Requires improvement

Norfolk and Suffolk NHS Foundation Trust

# Specialist community mental health services for children and young people

## Quality Report

Hellesdon Hospital
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Norwich
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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 Children, families and Young People's service | NR30 1BU |
| RMY01 | Trust Headquarters Hellesdon Hospital | West Norfolk children, families and young people's service | PE30 5PD |
| RMY01 | Trust Headquarters Hellesdon Hospital | Coastal IDT | IP3 8LY |
| RMY01 | Trust Headquarters Hellesdon Hospital | Bury South IDT | IP33 3NR |
| RMY01 | Trust Headquarters Hellesdon Hospital | Ipswich IDT | IP1 2DG |

# Summary of findings

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? | **Requires improvement**  |
| 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 the community mental health services for children and adolescents as 'requires improvement' overall because:

- If staff could not contact a patient requiring urgent assessment within 72 hours, they sent an 'opt in' letter out. The letter requested that the referred person make contact with the service within 14 days. If there was no contact, staff referred the person back to the original referrer and potentially discharged them.
- Waiting times from referral to assessment varied across the teams visited. Not all teams were meeting targets.
- We found that some staff had an unacceptable number of patients on their caseload.
- Staff were not up to date with mandatory training, including the Mental Health Act and Mental Capacity Act.
- Waiting times for allocation of a care co-ordinator could be several months in some instances.
- Core assessment and risk assessments were not completed in a timely manner following the first face to face assessment.
- Waiting times for psychological therapies ranged from three to eight months.
- There was not a standard physical health screening tool used across the service.
- Staff did not receive regular clinical supervision or annual appraisals.
- Patients were not involved in their care plans. Not all patients had care plans.
- There was limited flexibility in staff offering appointments outside of office hours.
- We found that staff could not navigate the electronic record system properly which resulted in delays with locating information.
- We saw significant gaps in patient records. Staff felt this was due to the change-over of the electronic records system.
- There were no systems for monitoring whether the risk levels of patients referred had changed.
- There were no systems to monitor whether targets were being met or actions taken if targets were not met

However:

- There was adequate medical cover throughout the 24 hour period. The trust had an on call rota system whereby a children and young people's consultant could be contacted.
- Staff knew how to report incidents, and there was feedback about significant events within the trust.
- Staff understood the process of making a safeguarding referral and had established links with local teams.
- There was a good range of skilled staff across the teams to deliver care and treatment.
- Crisis teams were able to respond to patients quickly.
- Clients and families contacted told us that staff were kind and respectful.
- We saw a variety of information around care and treatment for patients and families. Staff sign-posted patients to other organisations appropriately.
- Some services had recently developed weekly drop-in clinics that enabled staff to see patientson the waiting lists if they self-presented.
- Staff were aware of the vision and values of the trust and had discussed these in local team meetings.

# Summary of findings

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

### Are services safe?

**Requires improvement**

We rated the community mental health services for children and adolescents as ' requires improvement' for safe because:

- Waiting list times varied across the teams visited. We did not see a process which staff used to identify if a patient on the waiting list became more urgent.The patient or their representative had to make contact with the team. This did not demonstrate safe management of patients waiting to be seen.
- Some staff had excessive caseloads due to the demand upon the teams. We saw that many patients were seen by a doctor, but were waiting months for the allocation of a care coordinator and therapy because of staff capacity.
- Staff were not up to date with mandatory training and fell below the trust target.
- Some staff felt unsupported by colleagues after an incident had occurred and had been reported.
- Patients did not have adequate core and risk assessments in place.

However:

- There was adequate medical cover throughout the 24 hour period. The trust had an on call rota system whereby a children's and adolescents mental health (CAMHS) consultant was contacted.
- Staff could explain the process of how to make a safeguarding referral, and had established links with local safeguarding teams.
- Staff demonstrated a good knowledge of lone working policy and procedures.
- There was a clinic space at each location that contained basic equipment required to undertake a physical health assessment.
- There was minimal use of bank and agency staff.

### Are services effective?

**Requires improvement**

We rated the community mental health services for children and adolescents as 'requires improvement' for effective because:

- Core assessments and risk assessments were not completed by staff following the first face to face assessment
- There was not a standard physical health screening tool used across the service.
- Staff did not receive regular clinical supervision or annual appraisals.

# Summary of findings

- Not all patients had care plans.
- Staff found it difficult to navigate the electronic records system which delayed obtaining information.
- There were significant gaps in the recording of patients notes, which staff felt was due to the change-over in electronic systems.
- Only 63% of staff had received training in the Mental Health Act and only 72% had received training in the Mental Capacity Act.
- Patients were offered therapies but were then placed on a waiting list before they could commence this.

However:

- There was a good range of skilled staff to deliver care.
- All teams had regular multidisciplinary meetings.
- The teams sign posted patients to appropriate external agencies when required.
- Patients had access to an advocacy service
- Staff followed national guidance when monitoring side effects of anti-psychotic medications.
- There was an established trust and local inductions in place for new staff members.
- Staff across the teams delivered educational sessions to peers if felt this would be beneficial to their patient group.

**Are services caring?**

**Requires improvement** 

We rated the community mental health services for children and adolescents as 'requires improvement' for caring because:

- Half of the patients did not have care plans and those that did had not been involved in developing or reviewing these.
- There was a widespread lack of involvement of patients in their care. Out of 35 records we only found one where the patient had been involved.

However:

- Patients and their families told us that staff were kind and respectful.
- Staff had a good understanding of the needs of patients.
- There was appropriate involvement of families and carers.

**Are services responsive to people's needs?**

**Requires improvement** 

We rated the community mental health services for children and adolescents as 'requires improvement' for responsive because:

- Patients were not seen within target times between referral and assessment, which resulted in waiting lists across teams.

# Summary of findings

- We did not see a system whereby new referrals would be monitored if they did not attend appointments.
- We found there was little flexibility with the times of appointments offered.

However:

- There was a lot of available information around care and treatment for both young people and their families.
- Some services had recently developed a weekly drop-in clinic, which enabled staff to see patients on the waiting lists
- The crisis teams were able to respond quickly to patients

**Are services well-led?**

**Requires improvement**

We rated the community mental health services as 'requires improvement' for well led because:

- There were no systems for monitoring whether the risk levels of patients referred had changed.
- There were no systems to monitor whether targets were being met or actions taken if targets were not met
- Some staff reported that morale was poor due to the workload across the teams.
- There was no entry on the trust risk register reflecting concerns.

However,

- Staff were aware of the vision and values of the trust and had discussed these in team meetings.
- Patients, their carers and families had the opportunity to give feedback to the service.
- Staff felt able to raise concerns without victimisation and were aware of the whistle-blowing policy.
- Staff were passionate about their roles, enjoyed their work,

# Summary of findings

## Information about the service

- Norfolk and Suffolk NHS Foundation Trust provides services for the first time, who require longer term 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

In Norfolk there are

- In Central Norfolk there are two locations. Mary Chapman House had a community eating disorders service. A second location was at 80 St Steven's road where they had an early intervention team; youth assessment and duty team, and youth treatment teams.
- In West Norfolk there is Thurlow House where there was an early intervention team and a community eating disorders service.
- In Suffolk, the trusts operational model was based on integrated delivery teams (IDTs). These teams were responsible for coordinated delivery of community mental health services. They provided support for people of all ages with mental health difficulties within the designated locality. This included early intervention and support for children, adolescents and young people. The IDTs operated on a Monday to Friday basis (9am – 5pm), 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 IDTs, Bury North, Bury South, Central, Ipswich, and Coastal.

The specialist community mental health services for children and young people was last inspected on 20 and 23 October 2014 and was rated as requires improvement. We asked the trust to take actions regarding disseminating the learning of lessons following incidents; reviewing procedures for maintaining and storage of records; reviewing provision of out of hours and crisis services; reviewing procedures with commissioners for admitting young people to services and out of area placement arrangements, and to review their engagement processes with young people.

## Our inspection team

**Chair:** Dr Paul Lelliott Deputy Chief Inspector Care Quality Commission (CQC)

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

**Inspection Manager:** Lyn Critchley, Inspection Manager mental health hospitals.

The team that inspected this service consisted of two CQC inspectors and three SPAs who had recent child and adolescent mental health service (CAMHS) experience.

The team would like to thank all those who met and spoke with them 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 ongoing comprehensive mental health inspection programme.

# Summary of findings

## 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 visiting we reviewed information that we held about these services and asked a range of other organisations for information.

During our visit the team:

- spoke with five patients who were using the service
- interviewed two managers
- interviewed 19 other staff members including nurses, assistant practitioners, clinical team leader and therapists.
- spoke with seven carers of patients who were using the service.
- observed one face to face assessment
- observed one care review
- looked at 35 care records of patients using the service.
- looked at a range of policies, procedures and other documents relating to the running of the service.

Following the announced inspection:

- We made unannounced inspections to three community child and adolescent teams.

## What people who use the provider's services say

- Patients and their families told us staff had treated them with dignity and respect.
- Patients and their families told us that staff were enthusiastic in their work and had time for them.
- Carers and families told us that they were able to give feedback on the service verbally, or by filling in a questionnaire.
- Families felt there was a network of groups offered for support.
- One family member was surprised at how quickly their relative was seen by the eating disorder service.
- Two family members were unaware that they could complain if they were not satisfied with care and treatment of their relative.
- Patients and their families told us a letter they had received from community services, had a contact number for the crisis team if support was required before an appointment was attended.
- One carer told us that they had received a report from a doctor recently with the outcome of the assessment, which they were pleased about.

## Good practice

- The trust had trained some staff in systemic family therapy. Qualified staff had then gone on to train other staff. This enabled more staff to offer the therapy, which often patients would be on the waiting list for.
- 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 Foundation trust.

# Summary of findings

- The trust also had a compass outreach team based in Norwich. This provided therapeutic and intensive family support services to families with children who had been identified as being at risk of being placed into the care system.
- 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 when high safeguarding concerns had been raised. The service was available across Norfolk.

## Areas for improvement

### Action the provider MUST take to improve

- The trust must ensure that waiting times from referral to assessment and treatment are kept to a minimum.
- The trust must ensure that caseloads of individual staff members are manageable.
- The trust must ensure that patients are not waiting an excessive time to be allocated a care co-ordinator.
- The trust must ensure that staff receive, and are up to date with required mandatory training.
- The trust must ensure that staff receive regular clinical supervision.
- The trust must ensure that staff receive annual appraisals.
- The trust must ensure that all patients have a completed core assessment and risk assessment following a face to face appointment.
- The trust must ensure that all staff can navigate the electronic The trust must work with young people in formulating care plans and goals.
- The trust must be consistent in the physical health monitoring of patients.

### Action the provider SHOULD take to improve

- The trust should ensure that staff and patients are offered appropriate support following incidents.
- The trust should offer flexibility in appointments for patients

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 Community Youth Team | Trust Headquarters<br>Hellesdon Hospital |
| Great Yarmouth and Waveney Child and Adolescent mental health team | Trust Headquarters<br>Hellesdon Hospital |
| Early Intervention Team | Trust Headquarters<br>Hellesdon Hospital |
| Coastal IDT<br>Bury South IDT | Trust Headquarters<br>Hellesdon Hospital |
| Ipswich IDT | Trust Headquarters<br>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.

- The trust reported that 63% of staff across the service were up to date with mental health act training. This training is mandatory.
- The service had access to mental health act administrators who they could contact if they required specific guidance.
- Qualified staff we spoke with had a good understanding of the mental health act and how this applied to their work.

# Detailed findings

- Independent mental health advocates were accessible to patients across the service.

## Mental Capacity Act and Deprivation of Liberty Safeguards

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.

- The trust had a nominated lead in the Mental Capacity Act (MCA) who could be contacted for advice and guidance, as could one of the mental health act administrators.
- The trust had an established policy around the MCA.
- A total of 72% of staff across the service had received specific training.

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

- Staff had access to personal alarms whilst in the clinics seeing patients for appointments.
- Areas viewed were clean and well maintained by staff.
- There were clinic rooms with the necessary equipment to carry out physical examinations of patients.Each service had blood pressure machines, thermometers, weighing scales and height measuring equipment which would enable staff to undertake a basic physical examination if required.
- There was adequate hand washing facilities and gel available for staff to adhere to infection control principles. Handwashing posters were on display.

### Safe staffing

- Across the specialist community mental health services for children and young people, there was an overall core qualified establishment of 158 whole time equivalents, with a reported seven vacancies across the trust. There was a nursing assistant establishment of 42 whole time equivalent, nine of which were vacant. The overall staffing turnover rate across the service was 10%. Within the teams, there were psychiatrists, clinical psychologists and family therapists who provided care and treatment. Recruitment was an ongoing process. Staff reported that numerous staff had transferred to community teams from inpatient services across the trust.
- The sickness rate for the 12 month period ending March 2016 was three per cent across the service. This was below the national average of 4.63%.
- All teams assessed and reviewed their caseloads regularly, through weekly team meetings. Service managers told us that they would try to limit caseloads to 25 to 30 patients maximum. Data provided by the trust showed that caseloads varied hugely across the service. We learnt that one lead care professional was allocated 95 patients. However, it was unusual for staff to have an allocated caseload of over 30.
- Patients had to wait for allocation of a care co-ordinator in some cases between three and 12 months. This was due to the demand of referrals against the capacity of staff members, despite most areas being fully established in staffing numbers.
- The majority of the community teams did not use bank or agency staff. They relied on colleagues providing cover for any absence, leave, training or vacancies.Across the trust, between January and March 2016, 56 shifts had been covered by bank staff and eight by agency staff. Of these, five shifts had not been filled.These were required for the Ipswich IDT and was due to staff vacancies.
- There was 24-hour availability of a consultant if required via the trust on call system.
- The number of staff compliant with mandatory training was 71%, which was lower than the trust target of 90%.

### Assessing and managing risk to patients and staff

- An assessment was undertaken by staff for each referral during the triage stage. This was completed by the staff member onthe access and assessment teams. This initial assessment determined whether a referral was considered urgent or routine.
- We looked at 35 care records and saw core assessments and risk assessments were not inplace for 17 (49%) ofpatients. Core assessments covered information about home and family life and relationships; general physical health; schooling and previous mental health history. Risk assessments which staff had completed included crisis plans but these were not always detailed. There was the crisis team's contact number but not necessarily, any other means of coping or suggested plans.
- If there was deterioration in mental health of a patient on a waiting list, they were advised to contact the crisis team. If a patient had a care co-ordinator, they were encouraged to make contact with them.
- We did not see any routine monitoring of patients on the waiting list which would detect increases in levels of risk. We saw that patients and carers were encouraged to call the team if they felt it was necessary. The teams

Requires improvement

# Are services safe?

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

had also recently established weekly drop in clinics for patients on the waiting list who felt they needed to be seen. The emphasis was placed upon the patient and their carers.

- Staff were trained in safeguarding and were aware of how to make safeguarding alerts. We saw evidence of joint working with the local authorities where relevant.
- Staff had personal safety protocols in place, and were aware of lone working policies and procedures. We saw evidence of the 'buddy system' in place, 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.

### Track record on safety

- From January 2015 to March 2016 the trust reported five serious incidents requiring investigations. Two were in relation to unexpected deaths, two in relation to self-harming behaviour and one other injury. Staff we spoke to did not specify any specific learning points from significant incidents, but did state that they do receive information from senior staff once investigations are complete.

### 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 that they were open and transparent with young people and their families if things went wrong.
- Staff received feedback from investigation of incidents throughout the trust via email bulletins and alerts. Significant incidents were also discussed at monthly management meetings. This information was then disseminated to the teams.
- Staff we spoke to said there were a low level of incidents reported across the community.However, two staff members we spoke to recalled incidents they had reported, relating to aggression and deliberate self-harm. These staff members told us there was no debrief and both felt unsupported by colleagues following these incidents.

# 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

- Staff did not complete core assessments in a timely manner. We saw that 17 of the patients (49%) did not have a core assessment in place.
- Staff had not completed care plans with the patients. Out of the 25 records examined, 16 (46%) had care plans in place. Completed care plans we saw were holistic and recovery orientated.
- Care records were stored securely across the service on an electronic system. between services, notes were easily accessible.
- We saw that staff entered clinical updates in the patient records. However we observed that there were frequent significant time lapses between entries. Staff told us that this had occurred due to the changing over from one electronic recording system to another.

### Best practice in treatment and care

- Staff provided a range of therapeutic interventions in line with National Institute for Health and Care Excellence (NICE). Therapies included cognitive behavioural therapy (CBT), cognitive analytical therapy (CAT), dialectical behavioural therapy (DBT) and family therapy. However, we learnt that across teams there was a three to eight month waiting list for 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, pulse and temperature was often done by the GP at the time of the initial referral.Height and weight was recorded by staff 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 nationally recognised assessment tools. Examples of these included the child outcome research consortium (CORC) and brief assessments for adolescents (BAC-A).
- Over the last 12 months, the trust had participated in a national programme on treatment of depression in young people

### Skilled staff to deliver care

- The teams consisted of doctors, psychologists, family therapists, nurse specialists, registered mental health nurses, play therapists, assistant practitioners and support workers. Within the trust they could refer to occupational therapists or dieticians when required. We found that the service had a range of experienced and qualified staff.
- 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; while the local inductions gave staff the opportunity to work within the teams they will be permanently placed. Staff we spoke to told us that there were opportunities for further development within the trust.
- All teams had regular weekly team meetings. Staff told us they received monthly clinical and management supervision where they were able to reflect upon their practice. However, we found that clinical supervision varied across the service considerably, between 50% and 100%.
- Just under half of the staff (49%) across the service had not had an appraisal as of January 2016, this was below the trust target of 95%.
- Some teams had developed local, in house training sessions around themes such as eating disorders or autistic spectrum disorders (ASD). Different professionals with knowledge and experience would offer training sessions if thought to be beneficial to the staff group.
- Clinical team leaders told us that they would address poor staff performance with support from senior managers and advice from the human resources department, 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.

### 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.
- We saw that there was effective multidisciplinary agency working with external agencies such as the local authority and the criminal justice system, as appropriate.

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

- Training around the mental health act is mandatory for staff. Across the service, 63% had completed and were up to date with this.
- Staff told us they would contact the Mental Health Act administrative team if they needed any specific guidance about their roles and responsibilities under the Mental Health Act.
- Mental health Act training within the trust was mandatory.
- Qualified staff we spoke to had a good understanding of community treatment orders. (CTO's).
- Patients could access Independent mental health advocacy services and staff were clear how to access and support if necessary.

### Good practice in applying the Mental Capacity Act

- The trust had a policy on the Mental Capacity Act (MCA) which staff were aware of and could refer to. There was a MCA 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.
- Across the service 72% of staff had completed training around the MCA and deprivation of liberty.

Requires improvement

# 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 told us that staff had been supportive of them.
- Staff we spoke with had a good understanding of the needs of patients.
- Confidentiality was adhered too. All records and information were stored securely.
- Staff spoke with compassion about their roles and were proud of the work they undertook.

### The involvement of people in the care that they receive

- We examined 35 care records. One of these had a signed care plan. Staff had printed this off 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. We did not see any other evidence of involvement in care planning between patients and staff. Staff told us that this information would often be recorded in the general notes section of the clinical records.
- We saw that the teams had appropriate contact with the families and carers of patients.
- We did not see evidence of patient involvement with advocacy services, but staff were able to tell us of the process of accessing if required.
- Staff told us they routinely gave out questionnaires to patients and families to gain feedback of services.

# 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 had target times for the triaging of referrals. A patient who was considered to be an emergency referral should be seen or contacted within four hours, a patient with urgent priority within 5 days, and routine referrals within 28 days.
- The target from referral to assessment was 28 days across the trust.Data provided from the trust showed that referral to assessment times varied across the service. Teams in Norfolk were meeting these targets; however, teams in Suffolk were not. Bury South IDT reported to be achieving 88 days. This meant that there was a significant waiting list for patients awaiting assessment in this locality.
- Referral to treatment targets depended upon the locality. Trust data provided showed that the services were meeting their targets for referral to treatment times.
- We saw that the crisis teams were available to see patients immediately if necessary. There was a staff rota in place which offered flexibility, dependent upon the needs of the patients on any given working day. We saw that staff on duty could respond promptly to patients when they phoned in.
- If an appointment was offered, 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 told us that they would contact the referrer and discharge.
- At all clinics, staff would try to adhere to the appointment times offered. Staff told us that appointments would rarely be cancelled, but if they were, the patient would be told at the earliest opportunity.
- There was minimal flexibility with appointments. We saw many appointments were offered during school hours.Staff told us that many of these appointments would be declined.
- If a patient required hospital admission there would not always be a bed available. Data received from the trust on the 21 July confirmed that there were 11 out of area placements. This meant that it could be difficult for families to visit. Staff reported that they had known patients to be in placements in Manchester or Harrogate due to lack of local beds.
- Patients were discharged from the service when no further support was needed; when the young person did not want further support; did not attend multiple appointments; or if they moved out of area.

### 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.
- We saw that teams had identified and appropriate separate waiting areas for patients under 18 years and over 18 years.
- 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 ' voices and unusual beliefs' 'hearing voices' 'feeling suspicious' and depression Posters gave information about drop-in groups and local support available for support with sexuality, spiritual and pastoral care.

### Meeting the needs of all people who use the service

- The services could accommodate patients who had mobility difficulties or used a wheelchair. The trust had access to a number of ground floor rooms at different locations 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

### Listening to and learning from concerns and complaints

- The trust reported there were 59complaints across the service. Of these 10 were upheld and 25 were partially upheld. Staff told us that complaints tended to be around waiting for treatment, or dissatisfaction with care and treatment offered. No complaints were referred to the ombudsman.

# Are services responsive to people's needs?

Requires improvement

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

- We saw there were information leaflets across the service informing young people on how to make a complaint.
- Staff were able to explain how they would handle a complaint and the process of escalation.
- Two family members were unaware that they could complain if they were not satisfied with care and treatment of their relative. During interviews, one of the two expressed a desire to complain around the waiting times for assessment. The second did not wish to make a complaint, but stated they were not aware that they could complain about services received if they wished.

# 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 aware of the trusts values and visions.We saw posters across the service during inspection. Trust values had been discussed at team meetings with staff.Discussions among the teams had taken place to look at how they incorporate these into everyday practice.
- Staff knew who senior managers within the trust were. Some teams told us that they had visited and attended team meetings.

### Good governance

- On a weekly basis, the clinical team leaders reviewed information about new referrals and caseload management.
- There were different meetings around systems for governance and monitoring teams' performance. Examples of these were service line meetings, business team meetings and locality management meetings.
- Team managers told us that they had sufficient authority to undertake their role. All teams had some levels of administrative support.
- Team managers told us that they could, and had, submitted items of risk on to the trust risk register.
- There was a 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.
- Staff we spoke with knew about the whistle blowing policy and how to use this if required.
- Staff felt able to raise concerns without the fear of victimisation from other colleagues.
- Some staff reported that morale was low due to workload pressures and understaffing in some areas
- Staff confirmed that the trust does offer leadership development.
- We observed good team working whereby colleagues offered each other support.
- Staff were open and transparent and staff 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.

### Commitment to quality improvement and innovation

There was nothing significant to report.

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<br><br>Treatment of disease, disorder or injury | Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment<br><br>• The trust must ensure that waiting times from referral to assessment and treatment are kept to a minimum.<br>• The trust must ensure that caseloads of individual staff members are manageable.<br>• The trust must ensure that all patients have a completed core assessment and risk assessment following a face to face appointment.<br>• The trust must ensure that all staff can navigate the electronic care records system.<br>• The trust must ensure they work with patients in formulating care plans and goals.<br>• The trust must be consistent in the physical health monitoring of patients.<br><br>This was a breach of Regulation 12 |

| Regulated activity | Regulation |
|---|---|
| Assessment or medical treatment for persons detained under the Mental Health Act 1983<br><br>Treatment of disease, disorder or injury | Regulation 18 HSCA (RA) Regulations 2014 Staffing<br><br>• The trust must ensure that staff receive, and are up to date with required mandatory training.<br>• The trust must ensure that staff receive clinical supervision.<br>• The trust must ensure that staff receive annual appraisals.<br><br>This was a breach of Regulation 18 |