Inadequate

Norfolk and Suffolk NHS Foundation Trust

Specialist community mental health services for children and young people

Quality Report

Hellesdon Hospital
Drayton High Road
Norwich
Norfolk
NR6 5BE
Tel: 01603 3421412
Website: www.nsft.nhs.uk

Date of inspection visit: 3 April to 5 April 2019
Date of publication: 20/05/2019

Locations inspected

Location ID	Name of CQC registered location	Name of service (e.g. ward/ unit/team)	Postcode of service (ward/ unit/ team)
RMY03	Northgate Hospital	Child, family and young persons service Silverwood	NR30 1BL
RMYWF	Chatterton House	Child, family and young persons service Thurlow House	PE30 5PD
RMY01	Hellesdon Hospital	Child, family and young persons service Hotblack Road	NR2 4HN
RMYNR	Wedgwood House	Child, family and young persons service	IP33 3NR

Summary of findings

		IDT Bury South	
RMYMW	Walker Close	Child, family and young persons service, Mariner House	IP1 2GA

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.

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

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

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

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

Summary of findings

Contents

Summary of findings

Overall summary

We did not rate this inspection.

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

We found the following areas the trust needed to improve:

- Staff had overlooked some patients on the waiting lists and had not followed them up as per the trust's own procedure. Waiting list data that the trust collected was not always accurate and staff in some services had created their own waiting lists to be assured that information was being captured correctly.
- The quality of clinical record documentation was poor. Staff did not always update risk assessments following a change in risk and there was limited evidence of detailed crisis plans. Care plans were often written in the third person and did not routinely demonstrate that patients' voices were heard. Information was not stored on the electronic system in a logical or consistent manner which made it difficult for clinicians to see all interventions and actions in chronological order. Staff were unaware if alerts could be added which would bring concerns such as safeguarding or significant risk to the attention of staff immediately.
- Some teams still had a high number of vacant posts.This had an adverse impact on waiting times and staff morale.

However:

- Staff told us that they felt positive about recent changes to key leadership posts and that they were starting to see the impact of these. They felt the trust board were more visible than the previous board and listened to staff concerns. Staff were also positive about their immediate managers. We saw action being taken to improve the patient experience. There were examples of some staff being given delegated responsibility, enabling them to make changes more swiftly.
- Staff working for the under 14 teams were seeing patients more quickly than had been the case when we last inspected. Those under 14 patients deemed at high risk were being assessed and allocated to a practitioner promptly. There remained a waiting list but we saw evidence of this reducing, with clear plans to continue to act. There were fewer gaps in staffing in the under 14 teams than the Youth teams.

Summary of findings

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

Are services safe?

Inadequate

We found during inspection that:

- We reviewed 47 sets of clinical records across all locations. Staff did not record detailed risk management plans in most of these records. We saw letters written to GPs that outlined risks, but many contained no clear management or crisis plans; other than contact numbers. Many of the care records were written poorly. Ten out of the 47 records addressed risks with a management plan and demonstrated some evidence of patient view being captured. The remaining 37 records did not fully capture appropriate information. There was very little evidence of the patient's voice in documentation overall. Risk assessments were often not updated when there was a change of risk.
- There were gaps in care and the inspection team had to escalate eight cases to the local teams on site to follow up. The inspectors were unable to see recent clinical contact with these patients which caused concern they had been forgotten. It was confirmed that three patients had 'slipped through the net'. The other gaps identified were due to poor documentation.
- There had been a recruitment campaign based solely in Norfolk. The outcome resulted in recruitment to some posts. The youth teams all had problems recruiting. The Suffolk managers had to submit a separate business case to improve staffing, as Suffolk was not part of the original campaign. This plan was approved during the time of this inspection.
- In Ipswich, we saw evidence of the duty cover not always being staffed due to staff shortages. Norwich provided cover for three days per week. The managers confirmed this was a challenge and it remained a concern.

However:

- The trust had tried to be creative in their recruitment strategy. In Norfolk 30 staff from Band 3 to 5 had successfully been recruited. Some of those staff were in post and training was in progress to upskill these staff. Great Yarmouth managers told us that this had a positive impact in reducing the waiting list by almost half. The local teams had explored further what else they could do to recruit. We saw evidence of offering training

Summary of findings

and development as incentives to attract staff into post. Financial incentives were being considered for the most challenging areas, however there was no clear plan for this to happen for non-medical staff.

- The Great Yarmouth and Waveney under 14 team had a system in place which enabled clinical staff to more easily track patient progress.
- Each team described a newly introduced system of reviewing all assessments. Upon completion of a patient assessment, the clinician brought the case to the weekly multi-disciplinary meeting and held a post assessment discussion, known locally as PAD. Staff spoke positively about this as it meant that there was a clear system of multi-disciplinary review of each case. Staff said that there were agreed outcomes and decisions made that were clinically led and felt assured clinical decisions were being made appropriately. Staff appreciated the benefit of an organised forum to hold clinical discussions. Risk management was discussed at the meeting and a RAG rating confirmed.

Are services responsive to people's needs?

Inadequate

We found during inspection that:

- The trust had set a target for time from referral to triage to assessment and from assessment to treatment. They were not meeting these targets in all cases. In particular, the Suffolk and Great Yarmouth and Waveney service's Youth teams were struggling to meet demand. This was partly due to difficulties in recruiting to key posts. There appeared to be a disparity between Norfolk and Suffolk services in terms of resource, with Norfolk appearing to be better funded and staffed. The trust had developed and implemented a recovery plan to address the capacity and demand issues in Suffolk. Measures implemented included securing funding for more clinical posts. The trust took positive steps and agreed to these posts even though funding from the clinical commissioning groups had yet to be agreed.
- Figures provided by the trust demonstrated that some patients continued to wait significant amounts of time for assessment and treatment. There continued to be long waits for patients with attention deficit hyperactivity disorder in West Suffolk. In Great Yarmouth and Waveney Youth team, there were 118 young people waiting for assessment and 69 young people waiting for treatment. According to the figures provided, some young people had been waiting since May 2018 according to the figures provided. Some statistics provided for teams were

Summary of findings

incomplete. For instance, West Suffolk youth team figures only included awaiting assessment for all three teams, with just one team having figures for awaiting team treatment. The figures provided by the trust differed and generally were higher than the figures held locally. When reviewing care records from the awaiting assessment list we found patients on that list who had received their assessment and were waiting for treatment. We could not rely on figures being accurate.

- The Emotional Wellbeing Hub had a waiting list of 1100 people accrued from previous months. Managers were developing a plan to reduce this list.
- Patients who were waiting for assessment or treatment were added to the waiting list and risk assessed as red, amber or green. From the rating, the duty worker acted to contact patients and there was a clear procedure for staff to undertake. However, we saw in clinical records that this was not always evidenced and patients did not always receive the call as planned.

However:

- We saw that the under 14 services generally across all areas had lower amounts of children waiting. Great Yarmouth and Waveney had minimal numbers on their waiting list and there was a system for anyone assessed as high risk being seen swiftly and allocated for treatment.
- The emotional wellbeing hub in Ipswich had seen some improvements in waiting times in recent weeks. In March 2019 the team were able to triage and process all referrals for that month. This was a result of managers working with staff to implement improved systems of working that enabled staff to follow clear procedures. This was recorded whilst still experiencing staff shortages.

Are services well-led?

Inadequate 

We found during inspection that:

- Our evidence from other key findings demonstrated that there was a need to improve governance systems further to ensure accurate information is captured to support clinicians prioritise their work.
- Data was not accurate regarding waiting lists. The lists that the trust gave to inspectors indicated that some patients were either on the wrong waiting list or should not have been on a

waiting list at all. We also saw that not everyone was receiving phone calls as per the guidance and that some patients were being missed. The processes for managing lists needed further refinement. This was a concern raised at the last inspection.

- We did not review if audit was undertaken in relation to quality of care records. However, if there was audit in place, this did not affect change. The quality of clinical records across all locations was not adequate and action was required to address this deficit.
- Low morale amongst some staff had been recognised and the service was working actively with staff to respond to their concerns and make changes that would benefit them. Morale was lower in Suffolk than Norfolk.

However:

- There was a newly formed trust board and a new Chief Executive in post. Staff reported feeling listened to and some positive changes were emerging. Leaders acknowledged there was a significant amount of work to be carried out, however there was a sense of cautious optimism with many of the staff we spoke to.
- There were newly appointed leaders to some of the teams we visited. This was particularly evident in Suffolk where there had been significant concerns about management style at a local level. Despite the managers having been in post for a short period, there was evidence of positive change in leadership style. Leaders were visible to the service and approachable for staff. Staff were starting to feel listened to.

Managers had quickly identified key areas of priority, such as access to services, staff morale, culture and recruitment. Plans were emerging and some action had begun to take place. There was a sense of urgency to get things right but also recognition of the huge effort and commitment still required to improve services to young people.

Summary of findings

Information about the service

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

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

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

The Trust has a total of 12 locations registered with CQC and has been inspected 21 times since registration in April 2010.

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.

Our inspection team

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

Why we carried out this inspection

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

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

How we carried out this inspection

We have reported in the following domains:

- Safe
- Responsive
- Well Led

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

We have not given ratings for this core service.

During the inspection visit, the inspection team:

Summary of findings

- visited five locations across the trust and looked at six services
- spoke with 31 staff members; including managers, doctors, nurses, occupational therapists, psychologists and social workers
- looked at 47 care and treatment records of patients
- Looked at a range of policies and procedures.

Areas for improvement

Action the provider MUST take to improve

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

- The trust must ensure there is effective leadership of the children and young person service across Norfolk and Suffolk.
- The trust must review their systems for assessing and monitoring risks for patients on waiting lists for triage, assessment and treatment and provide a consistent approach to this across the children and young person service.
- The trust must review their recruitment processes and ensure there is adequate staff available to reduce the patient waiting lists for triage, assessment and treatment in the children and young person service.
- The trust must review their process for identifying risks on their register.
- The trust must review their systems to ensure that patients have risk assessments and care plans in the children and young person service.

Inadequate

Are services safe?

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

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

Our findings

Safe staffing

- The number, profession and grade of staff in post did not match the trust's staffing plan. We found vacancies in nearly all the teams. Where there was a significant gap, these were escalated onto the trust risk register.
- There had been a recruitment campaign based solely in Norfolk. The outcome resulted in recruitment to some posts. The youth teams, particularly in Suffolk, Kings Lynn, Great Yarmouth and Waveney, all had problems recruiting. The Suffolk managers had to submit a separate business case to improve staffing, as Suffolk was not part of the original campaign. This plan was approved during the time of this inspection.
- The trust had tried to be creative in their recruitment strategy. In Norfolk they had appointed 30 staff from Band 3 to 5. Some of those staff were in place and training was in progress to upskill these staff. Great Yarmouth managers told us that this had a positive impact in reducing the waiting list by almost half. The local teams had explored further what else they could do to recruit. We saw evidence of offering training and development as incentives to attract staff into post. Financial incentives were being considered for the most challenging areas, however there was no clear plan for this to happen for non-medical staff.
- There were long term medical consultant psychiatrist locums in post which reduced the impact of some long-term vacancies. However, recruitment to these posts remained a challenge. The trust had appointed three non-medical prescribers to support these gaps.
- In Suffolk we saw evidence of the duty cover not always being staffed due to staff shortages. Norwich provided cover for three days a week when the expectation was five days per week. The managers confirmed this was a challenge and remained a concern.

Assessing and managing risk to patients and staff

- We reviewed 47 sets of clinical records across all locations. Staff did not record detailed risk management plans in most of these records. We saw letters written to GP's that outlined risks, but there were no clear management or crisis plans in many instances, other than contact numbers. Well written records were in the minority. Ten out of the 47 records addressed risks with a management plan and demonstrated some evidence of patient view being captured. The remaining 37 records did not fully capture appropriate information. There was very little evidence of the patients' voice in documentation overall. Risk assessments were often not updated when there was a change of risk.
- There were gaps in care and we had to escalate eight cases to the local teams on site to follow up. The inspectors were unable to see recent clinical contact with these patients which caused concern they had been forgotten. It was confirmed that three patients had 'slipped through the net'. The other gaps identified were due to poor documentation.
- We raised a concern that a safeguarding referral had not been made for one patient. This was escalated to the local team. Staff had made an assumption that another agency had raised it which was untrue. Staff responded to the concern and before inspectors left, a comprehensive plan had been implemented. A consultant psychiatrist in one location was not confident they knew who the riskiest patients were and therefore could not be assured that there was appropriate oversight of all patients.
- Each team described a newly introduced system of reviewing all assessments. Upon completion of a patient assessment, the clinician brought the case to the weekly multi-disciplinary meeting and held a post assessment discussion, known locally as PAD. Staff spoke positively about this as it meant that there was a clear system of multi-disciplinary review of each case. Staff said that there were agreed outcomes and decisions made that were clinically led and felt assured clinical decisions were being made appropriately. Staff appreciated the benefit of an organised forum to hold clinical discussions. Risk management was discussed at the meeting and a RAG rating confirmed.
- The clinical system, called Lorenzo, did not have a specific location to review the patients' journey in one place, which meant staff would have to read copious records and clinical entries to understand the patient story. It was difficult to pull all information together.
- Care plans were not comprehensive and patients who were non-care programme approach did not have a

Inadequate

Are services safe?

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

care plan and relied on the GP letter as their plan of care. When interventions took place, it was hard to ascertain at what point the patients' treatment was at and there was limited evidence of updates to risk and care plans when needs changed.

- The under 14's Great Yarmouth and Waveney team had a system in place which enabled clinical staff to more easily track patient progress.

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 Trust had set a target for time from referral to triage to assessment and from assessment to treatment. They were not meeting these targets in all cases. Suffolk services as well as Great Yarmouth and Waveney services Youth teams in particular were struggling to meet demand. This was partly due to difficulties in recruiting to key posts. There appeared to be a disparity between Norfolk and Suffolk services in terms of resource, with Norfolk appearing to be better funded and staffed. The trust had developed and implemented a recovery plan to address the capacity and demand issues in Suffolk. Measures implemented included securing funding for more clinical posts. The trust took positive steps and agreed to these posts even though funding from the clinical commissioning groups had yet to be agreed.
- Figures provided by the trust demonstrated that some patients continued to wait significant amounts of time for assessment and treatment. For instance, in Great Yarmouth and Waveney, we saw that in the Youth team, there were 118 young people waiting for assessment and 69 young people waiting for treatment. Some young people had been waiting since May 2018 according to the figures provided. Some statistics provided for teams were incomplete. For instance, West Suffolk youth team figures only included awaiting assessment for all three teams, with just one team having figures for awaiting team treatment. There continued to be long waits for patients with attention deficit hyperactivity disorder in West Suffolk. The figures provided by the trust differed and generally were higher than the figures held locally. When reviewing care records from the awaiting assessment list we found patients on that list who had received their assessment and were actually waiting for treatment. We could not rely on figures being accurate.
- We saw that the Under 14 services generally across all areas had lower numbers of children waiting. Norwich services and Great Yarmouth and Waveney had minimal numbers on their waiting list and there was a system for anyone assessed as high risk being seen swiftly and allocated for treatment.
- The emotional wellbeing hub in Ipswich had seen some improvements in waiting times in recent weeks. In March 2019 the team were able to triage all referrals for that month. This was a result of managers working with staff to implement improved systems of working that enabled staff to follow clear procedures. This was achieved whilst still experiencing staff shortages. However, the team also had a waiting list of 1100 people from previous months. Managers were developing a plan to reduce this list.
- Patients who were waiting for assessment or treatment were added to the waiting list and risk assessed as red, amber or green. From the rating, the duty worker acted to contact patients and there was a clear procedure for staff to undertake. However, we saw in clinical records that this was not always evidenced and patients did not always receive the call as planned.

The facilities promote recovery, comfort, dignity and confidentiality

- We saw that soft furnishings in Great Yarmouth and Waveney had not been replaced since the last inspection. The chairs were torn and therefore remained an infection control risk. Staff advised that an order had been submitted two weeks prior to this inspection. The trust had known about this since October 2018. However, we observed that some floors had been replaced and more floors were due to be replaced, removing carpet from clinical and waiting areas.
- The reception area in Norwich had been identified as a risk on the trust risk register. Work was due to commence to refurbish this on 26 April 2019.
- There was limited space in the Bury St Edmond integrated delivery team building teams building. This impacted on privacy at times. For instance, the place where people were weighed was not totally private. A curtain had been put in place but staff said patients still felt uncomfortable.

Are services well-led?

Inadequate

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

Our findings

Leadership

- Several new board members joined the Trust in the Autumn of 2018 whist other key members are very newly recruited including the chair who joined in February 2019 and the Chief executive who started on 1 April 2019. We saw early evidence of positive impact. Staff reported feeling listened to and some positive changes to practice were emerging. Leaders acknowledged there was a significant amount of work to be carried out, however there was a sense of cautious optimism with many of the staff we spoke to.
- There were newly appointed leaders in some of the teams we visited. This was particularly evident in Suffolk where there had been significant concerns at a local level. Despite the managers having been in post for a short period, there was evidence of positive change in leadership style. Leaders were visible to the service and approachable for patients and staff. Staff were starting to feel listened to.
- Managers had quickly identified key areas of priority, such as access to services, staff morale, culture and recruitment. Plans were emerging and some action had begun to take place. There was a sense of urgency to get things right but also recognition of the huge effort and commitment still required to improve services to young people.
- Staff described improvement in communications. Staff were appreciative of leaders providing the opportunity to attend a wellbeing day and drop in sessions.

Culture

- Morale was lower in Suffolk than Norfolk. Suffolk staff described feeling overwhelmed with work and concerned that demand outstripped capacity, specifically where vacancies remained high. There were still concerns that the bullying culture had not completely been eradicated and some staff still did not feel looked after.
- Low morale amongst some staff had been recognised and the service was working actively with staff to respond to their concerns and make changes that would benefit them.
- Many staff expressed hope that they were seeing the beginning of change, felt the new senior managers in post were approachable and acting to improve patient care. Morale was higher in Norfolk, although there were also pressures relating to demand for services and capacity to meet that demand.
- A consultant psychiatrist expressed concern that some practices hindered their ability to carry out safe and effective care and they did not feel the concerns had been listened to.
- Most staff said that they now felt more confident in raising concerns without fear of retribution. Previously they had not believed they would be listened to. There remained some staff who did not yet feel confident.
- Staff in Norwich reported that the freedom to speak up guardian was visible and actively encouraging staff to talk to this person. Wellbeing champions had been identified within teams.

Governance

- We saw a framework in place of what must be discussed at team and directorate level in team meetings. We saw recent minutes of these meetings which evidenced essential information was discussed such as learning from incidents and complaints.
- We did not see evidence of audit in relation to quality of care records. However, if there was audit in place, this did not affect change. The quality of clinical records across all locations was not adequate and action was required to address this deficit.
- Our evidence from other key findings demonstrated that there was a need to improve governance systems further to ensure accurate information is captured to support clinicians prioritise their work.
- Managers told us that a young person attends and contributes to the locality governance meetings.
- The Care Quality Commission ratings on display in reception at Mariner House in Ipswich and in Great Yarmouth still showed the rating from the 2017 inspection and could be misleading to the public. It is a requirement for trusts to display the correct rating.

Management of risk, issues and performance

- Senior managers knew the trust risk register and how to escalate issues via the reporting system and locality meetings. However, there was no evidence of locally owned risk registers. Those staff asked, could not tell us if there was one.

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.

- Systems had been implemented to identify those most at risk and ensure safety plans were in place. This was in its infancy and needed appropriate clinical oversight to ensure plans were effective.
- Systems were not accurate regarding waiting lists. From the lists the trust gave inspectors, we saw evidence of patients sitting either on the wrong waiting list or incorrectly on a waiting list. We also saw that not everyone was receiving phone calls as per the guidance and some patients were being missed. The processes for managing lists needed further refinement. This was a concern raised at the last inspection.
- We saw that information was collected from services. However, we could not be assured of the accuracy of this data. For instance, we saw incorrectly added patients on waiting lists.
- Clinical information was accessible on the electronic clinical information system. However, it was not cohesively put together which made it difficult for clinicians to see all interventions and actions in in a logical or consistent manner. Staff were unaware if alerts could be added, which would bring to the staffs' attention immediately any concerns such as safeguarding or significant risk.

Information management