Care Quality Commission

Good

Norfolk and Suffolk NHS Foundation Trust

Community mental health services for people with learning disabilities or autism

Quality Report

Hellesdon Hospital
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Locations inspected

Location ID	Name of CQC registered location	Name of service (e.g. ward/ unit/team)	Postcode of service (ward/ unit/ team)
RMY01	Hellesdon Hospital	Intensive Support at Home Team	IP3 8LY
RMY01	Hellesdon Hospital	Ipswich IDT	IP1 2DG
RMY01	Hellesdon Hospital	LD CAMHS, Ipswich	IP1 2DG
RMY01	Hellesdon Hospital	Bury South IDT	IP33 3 NR
RMY01	Hellesdon Hospital	LD CAMHS, Waveney	NR32 3JQ
RMY01	Hellesdon Hospital	Adult Community LD, Waveney	NR32 3JQ

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.

Summary of findings

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

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

Summary of findings

Ratings

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

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

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

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

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

Summary of findings

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Summary of findings

Overall summary

We rated Norfolk and Suffolk community mental health services for people with a learning disability or autism as good because:

- The trust had invested in anti-ligature fittings in all the team bases (ligature points are where something can be tied in order to self- harm). The trust had ensured that ligature points across the sites were recorded on the environmental risk registers.
- The community services were situated in accessible areas. Standards of décor and furnishings varied across locations from good in Mariner House to basic in Waveney and Bury south integrated delivery team. There was a range of rooms at all sites that were used for interviews, activities and staff meetings. There were no alarms at the Waveney locations and staff did not carry personal alarms.
- Links with the local GP surgeries and other agencies were robust. Staff worked well as part of the wider integrated delivery teams at each community site as well as within their own multi- disciplinary teams.
- All patients had a care co-ordinator when under the care programme approach.
- Staff caseloads were manageable.
- Staff knew and applied lone working and safeguarding policies as part of their day to day work.
- The trust had clear referral and assessment processes. Assessments were comprehensive and included both current and historical information.
- Staff talked knowledgeably about issues of capacity and could give examples of when they applied this knowledge.
- Patients attended individual care reviews to discuss their care wherever possible. When a patient was assessed as lacking capacity, this was documented. Decisions regarding patient care were made following consideration of the patients' best interests.
- Staff morale was consistently high across the range of staff roles.
- Staff received managerial 1:1 and group clinical supervision monthly.
- Ongoing professional development was embedded within the learning disability teams.

However:

- The trust had not ensured that patients did not have an excessive wait to access specialist services such as speech and language therapy. Access to speech and language therapy, including for dysphagia assessments, remained inconsistent. This was a requirement of the last inspection in 2016. Patients and families continued to experience excessive waiting time to access speech and language therapy.
- A disparity existed in terms of access to specialist healthcare input dependent on where a patient lived.
- The variety of healthcare professionals available to support patients within teams differed.
- The trust had not advertised for a replacement to the consultant psychiatrist post in Ipswich. Some staff expressed grave concerns regarding the potential lack of consultant psychiatrist availability for this team.
- The child and adolescent community mental health team for people with learning disabilities or autism carried a low staff to patient ratio.
- Staff had not always recorded whether or not a copy of the care plan had been offered to the patient.
- Physical healthcare records were not easy to find or were missing in the notes.

Summary of findings

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

Are services safe?

Good

We rated 'safe' as good for community mental health services for people with learning disabilities or autism because:

- The trust had invested in anti-ligature fittings in all the team bases (ligature points are where something can be tied in order to self-harm). The trust had ensured that ligature points across the sites were recorded on the environmental risk registers.
- With the exception of Waveney, interview rooms were equipped with alarms to summon help if needed. There were no alarms fitted in Waveney, nor did staff carry personal alarms.
- Closed circuit television was in use with signage displayed to inform people who used the service.
- The community services were situated in accessible areas. Standards of décor and furnishings varied across locations from good in Mariner House to basic in Waveney and Bury south integrated delivery team. There was a range of rooms at all sites that were used for interviews, activities and staff meetings.
- All clinic rooms were clean and spacious and fit for purpose. Staff told us that these rooms were not used by community patients with a learning disability or autism.
- Staff knew what to do in the case of a medical emergency.
- Staff carried out initial risk assessments, and updated them as they got to know the patient or when something changed.
- Staff carried case-loads that were manageable.
- The child and adolescent community mental health team for people with learning disabilities or autism carried a low staff to patient ratio.
- All patients had either a care co-ordinator allocated to them or were seen regularly by a consultant psychiatrist depending on their level of need.
- Doctors prescribed medication in line with British national formulary and national institute for health and care excellence guidance.
- The trust's pharmacy supported the community teams if needed.
- Staff were up to date with mandatory training.
- Staff learned lessons from incidents and complaints at handover, team meetings, supervision and from trust bulletins.
- Staff knew what the duty of candour was. There was a clear complaints process.
- Social workers shared bases with the integrated delivery teams in Suffolk. Staff found this useful when querying social care issues relating to patients, including safeguarding.

Summary of findings

- There were robust safeguarding procedures in place, with a designated trust team to advise staff. Staff knew how to raise and report safeguarding concerns.
- Data provided by the trust showed that 86% of staff had completed mandatory training in the Mental Health Act. Mandatory training records provided on the Mental Capacity Act showed a 95% per cent uptake.

However:

- Some mandatory training was difficult to access or unavailable at the time of the inspection.

Are services effective?

Good

We rated effective as good because:

- Staff worked well as part of their own multi-disciplinary team and the wider integrated delivery teams. The intensive support at home team regularly attended the community team meetings.
- Staff met formally each week to share information, formulate plans and to review care in order to offer the best outcomes for patients.
- Staff worked with patients who had capacity to produce care plans that reflected their preferences and needs. Where capacity was lacking, staff considered best interest options. Staff supported patients to access advocacy services.
- Care records showed that physical concerns were monitored throughout treatment.
- Links with local GP surgeries and physical health nurses were robust. Staff alerted GP surgeries to the need for annual health checks for patients.
- Staff understood mental capacity and were able to describe best interest decisions.
- Staff used recognised rating scales to assess the progress of patients. Patient recorded outcome measures and in child and adolescent services, child outcome research consortium measures.
- Staff stored and shared information electronically. There were few paper records, and where these existed, there was a clear rationale for this. Staff kept information about the patients secure.
- Staff attended 1:1 managerial supervision and group clinical supervision monthly. All staff had an annual appraisal to help them identify goals for the year ahead and to reflect on the past 12 months.

Summary of findings

- There were systems in place to address poor performance. All staff undertook a comprehensive induction with the trust. Staff could access specialist training in learning disability and autism.
- Eleven audits showing compliance with the national institute for health and care excellence guidelines were completed from April 2016 to March 2017 in this service. These included unexpected deaths, infection prevention and control, confidentiality, care programme approach, health records and case management.

However:

- There were long waits for speech and language therapist input.
- Staff disciplines within teams varied, meaning that access to professional input differed according to where a patient lived.
- The trust had not replaced the consultant psychiatrist post in Ipswich. Some staff expressed grave concerns regarding the potential lack of consultant psychiatrist input availability to this team once the current post holder left.
- Some staff struggled with the use of the electronic recording system.

Are services caring?

Good

We rated 'caring' for community mental health services for people with a learning disability or autism as good because:

- Patients were encouraged to be involved in decisions about their treatment and care wherever possible.
- Staff actively engaged with patients in positive and responsive ways, listening and supporting them respectfully.
- Staff talked knowledgeably about capacity and best interest decisions.
- Staff took time to properly assess and formulate care according to individual need.

Are services responsive to people's needs?

Good

We rated 'responsive' for community mental health services for people with learning disabilities or autism as good because:

- The trust had clear referral and assessment processes. In East and West Suffolk, referrals were triaged and managed according to risk by the central access and assessment team. Core risk assessments were completed by these teams that included both current and historical information.

Summary of findings

- In Waveney, community teams managed their own referral systems and assessments. There were no access and assessment teams in Waveney.
- Duty workers provided cover from 9am until 5pm in the community teams who would, if needed, respond to urgent referrals. Out of hours, the access and assessment teams would respond to urgent referrals.
- The intensive support at home team was available to quickly respond to support patients to remain out of hospital by offering help and advice when there were changes in an individual's needs. This team worked intensively with patients for relatively short periods of time until a suitable plan had been devised that met the patients' need. This team worked from 7am until 9pm each day of the week.
- There were no waiting lists for access into the community teams.
- All teams had dedicated administrative support.
- Access to and within the community bases was suitable for patients with a physical impairment or who used a mobility aid. Disabled parking spaces were available at community bases. Information about care and treatment was available in accessible information format (previously known as easy read).
- Staff provided care plans in accessible information format. Staff used interpreters, sign language and friends and family where appropriate to help communicate with patients.
- Concerns and complaints were regularly reviewed and used as a learning opportunity as part of the wider integrated delivery team meetings.

However:

- Waiting lists existed for specialist professional support such as psychology, occupational therapy, art therapy and speech and language therapy.
- Written information was only available in English. For information written in other languages, a request had to be made.

Are services well-led?

Requires improvement

We rated 'well-led' for community mental health services for people with a learning disability or autism as requires improvement because:

- A disparity existed in terms of access to specialist healthcare input dependent on where a patient lived. In the integrated delivery teams there were different therapists in each of the teams and patients could only access services from the

therapists in their team. This meant that some patients did not get access to some therapies they needed. There were commissioner led agreements on service delivery that impacted on the care available.

- Patients and families continued to experience excessive waiting time to access speech and language therapy. In the adult team at Waveney there were 41 people on the waiting list for speech and language therapy, with 30 people who had been waiting in excess of 18 months. New referrals were sent a letter stating that the team did not offer this service at the current time and signposting to mainstream services.
- The trust did not have robust plans in place to ensure continuity of medical input in the Ipswich integrated delivery team. Staff told us they had not heard about any contingency plans to manage patients and that this had raised anxiety amongst staff. Staff said families and carers were concerned as they were frightened of losing continuity of care for their relative. Staff told us their immediate managers were trying hard to find out what plan was in place to manage this but so far had not been able to do so.
- The trust had not ensured that patients did not have an excessive wait to access specialist services such as speech and language therapy. Access to speech and language therapy, including for dysphagia assessments, remained inconsistent. This was a requirement of the last inspection in 2016.

However:

- Staff knew the values of the organisation and showed them in their work. Staff knew the senior management team and some said they had visited the teams. Staff we spoke with said that their working lives had improved significantly in the past 12 months and that morale had improved.
- Supervision, appraisals and mandatory training was monitored.
- Staff undertook audits and took actions to address failings.

Summary of findings

Information about the service

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 appointments. These services operated from 9am until 5pm, Monday to Friday.

The trust had worked within the principles of the transforming care agenda. Several wards had been closed 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, with the exception of Lowestoft where adult services were offered from aged 25 years. Sites at Lowestoft, Bury South and Ipswich were inspected. In general, caseloads varied from 12 to 24 people per care co-ordinator.

People supported by the Child and Adolescent Learning Disability team attended outpatient appointments with the consultant psychiatrist in the East of the county at Walker Close, and in the West at Ickworth Lodge. The age range of people who used this service ran from 0 years to 25 years. The team consisted of two learning disability nurses who visited young people at school and at home to offer assessments and support, and a consultant psychiatrist who saw people at community bases as outpatients. The team is expanding and had recruited other workers who had not started at the time of inspection.

The intensive support at home team was inspected 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 in order 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. At the time of the inspection, 18 people were being supported by this team.

The service is registered with the CQC for treatment of disease, disorder, or injury. It has been inspected three times since 2014. At the last inspection in July 2016, the overall rating for this service was requires improvement. The safe, effective and caring domains were rated as good; the responsive and well-led domains were rated as requires improvement. The following areas were identified as actions the provider must take to improve:

- The trust must ensure that leadership across this core service is joined up and consistent.
- The trust must ensure that effective governance systems are implemented across this core service that promote a uniform and consistent approach in managing caseloads and waiting lists to access services.
- The trust must ensure that patients do not have excessive waits for allocation of a care co-ordinator or to access services such as speech and language therapy and psychology.

This inspection has found that the trust has not met a requirement notice from the previous inspection. The requirement to eliminate excessive waits to access therapies, especially speech and language therapy, had not been addressed.

Our inspection team

Our inspection team was led by:

Chair: Dr Paul Lelliott, Deputy Chief Inspector, mental health CQC

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

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

Summary of findings

Lead Inspector: Lyn Critchley, Inspection Manager, mental health CQC

The team that inspected community based mental health services for people with learning disabilities or autism comprised two inspectors, an assistant inspector and two specialist professional advisors. A specialist advisor is a health professional with senior experience in working in services similar to this. A pharmacist supported the team as part of the inspection.

The team would like to thank all those who met and spoke with us during the inspection and who shared their experiences and perceptions of the quality of care and treatment at the trust.

Why we carried out this inspection

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

How we carried out this inspection

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

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

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

During the inspection visit, the inspection team:

- Checked the quality of the environment
- observed how staff interacted with patients
- spoke with eight people who were using the service
- attended one individual care review
- visited one person who used this service at home as part of a planned visit
- held telephone interviews with six carers
- examined 25 care and treatment records of people using the services
- looked at a range of policies, procedures and other documents relating to the running of the service
- attended a meeting group of 10 people who used the service
- spoke with the community team leaders of five of the teams
- interviewed 22 other staff members, including doctors, nurses, psychologists and a speech and language therapist
- 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

- Patients told us that doctors and other staff were approachable and kind. Some patients expressed that they thought the service was excellent, and that staff always went the extra mile to help them. Some patients told us they felt they would not be able to live their lives as successfully without the support of staff of the community teams.

Summary of findings

- Patients said they were involved in planning their care and could get an appointment with their consultant psychiatrist quickly. Nurse appointments happened as arranged at home. All the patients we spoke with said they would feel confident to make a complaint if they needed to.
- Of the carers we spoke with, all said how valuable the service was to them and their family. They told us referrals were managed quickly, that staff were responsive and how useful timely access to specialist professional input had been. Carers spoke of being able to easily contact the team for information and how, if appropriate, they were involved in care plan reviews.

Areas for improvement

Action the provider MUST take to improve

- The trust must ensure that patients do not have excessive waiting times to access speech and language therapy, including a dysphagia assessment.

Action the provider SHOULD take to improve

- The trust should ensure that staff at the Waveney bases are provided with personal alarms when working on a one to one basis with patients or be able to summon help via alarms fitted in the interview rooms.
- The trust should work towards providing equity in care to patients by ensuring the same access to therapies is available across the integrated delivery teams.
- The trust should ensure that all staff clearly document physical health and annual health checks in the patient notes.
- The trust should provide clear guidance on what action staff should take to ensure that the efficacy of depot medication is unaffected by a rise in temperature.
- The trust should ensure that sufficient detail is provided in patient notes that shows patient centred care is being provided.
- The trust should ensure that access to mandatory training is improved.

Care Quality Commission

Norfolk and Suffolk NHS Foundation Trust

Community mental health services for people with learning disabilities or autism

Detailed findings

Locations inspected

Name of service (e.g. ward/unit/team)	Name of CQC registered location
Intensive Support at Home Team	Hellesdon Hospital
Ipswich IDT	Hellesdon Hospital
LD CAMHS, Ipswich	Hellesdon Hospital
Bury South IDT	Hellesdon Hospital
LD CAMHS, Waveney	Hellesdon Hospital
LD Adult Community Team, Waveney	Hellesdon Hospital

Mental Health Act responsibilities

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

- Data provided by the trust showed that 86% of staff had completed mandatory training in the Mental Health Act. This was slightly below the trust target of 90%.
- People who used services had access to independent mental health advocates.

Detailed findings

Mental Capacity Act and Deprivation of Liberty Safeguards

- Mandatory training records provided by the trust on the Mental Capacity Act showed a 95% uptake. This was above the trust target for training which was 90%.
- Staff were able to explain how issues of capacity might affect this patient group.
- The multi-disciplinary team assessed and recorded capacity to consent when people who used this service were assessed as having impaired capacity.
- Staff assumed that people who used this service had capacity to make decisions.
- Staff knew where to obtain information regarding capacity.
- Some people who used this service were subject to Deprivation of Liberty Safeguards. Staff knew and could describe what being subject to Deprivation of Liberty Safeguards meant for persons who used this service. Staff understood their associated professional responsibilities when working with someone subject to Deprivation of Liberty Safeguards.
- Staff described the frustrations involved when applications for Deprivation of Liberty Safeguards or renewals were delayed.
- In the child and adolescent services, for children under 16, Gillick competency was assessed.

Good

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

- The trust had completed regular ligature audits that identified ligature risks. The trust had invested in anti-ligature bathroom fittings (ligature points are where something can be tied in order to self- harm) in most of the team bases. Where ligature points remained, risk assessments had been completed and mitigating actions put in place. The trust used closed circuit television (CCTV) to monitor communal areas. The trust had put signage in place to inform people of this.
- The provider undertook regular environmental risk assessments.
- There was a range of rooms at all sites that were used for interviews, activities and staff meetings. At the integrated delivery teams interview rooms were alarmed. However, there were no alarms in the interview rooms at the Waveney locations and staff did not carry personal alarms.
- Standards of cleanliness, décor and furnishings varied across the bases. Mariner House was visibly clean and well furnished, while interview rooms in Waveney and in Bury South were sparsely furnished. Cleaning records were not always available or visible.
- The trust had installed electronic monitoring of temperatures in clinic rooms. In the clinic room at Lowestoft adult community team, this system was not being used and the temperature was recorded on a paper form. In June 2017, there was one completed entry and the temperature for that day was recorded as over 25 degrees. Staff were unable to demonstrate that they had sought advice about this. Temperatures in the clinic room in Bury South integrated delivery team (IDT) and Coastal IDT exceeded 25 degrees on two days in July. Depot injection labelling indicated that these medications should be stored at below 25 degrees in order to maintain their efficacy.
- Staff knew what to do in the case of a medical emergency.

Safe staffing

- Staff in the adult community teams carried manageable caseloads of between 12 and 24, according to complexity. All people who used the service had either a care co-ordinator allocated to them or were seen regularly by the psychiatrist depending on their level of need.
- The child and adolescent mental health team in Ipswich, for people with learning disabilities or autism, comprised three professionals were working with a caseload of 80. The need for a bigger team had been recognised by the trust and advertisements had been placed for more staff. A band 5 nurse had been employed and was on trust induction at the time of the inspection.
- Doctors prescribed medication in line with British national formulary and national institute for health and care excellence guidance. The local GP then managed further prescriptions for patients.
- All staff received a formal trust induction on starting their employment.
- The training compliance for this service was 92% as of March 2017. This figure exceeded the requirement by the trust of 90%.
- Where there was a lower uptake than the trust standard, we were told that the training was either unavailable or inaccessible, and that staff had attempted to access this training.
- Each team held weekly learning sessions covering clinical aspects of care in order that staff could maintain their professional development.
- Data provided by the trust showed that 86% of staff had completed mandatory training in the Mental Health Act. Mandatory training records provided on the Mental Capacity Act showed a 95% per cent uptake.
- This service's sickness rate as of March 2017 was 3%, below the trust average of 5%. Turnover of staff was 9%, lower than the trust average of 12%.

Good

Are services safe?

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

Assessing and managing risk to patients and staff

- We examined 25 care records. Staff had included the person using the services' views, and where they lacked capacity, showed that best interest was considered. Staff had completed some care records without including much detail.
- Staff completed a core risk assessment on referral in the Waveney team or via the assessment and access team in the rest of Suffolk. This included both historic and current risks. Community staff carried out initial risk assessments and regularly updated them thereafter.
- Staff had included crisis plans in the majority of care plans.
- The trust had clear policies on lone working. Staff knew and could describe in detail the expectations surrounding lone working.
- The trust had safeguarding protocols in place with a designated trust team to advise staff. Staff were aware of the safeguarding processes and how they should respond if they had concerns. Staff told us who they would report safeguarding concerns to. They knew the local safeguarding procedure and understood their responsibilities about reporting concerns.
- Social workers work in the integrated delivery team in Ipswich. Staff said they found this useful when querying social care issues relating to this group of people who use the service, including safeguarding.

Track record on safety

- Staff were aware of their responsibilities to raise and record concerns and near misses. In the Waveney adult team, there had been a death to a patient who was open to the team. The manager said that this had not yet progressed to a coroner's hearing.

Reporting incidents and learning from when things go wrong

- Staff knew what and how to report an incident.
- Staff knew the importance of being open and transparent with patients, their carers and family.
- Staff learned from incidents following investigations via monthly forums, supervision, handovers and team meetings.
- Senior managers created trust wide 'key learning' posters each month that were used as a focus for team meetings and professional development.
- The trust offered debriefing time and support to staff following any incidents.

Are services effective?

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

Our findings

Assessment of needs and planning of care

- The access and assessment teams in East and West Suffolk completed core assessments at the point of referral. These included a brief overview of historical and current information. In Waveney, community teams managed their own referral systems and assessments. Further assessments were ongoing once the person had been accepted into the service.
- Some physical healthcare assessments and ongoing monitoring information was missing in patients' notes. Staff told us they continued to monitor patients' physical healthcare needs and alerted GP surgeries to the need for annual health checks for patients.
- The trust used an electronic recording system to store and monitor assessments and care plans. Some basic information about patients was kept in paper records that were stored securely.
- Some staff told us that the electronic recording system was difficult to use and wasted time.

Best practice in treatment and care

- Staff used a variety of nationally recognised rating scales to monitor patient's progress including the health of the nation outcome scales, patient recorded outcome measures and in child and adolescent services child outcome research continuum measures. The health of the nation outcome scale is anassessment and outcome measurement tool used to score the behaviour, impairments, symptoms, and social functioning people with learning disability and mental health problems.
- Staff linked with GP surgeries and practice nurses to ensure people who used services received an annual health check.
- National institute for health and care excellence (NICE) guidance was embedded within the policies of the trust to ensure that all staff followed recommended best practice.
- Patients were able to access psychological therapies recommended by NICE. However, ease of access to these therapies was dependent on where the patient lived.
- Staff took part in clinical audit such as care programme approach and infection control.

Skilled staff to deliver care

- The trust employed a range of staff disciplines. These included nursing staff, occupational therapists, psychologists, art psychotherapists, speech and language therapists, and psychologists. Not all these professionals were part of every team. There were long waits for patients accessing treatments from some specialist disciplines.
- All nurses were either qualified learning disability or mental health nurses.
- Social workers shared the offices at Mariner House that meant community team staff could quickly access social care advice.
- The trust held an intensive induction for all staff prior to them being allowed to work for the trust.
- Staff undertook a range of training that included learning disabilities and autistic spectrum disorder as part of the knowledge sharing days.
- Staff had 1:1 monthly managerial supervision and monthly group supervision.
- Poor performance was managed effectively by the manager with the help of a designated Human Resources business partner.

Multi-disciplinary and inter-agency team work

- Staff worked in a multi-disciplinary way and as part of the integrated delivery team.
- Staff of the wider integrated delivery team met regularly in different forums either weekly, monthly or on an ad hoc basis if needed. We saw team meeting minutes illustrating the content and frequency of these meetings.
- Staff had positive working relationships with the local area safeguarding boards.
- Strong links existed with GP surgeries. Staff regularly contacted the practice nurses in order to address the physical needs of patients.
- Staff of the child and adolescent learning disability team worked alongside other professionals in schools.

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.

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

- Eighty six per cent of staff had completed mandatory training on the Mental Health Act.
- Patients had access to independent mental health advocates.

Good practice in applying the Mental Capacity Act

- Ninety five per cent of staff had received training in the Mental Capacity Act.
- Staff recognised that patients had capacity to make decisions for themselves and took a multi-disciplinary approach in assessing patient capacity to make complex decisions. Doctors completed complex, decision specific capacity assessments.
- Staff knew that further information on capacity and a policy regarding the Mental Capacity Act could be found on the trust intranet.
- Records showed that staff supported patients to make decisions where they lacked capacity. Families and carers were also involved in supporting patients to make decisions if appropriate.
- Families and carers told us they were included in making best interest decisions for their relative.

Are services caring?

Good

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

Our findings

Kindness, dignity, respect and support

- Patients described the care they received as either very good or exemplary. They said staff were kind, encouraging and supportive.
- Interactions we observed between staff and patients were calm and respectful. Staff treated patients with dignity, listened carefully and were responsive to their needs.

The involvement of people in the care that they receive

- Patients told us they were fully involved in their Care Programme Approach reviews.
- Patients told us they had been offered copies of their care plans and that they had been involved in creating the care plan.
- Families and carers told us they had been invited to contribute to the patient's care plan when in a best interest decision role or when invited by the patient.
- An advocacy service was available to patients. There were posters advertising this at the community bases.
- Carers told us they had been invited to sit on staff interviews.
- Staff told us that feedback was sought via surveys but that there was a very poor return on this.

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

- The trust had clear referral and assessment processes. In East and West Suffolk, referrals were triaged and managed according to risk by the central access and assessment team. Core risk assessments were completed by these teams that included both current and historical information. In Waveney, community teams managed their own referral systems and assessments. There were no access and assessment teams in Waveney. Out of hours, patients would ring 111 or 999 in an emergency.
- Duty workers provided cover from 9am until 5pm in the community teams who would, if needed, respond to urgent referrals. Out of hours, the access and assessment teams would respond to urgent referrals.
- The intensive support at home team were available to respond quickly to support people who use this service to remain out of hospital by offering help and advice when there were changes in an individual's needs. This team worked intensively with patients for relatively short periods of time until a suitable plan had been devised that met the patient's need.
- Staff gave examples of following up on 'did not attend' appointments and what the policy was on this.
- Staff arranged with the person who used this service when they would like to be seen next at the home visit. Patients seeing only the consultant were offered appointments by the administration team that took into account people's availability and transport issues.

The facilities promote recovery, comfort, dignity and confidentiality

- All community bases had access to interview rooms. The comfort and décor of these rooms varied across the trust from very good to poor. However, staff told us that they mostly saw people in their own homes.
- Facilities included disabled car parking, lifts and wheelchair access.
- Access to staff areas were restricted or locked off from the public.

Meeting the needs of all people who use the service

- Access to and within the community bases was suitable for patients who might have a physical impairment or who used a mobility aid. Disabled parking spaces were available at community bases.
- Information about care and treatment was available in accessible information format.
- Staff provided care plans in accessible information format (previously known as easy read). Leaflets in languages other than English had to be requested. Staff used interpreters, sign language and friends and family where appropriate to help communicate with people using this service.

Listening to and learning from concerns and complaints

- Patients told us they knew how to make complaints.
- Concerns and complaints were regularly reviewed and used as a learning opportunity as part of the wider multi-disciplinary team meetings.
- Staff received feedback from complaints via supervision and weekly meetings.
- In the 12 months covered by data collection, there had been six complaints, none of which were upheld. These complaints related to clinical treatment, attitude of staff and communication (written and oral).

Are services well-led?

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 knew the trust vision and values, and showed these in how they worked.
- Staff gave examples of the senior management team visiting some community sites.

Good governance

- The psychiatrist at Mariner House at the time of the inspection was due to leave within three weeks. A notice period had been given to the trust of three months. The psychiatrist carried a caseload of 98 patients with complex needs, including medications. Staff said they had not heard about any contingency plans to manage patients and that this had raised anxiety amongst staff. Staff said families and carers were concerned as they were frightened of losing continuity of care for their relative.
- Patients and families continued to experience excessive waiting time to access some therapies. In the adult team at Waveney there were 41 people on the waiting list for speech and language therapy. Six of these referrals originated from 2011 and 30 people had been waiting in excess of 18 months. There was a vacancy in the team for a part-time speech and language therapist but the team had not managed to recruit to this post. New referrals were sent a letter stating that the team does not offer this service at the current time and signposting to mainstream services.
- In the integrated delivery teams, there were different therapists in each of the teams and patients could only access services from the therapists in their team. This meant that some patients did not get easy access to some therapies they needed.
- It was a requirement at the last inspection that the trust must ensure that patients did not have an excessive wait to access specialist services such as speech and language therapy. The trust's CQC remedial action plan update, dated 29th June 2017, indicated that the issue had been resolved and that actions had been taken to address waiting times. However while progress had been made in relation to accessing psychology services, access to speech and language therapy, including for dysphagia assessments remained inconsistent.
- Clinical staff participated in clinical audits and addressed any concerns arising from the audits. Audits for the past 12 months included hand hygiene and care programme approach.
- Staff had regular supervision. Managerial supervision on a 1:1 basis and group supervision was held each month.
- Staff received an annual appraisal.
- Teams attended inter professional peer led learning at least monthly.
- The teams worked to key performance indicators including supervision and care plan approach.

Leadership, morale and staff engagement

- The trust employed an approach to interviewing potential staff that was based on values rather than purely on qualifications.
- Staff we spoke to told us that they were able to raise concerns and complaints and were aware of the whistle blowing process.
- All staff had one protected day a month in order to meet with colleagues to share learning, follow up on reviews and to update paperwork.
- Staff turnover was 9% against a trust average of 12% between the months of March 2016 to April 2017.
- Staff told us things had improved greatly in the past 12 months and that team morale was good.
- We heard of one incident where a staff member indicated they had been bullied.

Commitment to quality improvement and innovation

- All teams were involved and committed to the Green Light Project.
- Bury South community team were piloting a new mental health plan that included triggers of and early warning signs of a person's wellness deteriorating. This form included all essential information needed about the person who uses this service and was in an easy read format.
- Community teams were linking people who used this service with the trust Recovery college.

Are services well-led?

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.

- Staff worked to the 'triangle of care' model especially when issues of capacity were evident.

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 9 HSCA (RA) Regulations 2014 Person-centred care Regulation 9 HSCA (RA) Regulations 2014 **Person-centred care** • The trust had not ensured that patients had timely access to speech and language therapy, including a dysphagia assessment. This was in breach of regulation 9