Requires improvement

Norfolk and Suffolk NHS Foundation Trust

Specialist community mental health services for children and young people

Quality Report

Hellesdon Hospital
Drayton High Road
Norwich
Norfolk
NR6 5BE
Tel:01603421421
Website:www.nsft.nhs.uk

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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	Trust Headquarters Hellesdon Hospital	Great Yarmouth and Waveney child, family and young people's service	NR30 1BU
RMY01	Trust Headquarters Hellesdon Hospital	West Norfolk child, family and young people's service	PE30 5PD
RMY01	Trust Headquarters Hellesdon Hospital	Central Norfolk child family and young people's service	NR1 3RE
RMY01	Trust Headquarters Hellesdon Hospital	Mary Chapman House child and family under 14 team	NR2 4HN
RMY01	Trust Headquarters	Child and family pathway	IP1 8LY

Summary of findings

	Hellesdon Hospital	children's treatment team Ipswich IDT Coastal IDT

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

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

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

Summary of findings

Ratings

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

Overall rating for the service	Requires improvement 
Are services safe?	**Requires improvement** 
Are services effective?	**Requires improvement** 
Are services caring?	**Good** 
Are services responsive?	**Requires improvement** 
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 specialist community mental health services for children and young people as requires improvement because:

- Ligature audits were either not present or incomplete in some teams.
- We had concerns in relation to patients safety at Thurlow House. Treatment rooms were not fitted with alarms and staff were not using personal alarms to summon help if required.
- The waiting rooms were used by young people and adults which was a potential safeguarding risk for children and young people. The trust partially addressed this issue at the inspection.
- At Thurlow House the administration area, interview rooms and rooms used for group session were not sound proofed. During the inspection we overheard confidential conversations relating to patients who use the service. We were concerned that patients were in these areas and could have heard these discussions too which is a breach of confidentiality.
- Staff had not completed 15 of the 44 risk assessments in full on the electronic recording system.
- The quality of care records we reviewed was variable, and dependent upon how confident and knowledgeable the staff member felt about using the electronic system.
- Recording of supervision was not centralised or standardised; supervisors were using different recording systems and tools across the service.
- In Suffolk there was one family therapist compared to seven in Norfolk, and no play therapist in Suffolk while there were five in Norfolk. This meant that Suffolk could not provide play therapy and had longer waiting lists for family therapy than in Norfolk.
- Teams were working in isolation of each other. This meant the service was not cohesive, and that lessons learned and good practice in the service was not being shared across the trust.
- Staff and doctors were only carrying out basic physical health checks, such as blood pressure, height, and weight on those patients receiving medication.
- There were waiting lists for allocation to care co-ordinators ranging from three weeks to eight months, and a seven-month wait for psychology.
- The staff we spoke with did not have a full understanding of the access criteria for children and young people.
- Ten staff and managers told us they were unclear about the overarching strategy and development plan for the children, family, and young people's service in Norfolk and Suffolk NHS.
- Not all managers were working to the same key performance indicators and governance systems such as monitoring supervision, training, and monitoring of waiting lists were not centralised.
- Managers did not ensure that staff completed a compliance level for all mandatory training of above 75%.
- Managers had not ensured that they had addressed the issues that were raised in the inspection carried out 2016.

However:

- Managers had been creative in addressing their staffing issues.
- Managers had introduced new systems for managing referrals and monitoring people on waiting lists.
- Patients waiting for care coordination had face-to-face initial assessments and eight weekly follow up reviews by the MDT team.
- Staff were following robust safeguarding processes, including joint working with other agencies.
- We saw evidence of effective handover between services within the organisation, such as community to crisis team or inpatient services.

Summary of findings

- Patients and carers spoke positively about the flexibility of the services, the knowledge and skills of staff to explain difficult concepts, and the trustworthiness of the information staff gave them.
- Services we visited were meeting their referral to assessment targets.
- Patients and carers waiting for care co-ordinators were offered regular support including brief intervention therapies based on skills training, manging stress and coping strategies.
- Staff reported that local level management was good. There were opportunities for professional development, and a stronger focus on regular staff support through clinical and managerial supervision, including opportunities for upskilling.
- Reporting and learning from incidents, and sharing this learning within individual teams was effective.

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:

- Fifteen of the 44 case notes we reviewed showed staff had not completed risk assessments in full on the electronic system. We found risk information recorded in daily contact notes, on assessments and risk management plans and at the bottom of care plans. CQC had reported on this at the last inspection.
- At Thurlow House, staff were not using personal alarms and treatment rooms were not fitted with alarms. Soundproofing between the administration area and waiting room was poor; we could hear a conversation from the administration office in the waiting room. In addition conversations could be heard between staff offices, interview and group rooms.
- The ad hoc room booking system left clients waiting for considerable lengths of time while a room to became available.
- There was a small reception area for both children and adults visiting the service, this was a safeguarding risk for children and young people.The trust partially addressed this issue at the inspection.
- Managers did not ensure that staff completed a compliance level for all mandatory training of above 75%.
- Ligature audits were either not complete or not present in the Norfolk teams. CQC had reported on this in the last inspection report.

However:

- Managers had been creative in addressing their staffing issues. They had looked at their recruitment and retention processes, skill mix in the teams, offering staff opportunities for secondments to gain additional skills and experience, sharing staff across teams and locations, creating new posts out of pre-existing difficult to fill posts, such as advanced nurse practitioners, and upskilling staff.
- Staff had addressed the management of waiting lists in both Norfolk and Suffolk areas. Managers had introduced new systems for managing referrals and monitoring people on waiting lists in February 2017. Team leaders had been working with staff to ensure that they dealt with all referrals in a timely manner and followed up clients who did not attend appointments.

Summary of findings

- Patients waiting for care coordination had face-to-face initial assessments and eight weekly follow up reviews by the MDT team. Staff reviewed waiting lists weekly in the Norfolk area and two weekly in Suffolk. Staff allocated patients to a key worker or case manager according to risk.
- Managers had addressed the previously identified issues with the Mental Capacity Act and Mental Health Act training. Records showed that staff were using Gillick principles to assess patients' competency.
- Staff were following safeguarding processes, including joint working with other agencies. Safeguarding discussions were part of the supervision process as well as team meetings. Managers had identified safeguarding leads, and staff knew who the safeguarding leads were.

Are services effective?

Requires improvement

We rated effective as requires improvement because:

- Care records were variable, some staff could operate electronic system, and in this case, their records were comprehensive, other staff who struggled with the electronic system did not have such comprehensive care records. CQC had reported on this at the last inspection.
- Staff and doctors were only carrying out basic physical health checks, such as blood pressure, height, and weight on those patients receiving medication.
- Recording of appraisal and supervision was not centralised and staff were not using the same recording tools. CQC had reported on this at the last inspection.
- The availability of specialist staff was not equal across the trust. In Suffolk there was one family therapist compared to seven in Norfolk, and no play therapist in Suffolk while there were five in Norfolk. This meant that Suffolk could not provide play therapy and had longer waiting lists for family therapy than in Norfolk.
- Teams were working in isolation of each other. Managers and staff in both Norfolk and Suffolk had very little contact with each other and services had developed independently of each other.

However:

- Specialist training, such as cognitive behavioural therapy, informed dialectical behaviour training, and systemic family therapy, were more readily available in house than it had been on our last inspection.
- We saw evidence of effective handover between teams within the organisation, such as community to crisis team or inpatient

Summary of findings

services. Three staff explained they had transferred from other teams within the trust to their present team and had been encouraged to maintain their working links with the previous team.

Are services caring?

Good

We rated caring as good because:

- Daily case notes were comprehensive and reflected what had happened in sessions and plans for next sessions. We saw how staff had sought and considered patients, families, and carer's views during intervention sessions.
- We saw staff interacting with, and talking about clients and carers in a caring manner.
- Patients and carers spoke positively about particular services and staff within those services. Including the flexibility of the services, the knowledge, and skills of staff to explain difficult concepts, the regular updates, and reports they received, and the trustworthiness of the information staff gave them.
- We saw how support groups had been set up for families and carer's.

However:

- Some carers and families had commented that it was difficult to get into the service and their family had been in crisis before staff had accepted the referral for their family member.
- Other carers did not think it acceptable that they had to wait so long for managers to allocate a care co-ordinator for their family member.

Are services responsive to people's needs?

Requires improvement

We rated responsive as requires improvement because:

- There were waiting lists ranging from a three weeks to eight months for care co-ordinators in some pathways, and a seven-month waiting list for psychology.
- The staff we spoke with did not have a full understanding of the access criteria for children and young people.
- There was no play therapy provision in the central or coastal teams in Suffolk.

However:

- There was an effective single point of access into the service and better management of waiting lists within teams.
- Facilities to deliver care were generally good across the service.

Summary of findings

- Following the introduction of new systems in February 2017, staff were managing referrals effectively and monitoring waiting lists. All services were meeting their referral to assessment targets.
- Patients waiting to be allocated to a care co-ordinator knew who they could contact if their situation deteriorated or changed.
- Staff made regular contact with the families and or carers of people waiting for care coordinators to offer support. This included the offer of brief intervention therapies based on skills training, manging stress and coping strategies.

Are services well-led?

Requires improvement

We rated well led as requires improvement because:

- Managers had not ensured that they had addressed the issues that were raised in the inspection carried out 2016. These included, staff completing risk assessments, ensuring staff were up to date with mandatory training, staff were able to navigate the electronic patient records system and in receipt of annual appraisals
- Staff and managers told us they were unclear about the overarching strategy and development plan for the children, families, and young people's service. They felt the Trust and not aligned what local plans they were aware of, to the needs of children, their families, and young people in the wider health and social care community.

However:

- The morale of staff and their enthusiasm to make the changes work was generally good across the service.
- Staff reported that management of their team and the treatment pathways they provided was good.
- Staff reported that there were opportunities for professional development. There had been a strong focus on regular staff support through clinical and managerial supervision, including opportunities for developing clinical skills.
- Team managers felt they had sufficient authority and administrative support to manage their teams.
- Safeguarding reporting, learning from incidents, and sharing this learning within teams was effective.
- Not all managers were working to the same key performance indicators and governance systems such as monitoring

Summary of findings

supervision, training and monitoring waiting lists were not centralised. This meant that different teams were focussing on different issues, which caused confusion for people using these services.

- Senior clinicians and some managers felt the trust did not consider their views about service developments. Staff felt that provider level management was too far removed from the clinical services to realise the impact of their decisions on the individual teams and the resources available.

Summary of findings

Information about the service

Norfolk and Suffolk NHS Foundation Trust provides community child and young people's mental health services (CAMHS). This includes people exposed to services for the first time, or young people who require longer-term care who have complex needs.

Specialist community mental health services for children and young people are provided throughout Norfolk and Suffolk. There are variations for services depending on the commissioning arrangements for the local area. Each location has a service manager and, there are pathways of care in each location with an identified clinical team leader.

There are four child, family, and young people's service bases in Norfolk. In West Norfolk Thurlow House provides the following pathways of care: Under 14's, Crisis support (up to 18 years), Early intervention for psychosis (up to adult), Eating disorders (14 – 18 years), and the Youth pathway (14-25 years).

In Central Norfolk, there are two locations. Mary Chapman House providing an Under 14's and an Eating disorder (14-18 years) pathway. A second location is at 80 St Steven's Road providing, Crisis and intensive support (up to 18 years), Early intervention for psychosis (up to adult), and the Youth pathway (14-25 years).

At Northgate hospital, there is the Great Yarmouth and Waveney child, family and young people's service (CFYPS). This site provides an under 14s service; an early intervention in psychosis service (all ages); a community crisis and support team (up to 18 years); a youth team (14-25 years); community eating disorder service (14-18 years); and an access and assessment service for all referrals into the children and family teams in the Norfolk region.

In Suffolk, the trusts operational model is based on integrated delivery teams (IDTs). These teams are responsible for coordinated delivery of community mental health services. They provide support, via care pathways, for people of all ages with mental health difficulties within the designated locality.

For children, families, and young people the pathways include - Enhanced under 14's, Early intervention for psychosis (14 -25 years), Community eating disorders, Youth pathway (14-25 years), and looked after children pathway (0-18 years).

The IDTs operate on a Monday to Friday basis (9 am – p.m.), although they did link in with other services, such as the access and assessment teams to provide a 24 hour assessment and intervention service. The trust had five integrated delivery teams at Bury North, Bury South, Central Stowmarket, Ipswich, and Coastal.

During this inspection, we inspected the West Norfolk, Central Norfolk, Great Yarmouth and Waveney, and the Central Ipswich and Coastal integrated delivery teams with the focus on services for children, families and young people.

The service was last inspected in July 2016 and given an overall rating of requires improvement. Requirement notices were issued due to breaches of regulation 12, safe care and treatment and, regulation 18, staffing. The trust was required to take the following actions to address these breaches.

- Ensure that waiting times from referral to assessment and treatment are kept to a minimum.
- Ensure that caseloads of individual staff members are manageable.
- Ensure that all patients have a completed core assessment and risk assessment following a face to face appointment.
- Ensure that all staff can navigate the electronic care records system.
- Ensure they work with patients in formulating care plans and goals.
- Be consistent in the physical health monitoring of patients.
- Ensure that staff receive, and are up to date with required mandatory training.
- Ensure that staff receive clinical supervision.

Summary of findings

- Ensure that staff receive annual appraisals.

During this inspection, we found that managers had not addressed all of these issues.

Our inspection team

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

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

The team that inspected the specialist community mental health services for children and young people consisted of three inspectors, and two specialist advisors.

The team would like to thank all those who met and spoke with the team during the inspection and were open and balanced in sharing 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 on-going 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:

- visited six locations, looked at the quality of the environments and observed how staff were caring for patients
- spoke with twelve patients and their carers who were using the service
- spoke with the managers or acting managers for each of the locations
- spoke with 31 other staff members; including doctors, nurses, therapists, and social workers
- attended and observed three multi-disciplinary meetings
- collected feedback from 15 patients using comment cards.
- looked at 44 treatment records of patients
- looked at a range of policies, procedures and other documents relating to the running of the service.

Summary of findings

What people who use the provider's services say

- We received feedback from twelve individual patients and carers, 15 comment cards and five patients and carers focus groups.
- Patients told us that staff were respectful and non-judgemental, that staff understood their needs and were able to explain things in a way they understood.
- Carers told us that once staff had accepted their referral the service they received had been very good and comprehensive.
- Carers and patients told us they liked the flexibility of appointments, and how key workers kept them informed of their family member's progress during treatment.

However:

- We heard how some families had found it difficult to get their loved one accepted into the service and only after significant deterioration, and carer stress had staff accepted the referral.
- Some carers and patients told us that while they appreciated the short interventions being offered they felt let down and back at square one when that intervention ended.

Good practice

- The Trust had a programme of upskilling suitably qualified staff to carry out specialist therapies under the direction and guidance of qualified therapists within the teams. This enabled more staff to offer the therapies, which addressed the issues of patients on the waiting list.
- The trust had continued to develop 'The Compass' centre. This centre provided a therapeutic education service for young people who might otherwise be placed in schools out of area. The compass centre was a partnership between Norfolk County Council children's services and Norfolk and Suffolk NHS Foundation trust.
- There was a parent and infant mental health attachment project (PIMH AP) at Mary Chapman house in Norwich. This service offered attachment based therapy and mental health support to parents and infants where the local authority had identified high safeguarding concerns.

Areas for improvement

Action the provider MUST take to improve

- The trust must ensure that all ligature audits for children's, family and young person's services are complete and in date.
- The trust must ensure that they protect patient's dignity and privacy at Thurlow House, Kings Lynn.
- The trust must ensure that children's safeguarding, in the waiting area at Thurlow House, is addressed.
- The trust must ensure that staff complete all risk plans in full on the electronic recording system.
- The trust must ensure that all staff are competent in the use of the electronic recording system.
- The trust must ensure that the recording of supervision is centralised and standardised.
- The trust must ensure that all teams within the children's, family and young people's service are working to common goals and practices.
- The trust must ensure that managers take all measures possible to reduce the waiting time for allocation to care co-ordinators.
- The trust must ensure that staff use personal alarms.

Summary of findings

- The trust must ensure that there are governance processes in place to monitor and improve the quality of care they provide.
- The trust must ensure that they meet the breaches of the Health and Social Care 2014 from the inspection carried out in 2016.

Action the provider SHOULD take to improve

- The trust should ensure that services and processes are developed in conjunction with the wider children's and family mental health community.
- The trust should ensure that there is a clear overarching strategy and development plan for children's, family and young people's services, and that all staff know and understand the strategy and plans for this service.

Norfolk and Suffolk NHS Foundation Trust

Specialist community mental health services for children and young people

Detailed findings

Locations inspected

Name of service (e.g. ward/unit/team)	Name of CQC registered location
Great Yarmouth and Waveney Child Family and Young person's service	Trust Headquarters Hellesdon Hospital
Central Norfolk Child Family and Young person's service	Trust Headquarters Hellesdon Hospital
West Norfolk Child Family and Young person's service	Trust Headquarters Hellesdon Hospital
Mary Chapman House Norwich	Trust Headquarters Hellesdon Hospital
Ipswich Central IDT Coastal IDT	Trust Headquarters 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.

- Mental Health Act administrators for the trust examined all Mental Health Act paperwork at the point of admission. Mental Health Act administrators carried out regular audits to ensure staff were applying the act correctly, and there was evidence of learning in management team minutes from these audits.
- Mental Health Act administrators were able to offer support to managers and doctors to make sure the trust

was following the Act correctly. They offered support to staff around Mental Health Act renewals, consent to treatment, and appeals against detention. Staff we spoke with knew who their Mental Health Act administrators were, or who they could go to for advice on the mental health act.

- Across the service, 77% of staff had received training in the Mental Health Act. Staff had a good understanding of the mental health act. Particularly about community treatment orders, the Code of Practice and guiding principles, and how these principles applied to their roles with young people subject to the mental health act.
- Staff adhered to consent to treatment and capacity requirements as required, and were able to explain to patients and their families or carers their rights and responsibilities under the mental health act.
- Patients had access to the independent mental health advocacy services and staff knew how to access and support engagement with the independent mental health advocates. We saw notices in the waiting rooms of team bases explaining how patients could get more information about the Mental Health Act if they required this.

Mental Capacity Act and Deprivation of Liberty Safeguards

- The trust had a policy on the Mental Capacity Act, which staff were aware of and could refer to. There was a mental capacity act lead appointed by the trust.
- Staff we spoke to were aware of their responsibilities in obtaining consent and understood the need to consider 'Gillick competency' for young people under the age of 16 years. Gillick competence is the principle used to judge capacity in children to consent to medical treatment. Staff were also aware of the 'Fraser' competence, which relates to a child under 16 who is deemed competent to receive contraceptive advice without parental knowledge.
- We found patients were encouraged to make decisions for themselves with the support of parents. Where appropriate and when patients lacked capacity and parents were not able to act on the patient's behalf, staff made decisions based on the patients best interests, recognising the importance of the person's wishes, feelings, culture, and history.
- Across the service, 80% of staff had completed training around the Mental Capacity Act and 79% of staff had completed deprivation of liberty safeguards. Staff showed a good understanding of the act and in particular the five statutory principles.

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

- Across the locations, clinical areas were clean and well maintained. Cleaning records were up to date and demonstrated that staff cleaned the environments regularly. We saw a range of maintenance schedules showing staff maintained the equipment. We saw that equipment was clean with stickers that were visible and in date.
- Staff adhered to infection control principles including handwashing. We saw notices in the toilets advising people to clean their hands, and at most, locations there were hand-sanitising gels available.
- The majority of interview rooms had some form of emergency alarm system, or staff carried personal alarms. However, at Thurlow House, none of the interview rooms had emergency alarms and while personal alarms were available staff did not carry them and did not know where to locate them.
- We saw ligature audits with risk management plans at all locations except Thurlow House, and Great Yarmouth and Waveney locations. Ligatures are places that people could tie something to with the intent of hanging themselves. At Thurlow House, and Great Yarmouth and Waveney, managers told us senior managers in the trust had indicated that carrying out ligature audits in community settings was not a priority task.
- All locations had clean and tidy clinic rooms with equipment to carry out basic physical health examinations such as height, weight, temperature, and blood pressure, the equipment for this purpose was clean and calibrated.

Safe staffing

- The trust set the core staffing levels for the service. The provider had estimated the number and grade of nurses required for the team using a recognised tool. The number of nurses matched this number on all shifts.
- The total number of substantive staff for this service was 371 whole time equivalents. The established level of registered nurses across the service was 146 whole time equivalents. At the time of the inspection, there were 26 registered nurse vacancies. The established level of unqualified nurses was 44 whole time equivalents. The service had four unqualified nurse vacancies. The team with the highest number of vacancies for qualified nurses was Mary Chapman House part of the Central child, family, and young person's team with nine vacancies.
- Across the Suffolk region, there had been a shortfall of three consultant psychiatrist posts for several months. We found that there were only two consultants covering all of Suffolk with two locum posts supporting them. We heard how the consultants in Suffolk were struggling to cope with number of patients requiring their input, including emergency referrals, and despite them having identified to the Trust the situation had not been resolved.
- Staff sickness rate for the service was 3% in the last 12 months. Staff turnover rate for the service was 12% in the last 12 months.
- Between 01 April 2016 to 31 March 2017 bank staff had covered 115 shifts for nursing assistants and qualified agency staff covered 150 shifts due to sickness, absence, or vacancies.
- The average caseload varied between nine and 30 cases per full time care co-ordinator in each team. Managers based caseload numbers on the type and complexity of work required, and the skills and experience of the staff member. Managers and staff managed and reassessed caseloads through monthly management supervision.
- We were not able to determine the numbers of patients on waiting lists. Managers explained that following the introduction, in February 2017, of a new process for managing new referrals and waiting lists, technically no one was waiting to access the service. We found that individual pathway team leaders were keeping separate waiting lists for each pathway within each locality team, and therefore the team manager did not necessarily collate the number of patients waiting centrally. However, when we spoke with managers they provided us with data that highlighted approximately 735

patients, across the trust were waiting for allocation of a care co-ordinator within the child, family and young people's community service. The waiting times for allocation ranged from a few weeks to nine months. The waiting time for psychology intervention was between two months in Norfolk and eight months in Suffolk.

- Staff processed new referrals through the single point of access. New patients were seen for an initial appointment within the trusts required timeframes. The timeframe was 28 days for routine referrals, 5 days for urgent referrals, and four hours for very urgent referrals.
- As at 25 March 2017, the compliance with mandatory training for the service was 85%, against the trusts target of 90%. Ten of the 33 pathway teams within the child, family, and young person's service achieved the trust target of 90%; this included Central children, family and young person's (CFYP) team, and Central Early Intervention Team with 100%. Great Yarmouth and Waveney Crisis team, and the Ipswich and Coastal under 14's teams with 100%. Central CFYP Junior Doctors scored the lowest with 68% compliance.
- The trust classed 26 training courses as mandatory for this service. Seven of the courses failed to achieve above 75% compliance. These included: basic life support with 69%, clinical risk assessment and management with 72%, fire training with 72%, information governance with 66%, immediate life support with 56%, medical mandatory training days with 62% and suicide prevention with 72%.

Assessing and managing risk to patients and staff

- We looked at 44 care records and found that staff had completed 29 core assessments and risk assessments fully. However, staff had not completed the core or risk assessments in 15 records.Although, we did find evidence of staff carrying risk assessments in other sections of the care records.
- Core risk assessments contained information about home and family life and relationships, physical health, schooling and previous mental health history. Risk assessments which staff had completed included crisis plans but these were not always detailed, and while the crisis team's contact number was present there were not necessarily, any other means of coping or suggested plans.
- Experienced staff from the access and assessment teams undertook risk assessment for each referral during the triage and initial assessment stage. This initial assessment determined whether staff considered a referral urgent or routine. Where there was any doubt about the severity of risk staff could access medical and or psychological opinion before allocating to a pathway with any recommendations.
- Staff we spoke with understood how to recognise deterioration in a patient's presentation and knew how to respond appropriately.
- Staff monitored patients on waiting lists for care co-ordinators, checking for any increased level of risk. While patients were on the pathway, and awaiting allocation to a permanent care co-ordinator, staff from the pathway maintained contact with the patient and their families or carers. Staff offered telephone support, brief interventions to manage any specific needs such as anxiety, carer stress, and coping strategies. During this waiting period, all patients received a routine six to eight weekly check in telephone call from an experienced staff member. The purpose of this call was to check how things were going, note any changes in presentation, and assess for risk. The multi-disciplinary team reviewed all patients waiting for a care co-ordinator at their weekly team meetings.
- Ninety four percent of staff had trained in safeguarding adults and safeguarding children level one and 89% of staff had been trained in safeguarding level three. Staff knew what a safeguarding issue was and explained the procedure for raising a safeguarding alert. We saw evidence of joint working with local authorities where relevant.
- With the exception of Thurlow House, we saw that teams had identified and appropriate separate waiting areas for patients under 18 years and over 18 years. At Thurlow House there was one small waiting area for both under 18's and over 18's, this meant that children's safeguarding could not be protected.
- Between 1 April 2016 and 31 March 2017, the service had made three adult safeguarding referrals and 127 child safeguarding referral to the local authority in the last year. Mary Chapman house had the highest number of safeguarding referrals at 29.

Requires improvement

Are services safe?

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

- Personal safety protocols were in place, and staff were aware of lone working policies and procedures. We saw evidence of the 'buddy system', whereby staff would contact a colleague to inform them of whereabouts at regular intervals. We saw that staff updated their electronic calendars so that others could access it.
- Staff advised us that they did not handle or transport medications for patients.

Track record on safety

- Between 1 April 2016 and 31 March 2017, trust staff reported seven serious incidents within this core service. Of these, one involved the death of a patient. The most common types of serious incident reported were, failure to obtain appropriate bed for child who needed it with five (71%). Two were incidents of apparent/actual/ suspected self-inflicted harm meeting the serious incident criteria.
- Staff we spoke with could identify changes made to the service because of lessons learned from significant incidents, including the new ways of managing and monitoring patient waiting lists.

Reporting incidents and learning from when things go wrong

- Staff we spoke to knew what incidents and accidents needed to be reported, and could tell us how they did this.
- Staff told us they were open and transparent with young people and their families if things went wrong.
- Staff confirmed they received relevant feedback from investigation of incidents both internal and external to the service. We saw the minutes of team meetings where mangers had given staff feedback from the investigation of incidents throughout the trust, as well as via email bulletins and alerts. Managers discussed significant incidents at monthly management meetings.
- Staff reported all incidents appropriately, and they were open and transparent and explained to patients when something went wrong.
- We saw evidence of change having been made by managers because of feedback from serious incidents including the introduction of a single point of access, and the introduction of the access and assessment teams.
- Staff told us they received a de-brief and support after a serious incident. This was usually delivered by the team manager or the team psychologist, with follow up if required.

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 44 care records. We found that staff had not completed core assessments in a timely manner in ten of these records. Of those completed records we did see, the records contained up to date, personalised, holistic, recovery-oriented care plans.
- All information needed to deliver care was stored securely on an electronic system. This meant that when staff transferred patients between teams or discharged to other services, notes were easily accessible. However, on a day-to-day basis staff told us information was not always readily available, for example when internet connections were poor.
- Some staff said they found the electronic system difficult to navigate, and this resulted in delays with accessing information, while other staff did not have a problem with this. Managers explained that the training for the electronic systems had been inconsistent across the teams, and the quality of training was variable.

Best practice in treatment and care

- Staff followed National Institute for Health and Care Excellence guidance for prescribing and provided a range of therapeutic interventions in line with National Institute for Health and Care Excellence. Therapies included cognitive behavioural therapy, cognitive analytical therapy, dialectical behavioural therapy, and family therapy.
- Interventions offered by the teams included sign posting to external agencies, as well as support for employment matters, housing and benefits.
- Physical health monitoring; for example blood pressure, pules and temperature was often done by the GP at the time of the initial referral. Staff recorded height and weight if there was a concern about a patient being underweight.
- The majority of care records we looked at did not have any regular physical health monitoring. Staff told us that the patients GP was responsible for completing annual physical health checks. However, we did find that staff followed NICE guidelines when screening for side effects of anti-psychotic medications prescribed.
- Staff used a range of nationally recognised assessment tools. Examples of these included the child outcome research consortium (CORC) and brief assessments for adolescents (BAC-A).
- Managers had carried out 12 clinical audits from 01 April 2016 to 31 March 2017. These included reports relating to unexpected deaths, infection control, and confidentiality awareness and safeguarding in clinical supervision. In addition, managers had produced reports relating to care programme approach quality and compliance, health records, caseload management, and quality of risk assessment in early intervention for psychosis.

Skilled staff to deliver care

- The teams consisted of doctors, clinical psychologists, family therapists, nurse specialists, registered mental health nurses, play therapists, occupational therapists, and assistant practitioners. Within the trust, staff could refer to physiotherapists and dieticians when required.
- Systems were in place for all new staff to undertake a trust and a local induction. The trust induction offered an overview of the trust and appropriate mandatory training. The local inductions gave staff the opportunity to develop role specific training and knowledge within the teams they were to work in. Staff we spoke with told us there were opportunities for further development within the trust.
- Some teams had developed local, in house training sessions around themes such as eating disorders or autistic spectrum disorders. Different professionals with knowledge and experience would offer training sessions if thought to be beneficial to the staff group.
- Eighty one percent of assistant practitioners had completed the Care Certificate standards. The Care Certificate is an identified set of standards that health and social care workers adhere to in their daily working life.
- All teams held regular team meetings. We saw the minutes of these meetings recording discussion about new referrals, caseloads, and high-risk patients.
- Staff told us they received monthly clinical and management supervision where they were able to

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reflect upon their practice. Individual team managers and supervising leads showed us records indicating that between 90% and 98% of staff had in date clinical and managerial supervision. The trust target was 89%.

- The trust did not collate supervision data centrally. Staff collated this data at team level in various ways and to variable standards. This meant that data reliability was not robust or consistent across the trusts or between teams.
- The trust's target rate for appraisal compliance is 89%. As at 24 April 2017, the overall appraisal rates for non-medical staff within this service was 55%. The overall appraisal rates for medical staff was 96%.
- Managers addressed poor staff performance promptly and effectively. Team managers told us they would address poor staff performance with support from senior managers and advice from the human resources department, if required.

Multi-disciplinary and inter-agency team work

- We saw evidence of weekly case management and team meetings, which were attended by all members of the multi-disciplinary team where possible.
- We saw that administration staff assisted the teams with collating information about referrals and appointments. This information was readily available for each team member.
- Staff entries in care notes and letters, showed there was effective multidisciplinary agency working with external agencies such as the local authority and the criminal justice system, as appropriate.
- We saw evidence of effective handover between teams within the organisation, such as community to crisis team or inpatient services. Three staff explained they had transferred from other teams within the trust to their present team and had been encouraged to maintain their working links with the previous team.

Adherence to the MHA and the MHA Code of Practice

- Mental Health Act administrators for the trust examined all Mental Health Act paperwork at the point of admission. Mental Health Act administrators carried out regular audits to ensure staff were applying the act correctly, and there was evidence of learning in management team minutes from these audits.
- Mental Health Act administrators were able to offer support to managers and doctors to make sure they were following the Act correctly. They offered support to staff around Mental Health Act renewals, consent to treatment, and appeals against detention. Staff we spoke with knew who their Mental Health Act administrators were, or who they could go to for advice on the mental health act.
- Across the service, 77% of staff had received training in the Mental Health Act. Staff had a good understanding of the mental health act. Particularly about community treatment orders, the Code of Practice and guiding principles, and how these principles applied to their roles with young people subject to the mental health act.
- Staff adhered to consent to treatment and capacity requirements as required, and were able to explain to patients and their families or carers their rights and responsibilities under the mental health act.
- Patients had access to the independent mental health advocacy services and staff knew how to access and support engagement with the independent mental health advocates. We saw notices in the waiting rooms of some team bases explaining how patients could get more information about the Mental Health Act if they required this.

Good practice in applying the MCA

- The trust had a policy on the Mental Capacity Act, which staff were aware of and could refer to. There was a mental capacity act lead appointed by the trust.
- Staff we spoke to were aware of their responsibilities in obtaining consent and understood the need to consider 'Gillick competency' for young people under the age of 16 years. Gillick competence is the principle used to judge capacity in children to consent to medical treatment. Staff were also aware of the 'Fraser' competence, which relates to a child under 16 who is deemed competent to receive contraceptive advice without parental knowledge.

Are services effective?

Requires improvement

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- We found patients were encouraged to make decisions for themselves with the support of parents. Where appropriate and when patients lacked capacity and parents were not able to act on the patient's behalf, staff made decisions based on the patients best interests, recognising the importance of the person's wishes, feelings, culture, and history.
- Across the service, 80% of staff had completed training around the mental capacity act and 79% of staff had completed deprivation of liberty safeguards. Staff showed a good understanding of the act and in particular the five statutory principles.

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 saw that staff interacted with patients in a respectful way. Patients reported that staff were supportive of them, understood their needs and involved their carers and families appropriately and only after seeking their permission.
- Patients described how staff were able to explain difficult issues clearly, using diagrams and pictures where necessary.
- Carers we spoke to had mixed feelings about the children's and young people's services. We heard from several people how services had been difficult to access and get into, some people felt they could only get help once their family member had gone into a crisis state by which time a lot of damage had already been caused. One carer told us that because they had moved from one area to another during their family member's treatment the treatment plan had come to a halt because the therapy they had been receiving was not available in the new area.
- Several carers told us about long waiting lists for appropriate treatment. They acknowledged that while waiting for therapy staff had offered short-term interventions. However, the application of the skills and knowledge, gained through the interventions, had not been sustainable without ongoing face-to-face sessions. They reported that this had added to, and increased carer stress that the service was not addressing.
- Other carers were very complimentary about the service they received once staff had allocated their family member to a key worker. We heard compliments about the flexibility of the services, the knowledge, and skills of staff to explain difficult concepts, the regular updates, and reports they received, and the trustworthiness of the information staff gave them.
- Confidentiality was adhered to.
- Staff spoke with passion and compassion about their roles and were proud of the work they undertook.

The involvement of people in the care that they receive

- We examined 44 care records. Fifteen had a signed care plan. Staff had printed the plans from the electronic system, sought a signature from the patient and then scanned back onto the system to demonstrate that the patient was in agreement with, and had signed the care plan.
- Staff told us joint care planning was part of their routine and on-going intervention with patients and their families and that this information was recorded in the general notes section of the clinical records.
- Care records showed that the teams had appropriate contact with the families and carers of patients.
- Patients had access to advocacy services. Staff would support patients to contact these services if required.
- Staff told us they routinely gave out questionnaires to patients and families to gain feedback of services. We saw some feedback from these surveys in team minutes and "you said we did" notices in the waiting areas of sites we visited.

Are services responsive to people's needs?

Requires improvement

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

Our findings

Access and discharge

- The access and assessment services in Suffolk and the single point of access service in Norfolk, had target times for the triaging of referrals. Staff saw or contacted emergency referrals within four hours; staff saw patients with urgent priority within five days, and routine referrals within 28 days. This core service was meeting the referral to first face to face contact times.
- In Norfolk staff acknowledged receipt of the referral to both the referrer and patient, and based on the initial referral information and identified patient needs, experienced staff allocated patients to one of the following care and treatment pathways within the locality teams. Under 14's, eating disorders, early intervention for psychosis, youth team, CRISIS and intensive support, or medical and complex assessment.
- In Suffolk, the system was different whereby following acknowledgement of the referral the new referral was passed to the children's and young person's part of the relevant integrated delivery team, and placed on the team's waiting list.
- Following the first contact, which was usually a letter or telephone call, staff arranged a face-to-face meeting with the patient and their families or carers. The purpose of the meeting was to carry out more in depth assessment of needs and level of risk. Following this meeting, staff confirmed which pathway would suit the patients' needs and an interim treatment plan was formulated while a care co-ordinator could be allocated from the treatment pathway.
- Staff were able to see urgent referrals to the service quickly. The crisis team and access and assessment teams would see referrals from 8 am to midnight. However, there was no service for patients under the age of 18 from midnight to 8 am.
- If staff offered an appointment and the patient did not attend, another appointment was offered by letter. If this further appointment was not attended, a member of the team would attempt to make telephone contact. If this failed staff contacted the referrer and general practitioner for further contact details and if after this there was still no contact the patient was discharged, the referrer and general practitioner were notified and a letter would be sent to the patient and any key family member.
- The staff we spoke with did not have a full understanding of the access criteria this meant that there was potential for some patients to fall through the gap of care.
- At clinics, staff would try to adhere to the appointment times offered. We saw that staff rarely cancelled appointments, but if they were, staff explained the situation to the patient at the earliest opportunity. Staff attempted to make clinic appointments at convenient times for patients were possible including early evening appointments.
- Staff showed us the various projects and attempts they had made to engage with patients who were reluctant to engage in mental health services. These projects included a community based art projects, and engagement through social activity and appropriate use of social media.

The facilities promote recovery, comfort, dignity and confidentiality

- There were multiple rooms for care and treatment including those for activities, therapy sessions, interviews, assessments, and physical health clinics. However, at Thurlow House we found multiple problems with suitability of the building. This included poor soundproofing between staff offices and client interview and group rooms, we could clearly hear conversation in the admin office while in the waiting room. Poor use of the space and rooms available giving staff the perception that they did not have adequate rooms in which to carry out therapy. The ad- hoc room booking system left clients waiting around for considerable lengths of time while waiting for a room to become available.
- In clinic waiting rooms, we saw there were a variety of information leaflets to include aspects of physical health, mental health issues, and the rights of patients. There was information on more specific topics such as 'hearing voices and experiencing unusual beliefs' 'feeling suspicious' and coping with depression. Posters gave information about the local support available for support with sexuality, spiritual and pastoral care.

Are services responsive to people's needs?

Requires improvement

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Meeting the needs of all people who use the service

- The services accommodated patients who had mobility difficulties or used a wheelchair. The trust had access to a number of ground floor rooms at different locations that staff offered for such appointments.
- The trust had access to an interpreter service and signers when and as required. Staff assured us that they could access these easily and book in advance for reviews and appointments.
- Information leaflets were available on request and staff were familiar with and knew how to use language line.
- We found there were variations in the interventions available between the Norfolk and Suffolk teams. While Norfolk teams offered play therapy, Suffolk did not, and while Suffolk provided dedicated Asperger's treatment, Norfolk did not. There were also seven qualified family therapists in Norfolk but only one in Suffolk. This gave rise to the belief amongst the population that the provider delivered services based on postcodes, and referrers, particularly those on the borders of the counties being confused about what was available to them and what was not.

Listening to and learning from concerns and complaints

- The service had 68 complaints in the last 12 months. The complaints related to admissions, discharge and transfer arrangements, delay or cancellation for outpatient appointments, breaches of privacy, and, or dignity. Managers had investigated these complaints. Forty- three had not been upheld, 23 were partially upheld, and 10 were fully upheld. Managers were still investigating 11 complaints.
- One complaint had been referred to the ombudsman, which related to care and clinical treatment of a family member. The ombudsman upheld the complaint.
- The service received 47 compliments during the last 12 months.
- Patients and their families knew how to complain and we saw information about this on the walls in waiting rooms. We saw three examples of when managers had given feedback to complainants in the form of a letter. One manager explained how they had made telephone contact with a regular complainant to give feedback as they had found this more helpful than a letter.
- Staff knew how to handle complaints appropriately. Seven staff we spoke with could recall having received feedback from their managers about complaints made against them.
- We saw evidence of staff having changed their systems and processes in response to feedback from complaints. Examples included the referral process, procedures for keeping in contact with patients and their families on waiting lists, and offering patients' and family's short pieces of structured work to support them while on waiting lists.

Are services well-led?

Requires improvement

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 we spoke with were unsure about the trusts vision and values for the children's, family, and young people's service. Three staff members commented on the fact that there was no director for children's services, or other significant person responsible for children's services across the trust. This meant that there was no secure figurehead to ensure cohesive strategy, vision and values across the children's, family and young people's services.
- The majority of staff we spoke with knew who their immediate service and operational managers were, but were not so sure who the mangers were above this level. None of them could recall the last time any senior managers had visited all the sites.
- We saw how individual team managers had clearly identified the objectives for their teams, and how the pathways of care within the teams worked to common purpose. However, we also found that individual teams and the services for children and young people across the trust were developing independently of each other. This was giving rise to the idea that children's, family, and young people's services in Norfolk and Suffolk were disjointed, unequal, and not cohesive.

Good governance

- Managers had not ensured that they had addressed the issues that were raised in the inspection carried out 2016. These included, staff completing risk assessments, ensuring staff were up to date with mandatory training, staff were able to navigate the electronic patient records system and in receipt of annual appraisals.
- Clinical team leaders reviewed information about caseloads, new referrals, and high-risk cases in weekly team meetings. When appropriate, staff participated in clinical audits.
- There were different meetings which focussed on governance systems and monitoring the teams' performance. Examples of these were service line meetings, business team meetings and locality management meetings.
- Managers used key performance targets to gauge the performance of their team; these were in an accessible format. However, not all managers were working to the same key performance indicators and governance systems such as monitoring supervision, training, and monitoring waiting lists, which were not centralised. This meant that different teams were focussing on different issues, which caused confusion for people using these services.
- We saw how managers had used this data to review caseloads and upskill staff to be able to deliver a range of therapies at a level appropriate to their grade and experience.
- We saw evidence in the minutes of team meetings that managers had been addressing mandatory training and supervision issues. However, not all managers were collating supervision data centrally and so they could not be certain that all staff were actually receiving supervision, as they should be.
- Managers told us they had sufficient authority to undertake their role. All teams had some level of administrative support.
- Managers told us they could, and had, submitted items of risk on to the trust risk register. We saw evidence that a risk relating to medical cover in the Great Yarmouth had been logged on this register.
- There was a clear line management structure in place. Most staff we spoke to felt supported by their manager and knew who to contact if they had any concerns.

Leadership, morale and staff engagement

- At time of inspection, there were no reported bullying or harassment cases in progress for this service. Staff felt able to raise concerns without the fear of victimisation from other colleagues. Staff we spoke with knew about the whistle blowing policy, and how to use this if required.
- During the twelve months preceding this inspection there was 4% staff absence due to sickness, and where this was evident, we saw how managers were supporting the absent staff to return to work.
- Seventeen of the staff we spoke with felt morale and support for each other within the teams was good, and in most of the teams we visited, staff spoke positively

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about their immediate team managers. However, fourteen other staff we spoke with reported that morale was low due to workload pressures, lack of direction for the service at a senior level, and inconsistency in the service across the trust.

- Staff confirmed that the trust offered leadership development.
- We observed good team working whereby colleagues offered each other support.
- Staff explained the need for openness and transparency with patients' and their families if things did not go as planned, and told us they had received 'Duty of Candour' training.
- Staff we spoke to felt they had opportunity to feedback on services and make suggestions around future service development, however, most of these same staff did not think senior managers listened to their views.

Commitment to quality improvement and innovation

- We heard how one staff member in conjunction with other members of their team was undertaking a research project about the impact and management of multiple trauma. The objective of the research was that it would underpin future service development around management of waiting lists across the trust.

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 10 HSCA (RA) Regulations 2014 Dignity and respect At Thurlow House, soundproofing was poor. Conversation could be heard between the administration office and waiting room, and between staff offices, interview and group rooms.

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 Ligature audits were either not complete or not present in the Norfolk area. There were significant ligatures at all locations delivering services in Norfolk. Staff were not completing risk assessment information on the electronic recording system.

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Treatment of disease, disorder or injury	Regulation 13 HSCA (RA) Regulations 2014 Safeguarding service users from abuse and improper treatment At Thurlow House there was a small reception area for both children and adults visiting the service; and was a safeguarding risk for children and young people.