients. There was information about carers groups, support groups, bereavement, recovery college course, activities and groups available to patients, smoking cessation, patient liaison services, and how to make a complaint. Reception areas of some services had posters displaying information about group activities and community services available to patients.

### Meeting the needs of all people who use the service

- The environment at CRHT in Hellesdon hospital had no disabled facilities. Whilst a toilet had been designated a disabled toilet, the light was not working and it had no disabled facilities.
- There was one doctor in the HTT in West Suffolk whose post was shared with the psychiatric liaison service at the acute NHS hospital. There was a lack of written entries made by the doctor after seeing patients, and the doctor told us they were unable to provide regular supervision to the non-medical prescriber nurse. There were delays in the doctor conducting medical reviews. Nursing staff confirmed this.
- At the HBPoS at the Fermoy Unit staff told us, and records showed, that staff were not available to take responsibility for patients detained under section 136 by police. Police officers needed to stay for the duration of the detention and could only be released once the assessment team arrived. We saw four records that confirmed this. The trust were not compliant with the MHA code of practice and patients were not offered appropriate clinical support whilst waiting for assessment.
- Staff told us there were significant delays in an AMHP attending HBPoS out of hours. In all admissions to HBPoS, 38% of cases had an AMHP arrive after a four-hour period. The longest wait for an AMHP to arrive was 16.5 hours at Woodlands.

# Are services responsive to people's needs?

Requires improvement

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

- Services provided a range of information leaflets for patients; however, there was limited availability of leaflets in a variety of languages. There were leaflets telling patients how they were able to access interpreter services.

### Listening to and learning from concerns and complaints

- The trust provided limited data about complaints. The service had four complaints in the last 12 months, one that was upheld, and no data was provided on the remaining three. The four complaints related to three psychiatric liaison services; however, the trust provided no further details. No complaints had been referred to the Ombudsman.
- We saw posters telling patients how to make a complaint. We spoke to five carers who told us they knew how to raise issues if they needed to and felt able to do so. Patients told us they knew how to make a complaint. The services had posters on the walls of offices telling staff about learning from recent complaints. We saw minutes of meetings where complaints and lessons learned were discussed and documented.

# Are services well-led?

Requires improvement

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

## Our findings

### Vision and values

- Staff were able to tell us about the trust vision and values. Core team leaders told us they had delivered sessions to their teams in sharing the values with their team. We saw minutes of team meetings, which confirmed this.
- One core team leader said they had good links with a board member who frequently visited their service.

### Good governance

- Core team leaders held meetings with their teams on a regular basis. We saw evidence of local governance meetings and team meetings where information was shared. This was seen in minutes of meetings.
- Core team leaders had made information from local governance meetings available to their staff. This was in the form of posters on office walls, minutes made available, and information contained in emails shared with staff.
- Core team leaders told us they were unable to access key performance indicator (KPI) information on target times in the electronic record system.
- Core team leaders did not monitor information on delayed discharges, caseload management and compliance with KPIs in all CRHT locations, HTT at Woodlands and Wedgwood, and the AAT team in Hellesdon. Local managers did not have access to key information from which to monitor team performance.
- Core team leaders recognised there were gaps in supervision, training and appraisal and had plans in place to address this. We saw appraisals that had been completed in June and supervision dates that were booked in for the future.
- Staff told us that since crisis and HTT teams separated this had had a detrimental effect on the service. Staff we spoke with reported a disconnect between Norfolk and Suffolk services, and bands of support worker staff differed between Norfolk and Suffolk.
- Core team leaders had access to the trust risk register and could filter the register to see the risks concerned with their own local services.

### Leadership, morale and staff engagement

- Staff we spoke to at Hellesdon HBPoS said they were motivated in their job. Staff who worked in the service were positive about their manager and said they felt supported.
- Staff morale was good in all services; we observed and spoke to staff who told us they enjoyed their jobs, and were positive about the work they did for patients.
- Staff felt supported by their managers; we observed core team leaders being supportive of their staff, and they told us they had supportive, visible senior managers. Core team leaders had made changes to provide clear governance structures, and had plans in place to improve compliance in key areas.
- Staff told us they respected their managers. Staff and managers told us they had regular team meetings, and we saw minutes of regular staff meetings where issues were discussed openly.
- Staff told us they worked in supportive teams and were well supported by their managers.
- Some staff told us there were frustrations following the restructure of services, which had resulted in downgrading of posts for some staff. Staff told us this had had a negative impact on morale amongst the staff whose roles had been affected. Staff reported differences between operating procedures and team structures in Norfolk and Suffolk, which caused confusion for staff and patients. Staff told us that because of the operating differences, they did not always feel that they worked for one trust.

### Commitment to quality improvement and innovation

- Core team leaders demonstrated innovation in practice, and delivered on ideas to improve patient care and overcome challenges within their services. Managers involved their staff in making decisions for service improvement.
- A pilot scheme was in place to improve service provision at Mariner House to evaluate 'delays in patient pathways'. While led by the core team leader, the staff contributed, and we saw flow charts of the scheme and actions arising from the work.
- At the HTT in Woodlands information about patients was easily accessible to staff, prior to going out to see them, from individual folders for patients, which contained risk assessments and care plans.

# Are services well-led?

**Requires improvement**

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

- The AFI team at Northgate hospital used innovative ways to manage the needs of their patients. The core team leader was involved in multi-agency working groups and had led the team to be able to deliver treatment in different ways to conventional home visits. An example of this is the 'early help hub' where patients' needs were discussed and multiple agencies could be involved. The core team leader made suggestions of how each agency could assist in the holistic treatment of the patient.
- The trust has ECTAS accreditation and PLAN accreditation and involvement with the QNIC and secure services accreditation schemes. The trust had previously attained accreditation with a number of schemes such as AIMS but these had been cancelled by the Royal College when the trust was put in special measures.

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<br><br>Treatment of disease, disorder or injury | Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment<br><br>• Identified environmental concerns in the health-based places of safety had not been addressed.<br>• The trust had not ensured that physical healthcare needs of patients admitted to health-based places of safety had been addressed and recorded.<br>• The trust had not ensured risk assessments for patients admitted to HBPoS were completed.<br>• The trust had not ensured the provision of alarms and working systems available to staff in CRHT locations.<br>• Medication was not stored, managed or transported as required by best practice in two CRHT teams.<br><br>Regulation 12 |

| Regulated activity | Regulation |
|---|---|
| Assessment or medical treatment for persons detained under the Mental Health Act 1983<br><br>Treatment of disease, disorder or injury | Regulation 18 HSCA (RA) Regulations 2014 Staffing<br><br>• The trust had not ensured compliance with monthly supervision for staff.<br>• The trust had not ensured staff received an annual appraisal in accordance with their own policy.<br>• The trust had not ensured staff received mandatory training in accordance with the trust policy.<br>• **There was not sufficient staffing for the out of hours crisis services.**<br>• **There was not sufficient staffing for the CRHT at Fermoy.**<br>• There was not sufficient medical input to the HTT in Suffolk (west) based at Wedgwood House.<br>• The trust had not ensured there were adequate staff to receive and support patients at the HBPoS at the Fermoy Unit. |

This section is primarily information for the provider

# Requirement notices

| Regulated activity | Regulation |
| --- | --- |
| Assessment or medical treatment for persons detained under the Mental Health Act 1983<br><br>Treatment of disease, disorder or injury | Regulation 17 HSCA (RA) Regulations 2014 Good governance<br><br>• The trust had not ensured that the overarching operating procedure clearly defined KPI response times for crisis services or clearly defined the way in which contact needed to be made with patients.<br>• The trust was not compliant with KPIs for response times to assessment in crisis services.<br><br>Regulation 17 |
| | Regulation 18 |