Norfolk and Suffolk NHS Foundation Trust

# Mental health crisis services and health-based places of safety

## Inspection report

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

Date of inspection visit: 3-17 November 2020
Date of publication: 22/01/2021

## Ratings

| | |
|---|---|
| Overall rating for this service | Requires Improvement |
| Are services safe? | **Requires Improvement** |
| Are services well-led? | **Requires Improvement** |

# Our findings

## Mental health crisis services and health-based places of safety

**Requires Improvement** 

The mental health crisis services and health-based places of safety are part of the mental health services delivered by Norfolk and Suffolk NHS Foundation Trust.

The crisis resolution and home treatment teams provide emergency assessments and an alternative to admission to hospital by providing intensive community support for adults who are experiencing acute mental illness with associated risks. The teams were also responsible for admitting patients to an inpatient unit if required. This service is available 24 hours a day, 365 days a year and covers Norfolk and Suffolk.

The health-based place of safety is a place where someone who may be suffering from a mental health problem can be taken by police officers, using the Mental Health Act, to be assessed by a team of mental health professionals.

We conducted an unannounced focussed inspection to respond to concerns that some patients had difficulty accessing crisis services in an emergency. We understood that the trust had set up a new first response service which had been developed to improve access to appropriate services. We also reviewed progress within the service following concerns found at our previous inspection in October 2019.The inspection was undertaken in the days immediately prior to the second national lockdown when the trust were seeing unprecedented demand on services.

We visited four service locations and spoke to staff from crisis, home treatment, psychiatric liaison teams and the new first response service, as well as reviewing the health-based places of safety at each of these locations. We reviewed 36 care records, 50 prescription charts and a range of documentation including policies, standard operating procedures and meeting minutes. We also conducted staff interviews and focus groups remotely following the site visits. We received feedback from several stakeholders regarding patient experience of services.

Our rating of this service stayed the same. We rated it requires improvement because the service did not follow systems and processes to safely prescribe, administer, record and store medicines and governance systems were not effective, the service did not have adequate access to medical cover in Bury St Edmonds and learning was not yet consistently shared with all staff.

### Is the service safe?

**Requires Improvement** 

Our rating of safe stayed the same. We rated it as requires improvement because:

- The service did not follow systems and processes to safely prescribe, administer, record and store medicines.

Staff in the Great Yarmouth and West Suffolk home treatment teams regularly used emergency dispensing by nurses to meet medicine supply needs of patients. This is despite its use only being intended for emergencies when the trust's pharmacy service is closed. We were not assured that this was being monitored safely or effectively.

# Our findings

Prescription charts and administration records were completed inconsistently across each of the three services visited. Medicines audit processes were inconsistent between teams. The records used by some teams did not include important information. For example, the records for the East Suffolk home treatment team did not include maximum daily doses of when required medications.

There was a high use of nurses dispensing emergency medicines to obtain medicine supplies for patients (there is an increased risk of errors with this type of supply) in both Great Yarmouth and Waveney Crisis Team and West Suffolk Home Treatment Team and we were not assured that this was being monitored safely or effectively.

- Good practice seen in one service was not shared consistently in other areas. However, the Trust demonstrated that there was a number of different forums for sharing good practice, including a crisis forum which had been stood down during the pandemic. Staff we spoke with told us they did not find it easy to communicate and share good practice across the various home treatment teams and some staff were not aware of systems in place. We were not assured that the current systems in place were sufficiently effective.

- Managers did not always share lessons learned from incidents with the whole team and the wider service. The trust demonstrated that had several mechanisms to share learning, including QI projects and MS Teams chat forums, but staff from two teams we spoke with were not aware of them.

The trust had six serious incidents resulting in the death of a patient between January and September 2020 with a further death reported the week prior to inspection. Staff in both Great Yarmouth and Waveney and West Suffolk teams told us that they did not routinely receive feedback about the outcomes or learning from incidents.

- Staff did not always see patients within set timescales following an emergency referral.

Staff did not always see emergency referrals within the four-hour target time. Prior to the Covid-19 pandemic, staff saw 83% of patients within four hours against a target of 95%. This dropped to 72% in June 2020 before increasing to 79% in September 2020. The average time from referral to assessment across the months January to September 2020 was 10 hours, but during May and September the average time from referral to assessment was 19 hours. Staff told us that demand had increased as a result of reduced community services during the pandemic, which had made it hard to meet this target. We received feedback from patients about their access to services which was a mixture of both positive and negative experiences reported.

- The crisis and home treatment team for West Suffolk did not have full time onsite clinical support from a doctor and staff spoken with were unaware of the appointment of a clinical pharmacist in July 2020. The team sometimes struggled to manage acutely unwell patients as quickly as they might need, due to the delay in obtaining and supplying appropriate medicines for those people.The lack of medical cover in West Suffolk was raised as a concern in the October 2019 inspection.

The trust had made progress in recruiting staff to meet the needs of patients, but some teams continued to have high vacancies. For instance, not all services had enough staff to meet the needs of patients in a timely manner. In Hellesdon crisis team, there was 66 unfilled day shifts in August 2020 with an average of 43 unfilled shifts in the previous three months. We recognised that the impact of the pandemic on staffing levels was a factor in the trusts ability to fill these shifts.

Since our last inspection in October 2019, the trust had established the First Response service. This service provided a 24/7 helpline for people of all ages in Norfolk and Suffolk who need urgent mental health support, so people could access support more easily. The implementation of this service was brought forward significantly in response to the

# Our findings

changing needs as a result of the pandemic. However, we were advised by the trust that demand for this service had exceeded commissioned levels of activity. The team had received a high volume of calls, and staff told us that the level of calls received was not manageable, which meant they could not answer calls in a timely manner. As a result, the trust had agreed an increase in funding so it could employ additional staff to meet demand.

The West Suffolk crisis team was required to support the first response team staff to manage the volume of calls and also provided psychiatric liaison cover out of hours. The Norfolk crisis teams also reported not having enough staff available to answer all calls. Feedback from The Suffolk user groups also confirmed that patients had difficulty getting through on the telephone lines to crisis and First Response teams. However, the trust had covered vacancies for registered nurses at crisis and home treatment teams in East Suffolk, East Norfolk, West Norfolk and Norwich were being actively recruited to and covered by agency staff in the interim.

Staffing is a known challenge for the trust and is a risk recorded on the trust risk register. We considered the trust was proactively trying to manage increased demand on their service at the time of the inspection. Since our last inspection in October 2019, the trust had increased staffing in the service line by 14%.

- Records from the Health based places of safety were not all clear, up to date and easily available to all staff providing care.

We reviewed 20 Health based place of safety records and saw that there was information missing from 10 records. The trust had introduced a new system of electronic recording in November 2020 to improve record keeping and the trust continue to work to improve this issue. However, the issues with contemporaneous records from the last inspection had not been fully addressed at the time of our visit.

However,

- Clinical premises where patients received care were safe, clean, well equipped, well furnished, well maintained and fit for purpose. Extra precautions were taken in line with national guidance to reduce the spread of Covid-19.
- Staff understood how to protect patients from abuse and the service worked well with other agencies to do so. Staff had training on how to recognise and report abuse and they knew how to apply it.
- Staff had received basic training in safeguarding with 100% compliance across the teams visited.
- Staff assessed and managed risks to patients and themselves. They responded promptly to sudden deterioration in a patient's mental health once the patient was within the service. Where appropriate, staff working in the mental health crisis teams worked with patients and their families and carers to develop crisis plans.
- Staff completed thorough risk assessments for patients in most cases. We reviewed 16 care records and saw that 14 care records were clear, comprehensive and updated in a timely manner.
- In line with national guidance to protect staff and patients during the pandemic, staff did not complete all assessments face to face. The trust had introduced a standard operating procedure to support staff to make decisions on which patients required face to face contact. Teams completed a triage assessment to decide whether patients required a face-to-face contact assessment and they agreed any decision to downgrade emergency referrals with the referring person.

# Our findings

## Is the service well-led?

**Requires Improvement** 

Our rating of well-led stayed the same. We rated it as requires improvement because:

- Our findings within the safe domain demonstrated that local oversight of governance processes did not always operate effectively at team level and performance and risk was not consistently managed well. However, we saw improvement from the previous inspection and increasingly systems were becoming embedded.

- There was a lack of audits across the service to monitor how teams were performing and ensure consistency between teams.

At our previous inspection in October 2019, we identified that the trust needed to make improvements in its medication management and care records. Following the inspection, the trust decided that routine audit had not produced the required improvements required and had, therefore, chosen to use a quality improvement methodology. This was yet to be fully reflected within their own policies. The Trust had a revised Assurance Framework with performance being monitored through the Quality and Performance meeting, Drugs and Therapeutic Committee and Quality Committee. Each of these groups had an Executive lead.

- Teams did not always have access to the information they needed to provide safe and effective care.

Great Yarmouth and Waveney Team had not had regular staff team meetings and did not routinely receive a debrief following an incident, or outcomes and learning from incidents. Staff in the West Suffolk teams also told us they did not routinely receive outcomes and learning from incidents.

However:

- Team Leaders had the skills, knowledge and experience to perform their roles, had a good understanding of the services they managed, and were visible in the service and approachable for patients and staff. Staff reported that local leaders were approachable and visible. However, staff told us that leaders above service manager level were not visible within services.
- Staff knew and understood the provider's vision and values and how they were applied in the work of their team.
- Staff felt respected, supported and valued within their teams. They reported that the provider promoted equality and diversity in its day-to-day work and in providing opportunities for career progression. They felt able to raise concerns without fear of retribution.
- There were improving and maturing multi-agency arrangements to agree and monitor the governance of the mental health crisis service and the health-based places of safety. The local acute trusts were particularly appreciative of the improved working relationships and availability and support of trust staff in the emergency departments to their teams. Managers of the service worked actively with partner agencies (including the police, ambulance service, primary care and local acute medical services) to ensure that people in the area received help when they experienced a mental health crisis; regardless of the setting.
- Local partnerships with police and GP surgeries worked well. However, feedback received from one partner agency reported that trust wide communication had suffered during the pandemic lockdown period.

# Our findings

- The trust gathered patient experience feedback to determine areas for improvement and it had supported staff to adapt to the demanding circumstances using a variety of strategies, technology, protocols and processes.

# Our findings

## Areas for improvement

Action the trust MUST take is necessary to comply with its legal obligations. Action a trust SHOULD take is because it was not doing something required by a regulation, but it would be disproportionate to find a breach of the regulation overall, to prevent it failing to comply with legal requirements in future, or to improve services.

The trust must ensure that staff follow systems and processes to safely prescribe, administer, record and store medicines. (Regulation 12.2.g)

The trust must ensure that staff receive debrief after incidents and that outcomes and lessons learned from incidents are shared with all staff. (Regulation 17.2.a)

The trust must ensure that emergency referrals are seen within four hours. (Regulation 12)

The trust must act to ensure there is adequate medical cover within the West Suffolk crisis and home treatment team. (Regulation 18 Staffing)

The provider should act to avoid breaching a regulation in future:

The trust should act to ensure that decisions to downgrade risk levels of patients are risk assessed and the reason clearly noted.

The trust should act to ensure that contemporaneous records are completed consistently for people who use health-based places of safety.

# Our inspection team

Our inspection team consisted of one inspection manager, four CQC inspectors, one CQC medicines inspector and a nurse specialist advisor.

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 |
|---|---|
| Treatment of disease, disorder or injury | Regulation 18 HSCA (RA) Regulations 2014 Staffing |

| Regulated activity | Regulation |
|---|---|
| Treatment of disease, disorder or injury | Regulation 17 HSCA (RA) Regulations 2014 Good governance |

| Regulated activity | Regulation |
|---|---|
| Treatment of disease, disorder or injury | Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment |