Inadequate

Norfolk and Suffolk NHS Foundation Trust

Specialist community mental health services for children and young people

Quality Report

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Locations inspected

Location ID	Name of CQC registered location	Name of service (e.g. ward/ unit/team)	Postcode of service (ward/ unit/ team)
RMY01	Hellesdon Hospital	80 St Stephens Road	NR1 3RE

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	Inadequate
Are services safe?	Requires improvement
Are services effective?	Requires improvement
Are services caring?	Requires improvement
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

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Overall summary

This was a focused inspection looking at specific areas of concern. The inspection was of the CAMHS youth service located at St Stephens Road, Norwich. The ratings shown in the report are from the previous inspection of specialist community mental health services for children and young people across the trust which took place in October 2019.

At this inspection we found the following areas where the trust needed to improve:

- We were not assured that patients who were on waiting lists for assessment or treatment were being adequately managed by the teams responsible for their care. Patients on those waiting lists were not always being adequately monitored or supported. Where a change in the patients' individual risk was identified, their risk assessments were not always being updated. We also found some appointments and therapy groups being cancelled as there were not enough staff available. This meant that there was a risk that patients whose needs changed might not be identified or receive support in a timely manner.
- Whilst the trust was working to rationalise the waiting lists in place and establish a principal list for each team, at the time of the inspection staff were still referring to numerous waiting lists. This was confusing, ineffective and did not ensure there was appropriate oversight for the teams.
- The building at 80 St Stephens Road was not well maintained and the décor was shabby. Internet access at the time of the inspection was not reliable which meant that patient records were not always accessible.
- Whilst the trust was refining its governance arrangements they were not yet working effectively for this service. The data on waiting lists needed improvement to ensure staff in the teams had the information they needed to meet the needs of the patients. The trust also needed to be assured that patients were being assessed and treated in a timely and safe manner. In addition, the meetings taking place in the service had been revised and needed to be embedded so they were working well. Staff particularly in the North team needed the support and guidance from leaders to use the new systems and processes.

However:

- In response to the concerns raised within this report, the trust leadership team provided assurance of action which had begun just prior to the inspection. For instance, on 13 February 2020, an executive-led rapid improvement board had been established. This aimed to accelerate improvements and had increased senior leadership oversight. The care group leadership team were spending four to five days per week at St Stephens Road. We were told of plans in place to undertake a large scale clinical review of the waiting list in early March 2020. A review of the duty system and supervision processes were also planned. New terms of reference for leadership meetings had been agreed including a specific section on learning from incidents, complaints and inquests. A programme of site meetings was planned along with maintenance walkarounds. This had already seen the implementation of hygiene audits and projects identified to improve the environment at 80 St Stephens Road.
- Recruitment into posts had begun and we saw key roles had been appointed to with plans in place for further recruitment. The trust had also increased senior management oversight to the service. This was an improvement on staffing which was of particular concern in the North team in December 2019.
- Work had begun just prior to this inspection to pull all the waiting lists together and provide a clear view and understanding of action required. This was being developed as one service user tracker list (SUTL) to monitor all patients. This system had been successfully implemented in other teams at the trust. It involved a weekly meeting to discuss actions required for patients on the list.

Summary of findings

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

Are services safe?

Requires improvement

The rating provided was the rating given following the inspection which took place in October 2019. This has not been revised.

We found the following areas the trust needed to improve:

- Staffing had not always been sufficient to meet patient need. In December 2019 there were large gaps in staffing in the North team. There was one Band 7 vacancy, four Band 6 vacancies and one Band 4 vacancy. This meant there were only two Band 6 staff in post in the North team. This was insufficient to address the needs of patients. Evidence of impact was reflected in patients' records. We saw that patients were not always being seen by clinicians in a timely way and that therapy groups were cancelled on more than one occasion. There was an increase in patients being added to the team-held waiting lists at this time due to staff leaving and a heavy demand from referrals. Staff admitted they had significant concerns that they could not manage caseloads safely and that patients were not always being seen according to their need or risk. At the time of our inspection we saw that staffing had improved due to an ongoing recruitment campaign. There were fewer vacancies and these were currently being advertised for recruitment.
- We reviewed 10 care records and found that four did not reflect all of the current risks. Crisis plans, if in place, were minimal in content, often just listing phone numbers of who to contact and lacked plans specific to the individual.
- We were not assured that processes for managing waiting lists, particularly team-held waiting lists, kept people safe. Where a patients' risk was discussed in team meetings and there was an identified change to risk, we saw that risk assessments were not always updated. There was no clear process to ensure patients on team-held waiting lists were appropriately monitored and supported. We saw large gaps in records, with one patient not having had direct contact since July 2019. Patient waiting list concerns had been mentioned at the last four inspections and it was disappointing that this had not been fully addressed within this team.
- Discussions about patients at case meetings did not always translate into action and did not transfer into patient records. It was unclear how actions were implemented and who was responsible to follow them up. Staff confirmed this was a risk.
- The building at 80 St Stephens Road was not well maintained. The décor was shabby and internet access was not reliable. The unreliable access to the internet meant that patient records

Summary of findings

were not always accessible. We saw this during inspection when there was a lack of access for several hours. Consequently, some patient sessions were cancelled by one of the teams in the building.

- The business resilience plan for the trust lacked sufficient detail at a local level. The plan talked about such events as loss of access to clinical records, however, there were no locally driven protocols to manage such events. This is despite it being a known issue as loss of connectivity had happened on previous occasions.
- There was a lack of structure for discussing lessons learned at meetings. Local team meetings did not have a clear meeting agenda. We saw that few meetings were documented as actually taking place although we were told some were happening. Of those meetings that did take place, there were several where lessons learned were not discussed at team level, despite there being discussions at clinical governance meetings.

However:

- The trust was aware of most of the concerns identified above and had recently provided additional leadership support. There was a review being undertaken by the lead nurse from the care group and a project lead was pulling all the waiting lists onto one tracker so everyone could see the patient journey. The trust provided evidence of a reduction in waiting times with the longest time reduced from over 52 weeks to 19 weeks.
- We saw evidence of incidents being reported. The manager confirmed that they would look at themes for learning. One theme the manager identified was of letters being sent to the wrong address due to records not being updated. A small system change was implemented and reported cases reduced significantly from 16 in November 2019 to one in January 2020.
- We saw that there had been some success in recruiting to vacant posts since December 2020 and two of the applicants had just started with more to follow.

Are services effective?
We did not inspect this domain.

The rating provided was the rating given following the inspection which took place in October 2019. This has not been revised.

Requires improvement

Are services caring?
We did not inspect this domain.

Requires improvement

Summary of findings

The rating provided was the rating given following the inspection which took place in October 2019. This has not been revised.

Are services responsive to people's needs?

Inadequate

The rating provided was the rating given following the inspection which took place in October 2019. This has not been revised.

We found the following areas the trust needed to improve:

- The team lacked effective systems to monitor and manage referrals, triage, assessment and treatment. None of the staff we spoke with understood the process or even knew if there was a process. This meant it was impossible to be assured that systems were safe and patients were seen in a timely and effective way.
- We were concerned that all staff spoken with had a different understanding of how they managed 'team-held' waiting lists. No-one was able to clearly articulate what was supposed to happen.
- The team struggled to keep up with referrals which came from a variety of sources. One senior clinician told us they did not know what the referral criteria were and that there was a perception that the team just took anyone that other teams did not take. Staff were concerned that there was an expectation to address the waiting list for assessment without the resource in place to then offer any treatment identified in this process.
- The lead nurse provided data that showed there were a total of 228 patients waiting for assessment, 149 of which were outside of the trust target for assessment. These figures were disappointing, but the trust provided evidence of plans in place, recently developed, to address this concern.

However:

- Work had just begun at the time of inspection to combine the various waiting lists and provide a clear view and understanding of action required. This was being developed as one service user tracker list to monitor all patients. This system had been successfully implemented at other teams in the trust. It involved a weekly meeting to discuss actions required for patients on the list.
- Post inspection we were told by the senior executive leadership team that extra clinics had now been scheduled at weekends to reduce the assessment waiting time.

Are services well-led?

Inadequate

The rating provided was the rating given following the inspection which took place in October 2019. This has not been revised.

Summary of findings

We found the following areas the trust needed to improve:

- There was a disconnect between the clinical team staff and managers. We spoke to a team that was fractured, concerned about the management of risk and lacking in leadership. We saw staff moving in different directions, making decisions about their work that did not follow process as there was a lack of understanding of what those processes were. Some staff felt they were not listened to when they tried to raise concerns.
- The meetings taking place in the service had been revised and needed to be embedded so they were working well. During the inspection we heard of a significant number of meetings, some with a lack of structure, clear agenda and process. It was significant that every member of staff spoken with did not understand the meeting structures or have a clear awareness of processes they needed to follow to address issues.
- We were not assured that waiting lists were accurate and this was also verified by the team managers. However, we saw work was being undertaken to begin to correct this.
- Further work was needed to ensure that the teams were applying and managing the risk registers to identify and manage potential risks safely.

However:

- Some staff reported that they felt that the recently appointed lead nurse was prioritising concerns appropriately and could see plans developing to address issues at pace.
- In response to the concerns raised within this report, the trust leadership team took decisive action and have already provided assurance of action which had begun just prior to the inspection. For instance, on 13 February 2020, an executive-led rapid improvement board had been established. This aimed to accelerate improvements and have senior leadership oversight. The care group leadership team were spending four to five days per week at St Stephens Road. We were told of plans in place to undertake a large-scale clinical review of the waiting list in early March 2020. A review of the duty system and supervision processes were also planned. New terms of reference for team meetings had been agreed, including a specific section on learning from incidents, complaints and inquests. A programme of site meetings was planned as well as maintenance walkarounds. This had already seen the implementation of hygiene audits and projects identified to improve the environment at 80 St Stephens Road.

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 Trust 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 Care Quality Commission placed Norfolk and Suffolk NHS Foundation Trust in special measures in 2017. There was a further inspection in 2018 and 2019. Following the 2019 inspection, there was an improvement in rating from inadequate to requires improvement overall. However, the core service for specialist community mental health services for children and young people remained with an inadequate rating. Despite the improved overall rating, the trust remained in special measures as it was too soon to judge if the early improvements made could be sustained.

The trust provides specialist community mental health services for children and young people for patients aged 0 to 25 throughout Norfolk and Suffolk under one registered location: Hellesdon Hospital and was rated as inadequate at the last inspection in October 2019.

The trust has been inspected six times in the last 12 months including this inspection.

There are 18 specialist community mental health services for children and young people team across the trust. During this inspection we looked solely at the Central Norwich youth team at 80 St Stephens Road, Norwich. This team sits within the specialist community mental health services for children and young people and supports patients aged 14 to 25. There were three youth teams at this location, North, South and Central. We predominantly looked at the North youth team which was where concerns had been raised leading to this inspection.

Our inspection team

The team that inspected the service comprised of one inspection manager and one CQC inspector.

Why we carried out this inspection

We carried out this inspection of 80 St Stephens Road, Norwich Youth team, as a result of whistleblowing information and other intelligence. This was a focussed, responsive, unannounced inspection specifically to look at patient case management, staffing and team management/leadership.

All requirement notices issued in the last inspection remain in place. The Section 29a warning notice amended in 2018 also remains in place.

We do not revise ratings following an inspection of this type. Ratings seen in this report were issued following the comprehensive inspection in October 2019 and remain in place.

How we carried out this inspection

We have reported on the following domains:

- Is it safe?

Summary of findings

- Is it responsive?
- Is it 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 focussed on issues raised following a whilstleblowing concern and other intelligence.

Therefore, our report does not include all the headings and information usually found in a comprehensive inspection report. Not all key lines of enquiry were explored within each domain, the inspection team focussed on specific areas of concern.

Before the inspection visit, we reviewed information that we held about the location.

During the inspection visit, the inspection team:

- spoke with the three managers
- spoke with seven other staff members; including doctors, nurses and occupational therapist
- spoke with the project lead for waiting lists
- attended and observed part of a team case meeting
- looked at 10 care and treatment records of patients
- looked at a range of policies, procedures and other documents relating to the running of the service.

Areas for improvement

Action the provider MUST take to improve

- The trust must ensure adequate staff resources are available to reduce the patient waiting lists for triage, assessment and treatment in the children and young person service and for attention deficit hyperactivity disorder patients. This incudes ensuring patients managed on team-held waiting lists are supported safely. Regulation 12: Safe care and treatment 12 (1)
- The trust must review their systems to ensure that patients have risk assessments which are updated as needed and care plans in the children and young person service. Regulation 12: Safe care and treatment 12 (2)(a), (b)
- The trust must review governance systems to ensure compliance with actions from past CQC inspections in the children and young person service. Regulation 17: Good governance 17(1), (2) (a), (b) and (f)
- The trust must ensure they support all managers to use the trust's governance systems and performance management systems in the children and young person service. Regulation 17 (1), (2) (a), (b), (c) and (f)
- The trust must ensure access to electronic records is available at all times. Regulation 17: Good governance 17 (1)

Norfolk and Suffolk NHS Foundation Trust

Specialist community mental health services for children and young people

Detailed findings

Name of service (e.g. ward/unit/team)	Name of CQC registered location
80 St Stephens Road, Norwich	RMY01

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 staffing

Staffing had not always been sufficient to meet patient need. In December 2019 there were large gaps in staffing in the North team. There was one Band 7 vacancy, four Band 6 vacancies and one Band 4 vacancy. This meant there were only two Band 6 staff in post in the North team. This was insufficient to address the needs of patients. Evidence of impact was reflected in patients' records. We saw that patients were not always seen by clinicians in a timely way and that therapy groups were cancelled on more than one occasion. There was an increase in patients being added to the team-held waiting lists at this time due to staff leaving and a heavy demand from referrals. This meant they no longer had a care co-ordinator until a replacement could be identified. Staff admitted they had significant concerns. They could not manage caseloads safely and patients were not always being seen according to their need or risk. However, staffing had improved at the time of inspection and appointments had been made to the majority of posts with some people now in post.

Managers told us that vacancies were advertised with some success and we saw during this inspection, two posts had been filled and those staff had recently started – one on the day of inspection and one the previous week. Other posts had been filled and the new appointees were awaiting a start date. The remaining vacancies continued to be advertised for recruitment. The impact on patient care was noticeable and although other teams within St Stephens Road had better staffing, there had not been sufficient action to support the North team. One staff member recruited could not start until September 2020 and the manager could not advise of a plan on how this vacancy would be managed until then.

Assessing and managing risk to patients and staff

We reviewed 10 care records and found that four did not reflect all of the patients' current risks. For instance, it was discussed in a team meeting that a patient's parent was at risk. This was not documented in the patient's records. Crisis plans, if in place, were minimal in content, often just listing phone numbers of who to contact and lacked plans specific to the individual.

We were not assured that patients on team-held waiting lists received adequate monitoring for changes to risk. We saw that risk assessments were not always updated when there was an identified change to risk.

Discussions about patients and actions from case meetings did not transfer into patient records. It was unclear how actions were implemented and who was responsible to follow up. Staff confirmed this was a risk.

There was no clear process to ensure patients on team-held waiting lists were appropriately monitored and supported. We saw gaps in records; one patient had not been contacted since July 2019. Another patient had several attendances at the acute hospital emergency department whilst waiting for allocation, the GP had followed up with concerns and in the summer of 2019 the liaison staff at the Accident and Emergency department submitted an incident report due to the lack of availability for support from the youth team. A further patient had been referred to the team in March 2019. The patient was added to the waiting list for a care co-ordinator in July 2019 but only made it to the priority meeting in January 2020. We were not assured that processes for managing waiting lists, particularly team-held waiting lists, kept people safe.

The trust was aware of some of the concerns identified above and they had been discussed at a recent engagement meeting between CQC and the trust. The trust had recently provided additional leadership support. There was also a review being undertaken by the lead nurse from the care group, and a project lead was pulling all the waiting lists onto one tracker so everyone could see the patient journey. Patient waiting list concerns had been mentioned at the last four inspections and whilst it is encouraging that action was now taking shape, it was disappointing that this had not previously been addressed in this team.

Staff access to essential information

The building at 80 St Stephens Road was not well maintained. Internet access was not reliable. This meant

Requires improvement

Are services safe?

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

that patient records were not always accessible. During inspection some patient sessions were cancelled by one of the teams in the building when there was a lack of access for several hours.

The business resilience plan for the trust lacked sufficient detail. The plan talked about events as loss of access to clinical records, however, there were no locally driven protocols to manage such events. This is despite loss of connectivity being a known issue that had happened on previous occasions.

Safe and clean environment

The décor was shabby and in need of improvement. The trust shared with us a plan to address this which included the redecoration of clinical areas, staff areas and group rooms.

Track record on safety

We reviewed the early learning report from a recent serious incident. We saw that at the time of the incident, the patient had recently been seen by clinicians. However, in the months prior to this we saw missed opportunities to engage with the patient, cancelled appointments and cancelled group sessions due to staff sickness. We saw evidence of a decline in the patients mental health that was not immediately acted upon. The patient was on the team-held list and did not have one single clinician overseeing their care. This is currently subject to a full root cause analysis investigation that has not yet been completed.

Reporting incidents and learning from when things go wrong

We saw evidence of incidents being reported. The manager confirmed that they would look at themes for learning. One theme the manager identified was several instances of letters being sent to the wrong address due to records not being updated. A small system change was implemented and reported cases reduced significantly from 16 in November 2019 to one in January 2020.

There was a lack of structure for feeding back lessons learned at meetings or via other methods of communication. Local team meetings did not have a clear meeting agenda and we saw that few meetings were documented as actually taking place. Of those meetings that did take place, there were several where lessons learned were not discussed at team level, despite there being discussions at clinical governance meetings. However, we did see some safety bulletins that had been shared with staff.

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.

Requires improvement

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

The team lacked effective systems to monitor and manage referrals, triage, assessment and treatment. None of the staff we spoke with understood the process or even knew if there was a process. This meant it was impossible to be assured that systems were safe, and patients were seen in a timely and effective way.

We were concerned that all staff spoken with had a different understanding of how they managed team-held waiting lists. No one was able to clearly articulate what was supposed to happen.

The team struggled to keep up with referrals which came from a variety of sources. One senior clinician told us the team did not know what the referral criteria were, and there was a perception by some team members that the team accepted patients that other teams did not take. We did not see evidence to support or refute this, however it was significant that this was the perception of the team. The staff member was concerned that the team was expected to address the waiting list for assessment without the resource in place to then offer support identified in this process. The trust told us that there is an expectation that the agreed process is applied consistently and that young people waiting for a service are safe. The Trust is working with partners to explore new care models and secure additional funding to meet the needs of children and young people.

The clinical lead showed us evidence of 54 patients on the North 'team-held' waiting list. The longest time a patient had been waiting was over 12 months. Plans were in development to address this as a priority action. Post inspection the leadership team provided assurance that the wait had reduced to 19 weeks.

The lead nurse provided data that showed there were a total of 228 patients waiting for assessment, 149 of which were outside of the target for assessment. These figures were disappointing, however, the trust shared with us a recently developed plan in place to address this. Post inspection, the trust told us extra clinics had been scheduled at weekends to reduce this wait.

We saw that there were several patient waiting lists, which added to staff confusion. Work had just begun at the time of inspection to pull all the lists together and provide a clear view and understanding of action required. This was being developed as one service user tracker list to monitor all patients. This system had been successfully implemented at other teams in the trust. It involved a weekly meeting to discuss actions required for patients on the list.

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, morale and staff engagement

Staff confirmed they still did not fully understand the care group leadership structure but did feel there had been more support recently. They were hopeful that improved processes would follow. Senior managers had reviewed the management structure in 2019. There were now 'care groups' across the trust with four key leaders for each group. However, leadership for this care group consisted of five key leaders. The extra lead identified, reflected the particular work required and size of the service. One post remained unfilled.

The team was fractured and concerned about the management of risk, lack of leadership, clear structures and processes. We saw staff moving in different directions, making decisions that did not follow process as there was a lack of understanding of what those processes were. Some staff told us that there was an air of learned helplessness and acceptance that the team was not functioning as it should.

Several staff expressed concern that the lack of structure hindered their ability to carry out safe and effective care and that they did not feel listened to when raising concerns. There was a disconnect between the team and managers.

However, some staff reported that they felt that the lead nurse was prioritising concerns appropriately and could see plans developing to address issues at pace.

Good governance

We were not assured of the governance structures within the team at 80 St Stephens Road. We saw a high number of meetings, with a lack of structure and process. It was significant that every member of staff spoken with did not understand the structures or have a clear awareness of processes they needed to follow. We were told of different structures from different staff.

Governance systems were not effective in supporting staff to prioritise their work. An effective system would allow staff to manage their work more efficiently.

In response to the concerns raised within this report, the trust leadership team provided assurance of action which had begun just prior to the inspection. For instance, on 13 February 2020, an executive-led rapid improvement board had been established. This aimed to accelerate improvements and have senior leadership oversight. The care group leadership team were spending 4 to 5 days per week at St Stephens Road. We were told of plans to undertake a large-scale clinical review of the waiting list early in March 2020. A review of the duty system and supervision processes were also planned. New terms of reference for leadership meetings had been agreed including a specific section on learning from incidents, complaints and inquests. A programme of site meetings was planned along with maintenance walkarounds. This had led to the implementation of hygiene audits and projects to improve the environment at 80 St Stephens Road.

Management of risk, issues and performance

We were not assured of processes to manage events such as loss of power and how the service would minimise risk to patients. However, we saw some work had commenced to look at this. Managers gave us a draft business impact analysis spreadsheet showing identified risks of not being able to deliver services. The business continuity plan or resilience plan provided oversight on what needed to happen in certain events such as loss of power. The team were unaware of there being any local protocols or plans on how this would be implemented within the local team. During inspection when there was a loss of access to the clinical records, one clinician told us that they planned to cancel appointments as it was unsafe. There was no thought to contact other services to access the information or consider an alternative plan.

We were told there was no local team risk register and that the care team were developing new risk registers attributable to the services they were now accountable for.

We were not assured that waiting lists were accurate and this was also verified by the team managers. However, we saw work was being undertaken to correct this.

We were not assured that patients could be kept safe as it was difficult to identify emerging risks using the current processes.

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 12 HSCA (RA) Regulations 2014 Safe care and treatment • The trust must ensure adequate staff resources are available to reduce the patient waiting lists for triage, assessment and treatment in the children and young person service and for attention deficit hyperactivity disorder patients. This incudes ensuring patients managed on team-held waiting lists are supported safely. • The trust must review their systems to ensure that patients have risk assessments which are updated as needed and care plans in the children and young person service.

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Treatment of disease, disorder or injury	Regulation 17 HSCA (RA) Regulations 2014 Good governance • • The trust must review governance systems to ensure compliance with actions from past CQC inspections in the children and young person service. • The trust must ensure they support all managers to use the trust's governance systems and performance management systems in the children and young person service. • The trust must ensure access to electronic records is available at all times.

This section is primarily information for the provider

Enforcement actions

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
Treatment of disease, disorder or injury	Regulation 17 HSCA (RA) Regulations 2014 Good governance Norfolk and Suffolk NHS Foundation Trust is in special measures and all enforcement action taken following the previous inspections in 2019 remain in place as they had not been addressed. A Section 29a Warning Notice was amended in 2018 and is not yet compliant. There were no new areas for improvement noted at this inspection. The concerns raised in this report were escalated to NHS Improvement/England for their consideration.