Requires improvement

Norfolk and Suffolk NHS Foundation Trust

Mental health crisis services and health-based places of safety

Quality Report

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Locations inspected

Location ID	Name of CQC registered location	Name of service (e.g. ward/ unit/team)	Postcode of service (ward/ unit/ team)
RMYNG	Woodlands	Crisis resolution and home treatment Team Woodlands Unit	IP4 5PD
RMY01	Hellesdon Hospital	Crisis resolution and home treatment Team Norwich	NR6 5BE

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

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

Summary of findings

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

Summary of findings

Ratings

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

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

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

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

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

Summary of findings

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Overall summary

We did not revise the rating for this inspection.

This was a focussed unannounced inspection. The inspection team did not look at all key questions or key lines of enquiry.

We found the following areas that the Trust needed to improve:

- The Crisis and Home Treatment Team in Norwich was in the process of change and was not consistent in providing safe care. There were occasions when staff failed to visit patients as planned. Staff told us that this was a daily occurrence because they were unable to keep up with demand. The team had a high caseload of patients and this was not managed safely. Contributory factors to the high case load were high staff turnover, vacancies, staff being away on courses, performance management, sickness and a change in criteria for accepting referrals. We found evidence that patients were not being reviewed within the Norfolk home treatment team as per the individual's agreed safety plan. The Ipswich home treatment team had a caseload of 50; which staff described as unmanageable. The impact in Ipswich was that the quality of care and crisis plans was variable and, at times, poor.
- Managers had asked staff to change the way they worked. The new way of working did not have a clearly defined policy to give guidance to staff on how to implement the changes. This meant some staff did not understand the reason for change, or how the change would improve patient experience.
- The Norwich crisis team did not have an embedded approach to learning from when things went wrong.

However:

- We saw evidence of patients being seen face to face within the four-hour target and where this was breached, there was documented rationale, safety plans in place and patients were kept informed in five of the six records we reviewed. Staff felt that the changes made to facilitate this had a positive impact on patient care.
- In response to concerns raised regarding Norwich services, the Trust added in extra support and resources to address risks.
- Some staff felt the trust board were more visible than the previous board and were beginning to listen to staff concerns. We saw action being taken to improve patient experience such as face to face assessments in a timely manner.

Summary of findings

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

Are services safe?

Requires improvement

We found the following areas the Trust needed to improve:

- Staff did not always attend planned visits due to those visits not always being added to the diary and high caseloads of up to 70 patients. Staff in Norwich advised that this was happening frequently, sometimes daily, and that patients would phone to find out why they hadn't been seen.
- Ipswich caseloads also were high. The impact of this was that some crisis and care plans in the home treatment team lacked detail and were not always updated to reflect current risk.
- There were gaps in care and we had to escalate three cases to the local teams on site to follow up. The inspectors were unable to see recent clinical contact with two of these patients which caused concern they had been forgotten. It was confirmed that these patients had 'slipped through the net'.
- Patients in both locations were seen in a room which contained ligature points. Staff could not find a ligature risk assessment for these rooms. Staff were unable to assure inspectors that patients were never left alone in the room. This was also raised as a concern following the previous inspection in 2018.
- The local clinical commissioning group had provided funding for 11 extra posts in the Norwich team. Despite this, we did not see improvements that matched this investment for many reasons, including high staff turnover and staff training.

However:

- We saw an improvement since the last inspection in how teams responded to emergency referrals.
- We found some good examples of detailed assessments and safety plans within both crisis teams.
- Staff responded promptly to known deterioration in a patient's mental health.

Are services effective?

Good

We did not inspect this domain

Are services caring?

Good

We did not inspect this domain

Are services responsive to people's needs?

Requires improvement

We found the following areas the Trust needed to improve:

- The crisis team in Ipswich covered the acute hospital accident and emergency department at night because the hospital

Summary of findings

psychiatric liaison team was not commissioned to provide 24-hour care. Following a serious incident the previous year, a recommendation was made to locate the crisis team within the accident and emergency department at night. However, staff were unable to access Trust electronic records at the acute hospital site due to IT deficits which the Acute hospital are responsible for. Staff had to leave the department to complete their clinical notes. Therefore, this recommendation had not been addressed and staff continued to be based away from the department. Staff had escalated this concern and action was being taken to address this. The manager was unable to say when the problem would be resolved and was chasing this issue daily.

- The Trust had not collected data in a consistent way. Figures provided by the Trust showed that both teams' compliance with emergency referrals of seeing patients for face to face assessment within four hours was low with Ipswich reaching 75% compliance and Norwich 50% compliance. However, the figures alone did not reflect fully what was happening as each team captured information differently.
- The health-based place of safety in Ipswich had a lounge area which overlooked other offices and there were no window blinds or frosting on the glass. This may impact on patient privacy and dignity.

However:

- There were clear targets set for time from referral to assessment and from assessment to treatment.
- The mental health crisis service was available 24-hours a day and was easy to access. The change to referral criteria meant that the service did not exclude patients who would have benefited from care. Staff assessed most patients promptly. We saw evidence of staff escalating concerns when unable to contact patients or when patients failed to turn up for appointments.
- The health-based places of safety were available when needed and there were plans in place to increase capacity at the Norwich site to meet increasing demands.

Are services well-led?

Inadequate

We found the following areas the Trust needed to improve:

- Staff in Norwich described feeling overwhelmed with work and concerned that demand outstripped capacity, specifically

where vacancies remained high. Morale was not as low in Ipswich, although staff also confirmed that there were pressures relating to demand for services and insufficient capacity to meet that demand.

- Staff in Norwich reported high levels of stress and anxiety regarding difficulties in meeting patients' needs, which was impacting on their own emotional wellbeing. Staff had utilised the freedom to speak up guardian to voice concerns although some staff remained fearful of raising concerns. Some staff were not sure if they had been listened to by senior managers and were unable to see positive changes. The team did not feel looked after.
- Team meetings did not reflect discussion of learning lessons in the Norwich team. There was no embedded system for effective reflective practice sessions or space to review and learn when incidents took place. We saw recent minutes of team meetings which lacked evidence of discussion of essential information such as learning from incidents and complaints. However, some staff could talk about lessons, having read emails and bulletins. We could not be assured that staff were informed of learning and that change took place as a result. We saw some change to practice in Ipswich as a direct result of a serious incident. However there lacked a consistent approach to learning from incidents across both services and required further development.
- There was a need to improve how information was gathered to ensure data was captured in a consistent way.
- IT issues had prevented the crisis team from relocating totally to the accident and emergency department at night as planned. The Acute hospital were responsible for addressing these issues. However, this prevented staff from fully integrating into the new location and staff confirmed that they had to return to their team premises to document information. This relocation at night was a requirement following a serious incident the previous summer and had yet to be completed.

However;

- Managers had identified key areas of priority, such as access to services, staff morale, culture and recruitment. Plans were emerging and some action had begun to take place. There was a sense of urgency to get things right but also recognition of the huge effort and commitment still required to improve services to the local population.

Summary of findings

- Managers knew the services and were able to explain plans in place to effect positive change. They understood the challenges and that change was required. Some change was happening to improve patient care.
- There were systems and procedures in place to ensure that the Trust could monitor their performance in areas such as staffing numbers, skills, training and supervision and performance. There were key performance indicators for assessment and treatment of patients. Leaders were aware of the areas of concern and there was evidence that action was being taken to address these concerns, resulting in improvements to care.

Summary of findings

Information about the service

Norfolk and Suffolk NHS Foundation Trust was formed when Norfolk and Waveney Mental Health NHS Foundation Trust and Suffolk Mental Health Partnership NHS merged on 1 January 2012. Norfolk and Waveney Mental Health NHS Foundation Trust had gained foundation trust status in 2008.

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

The 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 including nursing, medical, psychology, occupational therapy, social care, administrative and management staff. It had a revenue income of £227 million for the period of April 2017 to March 2018. In May 2018, the trust worked with over 25,000 individual patients.

The Trust has a total of 12 locations registered with CQC and has been inspected 22 times since registration in April 2010.

Mental health crisis services and health-bases places of safety (HBPoS) are part of the mental health services delivered by Norfolk and Suffolk NHS Foundation Trust.

We inspected two of the crisis services provided by this trust to review progress since the last inspection.

Our inspection team

The team that inspected the service comprised an inspection manager, one CQC inspector, and a nurse specialist advisor.

Why we carried out this inspection

This unannounced, focussed inspection was part of a programme to monitor performance. The Care Quality Commission placed Norfolk and Suffolk NHS Foundation Trust in special measures in 2017. There was a further inspection in 2018. The trust failed to make sufficient improvements and remained in special measures.

This unannounced, focussed inspection was part of a programme to monitor performance. We have not revised ratings following this inspection.

How we carried out this inspection

We have reported in the following domains:

- Safe
- Responsive
- Well Led

We did not follow up all the requirement notices issued at the last inspection. They will be looked at in detail during the next comprehensive inspection. This was an unannounced inspection. We focused on specific key lines of enquiry in line with the most concerning issues raised at the last comprehensive inspection in 2018.

Summary of findings

Therefore, our report does not include all the headings and information usually found in a comprehensive inspection.

We have not given ratings for this core service.

During the inspection visit, the inspection team:

- visited two locations across the trust and looked at two services, one in Ipswich and one in Norwich
- Visited two health-based places of safety in Ipswich and Norwich
- spoke with 29 staff members; including managers, doctors, nurses, peer consultant, occupational therapists, psychologists, recovery workers and social workers
- looked at 33 care and treatment records of patients
- Attended a handover meeting
- Attended a multi-disciplinary meeting
- Looked at a range of policies and procedures.

Requires improvement

Are services safe?

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

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

Our findings

Safe and clean environment

- In Norwich, patients were seen in a room which contained multiple ligature points. The mitigation for this was to ensure the room was locked when not in use and when in use patients were not left alone at any time. Staff confirmed there was occasion when staff left patients alone briefly. Staff could not find a ligature risk assessment for this room. In Ipswich, the interview room had less ligature points but there were some. Again, there was no risk assessment available, however Ipswich managers confirmed that this was under review.
- The reception area in Norwich was being refurbished during the inspection to improve the environment. This was expected to be completed towards the end of May 2019. The refurbishment was planned to improve facilities for patients.
- Inspectors visited two health based places of safety to review the environment. The Norwich facility was being expanded to enable the hospital to accept two patients at any given time. The new build was almost completed. Both Ipswich and Norwich suites were designed to assist the assessment process and enable a disturbed patient to be safely managed, and had observation facilities in place. There was an emergency alarm system and furniture that should not cause injury. In Ipswich, staff referred to the corridor space leading to the 136 suite as an airlock. We observed that both doors could be opened at the same time. This was a risk that staff advised they had not been aware of, so therefore had not been mitigated against.

Safe staffing

- The number, profession and grade of staff in post did not match the trust's staffing plan. We found vacancies across both teams. Where there was a significant gap, these were escalated onto the trust risk register. Staff turnover in Norwich was high and 6 staff we spoke to advised they either had found alternative employment or were looking elsewhere for jobs. There were 1.7 whole time equivalent staff vacancies in the crisis team in Ipswich. There has been an implementation of a twilight shift which has improved the team's ability to respond to support calls and cover accident and emergency. This is a significant improvement from the last inspection.
- The local clinical commissioning group had provided funding for 11 extra posts in the Norwich team. We did not see significant positive impact on service improvement for a number of reasons, including high staff turnover and staff training. Caseloads had increased and staff struggles to cope with the demand. At the time of inspection there were 70 patients on the caseload. Staff told inspectors that safe numbers was generally accepted as 35 to 40 but we were unable to clarify trust expectations.

Assessing and managing risk to patients and staff

- We saw an improvement since the last inspection on team response to emergency referrals. The Norwich team did not downgrade patients and attempted to see all patients within four hours of referral. We saw that there were breaches when some patients may not have been seen within this time. Of the six specific records of breaches reviewed in Norwich, we found that five had a documented reason with contact having been made with the patient and an appointment time given. The sixth patient, the plan was unclear and this was escalated to the team immediately who took swift action to address this concern. In Suffolk there continued to be evidence of patients being downgraded from emergency to urgent without being seen. However, this was due to there being a difference between Norfolk and Suffolk in how information was added to the clinical system. We reviewed seven records of patients who had been downgraded and all had appropriate rationale as the contacts were a support call, but had been logged as an emergency referral.
- We reviewed 33 sets of clinical records across both locations. The records reviewed were a mix of assessment and home treatment records. The quality of records was mixed. We found that all patients had a detailed risk assessment, however, in Suffolk we found four of the home treatment team records did not have a crisis plan and some plans within the Suffolk team were incomplete or had not been updated since early March 2019.

Requires improvement

Are services safe?

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

- We found some good examples of detailed assessments and safety plans across both teams.
- Staff responded promptly to any deterioration in a patients' mental health. Risks and the progress of patients was discussed at handover and reviewed daily.
- There remained a concern, specifically within the Norwich home treatment team that planned visits were not always documented and were missed. Staff advised that this was happening frequently, sometimes daily, and that patients would phone to find out why they hadn't been seen. We found examples of this in care records. Staff understood any missed visits were to be documented as an incident. However, the incidents we found had not been documented in this way. Therefore, it was impossible to understand truly the depth of the concern and managers would not have accurate data to manage service risks.
- There were gaps in care and we had to escalate three cases to the local teams on site to follow up. The inspectors were unable to see recent clinical contact with two of these patients which caused concern they had been forgotten. It was confirmed that these patients had 'slipped through the net'. There was a lack of detail with regards a safety plan for the third patient despite a decision being made to delay assessment until the following morning. Other gaps identified were due to poor documentation.

Are services effective?

Good

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

Our findings

We did not inspect this domain

Good

Are services caring?

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

Our findings

We did not inspect this domain

Are services responsive to people's needs?

Requires improvement

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

Our findings

Access and discharge

- The standard operating procedure for the crisis pathway was under review and due to be approved mid-May 2019. The criteria did not exclude patients who needed treatment and would benefit from it. Some staff in the Norwich team expressed concern about capacity to meet the increased demand that had recently occurred due to the changes of criteria.
- The were clear targets set for time from referral to assessment. Emergency referrals should be seen within 4 hours of referral. Urgent referrals should be seen within 120 hours.
- Figures provided by the trust indicated that the East Suffolk (Ipswich) team compliance with emergency referrals being assessed face to face within four hours was 75% and Norwich was 50%. However, the figures alone do not fully reflect what was happening. Each team captured information slightly differently so there was not a true comparison. The inspection team specifically reviewed a sample of records of patients in Norwich who had breached the target and found that five out of the six records demonstrated safe practice and discussion with the patient and family but had gone over the 4-hour target. In Suffolk we found a higher rate of non-face to face assessment where there was a downgrading of referrals. However, this was due mainly to all contacts being recorded as an emergency, when many were support phone calls where it would not be appropriate to hold a face to face assessment. This meant the figures could reflect more negatively than reality.
- The crisis team in Ipswich covered the acute hospital accident and emergency department at night as the hospital psychiatric liaison team was not commissioned to provide 24-hour care. There were issues of staff ability to access clinical information on the acute hospital site due to IT issues. Staff had to leave the department in order to complete their clinical notes. The responsibility for addressing this rested with the Acute hospital. These concerns had been escalated and action was being taken to address this, although the manager was unable to say when the problem would be resolved and was chasing this issue daily.
- The mental health crisis service was available 24-hours a day and was easy to access. The change to referral criteria, within the draft operational policy, meant that it did not exclude patients who would have benefited from care. Staff assessed most patients promptly. We saw evidence of staff escalating concerns when unable to contact patients or when patients failed to turn up for appointments.
- We saw efforts to engage with people who found it difficult or were reluctant to engage with services.
- Both teams tried to make follow up contact with patients as per their safety plan. However, we saw two examples of patients who were not followed up as per their plan.
- The health-based places of safety were available when needed and there were plans in place to increase capacity at the Norwich site to meet increasing demands.

The facilities promote recovery, comfort, dignity and confidentiality

- The room used in Norwich to see patients was not well maintained or comfortable. The Ipswich room was comfortable, well maintained and let in natural light.
- Rooms were limited in both Ipswich and Norwich. There was a booking system but at times staff had difficulties finding space.
- The reception area in Norwich was in the process of refurbishment to improve patient experience.
- The health-based place of safety in Ipswich had a lounge area which overlooked other offices and there were no window blinds or frosting on the glass. This may impact on patient privacy and dignity.

Are services well-led?

Inadequate

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

Our findings

Good governance

- There were systems and procedures in place to ensure that the Trust could monitor their performance in areas such as staffing numbers, skills, training and supervision and performance. There were key performance indicators for assessment and treatment of patients. Leaders were aware of the areas of concern and there was evidence that action was being taken to address these concerns, resulting in improvements to care.
- Team meeting did not reflect discussion of learning lessons in the Norwich team. There was no embedded system for effective reflective practice sessions or space to review and learn when incidents took place. We saw recent minutes of these meetings which lacked evidence of discussion of essential information such as learning from incidents and complaints. However, some staff could talk about lessons having read emails and bulletins. The trust could not be assured that staff were informed of learning and that change took place as a result. We saw some change to practice in Ipswich as a direct result of a serious incident, however there lacked a consistent approach across both services and required further development.

Leadership, morale and staff engagement

- Several new board members joined the trust in the Autumn of 2018 whist other key members were very newly recruited including the chair who joined in February 2019 and the Chief executive who started on 1 April 2019. We saw early evidence of positive impact. Some staff reported feeling listened to and some positive changes to practice were emerging. Leaders acknowledged there was a significant amount of work to be carried out, however there was a sense of cautious optimism with some of the staff we spoke to.
- Managers had identified key areas of priority, such as access to services, staff morale, culture and recruitment. Plans were emerging and some action had begun to take place. There was a sense of urgency to get things right but also recognition of the huge effort and commitment still required to improve services to the local population.
- In Ipswich, staff spoke appreciatively of both their local and senior Trust managers.
- Leaders were visible in the service and approachable to staff and patients.
- Managers knew the services and were able explain plans in place to effect positive change. They understood challenges and that change was required. Some change was happening to improve patient care.
- There were concerns regarding the moral within the Norwich team. Staff described feeling overwhelmed with work and concerned that demand outstripped capacity, specifically where vacancies remained high. There were still concerns that the bullying culture had not completely been eradicated and some staff still did not feel looked after. Morale was higher in Ipswich, although staff also confirmed that there were pressures relating to demand for services and insufficient capacity to meet that demand. Ipswich staff felt supported and listened to by their local managers.
- In Norwich staff reported high levels of stress and anxiety regarding meeting patients' needs which was impacting on their own emotional wellbeing. Many staff had utilised the freedom to speak up guardian to voice concerns although some remained fearful of raising concerns. Some staff were not sure if they had been listened to by senior managers and were unable to see positive changes.
- Managers we spoke to had recognised that morale was low, particularly in Norwich, and were working with staff to try and improve services and relationships. An example of this was that there had been two 'away days' to try to improve working relationships.

Some staff expressed hope that they were seeing the beginning of change, felt the new senior managers in post were approachable and were acting to improve patient care.

Management of risk, issues and performance

- Senior managers knew the Trust risk register and how to escalate issues via the reporting system and locality meetings.
- Staff felt that the increase in demand for services was, in part, related to changes made to the referral process without consultation or consideration for how this change could be safely implemented. However, we saw evidence of how local operational managers had been involved in this process. The delay in ratifying the operational policy was as a direct consequence of listening to staff feedback.

Are services well-led?

Inadequate

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

Information management

- There was a need to improve how information was gathered to ensure data was captured in a consistent way.
- IT issues had prevented the crisis team from relocating totally to the accident and emergency department at night as planned in Ipswich. The Trust advised us that the Acute hospital were responsible for addressing this issue. This prevented full integration into the new location and staff confirmed that they had to return to their team premises to document information. This relocation at night was a requirement following a serious incident the previous summer.