# Norfolk and Suffolk NHS Foundation Trust

## Inspection report

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

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

This report is a summary of our inspection findings. You can find more detailed information about the service and what we found during our inspection in the related Evidence appendix.

## Ratings

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

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

# Summary of findings

## Background to the trust

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

The trust has 392 beds and runs over 100 community services from more than 50 sites and GP practices across an area of 3,500 square miles. The trust serves a population of approximately 1.6 million and employs just over 3,600 staff. It had a revenue income of in excess of £227 million for the period of April 2018 to March 2019. In May 2019, the trust had worked with over 25,000 individual patients.

Norfolk and Suffolk NHS Foundation Trust has a total of 13 locations registered with CQC and has been inspected 22 times since registration in April 2010.

The trust collaborates with seven clinical commissioning groups.

The trust delivers the following mental health services:

- Acute wards for adults of working age and psychiatric intensive care units.
- Long stay/rehabilitation mental health wards for working age adults.
- Forensic inpatient/secure wards
- Wards for older people with mental health problems
- Learning Disability Ward
- Community-based mental health services for adults of working age
- Mental health crisis services and health-based places of safety
- Specialist community mental health services for children and young people
- Community-based mental health services for older people
- Community mental health services for people with learning disabilities or autism
- Other specialist mental health services

Since the last inspection, the trust had relocated one forensic inpatient ward and updated and re-opened the empty ward as an acute assessment ward in September 2019. The trust also opened a mother and baby unit in January 2019.

The trust has had 21 Mental Health Act monitoring visits since November 2018. Across all visits, there were 96 actions the trust was required to address.

The trust has previously been inspected four times under the comprehensive mental health inspection programme, in October 2014 (published February 2015), in July 2016 (published October 2016), July 2017 (published October 2017) and September 2018 (published in November 2018). Following the July 2017 inspection, the trust received an overall rating of inadequate and was placed in special measures. In September 2018 the Trust was inspected again and remained in special measures. The safe, responsive and well led domains were rated as 'inadequate', the effective domain was rated 'requires improvement' and caring was rated as 'good'.

We issued seven requirement notices against mental health core services as follows:

- Regulation 9 HSCA (RA) Regulations 2014 Person-centred care

# Summary of findings

- Regulation 10 HSCA (RA) Regulations 2014 Dignity and respect
- Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment
- Regulation 13 HSCA (RA) Regulations 2014 Safeguarding service users from abuse and improper treatment
- Regulation 16 HSCA (RA) Regulations 2014 Receiving and acting on complaints
- Regulation 17 HSCA (RA) Regulations 2014 Good governance
- Regulation 18 HSCA (RA) Regulations 2014 Staffing

We undertook three focussed inspections in April 2019 of three core services:

- Community-based mental health services for adults of working age
- Mental health crisis services and health-based places of safety
- Specialist community mental health services for children and young people

These inspections were focussed and not rated.

At this inspection, we found that the trust continued to show they did not meet the requirements of six of these regulations. However, the trust had met the requirement for Regulation 10.

**Our rating of this trust improved since our last inspection. We rated it as Requires improvement** 

## What this trust does

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

## Key questions and ratings

We inspect and regulate healthcare service providers in England.

To get to the heart of patients' experiences of care and treatment, we ask the same five questions of all services: are they safe, effective, caring, responsive to people's needs, and well-led?

Where we have a legal duty to do so, we rate the quality of services against each key question as outstanding, good, requires improvement or inadequate.

Where necessary, we take action against service providers that break the regulations and help them to improve the quality of their services.

## What we inspected and why

We plan our inspections based on everything we know about services, including whether they appear to be getting better or worse.

We inspected eight core services, which were either previously rated as inadequate, requires improvement or which we risk assessed as requiring inspection this time.

We inspected eight complete services:

# Summary of findings

- Acute wards for adults of working age and psychiatric intensive care units
- Wards for older people with mental health problems
- Wards for people with learning disabilities or autism
- Mental health crisis services and health-based places of safety
- Specialist community mental health services for children and young people
- Community-based mental health services for adults of working age
- Community-based mental health services for older people
- Community mental health services for people with learning disabilities or autism

We did not inspect the other three core mental health services during this inspection because the risk-based assessment did not indicate these services required an inspection this time or they were rated as good in a previous inspection.

Our comprehensive inspections of NHS trusts have shown a strong link between the quality of overall management of a trust and the quality of its services. For that reason, all trust inspections now include inspection of the well-led key question for the trust overall. What we found is summarised in the section headed Is this organisation well-led?

## What we found

### Overall trust

Our rating of the trust improved. We rated it as requires improvement because:

- We rated well-led, responsive, effective and safe as requires improvement and caring as good. In rating the trust, we took into account the previous ratings of the three core services not inspected this time. We rated the trust overall for well-led as requires improvement. This was an improvement from the last inspection. Four of the trust's 11 core services are now rated as good and five as requires improvement, one service was outstanding and one inadequate.
- The trust board and senior leadership team were newly formed. At our inspection in 2018 we had significant concerns about the safety, culture and leadership of the trust. Since then, there had been a change in leadership. At this inspection, we found that, although some of the concerns had not fully been addressed, there had been a shift in approach and foundations had been laid to improve the direction of travel. We saw early improvements in almost all areas, but there had not been enough time to judge if these changes would be sustained. For instance, recent changes to the leadership structure had not yet embedded throughout the whole organisation and there were still a few key posts to be filled. We saw early improvement with the trust moving in the right direction, however, there was still much work to be done.
- Our findings from key questions demonstrated that whilst governance processes had improved, they had not yet fully ensured that performance and risk were managed well. For instance, waiting lists remained high in the specialist children and young people community mental health teams. Staffing was also a concern within this core service. We saw risk assessments were not always updated within this core service.
- The environment in the learning disability inpatient service was not safe or fit for purpose. The trust had made little attempt to remove or reduce the number of ligature points or improve lines of sight, nor was it a recovery focussed environment, as it did not encourage independence due to the number of risks within the environment. We had identified in the last inspection that not all wards were safe and fit for purpose.

# Summary of findings

- Managers did not have effective oversight of medicines management nor checking of emergency equipment in six of the eight core services we inspected. Despite increased assurance work and an improved board assurance framework, medicines management issues we found had not been identified as a concern by the trust.
- The trust missed opportunities to prevent or minimise harm. For instance, we found that the management of patients on enhanced observations was not always robust within the inpatient wards with gaps being found in some documents. This posed a direct risk to patient safety. Staff did not ensure patient records in all section 136 suites were completed or added to the system in a timely manner. This posed a risk to patient safety as if the patient accessed another service within the trust there would be no information or previous plan for staff to access and use when making clinical decisions. Staff did not consistently implement the smoke free policy. This led to patient frustration and increased the risk of fire setting.
- We continued to see similar themes and recommendations (such as poor documentation in clinical records) from serious incident reviews which demonstrated learning was not always effective in improving practice. The trust recognised this and were proactively exploring ways to ensure learning took place across teams.
- Some services had not yet embraced the cultural changes leaders were trying to develop. In one location in Suffolk, across four core services, we were concerned that some staff continued to report a lack of engagement with managers and pockets of low morale. We also saw evidence of bullying in one team in Norwich. The trust had sight of these issues and had acted, however action taken had not yet been sufficiently embedded to create wholesale change.
- Some stakeholders did not feel that changes had truly positively impacted all patients, with feedback advising that some still did not feel listened to, with poor communication being a key feature of feedback from patients or their families. Equally, a lack of access to attention deficit hyperactivity disorder (ADHD) services and specialist children and adolescent community services (CAMH) was raised as a concern by stakeholders. We found that this aligned with our findings at this inspection.
- The new governance and management structure were not yet fully implemented and embedded within the new care groups. For example, the role of the people participation lead was new and not yet fully developed. Not all staff fully understood the roles and responsibilities of the leads. Leaders had not yet successfully provided all teams across the organisation with an understanding of how the new care groups worked. Some staff expressed concern that the organisational changes were too fast and lacked consultation.
- Not all teams provided a range of treatment and care for patients based on national guidance and best practice. For instance, some community services had significant waiting times for psychological therapies. Teams lacked enough psychology staff to provide the range of care recommended by the National institute for Health and Care Excellence guidelines.

However:

- Since the last inspection the trust had implemented a new quality strategy to include quality improvement (QI) as a core component within their strategic direction. The trust quality improvement plan (QIP) had been revised and was aligned to the new strategy. One hundred and eighty-seven staff had completed the three-day improvement leaders programme and were developing initiatives within local teams designed to improve care. Some of these initiatives had been identified as important by the local service users reflecting leaders increased focus on service user participation and co-production. We saw some of these initiatives within the local teams and noted increased efforts made to engage and listen to the service users voice. Staff across services told us that they were involved in the planning and delivery of their own service. This initiative was in the very early stages of implementation and had, therefore, not yet brought about the improvements that were envisaged.

# Summary of findings

- The trust had a 'putting people first' strategy aimed at improving service user participation and to facilitate cultural change and de-centralise decisions. Concerns had been raised about organisational culture in the last four inspection reports, and the 2018 inspection report identified concerns that there was widespread low morale with staff feeling 'done to'. Following the 2018 inspection, the trust leadership team undertook (and continued to undertake) a range of engagement visits to services ensuring they were accessible to staff, although some staff reported that were unaware of visits to their services. At this inspection, more staff reported a sense of optimism and hope that real change was happening. More staff felt listened to, felt they could influence change, felt supported and had good working relationships with their managers.
- The trust had improved its approach to learning from and managing serious incidents as a result of feedback from families and staff. Trust committees and the trust board had sight of incident data. The trust took proactive steps to address themes identified and improve ways to share learning across services. A new serious incident scrutiny panel and serious incident team had been created to report findings from investigations to the board. The trust recognised there was still work to be done to embed and improve this process further.
- The trust collected reliable data and analysed it. This was a significant improvement from the last inspection. Staff across most services could find the data they needed, in easily accessible formats, to understand performance, make decisions and improvements. The information systems were integrated and secure. Staff submitted data or notifications to external organisations as required. New ways of monitoring and addressing waiting lists had been implemented with evidence that many lists had reduced. This meant leaders were able to understand what was happening in their organisation and act when needed.
- The trust had participated in some national improvement and innovation projects and undertook a wide range of quality audits and research. The trust was involved in 65 approved research projects during 2018-19 with 1800 people recruited over the year. The trust was recognised as being in the top 15 highest mental health organisations nationally for research recruitment. The trust had undertaken a quality improvement programme, steered by the Royal College of Psychiatrists, to reduce the incidents of restrictive interventions and restraints as part of a national programme. This was a significant piece of work which continued to have impact. The programme involved the patient voice who shared their experiences with staff. This success has been recognised by the Royal College of Psychiatrists who are leading the national programme.

## Are services safe?

Our rating of safe improved. We rated it as requires improvement because:

- Staff had not always followed best practice when storing, dispensing and recording medication in six out of the eight core services. Internal audits were not effective in identifying concerns. This was raised as a concern following the last inspection in 2018. Medication management across five of the eight services we inspected was poor, despite reported trust oversight and audit. For instance, the hospital carried out internal audits which did not identify the concerns we found on inspection relating to errors.
- Staff did not always fully complete or update risk assessments for each patient in the community adult community service and specialist children and adolescent community services. This was raised as a concern following the last inspection in 2018.
- The environment in the learning disability inpatient service was not safe or fit for purpose. The trust had made little attempt to remove or reduce the number of ligature points or improve lines of sight. We had identified in the last inspection that not all wards were safe and fit for purpose.
- The trust missed opportunities to prevent or minimise harm. For instance, staff did not ensure patient records in all section 136 suites were completed or added to the patient notes system in a timely manner. This posed a risk to patient safety. Staff did not consistently implement the smoke free policy. This led to patient frustration and

increased risk of fire setting. Inspectors found cigarette lighters in patient rooms on two occasions during inspection. Lighters were not permitted on the wards but systems to prevent this were not always effective. We found that the management of patients on enhanced observations was not always robust within the inpatient wards with gaps being found in some documents. This posed a direct risk to patient safety.

- The trust did not have sufficient staff in three core services, to effectively manage caseloads. This impacted on staff ability to carry out tasks such as record keeping, one to one sessions, physical health checks, and update risk assessments. There was a lack of suitably qualified medical staff within the crisis and home treatment teams. The trust had not ensured that sufficient numbers of suitably qualified staff were available in all teams to meet the needs of people who used the service. In August 2019, there were 34 occasions, in Norfolk crisis teams, where staff had not been able to assess patients within the four-hour emergency target due to staffing levels. The trust had not ensured that sufficient numbers of suitably qualified medical staff were available to meet the needs of people who used the service.
- Equipment was not always maintained, and staff were not always completing checks on automated external defibrillators in community teams.

However:

- Staff had made significant improvements in reducing restrictive interventions within the acute wards for adults of working age and psychiatric intensive care units. Seclusion episodes had reduced and there was evidence of attempts by staff to use less restrictive interventions before considering the use of seclusion. Clinical documentation of seclusion episodes followed MHA code of practice guidance in most instances.
- Staff completed risk assessments on all patients within the inpatient wards which were updated as required. We saw evidence that incidents were reviewed, and immediate learning was acted on and shared within the team.
- Most of the premises were clean, well equipped, well-furnished and well maintained, with the notable exception of the learning disability inpatient service.
- Staff understood how to protect patients from abuse and the service worked well with other agencies to do so.
- Staff had training on how to recognise and report abuse, and they knew how to apply it.
- Access to clinical information overall had improved.

## Are services effective?

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

- Not all teams provided a range of treatment and care for patients based on national guidance and best practice. There were vacancies throughout teams in two core services which impacted on the ability to provide psychological therapies. Teams lacked sufficient psychology staff to provide the range of treatment recommended by the National institute for Health and Care Excellence guidelines. This was a concern raised at the last inspection.
- Not all teams received supervision and appraisal as per the trusts' policy. This was raised as a concern at the last inspection.

However:

- We found an improvement in care plan completion and saw that most reflected current need, were personalised and individual to the patient.
- Staff assessed the mental health needs of people on admission, and there were comprehensive physical health plans in most core services.

# Summary of findings

- Staff knew and understood their role in compliance with the Mental Health Act and Mental Capacity Act. Staff routinely carried out capacity assessments where necessary and consent to treatment was recorded for patients in most services. The trust provided effective support and governance to ward staff with Mental Health Act compliance, and paperwork showed correctly completed documentation.

## Are services caring?

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

- Staff showed caring attitudes towards their patients. We saw numerous positive interactions between staff and patients with complex needs and staff managed extremely challenging situations with knowledge and compassion. Staff demonstrated a respectful manner when working with patients, carers, within teams and showed kindness in their interactions.
- Patients and carers gave positive feedback about the caring nature and kindness of staff and made positive comments about the therapeutic relationships they had with their loved ones. Patients had access to advocacy services.

However:

- Stakeholder feedback told us that there were still times when patients where not spoken to with kindness and sometimes families told us there was a lack of communication.
- Not all teams could show how they involved patients, parents, carers and nearest relatives in the design and delivery of the service.

## Are services responsive?

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

- The design of the learning disability inpatient environment was not fit for purpose. It was not a therapeutic environment. The building was tired, poorly maintained and did not promote a welcoming or comfortable space for recovery.
- Waiting lists within the children and adolescent community services continued to be high. Trust data at the time of inspection showed that 421 patients were waiting for assessment. Only 39% of referrals were seen within the trust target of ten working days, with 150 people waiting more than ten days. This was raised as a concern at the last inspection.
- Some people waited over 12 months for assessment within the attention deficit hyperactivity disorder service. This team had just one nurse with a caseload of 175 patients with 120 people on the waiting list in August 2019. This had reduced to 80prior to the inspection in October 2019.
- Two core services had significant waiting times for psychological therapies in most teams.
- Discharge planning did not always contribute to patients staying out of hospital. There had been insufficient improvement within the acute and psychiatric intensive care service in the last 12 months. The number of readmissions had reduced on four wards but had increased on six wards.
- Staff had not always communicated effectively when transferring patients from one ward to another. This impacted on patient experience.
- There was not an effective system to record and review complaint outcomes and look at themes and trends. We saw plans to improve efficiency of the end to end complaint process, with plans to co-produce responses and a new electronic system had been approved, aimed at improving the recording and sharing of information in an effective

and speedier manner. These initiatives were yet to be implemented. The trust also confirmed there was a backlog of complaints. Complaints were not responded to in a timely manner with just 28% of complaints being resolved within target. We saw improved involvement with patients when responding to complaints and a new process for tracking and logging complaints was in place.

However;

- The trust was able to demonstrate how they responded to emergency and urgent referrals. Whilst we saw there remained breaches of targets, we also saw there was a reason given and a review undertaken when targets were missed. The process was an improvement from the last inspection.
- Bed management had improved. Figures provided by the trust demonstrated that the number of patients using out of area beds had significantly reduced since April 2019 which, at that time, had high numbers of patients placed out of area. However, further work was required to embed changes and improve this further so that beds were available not just within the trust but within the town closest to the patient's home.
- The trust had taken positive steps to reduce all other waiting lists and this had been successful in reducing waiting times, particularly within older peoples and adult community services. The trust had implemented a weekly 'tracker list' meeting and system to monitor patient waiting times, and ensure clinical priority was considered. This was undertaken for all services.
- The trust met the needs of all patients including those with a protected characteristic. Staff helped patients with communication, advocacy and cultural and spiritual support.
- We saw that people using the older people's community service, could access the service easily. Its' referral criteria did not exclude patients who would have benefitted from care. Staff assessed and treated patients who required urgent care promptly and patients who did not require urgent care did not wait too long to start treatment. Staff followed up patients who missed appointments. The service had significantly reduced the waiting times for patients to be assessed and commence treatment following referral since the last inspection.

## Are services well-led?

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

- The trust board and senior leadership team were newly formed. At our inspection in 2018 we had significant concerns about the safety, culture and leadership of the trust. Since then, there had been a change in leadership. At this inspection, we found that although some of the concerns had not fully been addressed, there had been a shift in approach and foundations had been laid to improve the direction of travel. We saw early improvements in almost all areas, but there had not been enough time to judge if these changes would be sustained. For instance, recent changes to the leadership structure had not yet embedded throughout the whole organisation and there was still a small amount of key posts to be filled. We saw early improvement with the trust moving in the right direction, however, there was still work to be done.
- Some stakeholders did not yet feel that changes had truly benefited all patients, with feedback advising that some still did not feel listened to, with poor communication being a key feature of feedback from patients or their families. Equally, a lack of access to attention deficit hyperactivity disorder (ADHD) services and specialist children and adolescent community services (CAMH) was raised as a concern by stakeholders. We found that this aligned with our findings at this inspection.

# Summary of findings

- Despite improved recruitment outcomes, we remained concerned about staffing, specifically within the CAMH community service and Adult ADHD team. Also, some Norfolk crisis teams were not meeting the target to see people within four hours with staffing being cited as the reason in 34 of the 46 breaches. Managers did not have effective oversight of medicines management and checking of emergency equipment across in six of the eight core services we inspected. This had not been identified as a concern by the trust.
- Managers did not have effective oversight of medicines management or checking of emergency equipment in six of the eight core services we inspected. Despite increased assurance work and an improved board assurance framework, medicines management issues we found had not been identified as a concern by the trust.
- Our findings from the other key questions demonstrated that while governance processes had improved, they had not yet fully ensured that performance and risk were managed well. Not all of the previous areas of concern had been addressed. Staffing levels were not sufficient in all areas. Some Norfolk crisis teams were not meeting the target to see people within four hours. Medication management required further work. The trust risk registers did not reflect all the concerns that we found regarding staffing levels, missed targets, record keeping and medication management.
- We raised concern about the effectiveness of systems to ensure learning took place across core services as appropriate. The quality assurance committee and trust board had sight of serious incident data. We saw similar themes and recommendations identified from serious incident reports such as poor documentation in clinical records. At the time of inspection there were 161 serious incidents open to the team. There were 80 serious incident actions outstanding, meaning that the recommendations and actions had not been signed off as completed within the services they related to.
- Morale remained low in some services such as inpatient wards and some community services at Bury St Edmunds, learning disability inpatient services and some children and young people services in Suffolk. In these services staff did not always feel listened to and expressed concern that care was not improving at a pace they would like. This was supported by core service findings in these areas.
- The trust had not yet addressed all the concerns raised in previous inspections.

However:

- We saw early improvements in almost all areas, (such as the points below) but there had not been enough time to judge if these changes would be sustained. For instance, recent changes to the leadership structure had not yet embedded throughout the whole organisation and there were still a few key posts to be filled. We saw early improvement with the trust moving in the right direction, however, there was still much work to be done.
- The trust quality improvement plan (QIP) had been revised and aligned to the new strategy. Further development work was ongoing supported by NHS Improvement/England to develop the reporting and monitoring aspects of the plan.
- Since the last inspection the trust had implemented a new quality strategy to include quality improvement (QI) as a core component within their strategic direction. One hundred and eighty-seven staff had completed the three-day improvement leaders programme and were developing initiatives within local teams designed to improve care. Some of these initiatives had been identified as important by the local service users in line with leaders increased focussed on service user participation and co-production. We saw some of these initiatives within the local teams and noted increased efforts made to engage and listen to the service users voice. Staff across services told us that they were involved in the planning and delivery of their own service.
- The trust had undertaken a quality improvement programme, steered by the Royal College of Psychiatrists, to reduce the incidents of restrictive interventions and restraints. This was a significant piece of work which continues to have impact. The programme involved the patient voice who shared their experiences with staff. This success has been recognised by the Royal College of Psychiatrists who are leading the national programme.

# Summary of findings

- The trust had a 'putting people first' strategy aimed at improving service user participation with a key aim to facilitate cultural change and de-centralise decisions. Concerns had been raised about organisational culture in the last four inspection reports, and the 2018 inspection report identified concerns that there was widespread low morale with staff feeling 'done to'. Following the 2018 inspection, the trust leadership team undertook (and continued to undertake) a range of engagement visits to services ensuring they were accessible to staff, although some staff reported that were unaware of visits to their services. At this inspection, more staff reported a sense of optimism and hope that real change was happening. More staff felt listened to, felt they could influence change, felt supported and had good working relationships with their managers.
- The trust had worked hard to ensure that the service user voice was integral to care delivery. The new people participation lead was one aspect, however there were numerous initiatives underway to increase the service user voice in all areas of the organisation. This was beginning to develop and grow.
- The trust had improved how they collected and used information and data to consider its performance. New ways of monitoring and addressing waiting lists had been implemented with evidence that many lists were reducing. The trust data was more reliable than we found in the 2018 inspection. This meant leaders were able to understand what was happening in their organisation and act when needed.
- We saw improvement of learning from lessons within local teams immediately following an incident. We saw the use of reflection, safety huddles, debrief and early learning took place with action taken to improve practice.
- The trust had participated in some national improvement and innovation projects and undertook a wide range of quality audits and research. The trust was involved in 65 approved research projects during 2018-19 with 1800 people recruited over the year. The trust was recognised as being in the top 15 highest mental health organisations nationally for research recruitment.

**Acute wards for adults of working age and psychiatric intensive support units**

- Our rating of this service improved. We rated it as requires improvement because:
- Staff did not always complete hourly observations in line with Trust policy. We found missing signatures on observation sheets and gaps in observations on four out of five wards that we checked. We could not be assured that observations were being completed correctly which could have an impact on patient safety.
- Staff did not always follow systems and processes when safely prescribing, administering, recording and storing medicines or completing daily and weekly checks of emergency equipment. Patients could be at risk of harm if medications are not safely prescribed.
- There were vacancies for psychology staff in Suffolk. Patients in Suffolk were not able to access adequate psychological therapies in accordance with National Institute for Clinical Excellence guidelines.
- The planning of patient's discharge did not always contribute to people staying out of hospital. The total number of readmissions within 28 days had not changed significantly since the last inspection from 253 to 245 readmissions. The number of readmissions to any ward had decreased on four wards but had increased on six wards. The trust told us that the readmission rates were slightly better than the national average.
- Managers did not provide consistent support to staff to implement the trust smoke free policy

However:

- Ward staff participated in the provider's promoting positive practice strategy and there had been a reduction in the number of episodes of restrictive practice, including restraint, across all wards.
- Staff had made improvements to care planning since the last inspection. We reviewed 78 care records and found that staff developed individual, holistic care plans through co-production with patients and their carers.

# Summary of findings

- Staff treated patients with compassion and kindness. They respected patients' privacy and dignity. They understood the individual needs of patients and supported patients to understand and manage their care, treatment or condition.
- The trust had developed a system-wide action plan and opened a new ward to address the high number of out of area placements which was a concern at the last inspection
- The trust had introduced a quality improvement leadership programme for staff at all levels and, as of September 2019, had trained 200 staff.
- Most of the staff we spoke with felt that the culture of the trust was improving. Staff felt more listened to, more positive about working for the trust and that senior managers were more visible.

**Community mental health service for adults of working age**

Our rating of this service improved. We rated it as requires improvement because:

- Staff did not always update risk assessments routinely or after incidents at all teams; we found this in 20 out of 57 records reviewed. We found out of date risk assessments at North Norfolk CMHT and Bury South IDT by up to four years. We found one patient who had been referred to Norwich City CMHT in January 2019 did not have a risk assessment or care plan present. Not all care plans were reviewed regularly and not all were up to date. We reviewed 57 care and treatment records. We found two patients at Norwich City CMHT and one patient at North Norfolk CMHT did not have a care plan present.
- We found that the recording of physical health was poor across most adult community teams. We reviewed 49 care records in this area, 30 of these records did not have physical health assessments recorded and 25 had no evidence of ongoing physical health monitoring. At Waveney CMHT we saw evidence of recording physical health checks on paper, but this was not transferred to their electronic system.
- There were waiting lists across all community sites for psychological therapies. Waiting lists for psychological therapies ranged from six and half weeks to one year. Staff told us they did not feel there was enough psychology staff which impacted on rising caseloads.
- We found staff at North Norfolk CMHT had not ensured medical equipment had been regularly checked or cleaned. Medicines management systems did not always adhere to trust guidance and policy. We found issues with stock management, poor oversight of clinic rooms and access to keys for medicine cabinets.
- The ligature risk assessment at Bury South IDT did not capture all risks in each room.
- Managers at Norwich City CMHT had little oversight of caseload allocation of incoming referrals. The referral process did not ensure equity of caseloads for staff. To ensure there was no waiting list for allocation, all new referrals were allocated immediately resulting in high caseloads ranging from 11 to 70 with an average of 47 per care co-ordinator. Staff told us they were unaware of trust plans to review the process, however the trust shared information on how they were acting to address caseload concerns. This demonstrated there was a need to ensure there was improved communication between managers and the staff teams.
- Suffolk staff reported a disconnect between them and higher senior management. Some community service staff within Suffolk teams said that they felt communication and visibility of higher senior management was poor.
- There was inconsistency with what was placed on the risk register. For instance, demand and capacity had been highlighted on the risk register in Norfolk community services, however, Suffolk services experienced the same issue and it had not added to their risk register.

# Summary of findings

- Managers had not reviewed capacity versus demand for services in the adult community mental health services, consequently the staffing establishment was based on a significantly lower number of open referrals to their services than the number of open referrals they had.

However:

- The number of patients on the waiting list had reduced and there was an improved system for monitoring patient waits. We saw systems in place to ensure those patients waiting were reviewed and emerging risks were identified earlier than before.
- Most clinical premises where patients received care were safe, clean, well equipped, well furnished, well maintained and fit for purpose. Staff managed waiting lists well to ensure that patients who required urgent care were seen promptly. Staff assessed and managed risk well and followed good practice with respect to safeguarding. This was an improvement since our last inspection.
- Staff provided a range of treatments that were informed by best-practice guidance and suitable to the needs of the patients. Staff engaged in clinical audit to evaluate the quality of care they provided.
- We saw effective multi-disciplinary working to benefit patients. The teams had effective working relationships with relevant services outside the organisation.
- Staff understood and discharged their roles and responsibilities under the Mental Health Act 1983 and the Mental Capacity Act 2005.
- Staff treated patients with compassion and kindness, respected their privacy and dignity, and understood the individual needs of patients. They actively involved patients and families and carers in care decisions.
- The service was easy to access. Staff assessed and treated patients who required urgent care promptly and those who did not require urgent care did not wait too long to start treatment. The criteria for referral to the service did not exclude patients who would have benefitted from care.

**Wards for older people with mental health problems**

Our rating of this service stayed the same. We rated it as good because:

- The service provided safe care. The ward environments were safe and generally clean. The wards had enough nurses and doctors. Staff assessed and managed risk well. They minimised the use of restrictive practices, managed medicines safely and followed good practice with respect to safeguarding.
- Staff developed holistic, recovery-oriented care plans informed by a comprehensive assessment. They provided a range of treatments suitable to the needs of the patients and in line with national guidance about best practice. Staff had engaged in clinical audit to evaluate the quality of care they provided.
- The ward teams included or had access to the full range of specialists required to meet the needs of patients on the wards. Managers ensured that these staff received training, supervision and appraisal. The ward staff worked well together as a multidisciplinary team and with those outside the ward who would have a role in providing aftercare.
- Staff understood and discharged their roles and responsibilities under the Mental Health Act 1983.
- Staff treated patients with compassion and kindness, respected their privacy and dignity, and understood the individual needs of patients. They actively involved patients and families and carers in care decisions.

However;

- The environment on Laurel ward, Abbeygate did not meet dementia friendly environment guidance.

# Summary of findings

- Managers did not have oversight of contract cleaning schedules on Maple ward, Abbeygate to ensure appropriate levels of cleanliness and infection control.
- Managers did not ensure that staff recorded capacity and best interest decisions on the correct document named in the trust policy.
- There were gaps in medicines administration records and clinic room checks on Abbeygate ward which meant that medicines related policies were not being followed.

**Mental health crisis services and health-based places of safety.**

Our rating of this service stayed the same. We rated it as requires improvement because:

- The trust had not ensured that sufficient numbers of suitably qualified staff were available in all teams to meet the needs of people who used the service. In August 2019, there were 34 occasions in Norfolk where staff had not been able to assess patients within the four-hour emergency target due to staffing levels. The trust had not ensured that sufficient numbers of suitably qualified medical staff were available to meet the needs of people who used the service.
- We reviewed 18 care records of patients using health-based places of safety. For ten patients who had used the section 136 suites at West Suffolk Hospital and Northgate Hospital there was a lack of contemporaneous records on the electronic recording system.
- The service had systems in place to safely prescribe, administer, record and store medicines but they did not always reflect local practice and staff did not always follow them. Each area conducted audits of prescription charts, but the audit process was inconsistent between teams and the good practice seen in some areas was not shared. The number of errors we found in some teams showed that the audit process was not effective in identifying and addressing gaps in recording.
- The crisis teams in Norfolk had not always met the target for seeing patients within four hours of receiving an emergency referral. Throughout 2019, the trust had not met its own target of 95%. The health-based places of safety were not always available when needed in West Suffolk.
- Our findings from the other key questions demonstrated that while governance processes had improved they had not yet fully ensured that performance and risk were managed well. Not all the previous areas of concern had been addressed. The corporate risk register did not reflect the concerns that we found regarding staffing levels, missed targets, record keeping and medication management.
- Managers in Norwich told us that while staff morale had improved it was not yet good, and that a positive culture was not fully embedded across the service. The trust needed to continue to develop communication across all staff groups.
- Some stakeholders had identified negative feedback from some patients regarding responsiveness and attitude of some staff. Whilst it was evident that work had been undertaken to address the culture of the organisation, this was evidence that more work was required.

However:

- Overall management of referrals and waiting times had improved. For example, managers had developed an electronic dashboard which showed them when patients had accessed the service, when referral to treatment targets had not been met the and the reasons for this. This allowed managers to support their teams to mitigate the risks to patients. Incidents were reported, investigated and learned from.
- Clinical premises where patients were seen were safe and clean and the physical environment of the health-based places of safety met the requirements of the Mental Health Act Code of Practice.

# Summary of findings

- The number of patients on the caseload of the mental health crisis teams, and of individual members of staff had reduced since our last inspection and was not too high to prevent staff from giving each patient the time they needed. Staff ensured that patients who required urgent care were seen promptly. Staff assessed and managed risk well and followed good practice with respect to safeguarding.
- Staff working for the mental health crisis teams developed holistic, recovery-oriented care plans informed by a comprehensive assessment and in collaboration with families and carers. They provided a range of treatments that were informed by best-practice guidance and suitable to the needs of the patients. Staff engaged in clinical audit to evaluate the quality of care they provided.
- The mental health crisis teams included or had access to the full range of specialist staff required to meet patient's needs in line with the current standard operating procedure for the crisis pathway. Managers ensured that these staff received training, supervision and appraisal. Staff worked well together as a multidisciplinary team and with relevant services outside the organisation.
- Staff treated patients with compassion and kindness and understood the individual needs of patients. They actively involved patients and families and carers in care decisions.
- Leaders had the skills, knowledge and experience to perform their roles, had a good understanding of the services they managed, and were visible in the service and approachable for patients and staff. Staff knew and understood the provider's vision and values and felt respected, supported and valued.
- Staff collected analysed data about outcomes and performance and engaged actively in local and national quality improvement activities.

**Community based mental health services for older people**

Our rating of this service improved. We rated it as good because:

- The service provided safe care. Clinical premises where patients were seen were safe and clean. The number of patients on the caseload of the teams, and of individual members of staff, was not too high to prevent staff from giving each patient the time they needed. Staff managed waiting lists well to ensure that patients who required urgent care were seen promptly. Staff assessed and managed risk well and followed good practice with respect to safeguarding. The trust now had environmental risk assessments, including ligature risks, in place across the service where patients were seen on trust premises.
- Staff developed holistic, recovery-oriented care plans informed by a comprehensive assessment and in collaboration with families and carers. They provided a range of treatments that were informed by best-practice guidance and suitable to the needs of the patients. Staff engaged in clinical audit to evaluate the quality of care they provided.
- The teams included or had access to the full range of specialists required to meet the needs of the patients. The trust had actively recruited psychologists and occupational therapists into teams. Managers ensured that these staff received training, supervision and appraisal. Staff worked well together as a multidisciplinary team and with relevant services outside the organisation.
- Staff understood and discharged their roles and responsibilities under the Mental Health Act 1983 and the Mental Capacity Act 2005.
- Staff treated patients with compassion and kindness, respected their privacy and dignity, and understood the individual needs of patients. They actively involved patients and families and carers in care decisions.

# Summary of findings

- The service was easy to access. Staff assessed and treated patients who required urgent care promptly and those who did not require urgent care did not wait too long to start treatment. The criteria for referral to the service did not exclude people who would have benefitted from care. The service had significantly reduced the waiting times for patients to be assessed and commence treatment following referral since the last inspection.
- The service was well led, and the governance processes ensured that procedures relating to the work of the service ran smoothly.

**Community mental health services for people with a learning disability or autism**

Our rating of this service stayed the same. We rated it as good because:

- Staff assessed and managed risks to patients and themselves. They responded promptly to sudden deterioration in a patient's health. When necessary, staff worked with patients and their families and carers to develop crisis plans. Staff monitored patients on waiting lists to detect and respond to increases in level of risk. Staff followed good personal safety protocols.
- Staff took a function-based approach to assessing the needs of all patients. They worked with patients, families and carers to develop individual care plans and updated them as needed. Care plans reflected the assessed needs, were personalised, holistic, function-based and recovery-oriented.
- Staff provided a range of treatment and care interventions that were informed by best-practice guidance and suitable for the patient group. They ensured that patients had good access to physical healthcare and supported patients to live healthier lives.
- Staff treated patients with compassion and kindness. They understood the individual needs of patients and supported patients to understand and manage their care, treatment or condition.
- Staff had the skills, or access to people with the skills, to communicate in the way that suited the patient.
- Leaders had the skills, knowledge and experience to perform their roles, had a good understanding of the services they managed, were visible in the service and were approachable for patients and staff.

However:

- The service did not meet the trust's target time of 12 weeks from referral to assessment. Patients were waiting for up to eight months for an assessment by the autism child and adolescent mental health team and up to nine months for an assessment by the autism adult team. Patients were waiting for over 12 months for an assessment by the attention deficit hyperactivity disorder adult team who had just one qualified nurse managing a caseload of up to 175 patients and a waiting list of 120 patients for over a year. The Waveney adult team and the Ipswich adult learning disability teams did not achieve supervision rates above 75 percent for their staff between July 2019 and September 2019.
- The Waveney adult team and the Ipswich adult learning disability teams did not achieve supervision rates above 75 percent for their staff between July 2019 and September 2019.
- The décor at the Waveney adult and child and adolescent service was tired, had peeling paint on its walls and required updating.

**Wards for people with a learning disability or autism**

Our rating of this service stayed the same. We rated it as requires improvement because:

- The trust had made little attempt to remove or reduce the number of ligature points in the bungalows, though this issue had not been raised in the previous inspection report. Bedrooms had several ligature points and no clear lines of observation from the corridor.

# Summary of findings

- The fence around the garden area created a potential safety risk. Patients could climb over the fence and abscond or attempt to climb the fence and injure themselves. There had not been any reported serious incidents relating to this risk.
- The design and safety of the bungalows did not support patient's treatment. It did not enable patients to develop their optimum level of independence or effective independent living skills. The environment was not homely, and décor was tired and dated.
- The design of the buildings used for learning disability inpatient services, meant one patient was cared for on an alternative ward, which was not a ward that was designed to meet their individual needs.
- Staff had not picked up a medicine error as part of their medicines check and audit. The administration of PRN medication was an issue reported on at a previous inspection, the trusts action plan for this was that the clinical team lead would ensure that PRN medication was being given appropriately, monitored and recorded.
- Staff found it difficult to locate care plans and risk assessments on the electronic system. There were numerous different care plans in different places on the electronic system. To overcome this staff kept summarised paper copies as well. This meant that staff could miss key information. Staff may not always have all the information they needed to implement or update care plans.
- There were no nurse call bells in any patient areas, patients could not summon help in an emergency.

However:

- This core service overall rating of requires improvement remained the same as the last inspection. Effective, caring and well led had improved from requires improvement to good, while safe went down from requires improvement to inadequate and responsive went down from good to requires improvement.
- Staff had the skills required to develop and implement good positive behaviour support plans to enable them to work with patients who displayed behaviours that staff found challenging. Staff developed holistic, recovery-oriented care plans informed by a comprehensive assessment. They provided a range of treatments suitable to the needs of the patients cared for in a ward for people with a learning disability and or autism. Treatments were in line with national guidance about best practice.
- The care team included or had access to the full range of specialists required to meet the needs of patients on the wards. Managers ensured that these staff received training, supervision and appraisal. Staff worked well together as a multidisciplinary team and with those people in other services who would have a role in providing aftercare.
- Staff understood and discharged their roles and responsibilities under the Mental Health Act 1983 and the Mental Capacity Act 2005. Staff treated patients with compassion and kindness, respected their privacy and dignity, and understood the individual needs of patients. They actively involved patients and families and carers in care decisions.

**Specialist mental health services for children and young people**

Our rating of this service stayed the same. We rated it as inadequate because:

- The trust had not fully addressed all issues reported at previous inspections. We rated responsive and well-led as inadequate. We rated safe and effective as requires improvement and caring as good.
- The trust had not addressed all actions identified at the inspection in 2018.These related to ensuring adequate staff available to reduce the patient waiting lists for triage, assessment and treatment, staff, for engagement of staff in development of the service in Suffolk, regular line management, clinical supervision and appraisal, risk assessments and infection control.

# Summary of findings

- The trust had not ensured adequate staffing to meet the needs of the service. This meant staff had extra pressure on them to deliver a better service without much additional resources.
- We continued to find examples of backlogs where patients waited a long time before receiving triage, assessment and treatment.
- The multi-agency 'emotional well-being hub' team triaged referrals for young people needing health or social care across Suffolk. They had reduced the number of patients awaiting triage from our 2018 inspection from 394 to 389. We found examples where staff took more than the trust target time of 28 days to contact patients and then direct them to the right service. Children and family and youth teams gave examples where assessments were not adequate which meant more work was required to effectively screen referrals.
- Staff had not fully completed or updated 28 patients (39%) comprehensive risk assessments. Staff did not always complete a comprehensive mental health assessment of each patient who were receiving treatment as 15 care plans (21%) across teams needed improvements. Staff in Norfolk and Suffolk still had different systems for assessing and monitoring risks for patients awaiting assessment.
- We found risks to patients' safety as staff did not always identify and report safeguarding concerns. Haverhill, Sudbury satellite clinics and North Bury did not have separate children waiting areas.
- Thirteen of 19 patients (68%) and 21 of 45 (47%) carers gave negative feedback about the support provided. Feedback themes included a lack of support when they contacted teams for help during a crisis and a lack of information or communication.
- Trust systems for engaging patients, carers, staff and stakeholders in the development of the children and young person service were not fully effective as we received concerning feedback about the accessibility and communication of the service. Staff at Ipswich youth did not record informal complaints and there was no evidence of how these were resolved. Responses were not always timely.
- The trust had not supported new managers (particularly in Suffolk) to help them access key performance indicator data, which posed a risk they would not have clear information to be able to check how their team was performing. We found pockets of low staff morale, for example, in Ipswich, South Bury and Central Norfolk teams.
- Improvements were still needed to ensure a safe and clean environment. Staff were not completing checks of automated external defibrillators at South Bury IDT and Ickworth Lodge locations. We found examples where teams were not routinely monitoring cleaning of rooms and equipment. The trust had not completed accurate ligature assessments at South Bury, Great Yarmouth, Waveney and West Norfolk teams, which captured all potential risks. This meant staff would not be aware of all areas which needed more supervision.

However:

- Staff treated patients with compassion and kindness, respected their privacy and dignity, and understood the individual needs of patients. They actively involved patients and families and carers in care decisions.
- The trust had made extensive changes to the leadership and were changing their systems for monitoring, assessing and mitigating the risks to patients. The trust now had two care groups for children families and young people services across the trust to give clearer accountability and oversight of this core service. The trust had improved the quality of their risk registers with more identification of the service risks. The backlog of patients waiting for treatment had reduced. The culture of children and young people's services had changed since our 2018 inspection. Staff told us their morale was improving and they were more hopeful that trust changes would make the service better.

# Summary of findings

- Staff provided a range of treatment and care for patients based on national guidance and best practice. We found examples of staff using the 'THRIVE' integrated, person-centred and needs-led approach. Staff used recognised rating scales to assess and record severity and outcomes such as Routine Outcome Measures (ROMS). They supported patients to live healthier lives.
- The trust had involved patients and staff in the development of Kingfisher ward their mother and baby unit.
- Staff understood their roles and responsibilities under the Mental Health Act 1983 and the Mental Health Act Code of Practice.

## Ratings tables

The ratings tables show the ratings overall and for each key question, for each service, hospital and service type, and for the whole trust. They also show the current ratings for services or parts of them not inspected this time. We took all ratings into account in deciding overall ratings. Our decisions on overall ratings also took into account factors including the relative size of services and we used our professional judgement to reach fair and balanced ratings.

## Outstanding practice

We found examples of outstanding practice in two core services we inspected.

For more information, see the Outstanding practice section of this report.

## Areas for improvement

We found examples of outstanding practice at some services. For more information, see the outstanding practice section of this report.

## Action we have taken

We issued six requirement notices to the trust. Our actions related to a breach of six legal requirements relating to six core services.

For more information, see the Areas for improvement section of this report.

## What happens next

We will check that the trust takes the necessary action to improve its services. We will continue to monitor the safety and quality of services through our continuing relationship with the trust and our regular inspections.

# Outstanding practice

- In the acute wards for adults of working age and psychiatric intensive care units, the trust had undertaken a quality improvement programme, steered by the Royal College of Psychiatrists, to reduce the incidents of restrictive interventions and restraints. This was a significant piece of work which has reduced the number of restraints used on the pilot acute wards. This programme has now rolled out to other wards for implementation. The programme involved the patient voice who shared their experiences with staff. This success has been recognised by the Royal College of Psychiatrists who are leading the national programme.
- In the community mental health services for people with a learning disability or autism, services had liaison staff who attended general practitioner surgeries to ensure that all patients had access to yearly physical health checks and to support general practice surgeries in making their services learning disability friendly. Liaison staff also had good links with the local general hospital to ensure that any physical health interventions were managed effectively.

# Summary of findings

## Areas for improvement

Action the trust MUST take is necessary to comply with its legal obligations. Action a trust SHOULD take is to comply with a minor breach that did not justify regulatory action, to prevent it failing to comply with legal requirements in future, or to improve services.

**Action the trust MUST take to improve**

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

**Wards for people with Learning Disability or autism**

- The trust must ensure that the internal and external environments at Walkers Close bungalows 3 and 4 are clean, secure, maintained and suitable for the purpose for which they are being used.
- The trust must ensure that they are following the trusts ligature removal and reduction policy and are doing all that is reasonably practicable to reduce ligature risks in bungalows 3 and 4 Walkers Close.

This was a breach of Regulation 12 Safe Care and Treatment

- The trust must ensure that the environment is conducive to effective therapeutic intervention.

This was a breach of Regulation 15 premises and equipment

**Community mental health services for people with learning disabilities or autism**

- The trust must ensure there are enough staff at the adult ADHD service and that caseloads are safe and manageable.

This was a breach of Regulation 12 Safe care and treatment

- The trust must improve the waiting times for patients to access an assessment at the adult and CAMHS autism service and the adult ADHD service.

This was a breach of Regulation 9 Person-centred care

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

- The trust must ensure staff complete observations in line with trust policy.
- The trust must ensure that medicine administrations are recorded clearly on prescription charts.
- The trust must ensure that medicines are administered in line with prescribers intended limits.
- The trust must ensure controlled drugs are stored and managed in line with trust and national guidance.
- The trust must ensure that a robust audit process is in place that identifies and rectifies errors and omissions on prescription charts.
- The trust must ensure that a female only day space is available on Yare ward.

This was a breach of Regulation 12 Safe care and treatment

- The trust must ensure that staff implement the trust smoke free policy.
- The trust must ensure that staff clearly communicate when patients are transferred between wards in Suffolk.
- The trust must ensure that staff record whether a patient's carer/advocate has been informed and the decision making around termination of seclusion when a patient has been secluded

# Summary of findings

- The trust must ensure that all staff complete mandatory training.
- The trust must ensure that all eligible staff have a regular appraisal.

This was a breach of Regulation 17 Good Governance

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

- The trust must ensure risk assessments are updated routinely and after incidents to reflect the patient's current presentation
- The trust must ensure medical equipment is regularly checked and each service has the necessary medical equipment to carry out physical health checks as required
- The trust must ensure they adhere to the medicines management policy, processes and procedures regarding safe storage and dispensing of medication.
- The trust must ensure all ligature risk assessments capture all risks
- The trust must ensure physical health checks are recorded on their electronic system
- The trust must ensure all patients have a care plan
- The trust must ensure all staff are supervised regularly
- The trust must ensure all mandatory training meets the trust target
- The trust must ensure psychology waiting lists are addressed

This was a breach of Regulation 12 Safe care and treatment

- The trust must ensure all patients have a care plan and that this addressed their needs

This was a breach of Regulation 9 Person-centred care

**Specialist community mental health services for children and young people**

- The trust must ensure adequate staff resources are available to reduce the patient waiting lists for triage, assessment and treatment in the children and young person service and for attention deficit hyperactivity disorder patients.
- The trust must ensure that staff receive regular line management, clinical supervision and appraisal in the children and young person service.

This was a breach of Regulation 18 Staffing

- The trust must review governance systems to ensure compliance with actions from past CQC inspections in the children and young person service.
- The trust must ensure they support all managers to use the trust's governance systems and performance management systems in the children and young person service.
- The trust must review and improve their systems for engaging and communicating with patients, carers, staff and stakeholders about the children and young person service.

This was a breach of Regulation 17 Good Governance

- The trust must review their systems to ensure that patients have risk assessments and care plans in the children and young person service.

# Summary of findings

- The trust must review their policy and process for ligature risk assessment in community teams, to ensure ligature risks are identified and managed in the children and young person service.
- The trust must ensure checks of automated external defibrillators take place as per the trust's standard.
- The trust must ensure that staff in the children and young person service follow the trust's infection control procedures and processes.

This was a breach of Regulation 12: Safe care and treatment

- The trust must ensure that systems and processes are established and operated effectively to prevent abuse of patients in the children and young person service.

This was a breach of Regulation 13: Safeguarding service users from abuse and improper treatment.

**Mental health crisis services and health-based places of safety**

- The trust should ensure that there are effective audit processes in place to identify and rectify medicines administration shortfalls and compliance with medicines related policies.
- The trust must ensure that contemporaneous records are kept for people who use health- based places of safety.

This was a breach of Regulation 12: Safe care and treatment

- The trust must ensure all staff are aware of the trust provision for senior medical cover.

This was a breach of Regulation 18: Staffing

- The trust must ensure that teams have access to policies that reflect the service provided.
- The trust must ensure that there are enough staff to safely manage the health-based places of safety and to meet emergency referral targets.

This was a breach of Regulation 17 Good governance

Action a trust SHOULD take is to comply with a minor breach that did not justify regulatory action, to prevent it failing to comply with legal requirements in future, or to improve services.

**Wards for people with a Learning Disability or autism**

- The trust should ensure that medicines audits are robust, and all medication errors are reported as per trust policy.
- The trust should ensure that all care plans are easy to find and in the correct place on the electronic record.

**Community mental health services for people with learning disabilities or autism**

- The provider should ensure speech and language provision is sought as soon as possible for the learning disability Waveney service.
- The provider should ensure that supervision is provided for all staff.

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

- The trust should ensure that body maps are completed after incidents or record where there is not appropriate.
- The service should ensure a process is in place for debriefing staff and patients after administration of rapid tranquilisation medicines.

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

- The trust should ensure the risk register is consistent across all services

# Summary of findings

- The trust should ensure all managers have oversight of allocation of referrals and staff caseloads
- The trust should ensure the staffing establishment reflects the current pace of referrals incoming to services

**Specialist community mental health services for children and young people**

- The trust should ensure that all staff understand and follow the trust's complaints policy in the children and young person service.

**Mental health crisis services and health-based places of safety**

- Managers at Woodlands House, Ipswich Hospital should review the security arrangements for keys for the clinic room.

**Wards for older people with mental health problems**

We found the following areas for improvement:

- The trust should review the environment on Laurel ward, Abbeygate to meet dementia friendly environment guidance.
- The trust should ensure that there are appropriate levels of cleanliness and infection control on Maple ward, Abbeygate and that internal systems provide this assurance.
- The trust should ensure that staff record capacity and best interest decisions on the correct document named in the trust policy.
- The trust should ensure that staff complete medicines administration records and clinic room checks on Abbeygate ward.

## Is this organisation well-led?

Our comprehensive inspections of NHS trusts have shown a strong link between the quality of overall management of a trust and the quality of its services. For that reason, we look at the quality of leadership at every level. We also look at how well a trust manages the governance of its services – in other words, how well leaders continually improve the quality of services and safeguard high standards of care by creating an environment for excellence in clinical care to flourish.

Our rating of the trust improved. We rated it as requires improvement because:

- We rated well-led, responsive, effective and safe as requires improvement and caring as good. In rating the trust, we took into account the previous ratings of the three core services not inspected this time. We rated the trust overall for well-led as requires improvement. This was an improvement from the last inspection. Four of the trust's 11 core services are now rated as good and five as requires improvement, one core service was rated as outstanding and one core service rated as inadequate.
- The trust board and senior leadership team were newly formed. At our inspection in 2018 we had significant concerns about the safety, culture and leadership of the trust. Since then, there had been a change in leadership. At this inspection, we found that although some of the concerns had not fully been addressed, there had been a shift in approach and foundations had been laid to improve the direction of travel. We saw early improvements in almost all areas, but there had not been enough time to judge if these changes would be sustained. For instance, recent changes to the leadership structure had not yet embedded throughout the whole organisation and there was still a small amount of key posts to be filled. We saw early improvement with the trust moving in the right direction, however, there was still work to be done.

# Summary of findings

- The trust had not fully addressed all issues reported at previous inspections. For instance, waiting lists remained high in the specialist children and young people community mental health teams. Staffing was also a concern within this core service. We saw risk assessments were not always updated within this core service.
- The environment in the learning disability inpatient service was not safe or fit for purpose. The trust had made little attempt to remove or reduce the number of ligature points or improve lines of sight, nor was it a recovery focussed environment, as it did not encourage independence due to the number of risks within the environment. We had identified in the last inspection that not all wards were safe and fit for purpose.
- Managers did not have effective oversight of medicines management nor checking of emergency equipment in six of the eight core services we inspected. Despite increased assurance work and an improved board assurance framework, medicines management issues we found had not been identified as a concern by the trust.
- The trust missed opportunities to prevent or minimise harm. For instance, we found that the management of patients on enhanced observations was not always robust within the inpatient wards with gaps being found in some documents. This posed a direct risk to patient safety. Staff did not ensure patient records in all section 136 suites were completed or added to the system in a timely manner. This posed a risk to patient safety as if the patient accessed another service within the trust there would be no information or previous plan for staff to access and use when making clinical decisions. Staff did not consistently implement the smoke free policy. This led to patient frustration and increased the risk of fire setting. Inspectors found cigarette lighters in patient rooms on two occasions during inspection. Lighters were not permitted on the wards but systems to prevent this were not always effective.
- We continued to see similar themes and recommendations (such as poor documentation in clinical records) from serious incident reviews which demonstrated learning was not always effective in improving practice. The trust recognised this and were proactively exploring ways to ensure learning took place across teams.
- Some services had not yet embraced the cultural changes leaders were trying to develop. In one location across two core services we were concerned that some staff continued to report a lack of engagement with managers and pockets of low morale. We also saw evidence of bullying in one team in Norwich. The trust had sight of these issues and had acted, however action taken had not yet been sufficiently embedded to create wholesale change.
- Some stakeholders did not feel that changes had truly positively impacted all patients, with feedback advising that some still did not feel listened to, with poor communication being a key feature of feedback from patients or their families. Equally, a lack of access to attention deficit hyperactivity disorder (ADHD) services and specialist children and adolescent community services (CAMH) was raised as a concern by stakeholders. We found that this aligned with our findings at this inspection.
- The new governance and management structure were not yet fully implemented and embedded within the new care groups. For example, the role of the people participation lead was new and not yet fully developed. Not all staff fully understood the roles and responsibilities of the leads. Leaders had not yet successfully provided all teams across the organisation with an understanding of how the new care groups worked. Some staff expressed concern that the organisational changes were too fast and lacked consultation. However, some staff from the specialist community and children and adolescent teams felt change was not fast enough to ensure patient care was sufficiently improved.
- Not all teams provided a range of treatment and care for patients based on national guidance and best practice. Some community services had significant waiting times for psychological therapies. Teams lacked sufficient psychology staff to provide the range of care recommended by the National institute for Health and Care Excellence guidelines.

However:

- Since the last inspection the trust had implemented a new quality strategy to include quality improvement (QI) as a core component within their strategic direction. The trust quality improvement plan (QIP) had been revised and was

aligned to the new strategy. One hundred and eighty-seven staff had completed the three-day improvement leaders programme and were developing initiatives within local teams designed to improve care. Some of these initiatives had been identified as important by the local service users reflecting leaders increased focus on service user participation and co-production. We saw some of these initiatives within the local teams and noted increased efforts made to engage and listen to the service users voice. Staff across services told us that they were involved in the planning and delivery of their own service.

- The trust had a 'putting people first' strategy aimed at improving service user participation and to facilitate cultural change and de-centralise decisions. Concerns had been raised about organisational culture in the last four inspection reports, and the 2018 inspection report identified concerns that there was widespread low morale with staff feeling 'done to'. Following the 2018 inspection, the trust leadership team undertook (and continued to undertake) a range of engagement visits to services ensuring they were accessible to staff, although some staff reported that were unaware of visits to their services. At this inspection, more staff reported a sense of optimism and hope that real change was happening. More staff felt listened to, felt they could influence change, felt supported and had good working relationships with their managers.
- The trust had improved its approach to learning from and managing serious incidents as a result of feedback from families and staff. Trust committees and the trust board had sight of incident data. The trust took proactive steps to address themes identified and improve ways to share learning across services. A new serious incident scrutiny panel and serious incident team had been created to report findings from investigations to the board. The trust recognised there was still work to be done to embed and improve this process further.
- The trust collected reliable data and analysed it. This was a significant improvement from the last inspection. Staff across most services could find the data they needed, in easily accessible formats, to understand performance, make decisions and improvements. The information systems were integrated and secure. Staff submitted data or notifications to external organisations as required. New ways of monitoring and addressing waiting lists had been implemented with evidence that many lists had reduced. This meant leaders were able to understand what was happening in their organisation and act when needed.
- The trust had participated in some national improvement and innovation projects and undertook a wide range of quality audits and research. The trust was involved in 65 approved research projects during 2018-19 with 1800 people recruited over the year. The trust was recognised as being in the top 15 highest mental health organisations nationally for research recruitment. The trust had undertaken a quality improvement programme, steered by the Royal College of Psychiatrists, to reduce the incidents of restrictive interventions and restraints as part of a national programme. This was a significant piece of work which continued to have impact. The programme involved the patient voice who shared their experiences with staff. This success has been recognised by the Royal College of Psychiatrists who are leading the national programme.

## Ratings tables

| Key to tables | | | | | |
|---|---|---|---|---|---|
| Ratings | Not rated | Inadequate | Requires improvement | Good | Outstanding |
| Rating change since last inspection | Same | Up one rating | Up two ratings | Down one rating | Down two ratings |
| **Symbol *** | ➔➔ | ↑ | ↑↑ | ↓ | ↓↓ |
| Month Year = Date last rating published | | | | | |

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

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

### Ratings for the whole trust

| Safe | Effective | Caring | Responsive | Well-led | Overall |
|---|---|---|---|---|---|
| Requires improvement ↑ Oct 2019 | Requires improvement ➔➔ Oct 2019 | Good ➔➔ Oct 2019 | Requires improvement ↑ Oct 2019 | Requires improvement ↑ Oct 2019 | Requires improvement ↑ Oct 2019 |

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

## Ratings for mental health services

| | Safe | Effective | Caring | Responsive | Well-led | Overall |
|---|---|---|---|---|---|---|
| Acute wards for adults of working age and psychiatric intensive care units | Requires improvement ↑ Oct 2019 | Requires improvement → ← Oct 2019 | Good ↑ Oct 2019 | Requires improvement ↑ Oct 2019 | Requires improvement ↑ Oct 2019 | Requires improvement ↑ Oct 2019 |
| Wards for older people with mental health problems | Good ↑ | Good → ← | Good → ← | Good → ← | Good ↑ | Good ↑ |
| Wards for people with a learning disability or autism | Inadequate ↓ Oct 2019 | Good ↑ Oct 2019 | Good ↑ Oct 2019 | Requires improvement ↓ Oct 2019 | Good ↑ Oct 2018 | Requires improvement → ← Oct 2019 |
| Community-based mental health services for adults of working age | Requires improvement ↑ Oct 2019 | Requires improvement → ← Oct 2019 | Good → ← Oct 2019 | Good ↑ Oct 2019 | Requires improvement ↑ Oct 2019 | Requires improvement ↑ Sept 2019 |
| Mental health crisis services and health-based places of safety | Requires improvement → ← Oct 2019 | Good → ← Oct 2019 | Good → ← 2019 | Requires improvement → ← 2019 | Requires improvement ↑ 2019 | Requires improvement → ← 2019 |
| Specialist community mental health services for children and young people | Requires improvement ↑ Oct 2019 | Requires improvement ↓ Oct 2018 | Requires improvement ↓ Oct 2019 | Inadequate → ← Oct 2019 | Inadequate → ← Oct 2019 | Inadequate → ← Oct 2019 |
| Community-based mental health services for older people | Good ↑ Oct 2019 | Good ↑ Oct 2019 | Good → ← Oct 2019 | Good ↑ Oct 2019 | Good ↑ Oct 2019 | Good ↑ Oct 2019 |
| Community mental health services for people with a learning disability or autism | Good → ← Oct 2019 | Good → ← Oct 2019 | Good → ← Oct 2019 | Requires improvement ↓ Oct 2019 | Good → ← Oct 2019 | Good → ← Oct 2019 |

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

# Wards for people with a learning disability or autism

**Requires improvement** 

## Key facts and figures

Norfolk and Suffolk NHS Foundation Trust have one inpatient ward for adults with learning disability and autism. The ward is located at Walker Close, Ipswich and consists of two bungalows. Bungalow number 3 has four male beds, and bungalow number 4 has four female beds, there is a further bungalow number 2 which is the administrative hub for this core service. However, at the time of our inspection managers had decommissioned two of the four female bedrooms and one of the male bedrooms because they had failed a fire inspection. At the time inspection there were two male patients and one female patient in residence.

The trust is registered with the Care Quality Commission (CQC) for the following regulated activities:

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

Treatment of disease, disorder, or injury.

At the last inspection of this core service in September 2018, the overall rating for this service was requires improvement. Safe, Effective, Caring, and Well led we rated as requires improvement while Responsive was rated as good.

At that time, we identified the following areas as actions the provider must take to improve:

- Staff must ensure that all patients have a detailed positive behaviour support plan or equivalent
- Staff must ensure that best interest decisions are clearly documented for patients who lack capacity to consent.
- Staff must ensure that Deprivation of Liberty Safeguards paperwork was completed correctly.

We also identified the following areas as actions the provider should take to improve:

- Staff should ensure that patients were supported to make decisions about their care and this is documented in their notes.
- Staff should ensure that patients with communication difficulties are involved in the planning of their care.

On this occasion our inspection was announced with 30 minutes notice to the leaders. Staff did not know we were coming. We carried out a comprehensive inspection of both the male and female bungalows.

Our inspection team consisted of a CQC inspector, a specialist advisor nurse, a specialist advisor social worker and an expert by experience.

At this inspection we found that the trust had met the requirements from the previous inspection regarding, positive behaviour support plans, documented best interest decisions for people who lacked capacity to consent, and correct completion of Deprivation of Liberty Safeguards paperwork.

Following a one-month closure in early 2019 the trust had installed a new management team to improve leadership and governance in this core service.

The service had also improved their involvement of patients in care decisions and planning for their care. The service actively used the patient participation leads to support the co-production of new care plans with patients that included risk issues and management of those risks.

# Wards for people with a learning disability or autism

Before the inspection visit, we reviewed information that we held about these services along with information requested from the trust.

During the inspection visit, the inspection team:

- spoke with two managers for the service
- carried out an inspection of the care environments
- spoke with nine other staff members, including nurses, clinical support workers, occupational therapists, behavioural therapists, social workers, and a doctor
- examined medicine management across the service
- reviewed three medication charts
- reviewed 3 patient care records
- observed three episodes of care
- spoke with two patients who were using the service and two carers, and
- Reviewed documentation and paperwork relating to the running of the ward.

## Summary of this service

Our rating of this service stayed the same. We rated it as requires improvement because:

The summary for this service appears in the Overall Summary of this report.

## Is the service safe?

**Inadequate** 

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

- The rating of inadequate was directly due the poor physical environment of the building.
- Bedrooms had several ligature points and no clear lines of observation from the corridor. We acknowledge some work had been undertaken but this was insufficient to ensure a safe environment. Mitigation was that patients always had to be supervised and escorted. This practice had the potential to restrict patients' development of confidence and skills to become independent.
- There were no nurse call bells in any patients' bedrooms, therefore patients could not summon help in an emergency. The environment was not homely, and the décor was tired and dated.
- The fence around the garden area created a potential safety risk. Patients could easily climb over the fence and abscond or attempt to climb the fence and injure themselves. Mitigation was that staff had to always supervise and escort patients. This was restrictive for patients who wanted to use the outside garden space for relaxation and leisure. There had not been any serious incidents reported relating to this risk.

- Clinical information was difficult to locate on the electronic system. There were numerous risk assessments and care plans in different places on the electronic system. To overcome this staff kept summarised paper copies as well. This meant that key information could be missed, and staff may not always have all the information they needed to deliver care.

However:

- The service had enough nursing and medical staff, who knew the patients and received basic training to keep patients safe from avoidable harm. This was an improvement from earlier in the year when there was no Consultant Psychiatrist which meant they could not accept admissions for a period of eight weeks.
- Staff assessed and managed risks to patients and themselves well. Staff had the skills required to develop and implement good positive behaviour support plans and followed best practice in anticipating, de-escalating and managing challenging behaviour.
- Although there were no designated seclusion rooms at the bungalows we did find evidence showing that staff had secluded patients in the quiet rooms. This had happened on two occasions in a six-month period, and for the shortest possible time, 15 minutes and one hour ten minutes respectfully. These rooms had suitable furniture for this purpose and staff kept correct and timely records during the seclusion period. Ward staff participated in the provider's restrictive interventions reduction programme. Recording of incidents and the use of body maps had all improved since our last inspection.
- Staff understood how to protect patients from abuse and the service worked well with other agencies to do so. Staff had training on how to recognise and report abuse, and they knew how to apply it.
- The service had a good track record on safety. The service managed patient safety incidents well. Staff recognised incidents and reported them appropriately. Managers investigated incidents and shared lessons learned with the whole team and the wider service. When things went wrong, staff apologised and gave patients honest information and suitable support. However, there was very little evidence of sharing learning from serious incidents from other services.

## Is the service effective?

**Good** ↑

Our rating of effective improved. We rated it as good because:

- Staff assessed the physical and mental health of all patients on admission. They developed individual care plans, which they reviewed regularly through multidisciplinary discussion and updated as needed. Care plans reflected the assessed needs, were personalised, holistic and recovery-oriented. Staff had worked with the patient's participation leads to co-produce a new style of care plan that, wherever possible, supported patients to make decisions about their care for themselves. This was an improvement on our previous inspection.
- Staff had undertaken care planning training, they demonstrated that they understood the difference between Care Program Approach (CPA) and non-Care Program Approach (NCPA), and their roles and responsibilities as a care co-ordinator for CPA. This was an improvement on what we found during our last inspection.
- Staff used recognised rating scales to assess and record severity and outcomes. Outcome measures included Health of the Nations Outcome Score (LD); Malnutrition Universal Screening tool (MUST); Physiological and Early Warning Signs (NEWS); and Stool record charts. Staff participated in clinical audit, benchmarking and quality improvement initiatives. Quality improvements included action plans for establishing routine use of ECG, Transfer pathway; skill mix and staff establishment.

- The team included or had access to the full range of specialists required to meet the needs of patients. Managers made sure they had staff with a range of skills needed to provide high quality care. They supported staff with appraisals, supervision and opportunities to update and further develop their knowledge and skills. Managers provided both a corporate and local induction program for new staff.
- Staff from different disciplines worked together as a team to benefit patients. They supported each other to make sure patients had no gaps in their care. The team had effective working relationships with staff from services that would provide aftercare following the patient's discharge and engaged with them early in the patient's admission to plan discharge.
- Staff understood their roles and responsibilities under the Mental Health Act 1983 and the Mental Health Act Code of Practice and discharged these well. Managers made sure that staff could explain patients' rights to them in a way they could understand and repeated this as and when required. Staff understood the provider's policy on the Mental Capacity Act 2005 and assessed and recorded capacity clearly for patients who might have impaired mental capacity. We saw evidence of best interest meetings having taken place.

However:

- Care planning information was not easy to find on the electronic record system. Staff confirmed that while all required information was on the system it was not always in the correct place, there were several care plans for each patient. To overcome this problem staff created their own hard copy summary care plans. This meant that some information may not always be available in a timely manner.

## Is the service caring?

**Good** ↑

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

- Staff treated patients with compassion and kindness. They respected patients' privacy and dignity. They understood the individual needs of patients and supported patients to understand and manage their care, treatment or condition.
- Staff involved patients in care planning and risk assessment and actively sought their feedback on the quality of care provided. Staff had been working with patients to coproduce new care plans based around "this is me". These care plans were considered alongside the standard electronic care plans. As part of care planning staff encouraged patients to discuss their likes and dislikes using visual cue cards to identify their hopes and fears. This was an improvement on our previous findings. Staff ensured that patients and their carers and family had easy access to independent advocates.
- Patient participation leads, people who were employed by the trust to ensure that patients and carers voices were heard at senior management level, had regular contact with the ward, the patients and their families and carers.
- Staff informed and involved families and carers appropriately. One carer told us staff had been particularly informative about why their relative behaved the way they did when they visited the ward and gave them some practical advice on how to respond to these behaviours. Another carer told us staff had explained the complexity of their relative's mental health condition and how they planned to ensure they would find the correct placement upon discharge, so that this did not break down as other placements had done.

# Wards for people with a learning disability or autism

## Is the service responsive?

**Requires improvement**  

Our rating of responsive went down. We rated it as requires improvement because:

- The design and safety of the bungalows did not support patient's treatment. Due to the high level of ligature points, mitigation for this was always that staff supervise and observe patients. This restricted patient's ability to develop enough confidence or coping skills to achieve their optimum level of independence or effective independent living skills. The décor was tired and dated and not homely.
- We were told of at least one patient who had to receive care out of service for a period of time due to the building at Walker Close not being appropriate to meet their needs. This patient was eventually brought back to the Trust. However, the design of the buildings used for learning disability inpatient services, meant this patient and one other, were cared for on alternative wards not designed to meet their individual needs.

However:

- Staff planned and managed discharge well. They liaised with services that would provide aftercare and were assertive in managing the discharge care pathway. As a result, patients did not have excessive lengths of stay and discharge was rarely delayed for other than a clinical reason.
- When patients were moved between services, such as from Walker Close to acute or PICU wards, staff maintained contact with patients during their stay on another ward and gave support to the receiving nursing staff. Staff continued to work with other agencies to locate appropriate aftercare placements and support, if transfer back to Walker Close was not possible.
- The food was of a good quality and staff made patients hot drinks and snacks at any time they requested them. The bungalows met the needs of all patients who used the service – including those with a protected characteristic. Staff helped patients with communication, advocacy and cultural and spiritual support.
- The service treated concerns and complaints seriously, investigated them and learned lessons from the results, and shared these with the whole team and the wider service.

## Is the service well-led?

**Good**  

Our rating of well-led improved. We rated it as good because:

- Leaders had the skills, knowledge and experience to perform their roles, had a good understanding of the services they managed, and were visible in the service and approachable for patients and staff. Leadership within this core had recently been reviewed to address the leadership issues we found on our last inspection.
- Staff knew and understood the provider's vision and values and how they were applied in the work of their team. Though some staff told us they were anxious that the trust had been considering plans to close this core service. Staff felt the trusts vision for how people with learning disability and autism should be managed in the hospital setting appeared to be leaning towards more mainstream mental health hospital care.

# Wards for people with a learning disability or autism

- Staff felt respected, supported and valued. They reported that training to enable them to carry out their roles effectively was readily available. Healthcare support workers told us managers encouraged them to be involved in clinical discussion about the people they cared for, and psychologists or the doctors facilitated education sessions to help them better understand their patients' behaviours.
- Staff reported that the provider promoted equality and diversity in its day-to-day work and in providing opportunities for career progression. They felt able to raise concerns without fear of retribution.
- Our findings from the other key questions demonstrated that governance processes operated effectively at ward level and that performance and risk were managed well.
- Managers were aware of the limitations that the environment at Walkers placed on them and their ability to offer a more therapeutic environment. We heard about a service review that was due to take place regarding this service, and which would be addressing this issue.
- Earlier in the year managers had taken the decision to close this ward for four weeks, as they did not have a suitably qualified responsible clinician to oversee the service. Managers told us this decision was discussed at length with the trust board, medical and senior multidisciplinary colleagues. Patients were transferred to other services and staff continued to support them and their nursing colleagues in the new environments. Some staff took advantage of this down time to refresh and update their training, while managers had opportunity to revise their admission criteria to ensure that they only took priority patients who they could work with effectively and safely within the limitations of their environment.
- Managers had access to the information they needed to provide safe and effective care and used that information to good effect.
- Staff engaged actively in local and national quality improvement activities. Managers had implemented the Green Light Tool Kit for learning disability, a range of practical materials including an audit framework designed to improve the quality of mental health services for adults with learning disability and autism.

However:

- Staff had not picked up a medicine error as part of their medicines check and audit. The error was that staff had administered, as required (PRN), medicines outside of the prescribed limits within a 24-hour period. We asked staff to complete an incident form in line with Trust policy. The administration of PRN medication was an issue reported on at a previous inspection, the trusts action plan for this was that the clinical team lead would ensure that PRN medication was being given appropriately, monitored and recorded.
- The new care groups had only just been implemented and some staff were not clear on how this would impact on their service or what it meant.

## Areas for improvement

We found areas for improvement in this service. See the Areas for Improvement section above.

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

**Requires improvement** 

## Key facts and figures

Norfolk and Suffolk NHS Foundation Trust provides acute and psychiatric intensive care support across twelve inpatient wards at five locations across Norfolk and Suffolk.

There are 206 beds in total.

Wards are located at:

**Chatterton House, King's Lynn:**

Samphire is a 16 bedded mixed sex acute admission ward.

**Hellesdon Hospital, Norwich:**

Thurne is a 15 bedded mixed sex admission and assessment ward.

Waveney is a 20 bedded female acute admission ward.

Glaven is a 20 bedded male acute admission ward.

Yare is a 16 bedded mixed sex acute admission ward (opened in September 2019).

Rollesby is a 10 bedded mixed sex psychiatric intensive care unit.

**Coastlands-Northgate, Great Yarmouth:**

Yarmouth Acute Ward is a 20 bedded mixed sex ward for acutely unwell patients.

**Wedgwood House, Bury St Edmunds**:

Northgate is a 21 bedded mixed sex acute admission ward.

Southgate is a 16 bedded mixed sex acute admission ward.

**Woodlands Ipswich:**

Avocet is a 21 bedded mixed sex acute ward.

Poppy is a 21 bedded mixed sex acute ward.

Lark is a 10 bedded mixed sex psychiatric intensive care unit.

This was an unannounced, comprehensive inspection.

The service was last inspected in September 2018 when an unannounced inspection took place to review actions required from previous inspections. The following requirement notices were issued to the Trust, following the inspection in September 2018 for the following regulatory breaches:

- Regulation 9 HSCA (RA) Regulations 2014 Person-centred care
- Regulation 10 HSCA (RA) Regulations 2014 Dignity and respect
- Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment
- Regulation 13 HSCA (RA) Regulations 2014 Safeguarding service users from abuse and improper treatment

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

- Regulation 16 HSCA (RA) 2014 Receiving and acting on complaints
- Regulation 17 HSCA (RA) Regulations 2014 Good governance
- Regulation 18 HSCA (RA) Regulations 2014 Staffing.

Before the inspection visit, we reviewed information that we held about these services and information requested from the trust.

During the inspection visit, the inspection team:

- spoke with 42 patients who were using the service and 11 carers
- spoke with the managers/leaders for each of the wards
- spoke with four modern matrons and a lead nurse
- spoke with 50 other staff members; including doctors, nurses, healthcare workers, occupational therapists, psychologists and pharmacists
- observed nine meetings and nine episodes of care
- reviewed documentation relating to the service, including policies and procedures and meeting minutes
- reviewed 78 records relating to patient risk assessments, physical health and care plans, and 62 patient prescription charts
- reviewed 37 records relating to episodes where staff secluded patients.

## Summary of this service

Our rating of this service improved. We rated it as requires improvement because:

The summary for this service appears in the Overall Summary of this report.

## Is the service safe?

**Requires improvement**  

Our rating of safe improved. We rated it as requires improvement because:

- Staffing and retention remained a challenge for the trust and wards frequently worked with fewer staff than planned. Staff described difficulties in meeting the demands of their roles.
- Staff were not completing hourly observations in line with trust policy. We found missing signatures on observation sheets and gaps in observations on four out of five wards that we checked. We could not be assured that observations were being completed correctly which could have an impact on patient safety.
- Staff did not always follow systems and processes when safely prescribing, administering, recording and storing medicines. Staff did not always keep accurate records of medicines administered, and sometimes medicines were administered above the limits of the prescription.
- Staff were not sufficiently supported with implementing the trust smoke free policy. Staff told us there was inconsistency in the way that managers implemented the policy

- Staff had not completed daily and weekly checks of emergency equipment, including defibrillators and emergency grab bags, on five wards

However:

- All wards were safe, clean, well equipped, well furnished, well maintained and fit for purpose. The trust had addressed the inconsistent quality of environmental risk assessments and addressed the environmental risks found at the last inspection, including identification and mitigation of fixed ligature points, replacing unsafe soap and towel dispensers and installation of improved CCTV systems.
- Staff assessed and managed risks to patients and themselves well and followed best practice in anticipating, de-escalating and managing challenging behaviour. Ward staff participated in the provider's promoting positive practice programme and there had been a reduction in the number of episodes of restrictive practice across all wards.
- Staff understood how to protect patients from abuse and the service worked well with other agencies to do so. Staff had training on how to recognise and report abuse, and they knew how to apply it.
- Staff had easy access to clinical information and it was easy for them to maintain high quality clinical records.

## Is the service effective?

**Requires improvement** 

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

- There was not adequate psychology provision in Suffolk. Patients on some wards had not had access to adequate psychological therapies and support, in accordance with National Institute for Clinical Excellence guidelines, since December 2018.
- The appraisal rates for non-medical staff were lower than the trust target of 90% for seven wards.

However:

- Staff assessed the physical and mental health of all patients on admission. They developed individual care plans, which they reviewed regularly through multidisciplinary discussion and updated as needed. Care plans reflected the assessed needs, were personalised, holistic and recovery-oriented. This was an improvement since the last inspection when care plans were generic and lacked the patient voice.
- Staff used recognised rating scales to assess and record severity and outcomes. They also participated in clinical audit, benchmarking and quality improvement initiatives.
- Managers made sure they had staff with a range of skills need to provide high quality care. They supported staff to update and further develop their skills. Managers provided an induction programme for new staff.
- Staff from different disciplines worked together as a team to benefit patients. They supported each other to make sure patients had no gaps in their care.
- Staff understood their roles and responsibilities under the Mental Health Act 1983 and the Mental Health Act Code of Practice and discharged these well. Managers made sure that staff could explain patients' rights to them.
- Staff supported patients to make decisions on their care for themselves. They understood the provider's policy on the Mental Capacity Act 2005 and assessed and recorded capacity clearly for patients who might have impaired mental capacity.

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

## Is the service caring?

**Good** ↑

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

- Staff treated patients with compassion and kindness. They respected patients' privacy and dignity. They understood the individual needs of patients and supported patients to understand and manage their care, treatment or condition.
- Staff involved patients in care planning and risk assessment and actively sought their feedback on the quality of care provided. They ensured that patients had easy access to independent advocates.
- Staff informed and involved families and carers appropriately.

## Is the service responsive?

**Requires improvement** ↑

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

- The planning of patient's discharge did not always contribute to people staying out of hospital. The total number of readmissions within 28 days had not changed significantly since the last inspection from 253 to 245 readmissions. The number of readmissions to any ward had decreased on four wards but had increased on six wards.
- Staff did not always clearly communicate when patients were transferred between wards in Suffolk.

However

- The design, layout, and furnishings of the ward/service supported patients' treatment, privacy and dignity. Each patient had their own bedroom and could keep their personal belongings safe. There were quiet areas for privacy.
- The food was of a good quality and patients could make hot drinks and snacks at any time.
- The service met the needs of all patients who used the service – including those with a protected characteristic. Staff helped patients with communication, advocacy and cultural and spiritual support.
- The trust had developed a system-wide action plan and opened a new ward to address the high number of out of area placements which was a concern at the last inspection. As of October 2019, the trust had 19 out of area placements which was a significant reduction since March 2019.
- The service treated concerns and complaints seriously, investigated them and learned lessons from the results, and shared these with the whole team and the wider service.

## Is the service well-led?

**Requires improvement** ↑

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

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

- Managers did not have effective oversight of medicines management and checking of emergency equipment. We found errors with medicine management and checking of emergency equipment on all wards across the acute service.
- Managers did not provide consistent support to staff to implement the trust smoke free policy.
- Managers did not have effective systems in place to ensure staff were observing patients in accordance with trust policy.
- The trust did not provide opportunities for staff across all disciplines to meet together and share learning.

However:

- Leaders had the skills, knowledge and experience to perform their roles, had a good understanding of the services they managed, and were visible in the service and approachable for patients and staff.
- Staff knew and understood the provider's vision and values, how they were applied in the work of their team and demonstrated them in their day to day work.
- Most of the staff we spoke with felt that the culture of the trust was improving. Staff felt more listened to, more positive about working for the trust and that senior managers were more visible. Staff told us they felt empowered to make changes and the new management structure was working well.
- Our findings from the other key questions demonstrated that governance processes operated effectively at ward level and that performance and risk were managed well.
- Ward teams had access to the information they needed to provide safe and effective care and used that information to good effect.
- Staff engaged actively in local and national quality improvement activities.

## Areas for improvement

We found areas for improvement in this service. See the Areas for Improvement section above.

# Wards for older people with mental health problems

**Good** ➔➔

See guidance note ICS 1 – then delete this text when you have finished with it.

## Key facts and figures

Norfolk and Suffolk NHS foundation Trust provides inpatient care to older patients in seven wards at four locations.

At Julian Hospital, Norwich in the Norfolk area there are four wards for older patients.

- Sandringham Ward is an acute admissions unit. It provides care and treatment to men and women with a functional mental health diagnosis. It had 16 beds, at the time of inspection and there were 16 patients.
- Beach ward is an acute admission ward for men with dementia. It offers assessment, and treatment for patients with acute care needs. It had 13 beds, at the time of inspection and there were 13 patients.
- Rose Ward is a mixed gender, sub-acute treatment ward for men and women experiencing dementia. It had 13 beds, at the time of inspection and there were 13 patients.
- Reed Ward is an acute admission ward for women with dementia. It offers assessment and treatment for patients with acute care needs. It had 12 beds, at the time of inspection and there were 12 patients.

At Carlton Court, Lowestoft in the Great Yarmouth and Waveney area there is one ward, Laurel Ward.

- Laurel Ward is a mixed gender admission and treatment unit. It provides care and treatment to men and women with dementia. The ward had 11 beds. At the time of inspection there were 10 patients.

At Ipswich hospital in the East Suffolk area, there is one ward known as the Willows, it is divided into two distinct and separate areas for older adults.

- The Willows is a mixed gender admission, assessment and treatment unit. It provides assessment, care and treatment for men and women with functional mental health diagnosis and dementia. The ward had 21 beds, 11 of these beds where for patients experiencing dementia, and 10 beds for patients experiencing functional mental illness.

At West Suffolk Hospital, Bury St Edmunds there is one ward for older patients known as Abbeygate, divided into two wards known as Laurel and Maple.

- Laurel Ward is a mixed gender acute admission and treatment ward for older people with dementia. It has seven beds, and at the time of inspection there were seven patients.
- Maple Ward is a mixed gender, acute admission and treatment ward for older people with functional mental illness diagnosis. It has 10 beds, and at the time of inspection there were 10 patients.

The last comprehensive inspection of this core service was in September 2018. At that time, we found the service had breached the following regulations: -

**Regulation 12(2)a,b.**

The trust must ensure they assess the risks to health and safety of patients while they are receiving treatment and care and do all that is reasonably practical to mitigate any such risks, including ligature reduction work on the wards.

The trust must ensure that they assess prevent and reduce the risk associated with the control and spread of, infections, including those that are health care associated.

# Wards for older people with mental health problems

**Regulation 17(2)e**

The Trust must ensure they seek and act on feedback from relevant persons and other persons in the services provided in the carrying on of the regulated activity, for the purposes of continually evaluating and improving such services.

We reviewed the breaches in detail at this inspection and found that the provider had taken actions to address the breaches and improve the care and treatment provided to patients.

The inspection of older adult inpatient wards took place between 8 and 18 October 2019. During the visits the inspection team:

- visited all seven wards and looked at the quality of the ward environment and observed how staff were caring for patients
- spoke with 14 patients who were using the service
- spoke with 14 carers of people using the service
- interviewed the managers or acting managers for each of the wards and two senior managers
- spoke with 32 other staff members; including nurses, doctors, occupational therapists, support workers and an advocate
- attended and observed two handover meetings two multidisciplinary clinical meetings, one board-round and two safety huddles
- looked at 34 care and treatment records of patients
- carried out a specific check of 45 medication charts
- Looked at a range of policies, procedures and other documents relating to the running of the service.

## Summary of this service

Our rating of this service stayed the same. We rated it as good because:

The summary for this service appears in the Overall Summary of this report.

## Is the service safe?

**Good**  

Our rating of safe stayed the same. We rated it as good because:

- All wards were safe, generally clean, well equipped, well furnished, well maintained and fit for purpose.
- The service had enough nursing and medical staff, who knew the patients and received basic training to keep patients safe from avoidable harm
- Staff assessed and managed risks to patients and themselves well and followed best practice in anticipating, de-escalating and managing challenging behaviour. Staff used restraint and seclusion only after attempts at de-escalation had failed. The ward staff participated in the provider's restrictive interventions reduction programme.

# Wards for older people with mental health problems

- Staff understood how to protect patients from abuse and the service worked well with other agencies to do so. Staff had training on how to recognise and report abuse, and they knew how to apply it.
- Staff had easy access to clinical information and it was easy for them to maintain high quality clinical records – whether paper-based or electronic.
- The wards had a good track record on safety. The service managed patient safety incidents well. Staff recognised incidents and reported them appropriately. Managers investigated incidents and shared lessons learned with the whole team and the wider service. When things went wrong, staff apologised and gave patients honest information and suitable support.

However;

- We inspected the male corridor of Maple ward, Abbeygate and were struck by very offensive odours emitting from a patient's bedroom. The contract cleaning team had been instructed not to clean if the patient was in his room, this had not been relayed to the nursing team. We raised this with the ward manager, who arranged for an immediate deep clean of the room. This was completed at the time of our inspection.
- There were gaps in medicines administration records and clinic room checks on Abbeygate ward which meant that medicines related policies were not being followed.

## Is the service effective?

**Good** 

Our rating of effective stayed the same. We rated it as good because:

- Staff assessed the physical and mental health of all patients on admission. They developed individual care plans, which they reviewed regularly through multidisciplinary discussion and updated as needed. Care plans reflected the assessed needs, were personalised, holistic and recovery-oriented.
- Staff provided a range of care and treatment interventions suitable for the patient group and consistent with national guidance on best practice. They ensured that patients had good access to physical healthcare and supported patients to live healthier lives.
- Staff used recognised rating scales to assess and record severity and outcomes. They also participated in clinical audit, benchmarking and quality improvement initiatives.
- The ward teams included or had access to the full range of specialists required to meet the needs of patients on the wards. Managers made sure they had staff with a range of skills needed to provide high quality care. They supported staff with appraisals, supervision and opportunities to update and further develop their skills. Managers provided an induction programme for new staff.
- Staff from a wide range of different disciplines worked together as a team to benefit patients. They supported each other to make sure patients had no gaps in their care. The ward teams had effective working relationships with other relevant teams within the organisation and with relevant services outside the organisation.
- Staff understood their roles and responsibilities under the Mental Health Act 1983 and the Mental Health Act Code of Practice and discharged these well. Managers made sure that staff could explain patients' rights to them.

However;

# Wards for older people with mental health problems

- We reviewed 34 patient records we saw capacity assessment records relating to hospital admission and treatment, but not best interest decision records, where patients did not have capacity. We looked at 16 records where medication was administered covertly, we saw that staff had assessed capacity and were able to locate evidence of best interest's discussion in narrative of patient notes, but not on the required form.

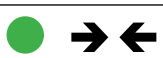
## Is the service caring?

**Good** 

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

- Staff treated patients with compassion and kindness. They respected patients' privacy and dignity. They understood the individual needs of patients and supported patients to understand and manage their care, treatment or condition.
- Staff involved patients in care planning and risk assessment and actively sought their feedback on the quality of care provided. They ensured that patients had easy access to independent advocates.
- Staff informed and involved families and carers appropriately.

## Is the service responsive?

**Good** 

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

- Staff told us that a bed was usually available when needed and that patients were not moved between wards unless this was for their benefit. Discharge was rarely delayed for other than clinical reasons. The service had dedicated bed managers allocated to each ward who liaised between the ward and community services and providers. The service also participated in the "red to green" initiative which aimed to facilitate safe and timely discharge from hospital.
- The design, layout, and furnishings of the wards generally supported patients' treatment, privacy and dignity. Each patient had their own bedroom with an en-suite bathroom and could keep their personal belongings safe. There were quiet areas for privacy.
- The food was of a good quality and patients had access hot drinks and snacks at any time.
- The service met the needs of all patients who used the service. Staff helped patients with communication, advocacy, cultural and spiritual support.
- The service treated concerns and complaints seriously, investigated them and learned lessons from the results, and shared these with the whole team and the wider service.

However;

- The environment on Laurel ward, Abbeygate, did not meet dementia friendly environment guidance.

## Is the service well-led?

**Good** 

# Wards for older people with mental health problems

Our rating of well-led improved. We rated it as good because:

- Leaders had the skills, knowledge and experience to perform their roles and were visible in the service and approachable for patients and staff.
- Staff knew and understood the provider's vision and values and how they were applied in the work of their team.
- Staff felt respected, supported and valued. They reported that the provider promoted equality and diversity in its day-to-day work and in providing opportunities for career progression. They felt able to raise concerns without fear of retribution.
- Ward teams had access to the information they needed to provide safe and effective care and used that information to good effect.
- Staff engaged actively in local and national quality improvement activities.

However;

- Managers did not ensure there were appropriate levels of cleanliness and infection control measures on Maple Ward, Abbeygate.
- Managers did not ensure the environment on Laurel ward, Abbeygate met dementia friendly environment guidance.
- Managers did not ensure that staff recorded capacity and best interest decisions on the correct document named in the trust policy.

## Areas for improvement

### We found the following areas for improvement:

We found areas for improvement in this service. See the Areas for Improvement section above.

# Community-based mental health services of adults of working age

**Requires improvement** **Requires improvement**

## Key facts and figures

Norfolk and Suffolk foundation Trust provides community-based mental health services for adults of working age.

This service was last inspected in November 2018 and received an overall rating of inadequate, with inadequate for safe, responsive and well-led, requires improvement for effective and a rating of good for caring. A further focussed inspection was carried out in May 2019.

Community-based mental health services for adults of working age provided support to patients and their families and carers living in Norfolk and Suffolk experiencing moderate to severe mental health problems. Staff visit patients in their own homes, at community hubs and GP surgeries.

Since the inspection in 2018, the trust had restructured the senior managers into five care groups for community services across the trust and there were now four care group leads for each community core service. These leads comprised of a people participation lead, service director, lead nurse and clinical director.

In Norfolk the services were known as Community Mental Health Teams (CMHT) and in Suffolk as Integrated Delivery Teams (IDTs). In Norfolk, the CMHT comprised of professionals solely working in the adult community mental health pathway. Those patients assessed to require a high level of contact were reviewed daily using the FACT approach – Flexible Assertive Community Treatment. In Suffolk, the IDTs comprised of professionals from a range of pathways including, but not solely, adult community mental health care. The adult IDTs divided into two teams, Enhanced Care Pathway (ECP), and the adult pathway in most of the IDTs we visited. However, Coastal IDT had merged these pathways and some other IDTs were due to do this shortly. The ECP pathway provided short-term intervention, with an emphasis on developing community networks and reintegration to reduce isolation. This service worked mainly with patients with moderate depression, anxiety and personality disorders. The adult pathway provided longer term intervention for patients aged 25 years and over, with severe and enduring mental health problems, including patients over 65 years if clinically appropriate.

In Suffolk a Section 75 partnership agreement with the Local Authority was in place. This is an arrangement between a local authority and an NHS body related to the National Health Services Act 2006. There was no similar arrangement for Norfolk.

Services received their referrals via the 'single point of access' team in Norfolk and the 'access and assessment team' in Suffolk. Referrals were also received from acute teams if the patient had been seen by inpatient or crisis services.

In our November 2018 inspection, we found breaches of the following:

• Regulation 12 HSCA (RA) Regulations 2014 Safe care and Treatment

• Regulation 17 HSCA (RA) Regulations 2014 Good Governance

Although we found improvements at this inspection, we found that this core service had not fully addressed all actions from our inspection in November 2018. We found continued breaches of the following:

• Regulation 12 HSCA (RA) Regulations 2014 Safe care and Treatment

• Regulation 17 HSCA (RA) Regulations 2014 Good Governance

The trust is registered for the following regulated activities:

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

# Community-based mental health services of adults of working age

• Treatment of disease, disorder or injury.

The inspection team visited 11 community teams across Norfolk and Suffolk between 07 October and 18 October. During the inspection we visited the following teams and look at all five key questions:

• Bury North IDT

• Bury South IDT

• Coastal IDT

• Great Yarmouth CMHT

• Ipswich IDT

• Long Term Treatment team

• North Norfolk CMHT

• Norwich City CMHT

• South Norfolk CMHT

• Waveney adult CMHT

• West Norfolk CMHT

Our inspection of this core service was short announced (staff knew we were coming 5 days prior to our visit) to ensure that everyone we needed to talk to was available. Before the inspection visit, we reviewed information that we held about these services and information requested from the trust. We also asked a range of other stakeholders for information and sought feedback from patients and carers at focus groups.

We inspected all five key questions for this core service.

During the inspection visit, the inspection team:

- visited 11 teams, looked at the quality of the care and observed how staff were caring for patients
- spoke with 22 managers including team managers
- interviewed 67 staff including nurses, occupational therapists, psychiatrists, psychologists, health care support workers, administration, peer support workers and carers leads
- reviewed 57 care records of patients
- spoke with 23 patients who were using the service
- spoke with 15 carers of patients who were using the service
- attended and observed 10 meetings and activities including multidisciplinary meetings and telephone support to patients
- reviewed 32 treatment cards
- carried out a specific check of the medication management in all teams looked at policies, procedures and other documents relating to the running of the service.

## Summary of this service

# Community-based mental health services of adults of working age

The summary for this service appears in the Overall Summary of this report.

## Is the service safe?

**Requires improvement** 

Our rating of safe improved. We rated it as requires improvement because:

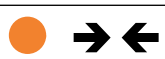
- Staff had not always updated risk assessments routinely or after incidents in all teams. This was identified as a concern at our previous inspection. We found staff had not updated risk assessments routinely or after incidents across all teams in 20 out of 57 records reviewed. We found out of date risk assessments at North Norfolk CMHT and Bury South IDT by up to four years. We found three risk assessments dated from September 2015 to April 2018 in North Norfolk CMHT, one risk assessment was dated April 2017 in Bury South. We found one patient who had been referred to Norwich City CMHT in January 2019 and did not have a risk assessment or care plan present.
- Staff at North Norfolk CMHT had not ensured medical equipment had been regularly checked. We also found this at our previous inspection. North Norfolk CMHT did not complete first aid box checks. Great Yarmouth CMHT had items out of date in the first aid box, however, replacements had been ordered before our visit. Bury North IDT had no stethoscope or ECG machine. The blood pressure machine was due for calibration in August 2019 and no update on this was present. We found West Norfolk CMHT stored cups and coffee in the clinic room. Waveney CMHT and North Norfolk CMHT did not routinely change the code to the clinic room after staff had left therefore there was a risk of unauthorised entry from previous staff.
- Staff at Great Yarmouth CMHT did not always sign medications in and out when visiting patients in the community. At Bury South IDT staff did not routinely carry out medication stock checks and we found medications unaccounted for. All IDT teams at the Bury South location used the clinic but there appeared to be no oversight of the clinic room management. Although North Norfolk CMHT were carrying out medication stock checks, we found a depot injection had expired in March 2018. This meant we could not be confident processes designed to provide assurance were effective. At North Norfolk CMHT staff could not show us spare keys for the medication cabinet. This meant that if the keys were misplaced, staff would not be able to access medicines stored in the medication cabinet.
- The ligature risk assessment at Bury South IDT did not capture all risks in each room. Environmental plans were also not always printed in colour so staff would not easily know which room was RAG rated.
- The staffing establishment had not kept pace with the number of referrals made into the service. At South Norfolk CMHT the staffing establishment was set for 750 open referrals, but the team had 1111 open referrals at the time of inspection. This impacted on the number of staff the trust was able to employ.
- At Norwich City CMHT, caseloads were very high, and the allocation of new referrals was inequitable across the staff team. Caseloads varied from 11 to 70 averaging 49. This was higher than at our previous inspection. This was above the Royal college of Psychiatrists Accreditation for Community Mental Health Services Standards for Adult Community Mental Health Services, which say full-time care co-ordinators should have a caseload of no more than 35 (reduced pro-rata for part-time staff). The earliest opportunity staff had of discussing their case load was at monthly management supervision sessions. Managers knew staff were unhappy about this situation but had no plans to address it.
- Mandatory training for Safeguarding Adults Level 3 was lower than the trusts target for compliance. Norwich City CMHT team 3 was 73%, Waveney adult community team was 70%, Bury South IDT team was 66% and at Ipswich IDT it

was 33%. These were all below our target of 75% compliance. We found the Safeguarding Children Level 3 training at Waveney adult community team and Bury North IDT it was 73%, at South Norfolk CMHT south east team it was 68%, at Ipswich IDT it was 67%, at Bury South IDT it was 59%, at Great Yarmouth CMHT and North Norfolk north west team it was 53% and at Norwich City CMHT team 3 it was 50%. These were all below our target of 75% compliance.

However:

- Staff assessed and managed risks to patients and themselves. They responded promptly to sudden deterioration in a patient's health. When necessary, staff worked with patients and their families and carers to develop crisis plans. Staff monitored patients on waiting lists to detect and respond to increases in level of risk. Staff followed good personal safety protocols.
- The teams had a good track record on safety. The service managed patient safety incidents well. Staff recognised incidents and reported them appropriately. Managers investigated incidents and shared lessons learned with the whole team and the wider service. When things went wrong, staff apologised and gave patients honest information and suitable support.
- Most clinical premises where patents received care were safe, clean, well equipped, well furnished, well maintained and fit for purpose.

## Is the service effective?

**Requires improvement** 

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

- Recording of physical health was poor across most adult community teams. We reviewed 49 care records in this area and 30 did not have physical health assessments recorded and 25 had no evidence of ongoing physical health monitoring. At Waveney CMHT we saw evidence of recording physical health checks on paper, but this was not transferred to their electronic system.
- The waiting list for psychological therapies was lengthy across all community sites we visited. Details of this can be found in the evidence appendix. Staff told us they did not feel there was enough psychology staff which impacted on rising caseloads.
- Not all care plans were reviewed regularly or up to date. We reviewed 57 care and treatment records. We found two patients at Norwich City CMHT and one patient at North Norfolk CMHT did not have a care plan present.
- Supervision rates were not meeting the trusts compliance rate. Data provided by local managers ranged from 47% in the Norwich City team 3 to 95.2% in North Norfolk CMHT. The trust's target rate for supervision compliance is 90%. Details of this can be found in the evidence appendix.

However:

- Staff used recognised rating scales to assess and record severity and outcomes. They also participated in clinical audit, benchmarking and quality improvement initiatives.
- Staff from different disciplines worked together as a team to benefit patients. They supported each other to make sure patients had no gaps in their care. The teams had effective working relationships with relevant services outside the organisation.
- Staff understood their roles and responsibilities under the Mental Health Act 1983 and the Mental Health Act Code of Practice.

# Community-based mental health services of adults of working age

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

## Is the service caring?

**Good** ➔➔

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

- Staff treated patients with compassion and kindness. They understood the individual needs of patients and supported patients to understand and manage their care, treatment or condition.
- Staff involved patients in care planning and risk assessment and actively sought their feedback on the quality of care provided. They ensured that patients had easy access to advocates when needed.
- Staff informed and involved families and carers appropriately.

## Is the service responsive?

**Good** ↑

Our rating of responsive improved. We rated it as good because:

- The service was easy to access. Its referral criteria did not exclude patients who would have benefitted from care. Staff assessed and treated patients who required urgent care promptly and patients who did not require urgent care did not wait too long to start treatment. This had improved since our previous inspection. Staff followed up patients who missed appointments.
- The service met the needs of all patients including those with a protected characteristic. Staff helped patients with communication, advocacy and cultural and spiritual support.
- The service treated concerns and complaints seriously, investigated them and learned lessons from the results, and shared these with all staff. This had improved since our previous inspection.

## Is the service well-led?

**Requires improvement** ↑

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

- There was a disconnect between some staff and senior management in Suffolk. Some community service staff within Suffolk teams said that they felt communication and visibility of higher senior management was poor. This was the same as our previous inspection. Staff across all community adult services said that a lot of things had changed and were continuing to change but it was still early days. Staff felt the introduction of the new care group leads may improve this connection, but they were all very new to post so hadn't seen much impact yet. Staff told us the care group leads were more accessible than higher senior managers. However, some staff felt that there was still a lack of cascading much needed information to move forward and were not sure of the impact this would have on their future, their jobs and the services.

# Community-based mental health services of adults of working age

- Managers at Norwich City CMHT had little oversight of caseload allocation of incoming referrals. The referral process within this team meant that the duty worker allocated patients to care coordinators and not managers, as occurred in all the other community services we visited. In Norwich City staff were aligned to the GP practices and new referrals were allocated to staff according to GP surgery. This meant that some staff had much higher caseloads than their colleagues and managers did not have oversight of the allocation process. The first chance staff were able to officially address this with managers was in monthly caseload management meetings. In this team some staff had caseloads above the maximum of 35 recommended by the Royal College of Psychiatry. Seventeen out of 41 staff had caseloads higher than 41. Eleven out of 41 staff had caseloads higher than 51. Caseloads across the whole of Norwich City CMHT varied from 11 to 70 averaging 49. Managers in this team had decided to have higher caseloads of patients to mitigate the need for a waiting list. Managers were aware that staff did not feel comfortable with this practice, however we did not hear how they intended to address the issue.
- There was inconsistency with what was placed on the risk register. Whilst demand exceeding capacity was on the risk register in Norfolk community services this also impacted on Suffolk community services, but it was not identified as a concern. Managers told us the staffing establishment was based on a significantly lower number of open referrals to their services than the number of open referrals they have. For example, South Norfolk CMHT the staffing establishment was set for 750 open referrals, but the team actually had 1111 open referrals at the time of inspection. Managers felt the staffing establishment had not kept pace with the number of referrals into the services and this impacted on staff caseloads, the services they could provide to patients and waiting lists.

However:

- Managers had the skills, knowledge and experience to perform their roles, had a good understanding of the services they managed, and were visible in the service and approachable for patients and staff. Staff felt respected, supported and valued by local managers. They felt able to raise concerns without fear of retribution.
- Staff knew and understood the provider's vision and values and how they were applied in the work of their team.
- Staff collected analysed data about outcomes and performance and engaged actively in local and national quality improvement activities.

## Areas for improvement

We found areas for improvement in this service. See the Areas for Improvement section above.

# Specialist community mental health services for children and young people

**Inadequate** 

## Key facts and figures

Norfolk and Suffolk NHS Foundation Trust provides specialist community mental health services for children and young people for patients aged 0 to 25 years throughout Norfolk and Suffolk under one registered location: Hellesdon Hospital.

We inspected 18 teams across the specialist community mental health services for children and young people:

**Suffolk**

- **Emotional Wellbeing Hub**, Landmark House, Ipswich (0-25 years). Suffolk multi-agency triage team for referrals.
- **Ipswich team**, Mariner House, 43 Handford Road, Ipswich IP1 2GA. Teams include: 0-14 years and 14-25 years youth teams.
- **Bury South team**, G Block, Hospital Road, Bury St. Edmunds, IP33 3NR. Teams include: 0-14 years, 14-25 years youth and the West Suffolk ADHD team under 18 years teams. Ickworth Lodge treatment centre is on site.
- **Bury North team**, Newmarket Hospital, Exning Road Newmarket CB8 7JG. 14-25 years youth team.
- **Coastal team**, Foxhall Road, Ipswich IP3 8LS West Suffolk 14-25 years youth team, Walker Close treatment centre is on site.
- **Central team**, Haymills House, Station Road East, Stowmarket IP14 1RF 14-25 years youth team.

**Norfolk**

- **Central Norfolk Child, Family and young Person Service,** St Stephens Road, Norwich NR1 3RE. Teams include: 14-25 years youth and crisis teams. Mary Chapman House Hotblack Road Norwich, NR2 4HN 0-14 years team.
- **Great Yarmouth and Waveney**, **Child, family and young people's service**, Northgate Hospital, Northgate Street, Great Yarmouth NR30 1BU Teams include: 0-14 years, 14-25 years youth and crisis teams. Silverwood treatment centre is on site.
- **West Norfolk Child, family and young people's service**, Thurlow House, Kings Lynn PE30 Teams include: 0-14 years, 14-25 years youth and crisis teams.

At this inspection we found that this core service had not fully addressed actions from our 2018 inspection. We found breaches of:

- Regulation 12 HSCA (RA) Regulations 2014 Safe care and Treatment
- Regulation 17 HSCA (RA) Regulations 2014 Good governance
- Regulation 18 HSCA (RA) Regulations 2014 Staffing
- Regulation 13 HSCA (RA) Regulations 2014 Safeguarding service users from abuse and improper treatment.

The trust had addressed some findings of the inspection in 2018 and was no longer in breach of:

- Regulation 16 HSCA (RA) Regulations 2014 Receiving and acting on complaints

The CQC have registered the location Hellesdon Hospital (which this core service is under) for the following regulated activities:

# Specialist community mental health services for children and young people

- Assessment or medical treatment for persons detained under the Mental Health Act 1983
- Treatment of disease, disorder or injury

Our inspection of this core service in October 2019 was unannounced (staff knew we were coming at short notice).

Before the inspection visit, we reviewed information that we held about these services and information requested from the trust.

The inspection team visited community teams on 8, 9, 10, 15, 16 and 17 October 2019.

During the inspection visit, the inspection team:

- visited teams to look at the environment
- had feedback from 19 patients who were using the service
- had feedback from 44 carers of patients who were using the service
- spoke with 20 managers of the service
- spoke with 60 staff including nurses, support workers, doctors, occupational therapists, peer support worker,
- psychologists, therapists, social workers and administration staff
- Spoke with three other professionals from external agencies
- Reviewed stakeholder feedback about the service
- observed eight staff multi-disciplinary team meetings
- observed six episodes of care
- reviewed 73 patient care and treatment records including, referral information, risk assessments and care plans.
- reviewed 24 staff records including supervision, appraisal and training records
- reviewed a range of policies, procedures and other documents relating to the running of the service.

## Summary of this service

Our rating of this service stayed the same. We rated it as inadequate because:

The summary for this service appears in the Overall Summary of this report.

## Is the service safe?

**Requires improvement** 

Our rating of safe improved. We rated it as requires improvement because:

- The trust had not fully addressed all issues reported at previous inspections.

# Specialist community mental health services for children and young people

- The trust had not ensured there were adequate staff available to meet the needs of the children and young person service and reduce the patient waiting lists for triage, assessment and treatment, since identified at our last inspection in 2018. Forty of 60 staff (67%) and nine of 20 (45%) managers we spoke with told us of staffing problems in their teams. Eleven of 18 teams we visited reported staffing vacancies and issues with not being able to recruit or gain agency staff to meet shortfalls.
- Improvements were still needed to ensure a safe and clean environment. Staff were not completing checks of automated external defibrillators at South Bury IDT and Ickworth Lodge locations as per the trust standard. We found examples where teams were not routinely monitoring cleaning of rooms and equipment. The trust had not completed accurate ligature assessments at South Bury, Great Yarmouth, Waveney and West Norfolk teams, which captured all potential risks. This meant staff would not be aware of all areas which needed more supervision.
- Staff had not fully completed or updated 28 patients (39%) comprehensive risk assessments. Staff in Norfolk and Suffolk still had different systems for assessing and monitoring risks for patients awaiting assessment.
- We found risks to patients' safety as staff did not always identify and report safeguarding concerns. HaverHill, Sudbury satellite clinics and North Bury did not have separate children waiting areas.

However:

- The trust had improved the quality of their risk registers with more identification of the service risks.
- The trust had increased the Emotional Wellbeing Hub staff establishment to include two additional band seven staff.
- The trust had given staff information for lone working to help keep them safe.
- Staff had systems in place to clean toys.
- Where managers gave us data on site teams had achieved 75% or above compliance with mandatory training.

## Is the service effective?

**Requires improvement** 

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

- The trust had not ensured that all staff had regular supervision and appraisal to ensure they had the right skills and knowledge for their role. Trust data for September 2019 showed six teams had achieved less than 75% staff compliance for appraisals, five teams did not have regular line management supervision and four teams did not have regular clinical supervision.
- Staff did not always complete a comprehensive mental health assessment of each patient who were receiving treatment as 15 care plans (21%) across teams needed improvements. Care notes across teams did not always implicitly link to care plans.
- Not all teams had a range of skilled staff, due to staff vacancies. Two stakeholders and two professionals stated that multi-disciplinary working between teams and external agencies could be improved.

However:

# Specialist community mental health services for children and young people

- Staff supported patients to make decisions on their care for themselves proportionate to their competence. They understood how the Mental Capacity Act 2005 applied to young people aged 16 and 17 and the principles of Gillick competence as they applied to people under 16. Staff assessed and recorded consent and capacity or competence clearly for patients who might have impaired mental capacity or competence. Staff understood their roles and responsibilities under the Mental Health Act 1983 and the Mental Health Act Code of Practice.
- Staff provided a range of treatment and care for patients based on national guidance and best practice. We found examples of staff using the 'THRIVE' integrated, person-centred and needs-led approach. They supported patients to live healthier lives.
- Staff used recognised rating scales to assess and record severity and outcomes such as Routine Outcome Measures (ROMS).

## Is the service caring?

**Requires improvement** 

Our rating of caring went down. We rated it as requires improvement because:

- During inspection, we found that thirteen of 19 patients (68%) and 21 of 45 (47%) carers gave negative feedback about the support provided. Feedback themes included a lack of support when they contacted teams for help during a crisis and a lack of information or communication. However, trust data indicated that 82% of patients felt they had a positive experience of the service.
- Teams were unable to show how they involved patients and parents and carers in the design and delivery of the service.

However:

- Staff treated patients with compassion and kindness, respected their privacy and dignity, and understood the individual needs of patients. They actively involved patients and families and carers in care decisions. Seventeen of 19 patients (89%) and 35 of 44 carers (78%) gave positive feedback about how caring staff were, often individuals and how staff were responsive and supported patients to manage their mental health.
- From a review of 73 care records, we saw that staff involved patients in care planning and risk assessment. When appropriate, staff involved families and carers in assessment, treatment and care planning. They supported or signposted carers for assessments.
- The emotional wellbeing hub had a peer support worker whose role was to contact families to give support, offer appointments and share information about community resources
- Youth managers said they involved patients in interviews for new staff.

## Is the service responsive?

**Inadequate** 

Our rating of responsive stayed the same. We rated it as inadequate because:

- The trust had not fully ensured since our 2018 inspection that patients were receiving the service they needed in a timely way. We found many patients were waiting longer than expected for triage, assessment and treatment. Trust data as of 21 October 2019 showed there were 421 patients currently awaiting assessment. One patient had been

waiting for a 'routine' appointment since March 2019. As of 21 October 2019, there were 223 patients waiting for treatment. Two patients had been waiting since February 2019. Central Norfolk Youth team had the highest number of patients waiting for treatment with 70. Trust data for April to September 2019 sent post inspection showed 16 occasions where the trust had breached their commissioned targets.

- The emotional wellbeing hub was the single point of access to Suffolk services. Whilst staff had reduced their waiting list backlog for telephone triage from 1100 (in April 2019) to 389, this was only a decrease by five patients since our 2018 inspection which had been 394. In the 12-month period between inspections, 39% of referrals had been seen within the trust's target of 10 working days and 150 patients had waited over 10 days. One patient was waiting 73 days. However, the more recent monthly figures in September and October 2019, demonstrated a slight improvement to 50%.
- Staff could not always respond as quickly as they wanted to patient referrals due to workload pressure and lack of resources. We found that twenty-two staff and managers (28%), three stakeholders and two other professionals said that there were challenges with access to services and long waiting times, particularly in Suffolk.
- The trust had not ensured that information was easily available about how they met patients, carers and those with diverse needs. Most teams did not have information leaflets available to give to patients or carers about their service. Staff at Ipswich youth did not record informal complaints and there was no evidence of how these were resolved.

However:

- The backlog of patients waiting for treatment had reduced. The trust had implemented a weekly 'service user tracker list' meeting and system to monitor patients waiting.
- Several teams had tried to make more child friendly environments to help children and young people feel more at ease. Great Yarmouth and Waveney teams used Silverwood which had more bright colourful chairs and cartoon characters on walls.
- Staff supported patients to access to education and work opportunities, including their recovery college.
- The trust had involved patients and staff in the development of Kingfisher ward their mother and baby unit.

## Is the service well-led?

**Inadequate** 

Our rating of well-led stayed the same. We rated it as inadequate because:

- The trust had not ensured effective leadership of this core service in a timely manner to fully address risks identified at previous inspections such as for staffing, improving waiting times for patients, staff appraisal and supervision and environmental risks. Leaders had not ensured that structures, processes and systems of accountability for the performance of the service were developed and embedded. Staff at all levels were not clear about their roles and accountabilities. Fourteen of 20 managers we met across teams were new in post. It was apparent they had not been developed and upskilled to take on their new responsibilities. For example, they did not all have easy access to key information about their team performance to show us when we visited. Some staff in teams did not know what was happening in the trust, particularly in Suffolk.
- Most staff told us they felt under pressure to do more without much additional resources. We found pockets of low staff morale, for example, in Ipswich, South Bury and Central Norfolk teams.

# Specialist community mental health services for children and young people

- Managers did not always work closely with other local healthcare services and organisations (schools, public health, local authority, voluntary and independent sector) to ensure that there was an integrated local system that met the needs of children and young people living in the area, as we received concerns from three stakeholders.
- Team managers were not able to demonstrate at local level that they engaged well with patients, staff, equality groups, the public and local organisations to plan and manage appropriate services despite trust assurances that this was in place.

However:

- The trust had made extensive changes to the leadership and were changing their systems for monitoring, assessing and mitigating the risks to patients. The trust now had two care groups for children families and young people services across the trust to give clearer accountability and oversight of this core service. The trust had improved the quality of their risk registers with more identification of the service risks.
- The culture of children and young people's services had changed since our 2018 inspection as staff told us their morale was improving. A lot of staff said it was "early days" but said they were hopeful that there were meaningful changes taking place and things were getting better. They were proud of the care they gave despite the challenges they had.
- North Bury team was involved with the University of East Anglia in DECRYPT (Delivery of Cognitive Therapy for Young People after Trauma), a randomised controlled trial aimed at supporting children and young people aged eight to 17 years who have developed post-traumatic stress disorder) as a result of exposure to multiple traumas. The trust was involved in a research programme; brief education supported treatment (BEST) for adolescent borderline personality disorder.

## Areas for improvement

We found areas for improvement in this service. See the Areas for Improvement section above.

# Community-based mental health services for older people

**Good** ↑

## Key facts and figures

Community mental health services for older people offer assessment and intervention services for older people with dementia and other mental health conditions associated with later life. The service is made up of sixteen teams across Norfolk and Suffolk.

The dementia intensive support teams (DISTs) and intensive older people's services (IOPS) offer assessment and intensive support to people with dementia or suspected dementia or anyone with complex needs.

The dementia and complexity in later life (DCLL) teams offer assessment, diagnosis and treatment in the community for adults experiencing memory problems, cognitive impairment, dementia and other mental health issues associated with later life.

In Norfolk and Great Yarmouth and Waveney, these are separate teams while in East and West Suffolk the CLL pathway is provided through five integrated delivery teams (IDTs) in Ipswich, Stowmarket, Bury St Edmunds and Newmarket. Memory clinics operate alongside the CLL teams or pathway.

The trust is registered for the following regulated activities:

Assessment or medical treatment for persons detained under the Mental Health Act 1993

Diagnostic and screening procedures

Treatment of disease, disorder or injury

The service was last inspected in September 2018 and requirement notices were issued in relation to:

- Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment
- Regulation 18 HSCA (RA) Regulations 2014 Staffing

We found that the trust had addressed the issues from the previous inspection. Environmental risk assessments including ligature risks were in place across the service, staff had access to emergency medication where needed and the trust had actively recruited psychologists and occupational therapists into teams.

The inspection team visited 12 community teams across Norfolk and Suffolk between 07 October and 18 October. During the inspection we visited the following teams:

East Suffolk Dementia and intensive support team

East Suffolk Integrated Delivery Team

Coastal Suffolk Integrated Delivery Team

Central Suffolk Integrated Delivery Team

West Suffolk Dementia and Intensive support Team

Central Norfolk Dementia and Complexity in Later Life and memory assessment team.

Great Yarmouth Older Peoples services

Central Norfolk Intensive older peoples service

# Community-based mental health services for older people

West Norfolk Dementia and Complexity in Later Life Team

West Norfolk Dementia and Intensive support Team

Waveney Dementia and Intensive support Team

Central Norfolk Dementia and Complexity in Later Life Team

Our inspection was announced at short notice (staff knew we were coming five days before we arrived) to ensure that everyone we needed to talk to was available. We inspected the whole service and looked at all key questions.

Before the inspection visit, we reviewed information that we held about these services and information requested from the trust.

During the inspection visit, the inspection team:

- visited 12 teams in 11 locations;
- spoke with 15 managers;
- spoke with 16 patients and 25 carers who were using the service;
- spoke with 41 members of staff including nurses, assistant practitioners, psychologists and occupational therapists;
- spoke with eight medical staff including consultant psychiatrists;
- Reviewed 83 patient care records; and
- Observed 13 episodes of care.

## Summary of this service

Our rating of this service improved. We rated it as good because:

The summary for this service appears in the Overall Summary of this report.

## Is the service safe?

**Good** 

Our rating of safe improved. We rated it as good because:

- All clinical premises where patents received care were safe, clean, well equipped, well furnished, well maintained and fit for purpose. The trust had ensured that environmental risk assessment, including ligature risks were in place across the service where patients were seen on trust premises. This was improved since the previous inspection.
- The service had enough staff, who knew the patients and received basic training to keep patients safe from avoidable harm. The number of patients on the caseload of the teams, and of individual members of staff, was not too high to prevent staff from giving each patient the time they needed.

# Community-based mental health services for older people

- Staff assessed and managed risks to patients and themselves. They responded promptly to sudden deterioration in a patient's health. When necessary, staff worked with patients and their families and carers to develop crisis plans. Staff monitored patients on waiting lists to detect and respond to increases in level of risk. The service had implemented a robust monitoring system since the last inspection and patients assessed as high risk of harm were reviewed daily. Staff followed good personal safety protocols.
- Staff understood how to protect patients from abuse and the service worked well with other agencies to do so. Staff had training on how to recognise and report abuse, and they knew how to apply it.
- Staff kept detailed records of patients' care and treatment. Records were clear, up to date and easily available to all staff providing care.
- The service used systems and processes to safely prescribe, administer, record and store medicines. Staff regularly reviewed the effects of medications on each patient's mental and physical health.
- The teams had a good track record on safety. The service managed patient safety incidents well. Staff recognised incidents and reported them appropriately. Managers investigated incidents and shared lessons learned with the whole team and the wider service. When things went wrong, staff apologised and gave patients honest information and suitable support.

However,

- The trust did not have a service wide system in place to log when staff had checked medical equipment was working correctly.

## Is the service effective?

**Good** 

Our rating of effective improved. We rated it as good because:

- Staff assessed the mental health needs of all patients. They worked with patients and families and carers to develop individual care plans and updated them when needed. Care plans reflected the assessed needs, were personalised, holistic and recovery-oriented.
- Staff provided a range of care and treatment interventions that were informed by best-practice guidance and suitable for the patient group. The service offered additional therapies since the last inspection including cognitive stimulation therapy and acceptance and commitment therapy. They ensured that patients had good access to physical healthcare and supported patients to live healthier lives.
- Staff used recognised rating scales to assess and record severity and outcomes. They also participated in clinical audit, benchmarking and quality improvement initiatives.
- The teams included or had access to the full range of specialists required to meet the needs of patients under their care. The trust had actively recruited psychologists and occupational therapists into teams since the last inspection. Managers made sure that staff had a range of skills needed to provide high quality care. They supported staff with appraisals, supervision and opportunities to update and further develop their skills. Managers provided an induction programme for new staff.
- Staff from different disciplines worked together as a team to benefit patients. They supported each other to make sure patients had no gaps in their care. The teams had effective working relationships with other relevant teams within the organisation and with relevant services outside the organisation.

# Community-based mental health services for older people

- Staff understood their roles and responsibilities under the Mental Health Act 1983 and the Mental Health Act Code of Practice.
- Staff supported patients to make decisions on their care for themselves They understood the provider's policy on the Mental Capacity Act 2005 and assessed and recorded capacity clearly for patients who might have impaired mental capacity.

## Is the service caring?

**Good** ➔➔

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

- Staff treated patients with compassion and kindness. They understood the individual needs of patients and supported patients to understand and manage their care, treatment or condition.
- Staff involved patients in care planning and risk assessment and actively sought their feedback on the quality of care provided. They ensured that patients had easy access to advocates when needed.
- Staff informed and involved families and carers appropriately.

## Is the service responsive?

**Good** ↑

Our rating of responsive improved. We rated it as good because:

- The service was easy to access. Its referral criteria did not exclude patients who would have benefitted from care. Staff assessed and treated patients who required urgent care promptly and patients who did not require urgent care did not wait too long to start treatment. Staff followed up patients who missed appointments. The service had significantly reduced the waiting times for patients to be assessed and commence treatment following referral since the last inspection.
- The teams met the needs of all patients including those with a protected characteristic. Staff helped patients with communication, advocacy and cultural and spiritual support.
- The service treated concerns and complaints seriously, investigated them and learned lessons from the results, and shared these with all staff.

## Is the service well-led?

**Good** ↑

Our rating of well-led improved. We rated it as good because:

- Leaders had the skills, knowledge and experience to perform their roles, had a good understanding of the services they managed, and were visible in the service and approachable for patients and staff.
- Staff knew and understood the provider's vision and values and how they were applied in the work of their team.

# Community-based mental health services for older people

- Staff felt respected, supported and valued. They reported that the provider promoted equality and diversity in its day-to-day work and in providing opportunities for career progression. They felt able to raise concerns without fear of retribution.
- Our findings from the other key questions demonstrated that governance processes operated effectively at team level and that performance and risk were managed well. The trust had improved access to the systems and processes for leaders to monitor compliance and quality of the service.
- Teams had access to the information they needed to provide safe and effective care and used that information to good effect.
- Staff collected analysed data about outcomes and performance and engaged actively in local and national quality improvement activities.

## Areas for improvement

We found areas for improvement in this service. See the Areas for Improvement section above.

# Mental health crisis services and health-based places of safety

**Requires improvement** 

## Key facts and figures

The mental health crisis services and health-based places of safety are part of the mental health services delivered by Norfolk and Suffolk NHS Foundation Trust.

The crisis resolution and home treatment teams provide emergency assessments and an alternative to admission to hospital by providing intensive community support for adults who are experiencing acute mental illness with associated risks. The teams were also responsible for admitting patients to an inpatient unit if required. This service is available 24 hours a day, 365 days a year and covers the area of Norfolk and Suffolk.

In Norfolk there are three crisis resolution and home treatment teams. They are based at Hellesdon hospital in Norwich, Northgate hospital in Great Yarmouth and Fermoy unit in King's Lynn. In Suffolk there are two crisis teams and two home treatment teams based at Wedgewood House in Bury St Edmunds and Woodlands unit in Ipswich. Emergency referrals for assessment are passed directly to the Norfolk based teams by the Single Point of Access service and to the Suffolk based teams by the Access and Assessment service.

An acute mental health liaison service is provided for people who present to James Paget hospital in Great Yarmouth, Norfolk and Norwich University hospital in Norwich, Queen Elizabeth hospital in King's Lynn, West Suffolk hospital in Bury St Edmunds and Ipswich hospital in Ipswich. These teams aim to provide prompt assessment of a patient's needs and signpost care appropriately.

The 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 the Mental Health Act, to be assessed by a team of mental health professionals. There are five health-based places of safety. These are at Northgate hospital in Great Yarmouth, Hellesdon hospital in Norwich, Chatterton House in King's Lynn, Woodlands unit in Ipswich and Wedgewood house in Bury St Edmunds.

This was an announced comprehensive inspection. The service was last inspected in May 2019 when an unannounced focused inspection took place to review actions required from previous inspections. The last comprehensive inspection took place in September 2018, we issued requirement notices to the trust, in respect of the following issues the trust must address:

- The trust must ensure that staffing levels out of hours are sufficient to meet local need.
- The trust must ensure that all premises are safe for their intended purpose.
- The trust must ensure that all ligature risks are identified and appropriate plans in place to reduce risk.
- The trust must ensure that processes are in place to ensure that lessons learned are shared across all crisis, home treatment and acute liaison services.
- The trust must ensure that all teams comply with the 4-hour emergency assessment target for referral to assessment.
- The trust must ensure that all teams are aware of their responsibilities for assessing patients presenting in emergency departments in crisis.
- The trust must ensure that staff are consulted and involved in service planning.
- The trust must ensure that systems accurately reflect the nature of patient contacts within their electronic patient record system in order to monitor the effectiveness of the assessment and treatment delivered to patients.

# Mental health crisis services and health-based places of safety

- The trust must ensure that all repairs to environments are completed in a timely manner to protect the privacy and dignity of patients.

During this inspection visit, the inspection team:

- visited 14 trust locations where care was delivered
- spoke with 13 patients who were using the service and two carers
- spoke with 20 managers/leaders
- spoke with 48 other staff members; including doctors, nurses, occupational therapists, mental health associate practitioners, peer consultants, social workers, psychologists and pharmacists
- observed five telephone triage/support calls with patients
- attended two staff handover meetings and one case formulation meeting
- reviewed documentation relating to the service, including policies and procedures and meeting minutes
- reviewed seven serious incident investigations
- reviewed 66 care records of patients using three crisis services
- reviewed 18 records for patients detained under Section 136 Mental Health Act 1983 in a health based place of safety
- reviewed medicines management
- reviewed information supplied by local commissioners and champions of people who use healthcare services
- reviewed information from staff focus groups held with the trust since our last inspection
- reviewed a range of feedback from stakeholders external to the organisation.

## Summary of this service

Our rating of this service stayed the same. We rated it as requires improvement because:

The summary for this service appears in the Overall Summary of this report.

## Is the service safe?

**Requires improvement** 

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

- The trust had not ensured that sufficient numbers of suitably qualified staff were available in all teams to meet the needs of people who used the service. In August 2019, there were 34 occasions in Norfolk where staff had not been able to assess patients within the four-hour target due to staffing levels. The trust had not ensured that sufficient numbers of suitably qualified medical staff were available to meet the needs of people who used the service.

# Mental health crisis services and health-based places of safety

- We reviewed 18 care records of patients using health-based places of safety. For 10 patients who had used the section 136 suites at West Suffolk Hospital and Northgate Hospital there was a lack of contemporaneous records on the electronic recording system.
- Staff did not always follow trust systems to safely prescribe, administer, record and store medicines. The trust's approach to audits to monitor prescribing, administration and compliance with medicines policies was inconsistent and did not always identify errors. In the Woodlands centre, the security arrangements for the clinic room keys were ineffective and access was not restricted to authorised staff only. Medicines were stored securely in all other areas.

However:

- The overall management of referrals and waiting times had improved. For example, managers had developed an electronic dashboard which showed them when patients had accessed the service, when referral to treatment targets had not been met the reason for these. This allowed managers to support their teams to mitigate the risks to patients. Incidents were reported, investigated and learned from. Breaches were reviewed to ensure patients remained safe.
- All clinical premises where patients received care were safe, clean, well equipped, well furnished, well maintained and fit for purpose. The physical environment of the health-based places of safety met the requirements of the Mental Health Act Code of Practice.
- Staff assessed and managed risks to patients and themselves. They responded promptly to sudden deterioration in a patient's health. When necessary, staff working in the mental health crisis teams worked with patients and their families and carers to develop crisis plans. Staff monitored patients to detect and respond to increases in level of risk. Staff followed good personal safety protocols.
- Staff received basic training to keep patients safe from avoidable harm. The number of patients on the caseload of the mental health crisis teams, and of individual members of staff had reduced since our last inspection and was not too high to prevent staff from giving each patient the time they needed.
- Staff understood how to protect patients from abuse and the service worked well with other agencies to do so. Staff had training on how to recognise and report abuse, and they knew how to apply it. This was an improvement from the last inspection.

## Is the service effective?

**Good** ➔➔

Our rating of effective stayed the same. We rated it as good because:

- Staff assessed the mental health needs of all patients. Staff working for the mental health crisis teams worked with patients and families and carers to develop individual care plans and updated them when needed. Care plans reflected the assessed needs, were personalised, holistic and recovery-oriented.
- Staff working for the mental health crisis teams provided a range of care and treatment interventions that were informed by best practice guidance and suitable for the patient group. They ensured that patients had good access to physical healthcare.
- Staff working for the mental health crisis teams used recognised risk assessments and rating scales to assess and record severity and outcomes. For example, in addition to the Health of the Nation Outcome Scale (HoNOS), staff in

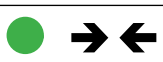
the crisis resolution home treatment team in west Suffolk used the describe, identify, choose, explain, share (DICES) risk assessment to formulate and contextualise individual patient presentation and risk. Staff working for other the crisis teams and in the health-based places of safety participated in clinical audit, benchmarking and quality improvement initiatives.

- The mental health crisis teams included or had access to the full range of specialists required to meet the needs of patients under their care. Managers made sure that staff had a range of skills needed to provide high quality care. They supported staff with appraisals, supervision and opportunities to update and further develop their skills. Managers provided an induction programme for new staff.
- Staff from different disciplines worked together as a team to benefit patients. They supported each other to make sure patients had no gaps in their care. The teams had effective working relationships with other relevant teams within the organisation and with relevant services outside the organisation.
- Staff understood their roles and responsibilities under the Mental Health Act 1983 and the Mental Health Act Code of Practice.
- Staff supported patients to make decisions on their care for themselves. They understood the provider's policy on the Mental Capacity Act 2005 and assessed and recorded capacity clearly for patients who might have impaired mental capacity.

However:

- There was not always evidence that rights had been provided for patients under detention within the section 136 suites.
- We reviewed 84 care records across this core service, for people who accessed support from the crisis, home treatment, psychiatric liaison team or health-based places of safety. We found the quality of care records had improved since our last inspection. However, 18 of these care records related to patients using health-based places of safety. For 10 of these patients who had used the 136 suites at West Suffolk Hospital and Northgate Hospital there was a lack of contemporaneous records on the electronic recording system.

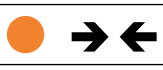
## Is the service caring?

**Good** 

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

- Staff treated patients with compassion and kindness. They understood the individual needs of patients and supported patients to understand and manage their care, treatment or condition.
- Staff in the mental health crisis teams involved patients in care planning and risk assessment and actively sought their feedback on the quality of care provided. They ensured that patients had easy access to advocates when needed.
- Staff informed and involved families and carers appropriately.

## Is the service responsive?

**Requires improvement** 

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

# Mental health crisis services and health-based places of safety

- The mental health crisis service phone line was not available to people who weren't currently using services. The trust had a contract for Norfolk to refer patients to MIND which we were told would extend to Waveney from December 2019. At the time of inspection there was no Crisis line for unknown patients in Suffolk other than to attend Accident and Emergency or to call 111. The trust was working with both Suffolk and Norfolk STP's to provide 24/7 Crisis support for all the population by 1 April 2020. This was raised in previous inspections. For people known to services, the mental health crisis service was available 24-hours a day and was easy to access.
- The service did not always meet the four-hour target for patients referred to the crisis resolution and home treatment teams in Norfolk. Throughout 2019, the trust had not met its own target for referral to assessment of 95%. In September 2019, the trust had met the target in just 73% of cases. In August 2019, there were 34 occasions out of forty four breaches in Norfolk attributable to staff not being able to assess patients within the four-hour emergency target due to staffing levels.
- The health-based places of safety were not always available when needed in West Suffolk. This was due to the suite being used for seclusion or as an additional bed when the acute wards were full.

However:

- Referral criteria for the mental health crisis teams did not exclude patients who would have benefitted from care. Staff assessed and treated patients promptly. Staff followed up patients who missed appointments.
- There was an effective local arrangement for young people who were detained under Section 136 of the Mental Health Act. Section 12-approved doctors and approved mental health professionals attended promptly when required.
- The services met the needs of all patients who use the service – including those with a protected characteristic. Staff helped patients with communication, advocacy and cultural support.
- The service treated concerns and complaints seriously, investigated them and learned lessons from the results, and shared these with all staff.

## Is the service well-led?

**Requires improvement** 

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

- Our findings from the other key questions demonstrated that while governance processes had improved they had not yet fully ensured that performance and risk were managed well. Not all of the previous areas of concern had been addressed. Staffing levels were not sufficient in all areas. Some Norfolk crisis teams were not meeting the target to see people within four hours. Medication management required further work.
- The corporate risk register did not reflect the concerns that we found regarding staffing levels, missed targets, record keeping and medication management.
- While multi-agency arrangements, to agree and monitor the governance of the mental health crisis service and the health-based places of safety were in place, further work was required in some areas to ensure that people in the area received help when they experienced a mental health crisis.
- Staff did not fully understand the new system of care groups and some felt there was a lack of involvement in the development of this structure.

# Mental health crisis services and health-based places of safety

- Managers in Norwich told us that while staff morale had improved it was not yet good, and that a positive culture was not fully embedded across the service. The trust needed to continue to develop communication across all staff groups.
- Stakeholders had identified negative feedback from some patients regarding responsiveness and attitude of some staff. Whilst it was evident that work had been undertaken to address the culture of the organisation, this was evidence that more work was required.

However:

- Staff had implemented recommendations from reviews of deaths, incidents, complaints and safeguarding alerts at the service level. This was an improvement from the last inspection.
- Leaders had the skills, knowledge and experience to perform their roles, had a good understanding of the services they managed, and were visible in the service and approachable for patients and staff.
- Staff knew and understood the provider's vision and values and how they were applied in the work of their team.
- Staff we spoke to felt respected, supported and valued. They reported that the provider promoted equality and diversity in its day-to-day work and in providing opportunities for career progression. They felt able to raise concerns without fear of retribution.
- Teams had access to the information they needed to provide safe and effective care and used that information to good effect.
- Staff collected analysed data about outcomes and performance and engaged actively in local and national quality improvement activities.

## Areas for improvement

We found areas for improvement in this service. See the Areas for Improvement section above

# Community mental health services for people with a learning disability or autism

**Good** ➔➔

## Key facts and figures

Community mental health services for people with learning disabilities or autism provide care for adult and child patients across Suffolk at a variety of accessible bases, as part of the wider integrated delivery teams (IDTs). All patients lived at home or in residential care, with home visit support from a care co-ordinator and/or outpatient appointment. These services operated from 9am until 5pm, Monday to Friday.

The trust had worked within the principles of the transforming care agenda. The trust closed several wards and the services were more focussed in the community. The inpatient and community teams are part of the same service and work as one team.

The trust did not provide any community mental health services for people with learning disabilities or autism in Norfolk.

Adult services offered care to people from the age of 18 upwards, except for Lothingland where adult services were offered from aged 25 years. In general, caseloads varied from 11 to 20 people per care co-ordinator. Although this was not the case for the adult attention deficit hyperactivity disorder service where caseloads were up to 175 for one nurse.

People supported by the Suffolk Child and Adolescent Learning Disability team attended outpatient appointments with the consultant psychiatrist in the East of the county at Walker Close and in West Suffolk at the Child Health Centre in Bury St. Edmunds. The age range of people who used this service ran from 0 years to 25 years.

We inspected the Suffolk intensive support at home team as part of the community services. Based at Walker Close, Ipswich, this team offered advice and extra support to families and carers through observation and formulation to avoid a hospital admission when the needs of the patients changed. The intensive support at home team operated from 7am until 9pm each day of the week.

The trust is registered with the CQC for the following regulated activities:

- Assessment or medical treatment for persons detained under the Mental Health Act 1983
- Treatment of disease, disorder, or injury.

At the last inspection in September 2018, the overall rating for this service was good. All domains were rated as good.

The following areas were identified as actions the provider should take to improve:

- Staff should ensure that patients are supported to make decisions about their care and this is documented in their notes.
- Staff should ensure that patients with communication difficulties are involved in the planning of their care.

Our inspection was announced (staff knew we were coming) to ensure that everyone we needed to talk to was available. We inspected sites at Lowestoft, Stowmarket and Ipswich and looked at all key questions.

This inspection has found that the trust had met the areas identified for improvement from the previous inspection regarding staff documenting support they provided to patients to make decisions and involving patients in the planning of their care.

# Community mental health services for people with a learning disability or autism

Before the inspection visit, we reviewed information that we held about these services and information requested from the trust. During the inspection visit, the inspection team:

- spoke with the managers of the adult services and the managers of the child and adolescent services
- spoke with 29 other staff members, including nurses, clinical support workers, occupational therapists and psychologists.
- examined medicine management across the service and medication charts
- reviewed 25 patient care records
- observed one multidisciplinary meeting
- observed three activity sessions
- observed one patient forum
- observed one home visit
- spoke with ten patients who were using the service and seven carers.

## Summary of this service

Our rating of this service stayed the same. We rated it as good because:

The summary for this service appears in the Overall Summary of this report.

## Is the service safe?

**Good** 

Our rating of safe stayed the same. We rated it as good because:

- Staff assessed and managed risks to patients and themselves. They responded promptly to sudden deterioration in a patient's health. When necessary, staff worked with patients and their families and carers to develop crisis plans. Staff monitored patients on waiting lists to detect and respond to increases in level of risk. Staff followed good personal safety protocols.
- Staff provided examples where incidents were reviewed, and effective action was taken to reduce the risk of further incidents.
- Staff understood how to protect patients from abuse and the service worked well with other agencies to do so. Staff had training on how to recognise and report abuse, and they knew how to apply it.
- Data requested from the provider for September 2019, showed that staff in the seven learning disability teams had undertaken mandatory training at a range between 87 percent to 96 percent that the trust had set as mandatory.

## Is the service effective?

**Good** 

# Community mental health services for people with a learning disability or autism

Our rating of effective stayed the same. We rated it as good because:

- Staff took a function-based approach to assessing the needs of all patients. They worked with patients and with families and carers to develop individual care plans and updated them as needed. Care plans reflected the assessed needs, were personalised, holistic, function-based and recovery-oriented.
- Staff provided a range of treatment and care interventions that were informed by best-practice guidance and suitable for the patient group. They ensured that patients had good access to physical healthcare and supported patients to live healthier lives.
- Staff used recognised rating scales to assess and record severity and outcomes. They also participated in clinical audit, benchmarking and quality improvement initiatives.
- Staff supported patients to make decisions on their care for themselves proportionate to their competence. Staff understood the Mental Capacity Act 2005 and assessed and recorded capacity clearly for patients who might have impaired mental capacity. Staff worked with the patient's support network to ensure best interest decisions were made when relevant.

However:

- The Waveney adult team and the Ipswich adult learning disability teams did not achieve supervision rates above 75 percent for their staff between July 2019 and September 2019.

## Is the service caring?

**Good** 

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

- Staff treated patients with compassion and kindness. They understood the individual needs of patients and supported patients to understand and manage their care, treatment or condition.
- Staff involved patients in care planning and risk assessment and actively sought their feedback on the quality of care provided. They ensured that patients had easy access to advocates when needed.
- Staff informed and involved families and carers fully in assessments and in the design of care and treatment interventions.

## Is the service responsive?

**Requires improvement** 

Our rating of responsive went down. We rated it as requires improvement because:

- The service did not meet the trust's target time of 12 weeks from referral to assessment. Patients were waiting for up to eight months for an assessment by the autism child and adolescent mental health team and up to nine months for an assessment by the autism adult team. Patients were waiting for over 12 months for an assessment by the attention deficit hyperactivity disorder adult team who had just one qualified nurse managing a caseload of 175 patients and a waiting list of 120 patients over a year.

However:

- Staff assessed and initiated care to patients who required urgent care promptly.

- Staff had the skills, or access to people with the skills, to communicate in the way that suited the patient.
- The service treated concerns and complaints seriously, investigated them, learned lessons from the results and shared these with all staff.

## Is the service well-led?

**Good** 

Our rating of well-led stayed the same. We rated it as good because:

- Leaders had the skills, knowledge and experience to perform their roles, had a good understanding of the services they managed, and were visible in the service and approachable for patients and staff.
- Staff knew and understood the provider's vision and values and how they were applied in the work of their team.
- Staff felt respected, supported and valued. They reported that the provider promoted equality and diversity in its day-to-day work and in providing opportunities for career progression. They felt able to raise concerns without fear of retribution.
- Our findings from the other key questions demonstrated that governance processes operated effectively at team level and that performance and risk were managed well.
- Teams had access to the information they needed to provide safe and effective care and used that information to good effect.
- Staff collected analysed data about outcomes and performance and engaged actively in local and national quality improvement activities.
- Managers from the service participated actively in the work of the local transforming care partnership.

# Outstanding practice

- Services had liaison staff who attended general practitioner surgeries to ensure that all patients had access to yearly physical health checks and to support general practice surgeries in making their services learning disability friendly. Liaison staff also had good links with the local general hospital to ensure that any physical health interventions were managed effectively.

# Areas for improvement

We found the following areas for improvement in this service:

We found areas for improvement in this service. See the Areas for Improvement section above.

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 the service provider was not meeting. The provider must send CQC a report that says what action it is going to take to meet these requirements.

For more information on things the provider must improve, see the Areas for improvement section above.

**Please note:** Regulatory action relating to primary medical services and adult social care services we inspected appears in the separate reports on individual services (available on our website www.cqc.org.uk)

**This guidance** (see goo.gl/Y1dLhz) describes how providers and managers can meet the regulations. These include the fundamental standards – the standards below which care must never fall.

| Regulated activity | Regulation |
|---|---|
| Assessment or medical treatment for persons detained under the Mental Health Act 1983<br>Treatment of disease, disorder or injury | Regulation 9 HSCA (RA) Regulations 2014 Person-centred care |

| Regulated activity | Regulation |
|---|---|
| Assessment or medical treatment for persons detained under the Mental Health Act 1983<br>Treatment of disease, disorder or injury | Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment |

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

| Regulated activity | Regulation |
|---|---|
| Assessment or medical treatment for persons detained under the Mental Health Act 1983<br>Treatment of disease, disorder or injury | Regulation 15 HSCA (RA) Regulations 2014 Premises and equipment |

| Regulated activity | Regulation |
|---|---|
| Assessment or medical treatment for persons detained under the Mental Health Act 1983<br>Treatment of disease, disorder or injury | Regulation 17 HSCA (RA) Regulations 2014 Good governance |

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 18 HSCA (RA) Regulations 2014 Staffing |

This section is primarily information for the provider

# Enforcement actions

We took enforcement action because the quality of healthcare required significant improvement.

# Our inspection team

Julie Meikle, Head of Hospital Inspection, CQC and Jane Crolley, Inspection Manager, CQC led this inspection. One executive reviewer and two specialist professional advisor with board experience and knowledge of governance supported our inspection of well-led for the trust overall. The team for the eight core service inspections included three inspection managers, 17 further inspectors,16 specialist advisors and 10 experts by experience.

Executive reviewers are senior healthcare managers who support our inspections of the leadership of trusts. Specialist advisers are experts in their field who we do not directly employ. Experts by experience are people who have personal experience of using or caring for people who use health and social care services.