Requires improvement

Norfolk and Suffolk NHS Foundation Trust

Community-based mental health services for older people

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)
RMY01	Hellesdon Hospital	West Norfolk dementia intensive support team (DIST)	PE30 5PD
RMY01	Hellesdon Hospital	West Norfolk dementia and complexity in later life (DCLL	PE30 5PD
RMY01	Hellesdon Hospital	Central Norfolk DIST	NR2 3TD
RMY01	Hellesdon Hospital	Central Norfolk North DCLL	NR2 3TD
RMY01	Hellesdon Hospital	Central Norfolk South DCLL	NR18 0WF
RMY01	Hellesdon Hospital	Great Yarmouth and Waveney DCLL	NR30 1BU
RMY01	Hellesdon Hospital	Great Yarmouth and Waveney DIST	NR33 8AG

Summary of findings

RMY01	Hellesdon Hospital	Great Yarmouth and Waveney DCLL	NR33 8AG
RMY01	Hellesdon Hospital	East Suffolk DIST	IP4 5PD
RMY01	Hellesdon Hospital	East Suffolk DCLL	IP1 2DG
RMY01	Hellesdon Hospital	East Suffolk DCLL	IP14 1RF
RMY01	Hellesdon Hospital	East Suffolk DCLL	IP3 8LY
RMY01	Hellesdon Hospital	West Suffolk DIST	IP33 3NR
RMY01	Hellesdon Hospital	West Suffolk DCLL	IP33 3NR

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

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

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

Summary of findings

Ratings

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

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

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

Contents

Summary of findings

Overall summary

We rated community-based mental health services for older people as requires improvement overall because:

- Risk assessments and care plans were not always in place and person centred. These were sometimes difficult to find on the electronic record system. People who used the service were not always given copies of their care plans.
- There was concern that high caseloads could compromise patient safety. Managers told us there were no waiting lists for routine assessments however five of the CLL teams failed to meet the 28 day target.
- There was a waiting list at Ipswich Coastal IDT for people to see a psychiatrist for routine appointments and clinics had to be cancelled due to insufficient numbers of doctors. This meant morale in this team was lower than elsewhere in the service. There were also difficulties accessing medical input in the Suffolk DISTs.
- The use of the Mental Capacity Act was not being consistently documented or considered for people who were thought to lack capacity across all the teams in the service.
- In Norfolk and Waveney, the dementia intensive support team provided emergency and crisis support till 9pm (8pm in Kings Lynn). Suffolk intensive support services did not provide out of hours crisis support; services closed at 5pm. People in crisis sought support from out of hours GP services, '111', '999' or the local authority emergency duty team.
- Some of the clinic and interview rooms did not promote privacy and confidentiality.
- Not all staff felt the teams were supported when requesting additional resources.

However:

- Across the service, 85% of staff had completed mandatory training; 96% of staff had completed Mental Health Act training and 96% had completed Mental Capacity Act training.
- Safeguarding training in most teams was between 95% and 100%, and staff knew how to identify abuse and make a safeguarding referral.
- Staff said they felt supported by their managers who provided effective leadership to the teams.
- Emergency and urgent referrals were responded to within timescales set by the trust.
- Staff responded quickly when people became unwell and arranged to see people in their own homes at a time convenient to them.
- Managers felt they could approach senior managers within the trust and said they came to visit the teams.

Summary of findings

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

Are services safe?

Requires improvement

We rated safe as requires improvement because:

- Caseloads were high and over capacity in some teams.
- There was a waiting list at Ipswich Coastal IDT for people to see a psychiatrist for routine appointments and clinics had to be cancelled due to insufficient numbers of doctors. There were also difficulties accessing medical input in the Suffolk DISTs.
- Not all patients had risk assessments and these had not always been updated. Many of the risk assessments we looked at lacked detail.
- The recording of medication at Great Yarmouth and Waveney DCLL was inaccurate in two instances. However, most recording and management of medications was good.
- At Wymondham there were three gaps in the recording of temperatures for the fridge in the clinic room.
- The fire risk assessment for Chatterton House identified that fire doors had been wedged open and not all equipment had been portable appliance tested. There were no plans in place to rectify this.

However:

- Facilities were clean and staff followed infection control procedures.
- There were good lone working protocols in place, which staff adhered to.
- Staff mandatory training was above trust target.
- Staff knew how to report incidents. Staff were transparent about areas where they could learn from things that had gone wrong and we saw evidence of how this had been discussed in supervision and team meetings.

Are services effective?

Requires improvement

We rated effective as requires improvement because:

- Care records information was put in a variety of places on the trust's electronic record system meaning staff found it difficult to access information.
- The Mental Capacity Act (MCA) was not being consistently documented or considered for people who were thought to lack capacity across all the teams in the service.
- Staff found it difficult to access specialist training despite being keen to do so.
- Supervisions and appraisals were not up to date in all teams.

Summary of findings

However:

- The staff team was skilled and delivered care within the national institute for health and care excellence (NICE) guidelines, for example, in relation to medication for dementia.
- People had access to psychological therapies through wellbeing teams, patient and carer groups and referral to psychology.
- Staff were using a variety of screening tools and outcome scales including the Health of the Nation Outcome Scales (HoNOS) to monitor outcomes.
- Staff considered people's physical healthcare needs within the assessment process.

Are services caring?

Good

We rated caring as good because:

- Staff were kind and compassionate about providing a high quality service and treated people who used the service with dignity and respect. Patients and carers confirmed that staff were polite and helped them.
- We saw that staff involved patients and their carers in assessments and ongoing work.
- Staff gave information at the time of assessment to make patients and carers aware of other services which might benefit them and how to access them, including advocacy services.

However:

- Patients were not always given copies of their care plans. Care plans were not always person centred and did not always include the patient's views.

Are services responsive to people's needs?

Good

We rated responsive as good because:

- Emergency and urgent referrals were responded to within timescales set by the trust. Staff responded quickly when people's mental health deteriorated.
- Staff were flexible in arranging appointments with people at times that were best for them and mostly visited people in their own home. Appointments were rarely cancelled and when they were people were contacted with an explanation and the appointment rearranged.
- Staff worked hard to offer a service to people who were difficult to engage or who missed appointments.
- People who used the services and their carers were extremely positive about the service they received.

Summary of findings

However:

- Five of the CLL teams failed to meet the 28 day target for routine assessments. However, managers told us there were no waiting lists for routine assessments.
- Some people with dementia were not always able to access out of hours support from the service and there was a lack of consistency across the areas in relation to how and when support could be accessed.
- Some of the clinic and interview rooms did not promote privacy and confidentiality.

Are services well-led?

Good

We rated well led as good because:

- Team managers provided effective leadership to the teams and promoted a culture of delivering high quality care.
- Staff were passionate about providing the best possible care to patients and their carers.
- Staff were aware of the values of the trust and worked to achieve these. Staff morale was high in most teams.
- Team managers told us that senior managers were accessible and supportive, and they could raise issues with them.

However:

- While managers used key performance indicators (KPIs) to monitor team performance, we found that not all poor performance had been highlighted or addressed, particularly in the Coastal IDT.
- There was little specialist training available and it was difficult to access.
- Supervisions and appraisals were not up to date in all teams.
- While caseload levels were monitored through supervision and team meetings, these were high in some services. Five CLL teams were not meeting targets for routine referrals to be assessed.
- At the Coastal IDT in Ipswich, three workers said that morale was very low, due to high caseloads, waiting lists and a lack of doctors which meant clinics had to be cancelled.

Summary of findings

Information about the service

Community mental health services for older people are provided by Norfolk and Suffolk NHS Foundation Trust. They 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 fifteen teams across Norfolk and Suffolk located in:

- West Norfolk (King's Lynn)
- Central Norfolk (Norwich and Wymondham)
- Great Yarmouth and Waveney (Great Yarmouth and Lowestoft)
- East Suffolk (Ipswich and Stowmarket))
- West Suffolk (Bury St Edmunds and Newmarket)

The dementia intensive support teams (DISTs) offer assessment and intensive support to people with dementia or suspected dementia. In Norfolk and Great Yarmouth and Waveney teams operate as crisis teams and are open from 8am to 9pm (8pm in King's Lynn), seven days a week, and work with older people with other mental health conditions. In Suffolk the teams work only with people with dementia, and are open from 9am to 5pm, weekdays only. Crisis work is referred to the Home Treatment teams.

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 six integrated delivery teams (IDTs) in Ipswich, Stowmarket, Bury St Edmunds and Newmarket. Memory clinics operate alongside the CLL teams or pathway.

All the teams are made up of community psychiatric nurses, healthcare assistants or support workers and occupational therapists. Social workers are co-located with most teams and there is also access to psychologists, consultant psychiatrists and doctors.

The CQC carried out a comprehensive inspection of this core service in October 2014 which was rated overall as 'requires improvement'. The trust was rated overall as 'inadequate'. Breaches of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 were identified. The trust sent the CQC its action plans to address these issues and we checked on this at this inspection.

Our inspection team

Our inspection team was led by:

Chair: Dr Paul Lelliott Deputy Chief Inspector Care Quality Commission (CQC)

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

Inspection Manager: Lyn Critchley, Inspection Manager mental health hospitals.

The team that inspected the community-based mental health services for older people consisted of two CQC inspectors, two Mental Health Act reviewers and two members of the medicines management team. We were also supported by specialist advisors including three nurses and a social worker.

The team would like to thank everyone who spoke to the inspectors and shared their experiences of working with patients and their understanding of the care and treatment offered by the trust.

Summary of findings

Why we carried out this inspection

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

How we carried out this inspection

To fully understand the experience of patients, we always ask the following five questions of every service and provider:

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

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

During the inspection visit, the inspection team:

- visited fourteen services at the ten sites and looked at the quality of the environment and observed how staff were caring for patients
- spoke with 18 people who were using the service
- spoke to 25 carers of people using the service
- attended a patient and carer support group
- spoke with the managers or acting managers for each of the teams
- spoke with 79 other staff members; including doctors, nurses, social workers, psychologists, healthcare assistants and a physiotherapist.
- attended and observed two multi-disciplinary team meetings.
- looked at 63 treatment records of patients.
- carried out a specific check of the medication management at each of the teams we visited
- looked at a range of policies, procedures and other documents relating to the running of the service

What people who use the provider's services say

We spoke to ten people who used services and nineteen carers. We also attended a memory group for eight patients and four carers. All were positive about the services they had received and spoke positively about their named worker. Two commented that it had taken some time to get into the service.

Good practice

We saw an example of good practice at Wymondham, where the team had developed an additional cognitive stimulation therapy group for younger people with dementia, which, in an effort to reduce stigma, met in a pub.

Summary of findings

Areas for improvement

Action the provider MUST take to improve

- The trust must ensure that all risk assessments and care plans are in place, updated consistently in line with multidisciplinary reviews and incidents and reflect the full and meaningful involvement of patients.
- The trust must ensure that there are appropriate facilities for staff to undertake their role and that facilities meet health and safety and fire regulations.
- The trust must ensure that the Mental Capacity Act is being consistently considered and documented for people who may lack capacity across all the teams in the service.
- The trust must ensure there are sufficient staff, including doctors.
- The trust must ensure that supervisions, appraisals and mandatory training are up to date at Coastal IDT in Ipswich.

Action the provider SHOULD take to improve

- The trust should improve access to 24 hour emergency and crisis support for people with dementia.
- The trust should ensure all clinic and interview rooms promote privacy and confidentiality.
- The trust should improve staff engagement.
- The trust should ensure that caseloads are monitored across all teams to ensure the safety of people who use the service.

Norfolk and Suffolk NHS Foundation Trust

Community-based mental health services for older people

Detailed findings

Locations inspected

Name of service (e.g. ward/unit/team)	Name of CQC registered location
West Norfolk DIST – Chatterton House, King's Lynn	Hellesdon Hospital
West Norfolk DCLL – Chatterton House, King's Lynn	Hellesdon Hospital
Central Norfolk DIST – The Julian Hospital, Norwich	Hellesdon Hospital
Central Norfolk North DCLL – The Julian Hospital, Norwich	Hellesdon Hospital
Central Norfolk South DCLL – Gateway House, Wymondham	Hellesdon Hospital
Great Yarmouth and Waveney DCLL – Northgate Hospital, Great Yarmouth	Hellesdon Hospital
Great Yarmouth and Waveney DIST – Carlton Court, Lowestoft	Hellesdon Hospital
Great Yarmouth and Waveney DCLL – Carlton Court, Lowestoft	Hellesdon Hospital
East Suffolk DIST – Woodlands Unit, Ipswich Hospital	Hellesdon Hospital
East Suffolk DCLL – Ipswich IDT (integrated delivery team), Mariner House	Hellesdon Hospital
East Suffolk DCLL – Coastal IDT, Walker Close, Ipswich	Hellesdon Hospital
East Suffolk DCLL – Central IDT, Stowmarket	Hellesdon Hospital

Detailed findings

West Suffolk DIS T – Hospital Road Site, Bury St Edmunds	Hellesdon Hospital
West Suffolk DCLL – Bury South IDT, Bury St Edmunds	Hellesdon Hospital

Mental Health Act responsibilities

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

- 96% of staff had received training in the Mental Health Act (MHA), ranging between 70% at Stowmarket and 100% at Central Norfolk North. All the staff we spoke with were knowledgeable about the Act and its impact on their work. They knew they could go to the central Mental Health Act team for advice and knew how to access this.
- People who used services had access to Independent Mental Health Act advocacy (IMHA) when they needed to.
- There were very few patients under a community treatment order (CTO) or guardianship. The Mental Health Act was generally used only when people required an assessment because of a deterioration in their mental health.
- Assessments under the Mental Health Act were sometimes undermined by a lack of beds. One person was assessed as requiring detention but left at home, supported by the community team, for eight days before being detained in Taunton, Somerset. Another person in a residential home was assessed as requiring detention and was left there for five days before being placed at St Neots.

Mental Capacity Act and Deprivation of Liberty Safeguards

- 94% of staff had completed mandatory training on the Mental Capacity Act. Staff had an understanding of the Act and knew where to go to get further advice within the trust.
- There was a lack to evidence in many of the teams to show that the Mental Capacity Act had been properly considered and people's capacity assessed where that was appropriate. Where mental capacity had been assessed there were differences in the templates used and in where the information was stored on the electronic record system.
- There were also good examples of the Mental Capacity Act being used both to support people to make their own decision and to act in their best interests when they were assessed to lack capacity.
- People had access to independent mental capacity advocacy (IMCA) where appropriate.

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

- Infection control was evidenced in all the team bases including use of alcohol gels and prominent hand washing signs.
- Team bases were clean and well maintained, and we saw records which showed they were cleaned regularly. Staff office space was mostly adequate, although the accommodation at Wymondham was extremely hot when we visited. The office space at the Julian Hospital DCLL had two telephone lines for eight people and the offices at Woodlands (East Suffolk DIST) could not accommodate all the workers in the team.
- Fire risk assessment for Chatterton House (West Norfolk DIST/DCLL) identified that fire doors had been wedged open and not all equipment had been portable appliance tested. There were no plans in place to rectify this.
- Patients were usually seen at home although some teams did use interview rooms to see people in. These were equipped with alarms or sensors and enabled private and confidential conversations to take place. In some of the rooms at Bury St Edmunds conversations could be heard in the room next door, which affected people's privacy.
- Clinic rooms were clean and well equipped to carry out basic physical examinations and monitoring, although the teams relied on GPs for the majority of physical health checks.

Safe staffing

- The trust employed 117 nurses and 85 healthcare assistants across the core service. Most of the services were fully staffed and information provided by the trust stated that the vacancy rate for qualified nurses was just over 3% which was below the trust average. Staff told us that staff shortages were mainly as a result of sickness. Staff in one team however, reported that the manager had been off sick for a year and no adequate cover had been provided, although staff did have managers in other parts of the service they could go to.
- Caseload numbers were monitored through team meetings and supervision but there was concern that high caseloads could compromise patient safety. Staff said that caseloads across the CLL teams were between 18 and 36 for qualified clinicians depending on levels of complexity. Some of the DIST teams operated a team caseload which was shared across all the workers in the team. In Norfolk, where the teams operated as an intensive and crisis team, they had 25-30. The Central Norfolk DIST had capacity to safely manage 45 but this had been as high as 55. In Suffolk where the teams worked from 9am till 5pm and did not cover weekends, team caseloads were 55-65.
- Managers in all the teams stated that they did not operate a waiting list and that work would be allocated within the trust's guidelines for emergency (four hour), urgent (72 or 120 hour) and routine (28 day) appointments. Information provided by the trust showed that most of the teams had not achieved the target for routine referrals.
- Six patients in the Coastal IDT team were waiting for allocation of a care co-ordinator. We looked at team meeting minutes for the previous three months and there was no evidence this had been discussed.
- Staff and managers in the Norfolk DISTs told us that access to a psychiatrist was quick when it was needed and within the trust's guidelines. This was supported by people who used the service and their carers. However, in the Suffolk DISTs, there were no psychiatrists in the team which could cause a significant delay in arranging quick access to a doctor where this was not deemed to be an emergency. The CLL pathway in the Coastal IDT in Ipswich had 59 people who required a routine appointment with the doctor and one referral from 24 May 2016 had not been seen. Five staff reported that access to a psychiatrist was extremely difficult and that many clinics had been cancelled due to a lack of doctors.
- 85% of staff had completed their mandatory training and in some of the teams this was between 90 and 100%. In the Coastal IDT however, only two out of 11 staff had completed all mandatory training.

Requires improvement

Are services safe?

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

Assessing and managing risk to patients and staff

- Of the 63 care records we reviewed, 51 had a risk assessment in place. However, many of these lacked detail and 11 of the 51 were not routinely updated. Crisis plans were in place where this was appropriate.
- The teams responded to a sudden deterioration in people's health. We observed multidisciplinary meetings where case discussions took place and risks were discussed. Staff and managers told us they were able to respond to a crisis and offer increased support at home.
- Safeguarding training was mandatory and was 100% in Central Norfolk CLL and East Suffolk DIST and 97% in East Suffolk Central IDT. Staff were aware of the trust's safeguarding policy, they knew how to recognise abuse, who to report this to within the trust and how to make a safeguarding alert directly to the multi-agency safeguarding hub (MASH).
- Staff explained lone working protocols in all teams, including a buddy system and arrangements to check on the safety of workers; we saw evidence of this. Staff were aware of these arrangements and said they felt safe carrying out their role.
- Overall, staff managed the recording and management of medications well, with clear records in place and arrangements for picking up and disposing of medication where necessary. However, we found that the recording of medication in Great Yarmouth and Waveney DCLL was inaccurate on two instances and the forms they used did not require a signature. We saw evidence that this was rectified on 19 July 2016. At Wymondham there were three gaps in the recording of temperatures for the fridge in the clinic room.
- We found that the clinic rooms at Bury St Edmunds and Stowmarket exceeded 25 degrees centigrade which could reduce the effectiveness of medication. Staff took action to contact the pharmacist for advice about what needed to be done to manage this effectively.

Track record on safety

- Staff reported four serious incidents requiring investigation between January 2015 and March 2016. These related to three deaths and a fall. Managers in all the teams told us that there was a very low rate of incidents in their teams.

Reporting incidents and learning from when things go wrong

- All staff knew how to report incidents. Staff were transparent about areas where they could learn from things that had gone wrong and we saw evidence of how this had been discussed in supervision and team meetings. We observed a team meeting where a serious incident from a different service was discussed and learning applied.
- Staff were debriefed after incidents.

Are services effective?

Requires improvement

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

Our findings

Assessment of needs and planning of care

- We reviewed 63 care records and saw that comprehensive assessments were usually completed in a timely manner.
- Care records, including assessments, care plans and risk assessments were not always in place, up to date and often lacked detail. Information was put in a variety of places on the trust's electronic record system meaning staff found it difficult to access information. Many staff told us that the electronic system did not help them record the information in the ways they needed. Care plans were often missing but the information was placed in the assessment.
- Care plans were not always person centred and did not always include the patients' views.

Best practice in treatment and care

- Staff used the national institute for health and care excellence (NICE) guidelines in relation to the assessment and treatment for dementia. There was evidence that this informed the prescribing of antipsychotic medication and Memantine.
- Staff told us that people had access to psychological therapies through wellbeing teams, patient and carer groups and referral to psychology.
- We saw an example of good practice at Wymondham. The team had developed an additional cognitive stimulation therapy group for younger people with dementia, which in an effort to reduce stigma met in a pub.
- Staff were using a variety of screening tools and outcome scales including the Health of the Nation Outcome Scales (HoNOS) to monitor outcomes. Staff and managers said they took part in clinical audits and we saw evidence of this at a multidisciplinary team meeting.
- Staff considered people's physical healthcare needs within the assessment process. Physical examinations and health checks were completed by people's GPs. Teams also had access to equipment in clinic rooms and could visit people's homes for ongoing physical health monitoring when needed.

Skilled staff to deliver care

- Most teams consisted of a full range of disciplines including psychiatrists, psychologists, nurses, occupational therapists, social workers and access to pharmacy input. However, there was a shortage of doctors in some Suffolk teams. The majority of staff were qualified nurses and had worked in the service for many years.
- Staff received an appropriate induction, which included mandatory training, a period of shadowing and visiting other teams.
- Supervision and appraisals were up to date in most of the teams and we saw evidence that the majority of staff received monthly supervision and yearly appraisals from managers. At the Central Norfolk DIST nearly 100% of staff received supervision in July 2016 and 80% in June 2016. However, 60% of staff received supervision in both April and May 2016. At the Coastal IDT in Ipswich we found that one member of staff had not had supervision for six months and another for three months, whereas the trust standard was every two months; more than 50% of appraisals were out of date.
- Staff were keen to pursue specialist training but told us this was difficult to access. This was confirmed by managers. There were a number of nurse prescribers across the service.

Multi-disciplinary and inter-agency team work

- Regular multidisciplinary team meetings took place in all the teams we visited. The frequency of meetings varied from team to team. We observed two examples of these which included discussions of new referrals, existing patients, medication storage and administration, safeguarding and care quality.
- We saw at the West Norfolk, Central Norfolk and East Suffolk DISTs there was a daily handover to discuss urgent cases and priority of work for each day. The West Suffolk DIST said they did not have a daily handover meeting.
- We observed effective communication between different professionals within the team and with external agencies such as independent care providers. There were good links with social care staff, helped by co-location of social workers within the team, especially in relation to arranging accommodation.

Are services effective?

Requires improvement

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

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

- 96% of staff had received training in the Mental Health Act (MHA). However, at Stowmarket the figure was 70%, below the trust target.
- Staff had a good working knowledge of the Act and where to go for advice and patients had access to an Independent Mental Health Advocate (IMHA) where required.
- Support was available to staff via a central Mental Health Act team and staff knew how to access this.
- None of the care records we looked at concerned people on a community treatment order (CTO).
- Staff could request an assessment under the MHA as required. However 12 staff from across teams said that there were delays in the assessment process. People would not be assessed because of a lack of beds, or they would be assessed and paperwork could not be completed and was left unsigned by the Approved Mental Health Professional (AMHP) until a bed could be found. We saw that one person assessed as requiring detention was left at home, supported by the community team, for eight days before being detained out of area. We saw that another patient in a care home was assessed as requiring detention and was left for five days before being placed at St Neots.

Good practice in applying the Mental Capacity Act

- 94% of staff had received training in the Mental Capacity Act 2005 (MCA). Stowmarket's compliance rate 79%.
- Staff we spoke to had an understanding of the Act and when it should be used and knew where to go for advice within the trust.
- In the Norfolk services, staff told us that they helped people to make decisions for themselves wherever possible and worked with them to make decisions in their best interests where they lacked capacity. However, there was a lack of evidence to show they had assessed capacity appropriately. Records did not show assessments had taken place where there were concerns about a person's capacity to make decisions. In the West Norfolk DCLL staff did not complete formal MCA assessments. In Central Norfolk DIST, staff said that they completed MCA assessments but were unable to show us any examples. In Central Norfolk North DCLL staff said they completed MCA assessments for specific decisions but we were unable to locate any records; other staff said they did not undertake formal capacity assessments as this was left to social workers and psychiatrists.
- In the East Suffolk DIST and East Suffolk CLL we saw four examples of completed MCA assessments and best interests decisions recorded on the electronic system. Mental Capacity Act assessments were kept in different places within the electronic record system. Staff at West Suffolk DIST at Bury St Edmunds told us they assessed capacity and attended best interests meetings, but these decisions were sometimes recorded in case notes and not as a formal assessment.

Good

Are services caring?

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

Our findings

Kindness, dignity, respect and support

- We observed six interactions between staff and patients and carers wh
- We spoke with staff and managers who were passionate about providing high quality services.
- All the patients and carers we spoke with said that staff were extremely friendly, polite and caring. They said that they were very helpful, offered help and support and showed them where else they could get support from.

The involvement of people in the care that they receive

- Care plans were not always person centred and did not always include the patients' views.
- Staff gave information packs to people when they were assessed. Information leaflets were also available at team bases, including information about advocacy and how to access this service.
- We observed an appointment where the person was fully involved in the assessment and the plans which were made as a result. We observed visits where staff were extremely caring and involved the patient fully in the treatment plan.
- We spoke to ten patients who all said the support they received helped them cope with their condition. However, records did not capture this involvement within assessments and care plans. Patients and their carers were involved in planning their care, but had not received a copy of their care plan, were not always aware that they had a care plan or what was in it. All three patients we spoke to in the Great Yarmouth and Waveney team had received care plans.
- Patients and carers had the opportunity to feedback about the service. We saw a report on a questionnaire about the central memory assessment and treatment service.

Are services responsive to people's needs?

Good

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

Our findings

Access and discharge

- There was a single point of access and referrals were triaged and sent onto the different teams for allocation.
- There were clear referral criteria for people to access services. This differed across Norfolk and Suffolk due to commissioning constraints. The DIST teams in Norfolk worked with people with all mental health conditions such as anxiety, depression, psychosis, confusion, dementia and behavioural problems, whereas the Suffolk DISTs only accepted people with dementia as other conditions were dealt within the mainstream community teams including the CLLS.
- The trust set response times as emergency (four hours), urgent (72-120 hours) and routine (28 days).
- Prior to our inspection the trust supplied data that stated that nine out of the 12 teams had not met routine target times at an average of 39 days from referral to assessment. At the time of our inspection referral to assessment in the CLL teams varied from 17 to 39 days. Five of the teams failed to meet the 28 day target.
- In East Suffolk CLL pathway at the Coastal IDT in Ipswich we were told that six people were waiting to be allocated a care co-ordinator.
- The DISTs in Norfolk were able to see people urgently, including access to a psychiatrist. In Suffolk the DISTs did not have any psychiatry as part of the team and managers told us that there could be significant delays in accessing psychiatry.
- Staff told us and we observed that they responded quickly to a deterioration in a patient's mental health by visiting promptly and arranging intensive support. This could include referring to a doctor or for an MHA assessment.
- Clinics were cancelled on a regular basis at the Coastal IDT at Ipswich. In other teams this was not the case. Most staff told us that appointments were rarely cancelled and if they were, they would contact patients and carers with an explanation and the appointment would be rearranged as soon as possible.
- Staff across many teams stated that they had difficulty arranging hospital admission for people whose mental health had deteriorated and that there were insufficient beds. They said that on several occasions mental health act assessments of people were delayed because there were no beds available to admit people to. We looked at two examples of this where there was a delay of five and eight days and where in both cases an out of area bed placement was arranged.
- The service did not offer an out of hour's service for people with dementia. The DISTs in Norfolk and at Lowestoft offered a seven day a week service from 8am to 9pm, while the Suffolk DISTs worked weekday 9am to 5pm only. We were told that emergency support for people with dementia could be accessed by calling '111', '999' or by calling the local authority's emergency duty team. In King's Lynn we were told that there was a crisis team but they did not always work with people with dementia.
- Managers told us that they would actively try to engage with people who were reluctant to engage with services. Staff told us they would try to see people at a time and place that was convenient to them. People who did not attend an appointment were contacted again by phone or letter and efforts were made to rearrange.

The facilities promote recovery, comfort, dignity and confidentiality

- Interview rooms were available for group therapy sessions and individual appointments. In King's Lynn the room was very comfortable and bright, but we saw that in Bury St Edmunds and Stowmarket the rooms could be very hot. At Stowmarket, rooms were not soundproofed and we could hear conversations in the room next door.
- Clinic rooms were well equipped to carry out basic physical examinations, but the teams relied on GPs for the majority of physical health checks.

Meeting the needs of all people who use the service

- Most of the buildings were fully accessible for people who used wheelchairs. Where this was not the case aleternate arrangements had been made. For example, the CLL pathway team at Mariner House, Ipswich was based on the third floor but patients were seen on the first floor which had lift access.

Are services responsive to people's needs?

Good

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

- There was information about services and treatment at the team sites. Staff could arrange for these to be printed in different languages when needed. Staff were aware of how to access interpreters.
- Information was available about how patients could access advocacy services.

Listening to and learning from concerns and complaints

- Leaflets were provided at the beginning of the assessment process, including details of how to complain.
- Eighteen complaints were received between March 2015 and March 2016, of which eight were upheld either fully or in part. None were referred to the parliamentary health service ombudsman.
- Most of the managers we spoke with said they had received no formal complaints in the previous twelve months. They said that they were usually able to resolve complaints in an informal manner.
- Staff told us that they knew how to report and respond to complaints and explained the process to us.
- We saw many examples of cards and letters giving positive feedback.

Are services well-led?

Good

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

Our findings

Vision and values

- Staff were aware of the trust's vision and values and were in agreement with them. These were displayed at all the offices we visited and managers shared these with staff at meetings and briefings.
- The teams' values and objectives reflected the vision and values.
- Managers were aware of who the senior managers were and could name them. They told us that they visited the service every two to three months and felt supported by them.
- Staff members in some of the teams were not aware of who senior managers were and said they had not seen them. This led some to feel the teams were unsupported and they were not confident that issues would be adequately addressed.

Good governance

- Overall compliance with mandatory training was 85%. We looked at data from managers and confirmed that compliance was at a high level in most of the teams. However, at East Suffolk CLL (Ipswich Coastal IDT) only two staff were up to date with mandatory training and none of the staff were up to date with safeguarding adult training. At Stowmarket only 70% of staff were up to date with Mental Health Act training and 79% of staff up to date with Mental Capacity Act training. We saw evidence that managers monitored compliance rates and identified issues that affected compliance, such as sickness and maternity leave.
- We saw that in most teams staff received regular supervision and appraisal and that this was properly monitored. Supervision was arranged monthly and where it had been cancelled, managers would try to rearrange this quickly. Staff in most teams confirmed they received supervision monthly and said they felt well supported by their team managers. However, in Ipswich Coastal IDT we found one staff member had not received supervision over a three month period and another where there was a gap of six months.
- We saw evidence at team meetings of staff taking part in clinical audit.
- We saw that in team meetings and in supervisions staff learned from incidents and feedback, including from serious incidents that had happened in another service.
- Staff told us and we saw that the electronic record system was slow, difficult to use and not always set out in a way that helped the team record information. Staff told us that workloads were high and that they were sometimes overwhelmed by the increasing amount of paperwork. A lot of time was spent completing administrative tasks which could impact on patient care. Some teams had developed their own paper care plans to use instead of those on the electronic record system.
- We saw little evidence in some teams of how the Mental Capacity Act (MCA) had informed practice in relation to people who may have lacked capacity. However, we also saw some excellent examples of how the MCA had been used.
- We saw that managers used key performance indicators (KPIs) to monitor team performance in relation to risk assessments, referral to assessment times, care plan quality, CPA reviews and care co-ordinator allocation. Stowmarket had an action plan to address targets that were not being met in relation to waiting times and mandatory training. However, we found that not all poor performance had been highlighted or addressed, particularly in the Coastal IDT.
- Managers told us they had the authority to carry out their role. We saw that they were supported by administrative staff. Managers and staff were able to submit items to the trust's risk register.

Leadership, morale and staff engagement

- Sickness rates varied across the teams, averaging at just over 3.5%, which is below the national average.
- We were told that there were two cases of harassment in Bury St Edmunds and Great Yarmouth in the last twelve months. These were resolved by mediation and by the trust taking appropriate action. Staff told us they were aware of the whistle blowing process and would use it to raise concerns. We spoke to a member of staff who had used it and had felt supported by the process. Senior staff told us that they could raise concerns

Are services well-led?

Good

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without fear of victimisation. In Norfolk teams, some of the nurses and healthcare assistants were concerned that they would be treated negatively if they raised concerns.

- Staff morale and job satisfaction was good across most of the teams we visited. Staff in most services we visited told us that they felt well supported by team managers and clinical leads. We saw that team members supported each other and had developed positive ways to help the team function more effectively. Some staff told us that they felt the service would benefit from additional staffing as it would help them to offer more care than they were able to. Specific issues were raised with managers in supervision and team meetings. Managers told us that morale had improved significantly over the past two years.
- At the Coastal IDT in Ipswich, three workers said that morale was very low, due to high caseloads, waiting lists and a lack of doctors.
- Staff told us that they were given the opportunity to contribute to service development. Team days were arranged away from the service to consider service developments. In Suffolk, the teams had protected time to discuss service issues which could be brought to the attention of senior managers.

Commitment to quality improvement and innovation

- We saw an example of good practice at Wymondham, where the team had developed an additional cognitive stimulation therapy group for younger people with dementia, which in an effort to reduce stigma met in a pub.

This section is primarily information for the provider

Requirement notices

Action we have told the provider to take

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

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Treatment of disease, disorder or injury	Regulation 18 HSCA (RA) Regulations 2014 Staffing The trust had not ensured that there were sufficient staff, including doctors. The trust had not ensured that supervision, appraisals and mandatory training were up to date at the Coastal IDT in Ipswich. This was a breach of Regulation 18

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Treatment of disease, disorder or injury	Regulation 11 HSCA (RA) Regulations 2014 Need for consent The trust had not ensured that the Mental Capacity Act was being consistently considered and documented for people who may lack capacity across all the teams in the service. This was a breach of Regulation 11

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Treatment of disease, disorder or injury	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment The trust had not ensured that all risk assessments and care plans were in place, updated consistently in line with changes to patients' needs or risks, or reflected patient's views on their care. The trust had not ensured that there were appropriate facilities for staff to undertake their role. This was a breach of Regulation 12