Inadequate

Norfolk and Suffolk NHS Foundation Trust

Community-based mental health services for adults of working age

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	Mariner House	IP1 2GA
RMY01	Hellesdon Hospital	Coastal Integrated Delivery Team	IP3 8LY
RMY01	Hellesdon Hospital	Central North East and North West Community Mental Health Services	NR6 5BE
RMY03	Northgate Hospital	Great Yarmouth Community Mental Health Team	NR30 1BU

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

Mental Health Act responsibilities and Mental Capacity Act / Deprivation of Liberty Safeguards

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

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

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

Summary of findings

Contents

Summary of this inspection

Page

Overall summary 5

The five questions we ask about the service and what we found 6

Information about the service 10

Our inspection team 10

Why we carried out this inspection 10

How we carried out this inspection 11

Areas for improvement 11

Detailed findings from this inspection

Findings by our five questions 13

Summary of findings

Overall summary

We did not revise the rating for this inspection.

This was a focussed, unannounced inspection. We found that some progress had been made in all areas, but not enough to be assured that the requirements had been addressed. Therefore, all requirement notices issued in the last inspection remain in place.

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

- The quality of clinical record documentation was variable in some of the services we visited. Staff did not always update risk assessments following a change in risk, and we found out of date risk assessments. Staff had not ensured that crisis plans were in place for all patients.
- The quality of letters to GP's varied between teams and not all patients received a copy. These letters also act as a care plan for some patients which meant some patients did not receive a plan of their care.
- Staff did not always upload clinical information in a timely manner, and information was not stored on the electronic system in a logical or consistent manner. This made it difficult for clinicians to see all interventions and actions in chronological order.
- We found staff had not always contacted patients as per Trust procedure. The staff at two of the six services we visited could not provide the numbers of patients waiting from referral to assessment and assessment to treatment. This meant we could not be assured that patient risk was always known or managed.
- The figures held by the local teams for the number of people awaiting assessment and for waiting times differed from, and were generally higher than, the figures held by the Trust. Therefore, we were not assured that managers had oversight of waiting times and that information provided to CQC were accurate.
- Some adult community teams still had a high number of vacant posts. This impacted on patient waiting times and staff morale in these areas.

However:

- Staff told us that they felt positive about recent changes to leadership posts and that they were starting to see a positive change in leadership style. Staff felt the Trust board were more visible than the previous board. Staff concerns had been listened to and communication had improved in some areas. Staff were positive about their immediate managers and felt more supported.
- Clinical documentation was inconsistent across the services we visited. However, in two individual teams, the standard of risk assessment and care plans had improved and included evidence of the patient voice. We also observed some proactive management of risk with clients on waiting lists at Norfolk.
- Managers used innovative ways of staffing the team in one of the services we visited. This meant roles were identified and posts filled to manage patients risk more effectively.
- Managers had identified key areas of priority, such as access to services, staff morale, culture and recruitment. Plans were emerging, and some action had begun to take place. There was a sense of urgency to get things right but also recognition of the huge effort and commitment still required to improve the services for adults in the community.

Summary of findings

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

Are services safe?

Inadequate

We found the following areas the Trust needed to improve:

- We reviewed 69 sets of clinical records across all locations. At Great Yarmouth we found risk assessments out of date for many of the patient group. However, those risk assessments in date were detailed. At Coastal IDT we found five records out of 12 reviewed without crisis plans. We found one patient record where a doctor had requested medical information from another Trust team. However, this had not been received and had not been followed up. We informed the team manager of this during inspection who followed up this request. One patient had been discharged from the service and we found that no letter had been sent to the GP as per the normal protocol. Staff stated this was an oversight and acted to rectify this during inspection. We found one patient referral that had been overlooked as it had not been printed and put in the referral tray. Two referral meetings had been held subsequently, however this patient had not been reviewed despite remaining on the allocation list. This was brought to the attention of managers during the inspection.
- We observed inconsistent processes for non-care programme approach patients. Great Yarmouth sent out a letter with a comprehensive care plan to the GP and the patient. However, Coastal IDT sent out a letter with no care plan and five lines of limited information. This was sent straight to the GP and nothing was sent to the patient unless the patient was aware they could specifically request this. This meant the patient did not receive a copy of their care plan.
- We were told that within Suffolk teams the service had been unable to recruit following the recent recruitment campaign, and despite the financial incentives being offered to attract staff to the service. The manager at Suffolk told us they requested agency staff. However, the availability of agency staff for the service was poor which resulted in frequent shortfalls.
- We were told that Great Yarmouth had a fully staffed psychology team. However, there was still up to a two year wait for individual psychological therapy for patients. The Ipswich team comprised of the enhanced community pathway and the adult pathway for adults of working age. One pathway had psychological services in place for patients. However, the other did not, therefore this resource was stretched across the two teams.

However:

Summary of findings

- Staff at Ipswich IDT and Norfolk North West and North East teams completed risk assessments and care plans with evidence of the patient voice and the standard had improved.
- We saw flexibility with recruitment in Norfolk adult services and a commitment to drive forward innovative ways of staffing the team. Specific roles were identified to support access to treatment and assessment, while ensuring the management of patient risk. Most of those staff were in place and training was in progress to upskill them.

Are services effective? — Requires improvement

Are services caring? — Good

Are services responsive to people's needs? — Inadequate

We found the following areas the Trust needed to improve:

- The staff at two of the six services we visited could not provide the numbers of patients waiting from referral to assessment and assessment to treatment. Therefore, we could not be assured patient risk was managed. Those services who held figures locally differed and generally were higher than the figures held by the trust. We were not assured managers had oversight of waiting times and that figures provided were accurate.
- The Trust had set a target for time from referral to triage and assessment, and from assessment to treatment. Staff were not meeting these targets in all cases. Suffolk services as well as Great Yarmouth were struggling to meet demand. Staff told us this was due to the difficulties recruiting to posts. Both Norfolk and Suffolk services were running Saturday morning clinics to reduce waiting lists and staff were paid overtime to support this in the short term. Staff could not update us on any future actions planned to meet this deficit in the teams.
- We found Ipswich IDT staff had not contacted all patients according to their risk, as per Trust procedure. At Coastal IDT, eight patients were on the waiting list with no risk rating identified. We saw examples where a patient rated as amber had not been contacted for 32 days. A patient rated red had not been contacted for 17 days. One patient waited 44 days for assessment and was rated amber risk. At the point of inspection, the patient had not been contacted for 24 days. An urgent referral to the team was not actioned for 32 days and had remained red risk. However, there was no rationale for the length of wait and we found no recorded contact with the patient. We found at Great Yarmouth gaps in contacts with

Summary of findings

patients. For example, staff carried out a telephone triage and identified the need as a routine referral, then placed the patient on the face to face assessment waiting list. The appointment was booked for 86 days later and there had been no contact recorded with this patient during this time. The records were annotated with "no contact in-between due to caseload restraints" we found this documented in a further three of the records viewed at this service.

However:

- We saw some proactive management of patients' risk on waiting lists at Norfolk. Staff had been recruited and tasked with specific roles managing patient risk as per Trust procedure. In the Ipswich IDT team in Suffolk, the flexible assertive community treatment model was used for managing patients on the waiting lists and staff knew where their patients were in terms of waiting and managing their risk.

Are services well-led?

Inadequate

We found during inspection that;

- Staff morale was lower in Suffolk than Norfolk. Suffolk staff described feeling overwhelmed with work and concerned that demand outstripped capacity, specifically where vacancies remained high. There remained some staff who did not yet feel confident about raising concerns, and worried that this would affect their working relationship with some managers as well as their future career progression.
- Senior managers knew the Trust risk register and how to escalate those risks via the Trust reporting system. Staff we spoke with in services where recruitment was a concern were aware this was on the risk register but did not see this as effective in managing those risks, as recruitment was still an issue.
- Trust systems did not have accurate data regarding waiting lists. We saw evidence of a patient on the list who was currently an inpatient, as well as patients on the list with no risk rating identified. We observed that not all patients were contacted as per Trust procedure. There was still a need in some of the services we visited for more robust management of waiting lists. However, we saw some improvement since the last inspection where this was raised as a concern.
- Our evidence from other key findings demonstrated that there was a need to improve governance systems further to ensure accurate information is captured to support clinicians to prioritise their work.

Summary of findings

However;

- Several new board members joined the Trust in Autumn 2018 whist other key members were very newly recruited, including the chair who joined in February 2019 and the Chief Executive who started on 01 April 2019. We saw early evidence of positive impact. Staff reported feeling listened to and some positive changes to practices were emerging.
- There were newly appointed leaders in some of the teams we visited. Despite the managers having been in post for a short period, there was evidence of positive change in leadership style. This change was particularly evident in Suffolk where staff told us during our visit there was more presence and visibility of local leaders who were approachable for patients and staff. Staff were starting to feel listened to and long-standing issues were being addressed.
- Managers had identified key areas of priority, such as access to services, staff morale, culture and recruitment. Plans were emerging, and some action had begun to take place. There was a sense of urgency to get things right but also recognition of the huge effort and commitment still required to improve the services for adults in the community.
- Staff described improvement in communications, including more skype meetings and pop up forums to address needs and change.

Summary of findings

Information about the service

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

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

The Trust has 392 beds and runs over 100 community services from more than 50 sites and GP practices across an area of 3,500 square miles. The Trust serves a population of approximately 1.6 million and employs just over 3,600 staff including nursing, medical, psychology, occupational therapy, social care, administrative and management staff. It had a revenue income of £227 million for the period of April 2017 to March 2018. In May 2018, the Trust worked with over 25,000 individual patients.

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

The Trust provides specialist community mental health services for adults of working throughout Norfolk and Suffolk under one registered location: Hellesdon Hospital.

Following the most recent inspection in September 2018 we rated specialist community services for adults of working age adults as inadequate.

All the areas for improvement identified during the inspection carried out in September 2018 remain in place. No new areas for improvement were identified during this inspection. The specific areas we looked at had not improved sufficiently to remove them as a requirement. The areas we looked at were:

- The Trust must ensure that all patients risks are assessed and managed, and that risk assessments and care plans are in place and updated consistently in line with changes to patients needs or risks.
- The Trust must ensure all patients are allocated a care coordinator and provided with timely access to services or treatment
- The Trust must ensure that audit outcomes and needs identified are addressed.

Our inspection team

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

Why we carried out this inspection

The Care Quality Commission placed Norfolk and Suffolk NHS Foundation Trust in special measures in 2017. There was a further inspection in 2018. The Trust failed to make sufficient improvements and remained in special measures.

This unannounced, focussed inspection was part of a programme to monitor performance. We do not revise ratings following an inspection of this type.

Summary of findings

How we carried out this inspection

We have reported in the following domains:

- Safe
- Responsive
- Well Led

We did not follow up all the requirement notices issued at the last inspection. They will be looked at in detail during the next comprehensive inspection. This was an unannounced inspection. We focused on specific key lines of enquiry in line with the most concerning issues raised at the last comprehensive inspection in 2018. Therefore, our report does not include all the headings and information usually found in a comprehensive inspection.

We have not revised the ratings for this core service.

During the inspection visit, the inspection team:

- visited four locations across the Trust and looked at four services
- spoke with 48 staff members; including managers, doctors, nurses, occupational therapists, psychologists and social workers
- looked at 69 care and treatment records of patients
- Attended one referral meeting
- Looked at a range of policies and procedures.

Areas for improvement

Action the provider MUST take to improve

All the areas for improvement identified during the inspection carried out in September 2018 remain in place. No new areas for improvement were identified during this inspection. The specific areas we looked at had not improved sufficiently to remove them as a requirement. The areas we looked at were:

- The Trust must ensure that all patients risks are assessed and managed, and that risk assessments and care plans are in place and updated consistently in line with changes to patients needs or risks.
- The Trust must ensure all patients are allocated a care coordinator and provided with timely access to services or treatment.
- The Trust must ensure that audit outcomes and needs identified are addressed.

Norfolk and Suffolk NHS Foundation Trust

Community-based mental health services for adults of working age

Detailed findings

Name of service (e.g. ward/unit/team)	Name of CQC registered location

Inadequate

Are services safe?

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

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

Our findings

Safe staffing

- The number, profession and grade of staff in post did not match the trust's staffing plan. We found vacancies in nearly all the teams. Where there were significant gaps in Suffolk teams, these had been escalated onto the Trust risk register. However, managers reported this had not had any impact on the current staffing situation and did not know what was happening at Trust level to address this.
- There had been a recruitment campaign based solely in Norfolk. The outcome resulted in recruitment to some posts and improved staffing in some individual teams. The adult teams in Ipswich and Great Yarmouth all had problems recruiting. We were not informed on inspection of any future recruitment plans. Staff told us that the Coastal team was now fully staffed.
- Staff told us that within the Suffolk teams the service had been unable to recruit, despite the financial incentives being offered to attract staff to service. The manager at Suffolk told us the service was registered with an agency. However, the availability of agency staff for the service was poor so did not help with regular shortfalls. However, we saw flexibility in Norfolk adult services. There was a commitment to drive forward innovative ways of staffing the team. To do this much needed roles had been identified to support access to treatment and assessment while ensuring the management of patient's risk. Most of those staff were in place and training was in progress to upskill them.
- There were long term consultant psychiatrist locums in post which reduced the impact of some long-term vacancies. However, in Great Yarmouth there was one locum in post and the service could not recruit a further locum to the service. Therefore, recruitment to these posts remained a challenge. This was a concern in Ipswich where 50% of cover was provided by locum doctors. Staff reported there were times when consulting with a doctor was difficult. Managers reported that this was still a challenge that the services faced and remained a concern. The Chief Medical Officer was working with colleagues from East London Foundation Trust to reduce the numbers of senior medical locums.
- We were told that Great Yarmouth had a fully staffed psychology team. However, there was still up to a two year wait for individual psychological therapies for patients. The Ipswich team comprised of the enhanced community pathway and the adult pathway for adults of working age. One pathway had psychology services in place for patients. However, the other did not, therefore this resource was stretched.

Assessing and managing risk to patients and staff

- We reviewed 69 sets of clinical records across all locations. At Great Yarmouth risk assessments were out of date for many of the patient group. However, those risk assessments in date were detailed. At Coastal IDT we found five out of 12 records without crisis plans. We found one patient record where a doctor requested medical information from another Trust team. However, this had not been received and had not been followed up. We informed the team manager of this during inspection who followed up this request. One patient had been discharged from the service and we found no letter had been sent to the GP as per the normal protocol. Staff stated this was an oversight and acted to rectify this during inspection. We found one patient referral that had been overlooked as it had not been printed and put in the referral tray. Two referral meetings had been held subsequently, however this patient had not been reviewed despite remaining on the allocation list. This was brought to the attention of managers during the inspection. However, staff at Ipswich IDT and Norfolk North West and North East teams completed risk assessments and care plans with evidence of the patient voice and the standard had improved. We saw evidence of risk assessments and care plans being updated in the last six months at Ipswich.
- There were two patients waiting for transfer between Ipswich and coastal IDT and there was no evidence the transfer policy was being adhered to. There was no

Inadequate

Are services safe?

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

collaborative working between the teams. Two patients had been waiting for 34 and 71 weeks respectively to be transferred to another team. The patients were still receiving care.

- We observed inconsistent processes for non-care programme approach patients. Great Yarmouth sent out a letter and comprehensive care plan to the GP and the patient. However, Coastal IDT sent out a letter with no care plan and five lines of limited information this went straight to the GP and nothing was sent to the patient unless they were aware they could specifically request this. Therefore, the patient did not receive a plan of care.
- Each team described the system for reviewing all assessment outcomes. Staff held discussions via multidisciplinary meetings, clinical and referral meetings. The benefits of an organised forum to hold clinical discussions meant that risk management was discussed at the meeting and a risk rating confirmed along with an action plan.
- The clinical system, called Lorenzo, did not have a specific location to review the patients' journey in one place, which meant staff would have to read copious records and clinical entries to understand the patient story. It was difficult to pull all information together. We saw clinical entries entered late on the electronic clinical system regarding patients. For example, a welfare call was not entered onto the Lorenzo system until 14 days later. This was a theme raised by staff we spoke with throughout the inspection. Staff also raised a concern that information was duplicated on the system which was time consuming. However, there was a pilot scheme currently running at services for a new risk assessment template which the Trust will implement if appropriate. We saw evidence of this new document being completed and staff felt this was a positive change.

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

We did not inspect this domain

Good

Are services caring?

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

Our findings

We did not inspect this domain

Are services responsive to people's needs?

Inadequate

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

Our findings

Access and discharge

- We found staff had not contacted patients as per Trust procedure. The staff at some of the services we visited could not provide the numbers of patients waiting from referral to assessment and assessment to treatment. Those services who held figures locally differed and generally were higher than the figures held by the trust. For example, staff at Ipswich IDT reported 265 patients waiting for assessment and 111 patients waiting from initial assessment to treatment. The Trust figure provided for the same service reported only eight patients waiting from referral to assessment, and six patients waiting from initial assessment to treatment. Therefore, we were not assured managers had oversight of waiting times and that figures provided were accurate.
- The Trust had set a target for time from referral to triage of five days for urgent referrals and 28 days for routine referral. From assessment to treatment the target was 18 weeks. They were not meeting these targets in all cases. Suffolk services as well as Great Yarmouth were struggling to meet demand. This was due to the difficulties recruiting to posts. Both Norfolk and Suffolk services were running Saturday morning clinics to reduce waiting lists, and staff were being paid overtime to support this short term. Staff could not update us on any future actions planned to meet this deficit in the teams.
- We saw some proactive management of patient risk on waiting lists in Norfolk. The Ipswich IDT team in Suffolk, used the flexible assertive community treatment model for the management of patients on waiting lists, and staff knew where their patients were in terms of waiting and managing risks. Staff at Coastal IDT and Great Yarmouth also had a system to manage patient cases on the waiting lists. However, staff could not provide figures of patients waiting for assessment and treatment in their service. This did not give us assurance all patients risk was managed.
- We found Ipswich IDT staff had not contacted patients as per Trust procedure. At Coastal IDT, eight patients were on the waiting list with no risk rating identified. We saw examples where a patient rated amber had not been contacted for 32 days. A patient rated red had not been contacted for 17 days. One patient waited 44 days for assessment and was rated amber risk. At the point of inspection, the patient had not been contacted for 24 days. An urgent referral to the team was not actioned for 32 days and had remained red risk. However, there was no rationale for the length of wait and we found no recorded contact with the patient. We found at Great Yarmouth gaps in contacts with patients. For example, staff carried out a telephone triage and identified the need as a routine referral, then placed the patient on the face to face assessment waiting list. The appointment was booked for 86 days later and there had been no contact recorded with this patient during this time. The records were annotated with "no contact in-between due to caseload restraints" we found this documented in a further three of the records viewed at this service.

Patients The facilities promote recovery, comfort, dignity and confidentiality

- The services we visited were clean. The waiting rooms were pleasantly decorated with adequate seating, and information for patients to refer to. Staff told us it could be difficult to book individual rooms for patients at times, however, they managed this with team co-operation and a willingness to be flexible.

Are services well-led?

Inadequate

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

Our findings

Leadership

- Several new board members joined the Trust in Autumn 2018, whilst other key members were very newly recruited including the chair who joined in February 2019 and the Chief Executive who started on 01 April 2019. We saw early evidence of positive impact. Staff reported feeling listened to and some positive changes to practice were emerging. Leaders acknowledged there was a significant amount of work to be carried out, however there was a sense of cautious optimism with many of the staff we spoke with.
- There were newly appointed leaders in some of the teams we visited. Despite the managers having been in post for a short period, there was evidence of positive change in leadership style. This change was particularly evident in Suffolk where staff told us during our visit there was more presence and visibility of local leaders who were approachable for patients and staff. Staff were starting to feel listened to and long-standing issues were being addressed. However, Ipswich IDT was still carrying a vacancy for a team manager and we were informed the service was finding recruiting to this post extremely difficult. Staff in some areas we visited stated they were waiting to see the outcomes of this approach and felt this is a step in the right direction.
- Managers had identified key areas of priority, such as access to services, staff morale, culture and recruitment. Plans were emerging, and some action had begun to take place. There was a sense of urgency to get things right but also recognition of the huge effort and commitment still required to improve the services for adults in the community.
- Staff described improvement in communications, including more skype meetings and pop up forums to address needs and change. In Suffolk we were told by managers that there was a definite presence of locality managers at the services who are extremely supportive. However, staff felt that the executive team did not have a full understanding of the waiting times and referral processes, and how these were conducted.

Culture

- Staff morale was lower in Suffolk than Norfolk. Suffolk staff described feeling overwhelmed with work and concerned that demand outstripped capacity, specifically where vacancies remained high. However, one part of a team in Suffolk had recruited to some posts and were more optimistic about the future if the retention of staff was maintained. However, morale still varied amongst staff.
- Low morale amongst some staff had been recognised and the service was working actively with staff to respond to their concerns and make changes that would benefit them. This was evident with staff interviewed in Ipswich IDT who could see some change in this area through managers visibility and a hands-on approach.
- During the inspection, staff at Coastal IDT told us there were not always positive working relationships with other community teams. For example, two patients had been waiting for 34 and 71 weeks respectively to transfer to another team as they had moved to a different area. The patients were still receiving appropriate care. Staff at Coastal IDT also told us that they lacked confidence in some of the information received from the access and assessment team and this service operated with a high level of agency staff who did not always understand how they worked.
- Many staff expressed hope that they were seeing the beginning of change, felt the new senior managers in post were approachable and acting to improve patient care. Morale was higher in Norfolk overall.
- Most staff said that they now felt more confident in raising concerns without fear of retribution. Previously they had not believed they would be listened to. There remained some staff who did not yet feel confident and felt raising concerns would affect there working relationship with some managers as well as their future career progression.

Governance

- We saw a framework in place regarding what must be discussed at team and directorate level in team meetings. Staff meetings were held with staff and learning from themes were discussed and key learning displayed for staff to read.
- We saw some evidence of quarterly audits being conducted regarding staff caseloads, the quality of notes, care plans and risk assessments. This was not seen consistently across all services.
- Our evidence from other key findings demonstrated that there was a need to improve governance systems

Are services well-led?

Inadequate

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

further to ensure accurate information is captured to support clinicians prioritise their work. The trust had appointed a programme lead whose role included a requirement to address these concerns.

- The Care Quality Commission ratings on display in reception at Mariner House in Ipswich still showed the rating from the 2017 inspection and could be misleading to the public. It is a requirement for trusts to display the correct rating.

Management of risk, issues and performance

- Senior managers knew the Trust risk register and how to escalate those risks via the Trust reporting system. Staff did not know how recruitment was being addressed, despite it being an issue on the risk register. Not all staff understood the value of the risk register.
- Systems were not accurate regarding waiting lists, as has been described throughout the report. For instance, we saw evidence of a patient on the list who was currently an inpatient, as well as patients on the list with no rag rating identified. We observed that not all patients were contacted as per Trust procedures. There was still a need in some of the services we visited for more robust management of their waiting lists. However, we saw improvement had been made since the last inspection where this issue was raised as a concern.

Information management

- Clinical information was accessible on the electronic clinical information system. However, it was not cohesively put together which made it difficult for clinicians to see all interventions and actions in a logical or consistent manner. The Trust has recently run a pilot scheme and have introduced the implementation date of a new risk assessment tool to improve the use of this system. Staff felt this is a positive step.