Inadequate

Norfolk and Suffolk NHS Foundation Trust

Community-based mental health services for adults of working age

Quality Report

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Locations inspected

Location ID	Name of CQC registered location	Name of service (e.g. ward/ unit/team)	Postcode of service (ward/ unit/ team)
Trust Headquarters	RMY01	Central City 1,2,3 CMHS	NR6 5BE
Trust Headquarters	RMY01	Central North East and North West CMHS	NR6 5BE
Trust Headquarters	RMY01	Great Yarmouth CMHS	NR30 1BU
Trust Headquarters	RMY01	West Norfolk CMHS	PE30 5PD
Trust Headquarters	RMY01	Central South East and South West CMHS	NR18 0WF
Trust Headquarters	RMY01	Waveney CMHS	NR32 1PL
Trust Headquarters	RMY01	Ipswich IDT	IP1 2GA

Summary of findings

Trust Headquarters	RMY01	Coastal IDT	IP3 8LY
Trust Headquarters	RMY01	Central IDT	IP14 1RF
Trust Headquarters	RMY01	Bury North IDT	CB8 7JG
Trust Headquarters	RMY01	Bury South IDT	IP33 3NR

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

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

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

Summary of findings

Ratings

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

Overall rating for the service	Inadequate 
Are services safe?	**Inadequate** 
Are services effective?	**Requires improvement** 
Are services caring?	**Good** 
Are services responsive?	**Requires improvement** 
Are services well-led?	**Inadequate** 

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

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

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

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

Summary of findings

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Summary of findings

Overall summary

We rated community-based mental health services for adults of working age as inadequate because:

- Concerns were identified with all clinic rooms. These included out of date equipment. Equipment not calibrated or safety checked. Inconsistent clinic room and fridge temperature monitoring, with a lack of robust systems in place for the monitoring of safe medication storage.
- Automated external defibrillators (AED) were removed by the trust for these services, with front line staff lacking knowledge of the alternative arrangements in place.
- We found six of the clinic rooms inspected did not hold emergency medication, but continued to administer injections.
- There was a 59% completion rate for staff appraisals for community adult services; however, we identified one service with a completion rate of 27% (Bury South ECP). It was therefore unclear how training and performance issues were identified and managed.
- Service managers were unable to consistently assure us through data recorded that staff received regular clinical or managerial supervision .Some service managers held spreadsheets to monitor completion. The trust did not provide data relating to supervision prior to the inspection.
- Only four teams achieved the trust's 90% or above compliance target for mandatory training.
- Ligature risk audits were out of date, or lacked detail to enable staff to manage and mitigate risks to patients accessing services for treatment.
- Personal safety alarms for staff did not work at the Great Yarmouth and West Norfolk CMHS sites inspected placing staff at potential risk. This was not in line with lone working practices.
- There was variable quality of recording of patient records including care plans, risk assessments and crisis plans with inconsistent details regarding drug sensitivities and health care monitoring.
- Community adult services were 28% over capacity in relation to the number of referrals received, and staffing levels to meet those needs. Norfolk service managers had submitted a joint report to the trust board and this concern was on the trust risk register. At the time of the inspection, these concerns had not been addressed.
- There were high patient waiting lists in some teams, with inconsistent practices in place to robustly manage the risk for those patients awaiting allocation of a care coordinator, access to services or treatment.
- Some staff reported allegations of bullying cultures within the management teams, and reluctance to implement whistleblowing procedures for fear of reprisals.
- Community adult services had staffing vacancies of 9% and 4% sickness levels; with 2954 shifts covered by agency qualified nurses between 1 April 2016 and 31 March 2017. Core service sickness rates were below the trust average of 5% and turnover rates were in line with the trust average of 12%.
- Patients received substandard levels of physical health care monitoring, with staff acknowledging this was as a result of workload pressures.
- Services held patient waiting lists varying in size from 3 to 141 patients. There were inconsistent practices for the management of risks associated with waiting for treatment and allocation to a care coordinator. Based on waiting list numbers provided during the inspection, there were approximately 473 patients on waiting lists who did not have an allocated care coordinator.
- Alarm pull cords in some accessible toilets were not working and staff did not appear to know how to respond when these were pulled.

However:

- Staff interacted with patients and their family members with care and compassion. Staff spoke

about the patients on their caseloads with knowledge of their needs, social and medical histories. Staff offered practical and emotional support to carers and family members.

- Staff treated patients with respect, and showed professionalism when handling challenging situations.

- The trust scored 93% in the May 2017 friends and family test for patients who would recommend the service. This was an improvement from the previous year when the trust scored 62%.

Summary of findings

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

Are services safe?

Inadequate 

We rated community-based mental health services for adults of working age as inadequate for safe because:

- Ligature risk audits were out of date, or lacked sufficient detail to enable staff to manage and mitigate risks to patients accessing services for treatment.
- Personal safety alarms for staff did not work at Great Yarmouth and West Norfolk CMHS sites placing staff at potential risk and not in line with lone working practices.
- Concerns were identified with all clinic rooms. These included out of date equipment. Some equipment was not calibrated or safety checked. Inconsistent clinic room and fridge temperature monitoring took place, with a lack of robust systems in place for the monitoring of safe medication storage.
- Automated external defibrillators (AED) were removed by the trust for these services, with front line staff lacking knowledge of the alternative arrangements in place.
- Alarm pull cords in some accessible toilets were not working and staff did not appear to know how to respond when these were pulled.
- Six of the clinic rooms inspected did not hold emergency medication for use on site or in the community, but continued to administer injections. Emergency medication is required in the event a patient experiences an allergic reaction to medication once administered.
- Staff and managers were unfamiliar with the trust's policies and procedures for the reporting and recording of incidents and errors relating to medication administration.
- There was limited pharmacy oversight for Norfolk and Suffolk adult community services.
- Data provided prior to the inspection highlighted significant use of bank qualified nursing staff with 2954 shifts covered between 1 April 2016 and 31 March 2017.
- We identified inconsistent caseload allocation levels across Norfolk and Suffolk.
- There was variable quality of recording of patient records including care plans, risk assessments and crisis plans with inconsistent details regarding drug sensitivities and health care monitoring.

Summary of findings

- Norfolk service managers had submitted a joint report to the trust board to alert them to the fact community adult services were 28% over capacity in relation to the number of referrals received, and staffing levels to meet those needs. At the time of the inspection, these concerns had not been addressed.
- Some teams held high waiting lists with inconsistent practices in place to robustly manage the risk for those patients awaiting allocation of a care coordinator and access to services or treatment.

However:

- Staff used formulation and clustering tools to identify risks, develop action plans and identify severity of patient needs.
- Duty teams offered high levels of telephone support; they used this to manage patient need when staff were on leave.
- Staff worked closely with other agencies and professionals to collaboratively manage shared patient risks.
- Front line staff had a good safeguarding knowledge and awareness of the trust's procedures to follow where concerns for adult or child safety were identified.
- Lone working practices were in place including use of buddy systems and individual whereabouts monitoring boards.

Are services effective?

We rated community-based mental health services for adults of working age as requires improvement for effective because:

- Patients received substandard levels of physical health care monitoring, with staff acknowledging this was as a result of workload pressures.
- Service managers were unable to assure us through trust data records that staff received regular clinical and managerial supervision and appraisals. They were unable to demonstrate that performance issues were robustly monitored and addressed. The trust did not provide data relating to supervision prior to the inspection. The trust data reported appraisal compliance for non-medical staff to be 59%.
- Mental Health Act and Mental Capacity Act training compliance was low for some teams.
- Mental Capacity Act assessments were not clearly recorded where relevant.
- From the 99 medication cards examined we found 20 did not have a copy of the patient's MHA paperwork stored with it.
- Frontline staff were unaware of clinical audit findings and were not involved with audits at a service level.

Requires improvement

Summary of findings

- Most teams held psychology waiting lists. We found one patient had been waiting since June 2016.

However:

- When new staff joined the team, they received a thorough induction and shadowing opportunities with colleagues.

Are services caring?

Good

We rated community-based mental health services for adults of working age as good for caring because:

- Staff interacted with patients and their family members with care and compassion. Staff spoke about the patients on their caseloads with knowledge of their needs, social and medical histories. Staff offered practical and emotional support to carers and family members.
- Staff treated patients with respect, and showed professionalism when handling challenging situations.
- Patient records demonstrated involvement in care programme approach reviews, and staff confirmed these were consistently completed face to face, involving patients, carers and family members.
- City 1, 2 and 3 teams and Coastal IDT gave examples of patient and carer forums held regularly to seek feedback and to use the information received to inform service development and team priorities.
- The trust implemented the triangle of care scheme. Carer assessors within teams had a lead role to train staff and ensure the needs of carers were a shared priority with the needs of patients when completing assessments.
- The trust scored 93% in the May 2017 friends and family test, with 5% of respondents reporting they would not recommend the trust. 88 out of a total of 122 respondents indicated they would be extremely likely to recommend, with 26 likely and 6 extremely unlikely to recommend.

However:

- Patient records reviewed contained variable recorded evidence of patient and family involvement. The electronic recording system did not indicate where copies of care plans had been offered.
- Some patient crisis plans were not personalised documents and did not contain patient's protective factors and plans for implementation in the event of deterioration or relapse.

Summary of findings

- Some carers expressed frustration at the lack of recognition they received for the level of support they gave to patients and their families.

Are services responsive to people's needs?

Requires improvement

We rated community-based mental health services for adults of working age as requires improvement for responsive because:

- Services held patient waiting lists varying in size from three to 141 patients. There were inconsistent practices for the management of risks associated with waiting for treatment and allocation to a care coordinator. Based on waiting list numbers provided during the inspection, there were approximately 473 patients on waiting lists who did not have an allocated care coordinator.
- The IDTs did not use caseload management tools during management supervision as a means of supporting staff with planning patient discharges. This meant some staff lacked confidence in discharging patients from their caseload.
- There was a lack of meeting rooms at some sites for treatment sessions.
- There was inconsistent implementation of the trust's 'non-access visits and missed/ cancelled appointments' policy in relation to the risk management of patients that staff were unable to make contact with.

However:

- The duty teams offered high levels of telephone and face to face support to patients experiencing crisis. We observed practical advice and support offered along with proactive arrangements for patients to receive medical reviews with their consultants.
- Staff and patients reported a flexible approach to working to maximise engagement with patients, and to fit around the needs of carers. For example, offering appointments outside of standard working hours, whilst ensuring use of the trust's lone working policy.
- Regular referral and allocation meetings were held. This offered an opportunity to review patients on the waiting list and re prioritise when needed. We observed teams to use the FACT approach as another method of responding to patients with increased levels of need.
- Most clinic areas were accessible for patients with disabilities.
- Staff were able to access interpreters and signers to support with treatment and interaction with patients where needed.

Summary of findings

- There was some evidence of trust wide learning from complaints during business and governance meetings.
- We saw examples of compliments and positive feedback from patients including thank you cards on display.

Are services well-led?

We rated community-based mental health services for adults of working age as inadequate for well led because:

- Some staff reported allegations of bullying cultures within the management teams, and reluctance to implement whistleblowing procedures for fear of reprisals.
- The wider trust had not maintained up to date environmental and ligature risk audits or reviewed the condition and suitability of treatment facilities and clinic rooms, placing patients at potential risk.
- Service managers were unable to consistently assure us through data recorded that staff received regular clinical or managerial supervision .Some service managers held spreadsheets to monitor completion. The trust did not provide data relating to supervision for this core service prior to the inspection. It was therefore unclear how training and performance issues were identified and robustly managed.
- Only four teams achieved the trust's 90% or above compliance target for mandatory training.
- The trust were aware of vacancy levels within these teams but progress with recruitment and encouraging active staff retention was slow and many posts remain unfilled.

However:

- Service managers escalated concerns such as staffing vacancies and waiting lists on the trust's risk register.

Inadequate

Summary of findings

Information about the service

Community-based mental health services for adults of working age was last inspected in July 2016. They received an overall rating of requires improvement, with requires improvement for safe and effective domains and a rating of good for caring, responsive and well-led. Since the last inspection, the trust had restructured the Norwich central based services and divided them into a total of seven teams - three city services, two southern and two northern services.

Community-based mental health services for adults of working age provided support to patients and their families and carers living in Norfolk and Suffolk experiencing moderate to severe mental health problems. Staff visited patients in their own homes, at community hubs and GP surgeries.

In Norfolk the services were known as Community Mental Health Services (CMHS) and in Suffolk as Integrated Delivery Teams (IDTs). In Norfolk, the CMHS comprised of professionals solely working in the adult community mental health pathway. Patients assessed to require a high level of contact during the office hours due to risk or changes in presentation or those who staff identified to require monitoring were reviewed daily using the FACT approach – Flexible Assertive Community Treatment.

In Suffolk, the IDTs comprised of professionals from a range of pathways including, but not solely, adult community mental health care. The adult pathway divided into two teams, Enhanced Care Pathway (ECP), and the adult pathway.

The ECP pathway provided short-term intervention, with an emphasis on developing community networks and reintegration to reduce isolation. This service worked mainly with patients with moderate depression, anxiety and personality disorders.

The adult pathway provided longer term intervention for patients aged 25 years and over, with severe and enduring mental health problems, including patients over 65 years not experiencing dementia or complexities related to aging, and those patients experiencing their first episode of psychosis.

In Suffolk a Section 75 partnership agreement with the Local Authority was in place. This is an arrangement between a local authority and an NHS body related to the National Health Services Act 2006.

Services received their referrals via the Single Point of Access teams and from acute teams if the patient had been seen by inpatient or crisis services.

From the last inspection in July 2016, the following areas of improvement were identified for community-based mental health services for adults of working age:

Action the trust MUST take to improve:

- The trust must ensure that all care programme approach reviews take place and are fully recorded.
- The trust must ensure that internal audits on medicine management identify areas for improvement and address any concerns identified.
- The trust must ensure that further training in the use of the trust's electronic record system is available to those staff that require it.

Action the trust SHOULD take to improve:

- The trust should ensure that consideration of mental capacity is fully recorded.
- The trust should review the different working arrangements within each team, in order to ensure the consistency of care provided to patients.

The musts and shoulds were reviewed as part of the inspection process. We found that some of the concerns identified in the last inspection report had not been addressed by the trust.

Our inspection team

Our inspection team was led by:

Chair: Dr Paul Lelliott, Deputy Chief Inspector, mental health CQC

Summary of findings

Shadow chair: Paul Devlin, Chair, Lincolnshire partnership NHS Foundation Trust

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

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

The team that inspected community-based mental health services for adults of working age as part of an announced, comprehensive inspection consisted of 12 people:

One CQC inspection manager, three CQC inspectors, seven specialist professional advisors with a variety of backgrounds including psychology, mental health nursing, social work and occupational therapy and an expert by experience (someone that had personal experience of using or caring for someone who uses mental health services). A specialist pharmacy inspector collected additional information.

In week one, teams visited Central City teams 1, 2 and 3 CMHS, Central North East and North West CMHS based on the Hellesdon Hospital site, Norwich. Central South East and South West CMHS based at Gateway House, Wymondham. Great Yarmouth CMHS and West Norfolk CMHS based at Chatterton House, Kings Lynn.

In week two, teams visited Ipswich and Coastal IDTs based in Ipswich, Central IDT based at Haymills House in Stowmarket, Bury South IDT in Bury St Edmonds, Bury North IDT at the Sage Centre in Newmarket and Waveney CMHS at Victoria House in Lowestoft.

Why we carried out this inspection

We inspected community-based mental health services for adults of working age as part of our ongoing comprehensive mental health inspection programme. This was an announced inspection.

How we carried out this inspection

To fully understand the experience of people who use services, we always ask the following five questions of every service and provider:

- Is it safe?
- Is it effective?
- Is it caring?
- Is it responsive to people's needs?
- Is it well-led?

Before the inspection visit, we reviewed information that we held about these services, asked a range of other organisations for information and sought feedback from patients at focus groups.

During the inspection visit, the inspection team:

- visited 15 teams across 10 trust sites and looked at the quality of the treatment environment and observed how staff interacted with patients
- spoke with 48 patients who were using the service
- interviewed 23 managers aligned to each service
- met with 108 other staff members; including doctors, nurses, social workers, occupational therapists, administration and support staff
- spoke with nine family members or carers
- attended and observed 11 meetings these included team risk management, referral and allocation meetings
- observed 10 episodes of care and treatment between staff and patients in clinics and community settings
- examined in detail 89 care and treatment records
- reviewed 99 patient medication cards
- Examined a range of policies, procedures and other documents relating to the running of this core service.

Summary of findings

What people who use the provider's services say

We spoke to 48 patients and nine carers or family members during the inspection.

- Patients told us that staff were responsive to their needs, were caring and treated them politely. Patients gave examples of where staff had offered support and encouragement to attend groups and reintegrate into their local community, and offered support in times of crisis.
- Some patients reported to have been involved in the development of their care plans and spoke about the value placed on this by staff. The patient records reviewed during the inspection contained variable documented evidence of patient and family involvement. The electronic recording system did not indicate where copies of care plans had been offered.
- Patients confirmed medication side effects were explained to enable them to make informed decisions.

However:

- Some patients told us that in the event of requiring crisis support this could take a day for services or support to be put in place.
- Some carers expressed frustration at the lack of recognition they received for the level of support they gave to patients and their families.

Good practice

- The peer support worker role was imbedded into teams in Norfolk since the 2016 inspection, with staff reporting to feel integrated within the service. A new 'peer support navigator' role was in place at Central South CMHS. This offered patients up to six sessions with the staff member to prepare for discharge from the CMHS and aid reintegration into their local community. This role offered patients the opportunity to work with a staff member with lived experience of being discharged from services, and offered great insight and understanding of the anxieties patients could be experiencing at this time of change.
- One of the clinical team leaders for Central South in Norfolk was taking a lead role within community teams for developing services and support for pregnant patients and patients with children. They were responsible for disseminating information to all adult community services in the trust and collating case examples to be discussed at trust meetings, working collaboratively with children services and other agencies. This project and associated changes and development of policies and procedures were linked to the lessons learnt and analysis of serious incidents within the trust.
- The service manager for Coastal IDT had designed and implemented an intranet page only accessible to their service staff. This contained links to policies, local community resources and minutes from meetings. Designed to support staff to keep abreast of information and service development without overloading them with multiple emails.

Areas for improvement

Action the provider MUST take to improve

- The trust must complete detailed ligature risk audits for all community services.
- The trust must ensure staff have access to working personal alarms, and that systems are in place staff to know how to respond in the event these are activated.

Summary of findings

- The trust must ensure all clinic rooms are equipped with emergency medication for use on site and in the community.
- The trust must ensure that alternative procedures are in place for staff to follow in the event of a medical emergency.
- The trust must ensure clinic room temperatures are consistently monitored and staff liaise with pharmacy services to seek advice in relation to safe medication storage and efficacy.
- The trust must ensure effective systems are in place for the monitoring and recording of clinical and managerial supervision and appraisals for all staff.
- The trust must ensure staff are up to date with all mandatory training courses, and that adequate systems are in place for training attendance to be recorded.
- The trust must ensure robust systems are in place for the management of waiting lists, and ensuring consistent approaches across Norfolk and Suffolk for management of patient risk. The trust must review the unallocated cases in community services and ensure that there is an allocated care coordinator.
- The trust must ensure that all staff consistently adhere to the non-access visits and missed/ cancelled appointments policy and that all attempts and contact with patients are documented.
- The trust must ensure the consistent use of caseload management tools.
- The trust must ensure that a copy of all relevant mental health act paperwork is attached to medication cards to ensure medication administration is in line with the MHA Code of Practice.
- The trust must ensure patients receive regular physical health care monitoring, and that systems are in place for this information to be recorded, including where a patient refuses.
- The trust must improve the quality and detail of patient risk assessments, care plans and crisis plans, ensuring patient and carer involvement where appropriate.
- The trust must ensure that staff document all mental capacity assessments where required in patient's records.
- The trust must ensure that all clinical staff and managers are familiar with procedures to follow in the event of a medication error or incident.
- The trust must ensure that all service managers and team leaders have training and support to enable them to access information on staff compliance with appraisals, supervision and training.
- The trust must ensure regular audits are completed of clinic room equipment and medication and comprehensive measures are implemented to ensure issues such as equipment requiring calibration is addressed.
- The trust must ensure all alarm pull cords in accessible toilets are in working order and that staff know how to respond in the event of these being pulled.

Action the provider SHOULD take to improve

- The trust should review their internal procedures to ensure staff can meet with patients in appropriate environments.
- The trust should ensure that staff record drug sensitivities on all medication cards.
- The trust should investigate all allegations of bullying and harassment.
- The trust should ensure confidentiality with whistleblowing procedures.
- The trust should ensure information leaflets are easily accessible in different languages.
- The trust should review their patient record system to reflect the number of times staff attempt to make contact with patients.
- The trust should ensure all teams have appropriate methods of transporting medication safely in the community in line with the trust's medication management policy.

Norfolk and Suffolk NHS Foundation Trust

Community-based mental health services for adults of working age

Detailed findings

Locations inspected

Name of service (e.g. ward/unit/team)	Name of CQC registered location
Central City 1,2,3 CMHS	RMY01
Central North East and North West CMHS	RMY01
Great Yarmouth CMHS	RMY01
West Norfolk CMHS	RMY01
Central South East and South West CMHS	RMY01
Waveney CMHS	RMY01
Ipswich IDT	RMY01
Coastal IDT	RMY01
Central IDT	RMY01
Bury South IDT	RMY01
Bury North IDT	RMY01

Detailed findings

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.

- Staff completed mandatory MHA training as part of their induction, then regular refresher courses. With completion compliance ranging between 54% for Central North West CMHS and 100% at West CMHS and between 69% at Bury South IDT and 100% at Bury North IDT, based on data provided prior to the inspection. The Trust compliance target was 90%.
- The trust Mental Health Act (MHA) administration office oversaw MHA paperwork, and had responsibility for completion of regular quality audits. Staff could contact the office for advice and guidance when required.
- From the 89 patient records viewed during the inspection 20 patients received care under a Community Treatment Order (CTO).

However:

- We found 20 medication cards without MHA paperwork attached to them. Staff at West Norfolk CMHS and Waveney CMHS did not recognise the importance of MHA paperwork in relation to consent to treatment. This was not in line with MHA code of practice of ensuring MHA paperwork is kept with medication cards 'to minimise the risk of the patient being given treatment in contravention of the provisions of the Act.'
- Two patients had their CTOs recalled during the inspection. We observed staff following the trust's procedure to source an inpatient bed, and working with the patient, responsible clinician and the other professionals involved.
- The CQC mental health act review team completed a review of CTO paperwork in community services and identified an invalid CTO in place at Ipswich IDT. This matter was escalated to the trust's MHA administration team who liaised with the service manager and patient involved.
- Staff at Bury South IDT and Central IDT reported minimal support or involvement in paperwork audits by the MHA administration team.

Mental Capacity Act and Deprivation of Liberty Safeguards

- Staff interviewed had completed Mental Capacity Act (MCA) mandatory training. They were aware of the five statutory principles. With completion compliance ranging between 56% for South East CMHT and 100% City 3 Team and between 67% for Central IDT and 100% Bury North IDT. The Trust training compliance target was 90%.
- From the 89 patient records examined, we found 16 examples of where staff identified the need for MCA assessments but this had not completed. Other examples included where staff had been asked to provide capacity status for a patient by a professional such as a solicitor, or where consent to treatment was recorded but there was no record of assessment completion to support this decision.
- No teams reported to have made Deprivation of Liberty Safeguard applications to the local authority within the last six months.

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 and clean environment:

- We found examples of out of date ligature risk audits and audits containing minimal details to enable staff to mitigate risks. We found audits with environmental ligatures not included.At Central South East and South West CMHS patients had only been attending Gateway House for appointments in the last month, yet prior to authorising patient access, a ligature risk audit had not been completed. As such, we identified areas of environmental concern including waste bins containing rubbish bags and ligature points including in the toilets accessible to patients. At Bury South IDT the ligature risk audit had not been reviewed since May 2016 and the inspection team identified ligature not included on the audit such as door handles and office furniture.There was no ligature risk audit for Waveney CMHS. Great Yarmouth CMHS had not completed environmental ligature risk audits in relation to all treatment areas accessed by patients. Some waiting areas including at Ipswich IDT contained furniture that was not floor fixed which could be used as a weapon or to damage property.
- Personal alarms for staff were not in working order at West Norfolk CMHS. At Great Yarmouth CMHS if staff activated their personal alarms, they could not be heard in all areas of the building affecting on robust responses. At Bury South IDT, each office had a desk based alarm, which did not offer staff a method of sourcing assistance in an emergency when away from the desk.
- Waiting areas and interview rooms were clean and comfortable, however furniture and decoration at some sites was tired and in need of improvement. Most interview rooms were fitted with spy holes or viewing panels in the doors, for use by staff in the event of an emergency. We identified treatment rooms with poor sound proofing at West Norfolk CMHS. This potentially impacted on patient privacy and dignity. The use of the room was ceased during the inspection.
- We identified areas of concern with all clinic rooms inspected. These included equipment that was not calibrated such as blood pressure monitors, weighing scales and thermometers with no systems in place for staff to complete regular checks of safety or condition. Out of date equipment included equipment for blood taking. There was inconsistent monitoring of clinic room and fridge temperatures. Staff had not considered the risks to medication efficacy if stored in high or inconsistent temperatures or taken action to mitigate these risks. This was not in line with the trust's policy on medication management.
- The trust had introduced a wireless, electronic clinic room temperature monitoring system. In the clinic room used by City 1, 2 and 3 CMHS the room was consistently a high temperature resulting in the monitoring equipment making an audible alarm to alert staff. To overcome this issue, the battery had been removed from the equipment to stop the alarm from sounding.
- Waveney CMHS clinic room was very small, with no examination couch for provision of depot injections resulting in administrating with patients in a standing position, and consistently high environmental temperature readings.
- Central IDT did not have an ECG machine or blood glucose monitoring equipment.
- At Bury south IDT, confidential patient information dating back to 2015 was not stored securely, and loose medication was found in a cupboard.
- Central South East and West CMHS, Great Yarmouth CMHS, Waveney CMHS, West Norfolk CMHS, Ipswich IDT, Coastal IDT and Bury South IDT did not have automated external defibrillators (AED), emergency equipment on site. Bury North IDT had a defibrillator but this was not calibrated. Some teams did not have emergency equipment such as oxygen and adrenaline in place, yet administered depot injections. The trust informed us subsequently that automated external defibrillators were in place for in-patient services. Community staff were not aware that they could access these if needed.
- Staff completed basic life support (BLS) training provided by the local NHS ambulance trust. Compliance

Inadequate

Are services safe?

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

ranged from 50% for Central South East CMHS and 85% for Central North West CMHS. For IDTS compliance ranged between 47% for Coastal and 92% for Bury South. Staff told us the BLS course included use of the AED emergency equipment.

- Staff including service managers were unfamiliar with the trust's policy for reporting medication errors, and the need to document these incidents on the trust's electronic recording system.
- Staff did not consistently complete clinic room checks or medication audits.

Safe staffing:

- From data provided by the trust prior to the inspection, community services for adults of working across Norfolk and Suffolk had a total of 503.54 substantive staff as of 31 March 2017. Between April 2016 and March 2017 a total of 58.34 substantive staff left.As of 31 March 2017 these services had overall vacancy levels of 9% and 4% total permanent staff sickness. There were 12% qualified nursing vacancy rate and a 12% nursing assistant vacancy rate. Core service sickness rates were below the trust average of 5% and turnover rates were in line with the trust average of 12%.
- From the 1 April 2016 to 31 March 2017 community services for adults of working age had a total of 39 shifts covered by qualified nurse bank staff and 2954 shifts filled by qualified nurse agency staff. There were no shifts covered by bank or agency for nursing assistant staff for the same period. Services reported to struggle to recruit to band 5 nursing posts across Norfolk and Suffolk. Service managers reported that current guidance from the trust was for newly qualified nurses to work in ward environments initially to ensure the correct level of support. Service managers reported to understand the reasoning behind this guidance, but with the level of vacancies across community services, were of the opinion that the needs of newly qualified nurses could be met in the community as long as services implemented robust induction and mentoring schemes.
- There were no occupational therapists employed in Central North East and West CMHS, Ipswich IDT or Bury North IDT. Staff were unclear how to request specialist support for patients when required and reported the lack of occupational therapists within the multi-disciplinary team as a concern.
- The trust was actively recruiting, with vacancies either out to advert or interview dates agreed. Ipswich IDT and Waveney CMHS vacancy levels were on the trust's risk register due to the impact this had on meeting the needs of patients on their waiting lists.
- Where agency staff worked within teams, they were on long term contracts, familiar with the patient group and geographical area, and reportedly in receipt of training and supervision. However, service managers acknowledged that use of agency staff could impact on the consistency of care delivered to patients as these staff members did not have to provide advanced notice if they wished to have leave or cease working in the team. Great Yarmouth CMHS had a consultant psychiatrist vacancy, Coastal IDT and Bury South IDT used locum psychiatrist consultants.
- Caseloads for full time staff in CMHS and IDTs ranged between 25 and 35 patients for full time staff, although we found examples of staff holding caseloads of up to 60 patients, and some team leaders holding active caseloads in addition to their managerial responsibilities. Some staff reported to feel under pressure or struggling to provide the level of support to patients especially those with complex needs. Service managers told us, caseload allocation rates were linked to patient complexity and risks. CMHS used a caseload management tool in Norfolk. Caseload management tools were not in use at the IDTs in Suffolk.
- Staff used mental health formulation and clustering tools to identify risks, develop action plans and identify severity of patient needs. This helped inform the priority for allocation, and identification of the correct care coordinator in relation to skills and experience.
- Where staff members were off sick or on leave, services used a duty system and communicated patient needs within the team meetings to ensure consistent coverage.
- Consultants care transferred with patients if they were admitted to inpatient services, and linked with crisis and out of hours services for a consistent approach. Staff

Inadequate

Are services safe?

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

reported to be able to seek advice from the consultants either face to face or by telephone enabling them to escalate concerns and agree plans of approach for patients in a timely way.

- Staff had completed mandatory safeguarding training for working with children and adults. Completion compliance for adult level one training ranged between 89% Central North East CMHS and 100% for City 1 CMHS and between 86% for Bury South IDT and 100% for Bury North IDT.
- Staff completed a minimum of level one child safeguarding training, with some staff completing level three training in relation to their role and responsibilities. Completion compliance for level one child safeguarding training ranged between 89% Central North East CMHS and 100% Great Yarmouth CMHS. For IDTs completion compliance ranged from 86% Bury South and 100% Ipswich IDT. Level three children safeguarding overall compliance ranged from 73% to 100%.
- We reviewed a sample of fire risk assessment documents for Central North East and West CMHS, South Central East and West CMHS, Ipswich IDT and Coastal IDT. Where areas of concern were identified or action points were listed, services managers were working closely with the trust's estates team and fire safety inspectors to manage or address the issues.

Assessing and managing risk to patients and staff:

- Staff in the single point of access teams screened new referrals and completed initial assessments and reviewed historic clinical risks. Teams discussed risks collaboratively as a professional group at daily FACT meetings and during regular team referral meetings. This information was included in meeting minutes.
- From the 89 patient records reviewed, most contained comprehensive assessments, and documented involvement from the patient, carers and family members as well as interagency working in the management of risks. However, there were 17 records with no care plan or ones that were out of date. There were 25 records found to have out of date risk assessments or risk assessments that did not link effectively with the needs identified in the patient's care plans.
- We found examples of risk assessments not updated since 2015, and examples of patients with known suicidal or self-harm histories where family members alerted staff to changes in the patient's presentation yet contemporaneous notes were not updated for four months prior to the inspection. The inspection team escalated this concerning information to the relevant service manager during the inspection visit.
- Crisis plans varied in quality and details. We found examples of wording in patient's plans advising that in the event of crisis or needing support, the patient should contact their care coordinator. This option was only available to patients during office hours. This did not offer patients robust strategies in the event of a crisis.
- Patients told us staff offered practical advice and support, but consistently identified that if they required crisis support they would expect to have to wait approximately one day. Relationships between community services and the out of hours services varied across Norfolk and Suffolk. We were unable to find a clear policy for staff to follow identifying the expectations when making a referral for crisis support for patients. Some teams developed local protocols to aid collaborative working. Service managers told us they liaised with the managers for out of hours services to ensure that patients received the required levels of support.
- Staff worked collaboratively with other agencies including the police, child and adult social care services to manage shared risks.
- Norfolk community services identified they were 28% over capacity for the number of referrals teams received in relation to staffing levels to assess and care co-ordinate patients. These concerns were on the trust's risk register and we viewed a copy of the report entitled 'community service line pressures report' that service managers for Norfolk had jointly submitted to the trust board. At the time of the inspection, these concerns had not been addressed.
- Waiting lists numbers for services ranged from three patients (City 2 CMHS) to 141 (West Norfolk CMHS). Central IDT and Bury North IDT did not have waiting lists at the time of the inspection. Waiting lists consisted of patients who had received an initial assessment by the

Single Point of Access Team, and were awaiting allocation to a care coordinator within community services. Or there were patients who had been allocated to a care coordinator, this staff member had left or changed roles, and the patient was placed on a waiting list pending re-allocation. Separate waiting lists were in place for patients on care programme approach 117 aftercare, to ensure staff monitored when reviews and reports were due for completion.

- In Norfolk, a designated staff member was responsible for overseeing all waiting lists for adult community services. Their role was to maintain regular contact with patients on waiting lists, and to escalate any risks or deterioration in mental health condition to team leaders and service managers so they could increase allocation priority. This staff member was named point of contact for patients on the waiting list to reduce the amount of calls made to the service duty teams. It was difficult to ascertain how one staff member could achieve high levels of oversight and sufficient management of associated risks for the whole locality. Suffolk did not have a similar model in place.
- Based on waiting list numbers provided during the inspection, there were approximately 473 patients on waiting lists who did not have an allocated care coordinator.
- Patients in Suffolk awaiting allocation were contacted regularly by team duty workers, with changes in presentation or concerns escalated to team leaders or service managers for allocation or transfer to the home treatment teams.
- Staff triaged new referrals prior to placing them on the waiting lists for each service. At this point, each patient was RAG rated, with an indication of response times. Staff sent new referrals a letter with information about the service, and who to contact in the event of crisis of experiencing deterioration in their mental health condition. Patients RAG rated as 'red' were to be seen within three to five days; 'amber' within 10 to 14 days and 'green' within 6-8 weeks.
- The trust's electronic patient records system did not recognise attempts to contact a patient for example by telephone. It only recorded actual contact with patients at the point the staff member spoke with the patient or met with them face to face. Staff told us this did not accurately reflect the amount of time spent trying to make contact with patients. Clear records of this information would also assist with any potential serious incident investigations.
- From information provided by service managers during the inspection, most non-urgent patients were seen within 4-6 weeks, however one patient had been waiting for a psychology assessment since June 2016.
- Staff demonstrated clear knowledge of trust safeguarding processes and procedures, and recognised the different types of potential abuse. Staff accessed support and advice from the trust safeguarding team as well as their managers. Safeguarding cases were a fixed agenda item for business and governance team meetings. Adult community services for Norfolk and Suffolk had made 43 safeguarding referrals between 1 April 2016 and 31 March 2017. Staff completed entries on the trust's risk recording database for all safeguarding incidents, which service managers signed off.
- In most teams, staff adhered to the trust lone working policy meeting with patients in pairs or on trust premises where staff identified concerns. Services had systems in place for staff to contact their administration team or the duty desk if they required assistance or to confirm their safety after a visit. However, we identified confusion at Ipswich IDT in relation to lone working practices. We spoke with administration staff who reported that staff should contact the duty team in the event of needing support or to confirm they were safe after a visit. We then spoke with the duty team who advised staff should contact the administration team.
- Procedures were in place for staff to take medication and depot injections on community visits. Staff used special storage cases, and followed trust policy regarding transportation and dispensing, however storage cases were not in place at West Norfolk CMHS. Arrangements were in place for disposal of medication and reporting administration errors, however some staff and managers lacked awareness of these procedures. Where the inspection team identified errors or concerns, we could not find evidence that staff had escalated this information to their managers or recorded information on the trust's risk reporting system.

Inadequate

Are services safe?

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

- Staff at Central North East and West CMHS and Great Yarmouth CMHS used a risk assessment and management framework to aid staff to manage patients in the community assessed to be high risk. Staff reported to find use of this framework, and discussions with their team leaders beneficial.
- Emergency medication such as adrenaline was not stored in six of the clinic rooms for use on site or when administering medication in the community. From reviewing trust policies and patient records, protocols for completion of risk assessment in relation to allergic reaction was not in place. This presented potential risks to patients as some of the trust sites and homes visited were in rural locations and access to emergency services could be delayed.

Track record on safety:

- Between 1 April 2016 and 31 March 2017 community services for adults of working age across Norfolk and Suffolk reported a total of 73 serious incidents. Sixty five of those involved the unexpected death of a patient.
- The most common type of serious incident was apparent, actual or suspected self-inflected harm meeting the serious incident criteria.
- Serious incidents were a fixed item on business and governance team meeting agendas from copies of minutes viewed during the inspection. This offered a forum for sharing lessons learnt and dissemination of information by managers. However, some service managers struggled to provide a breakdown of incident figures, reporting that the trust held this information centrally.
- Service managers identified a proportion of the community patient deaths to be linked to their long term physical health conditions.

Reporting incidents and learning from when things go wrong:

- Serious incidents, investigation outcomes and lessons learnt were discussed with staff during supervision and in monthly business and governance meetings, staff attendance at these meetings was mandatory.
- Staff demonstrated working knowledge of trust procedures to follow in the event of an incident, and utilised the trust electronic recording system for reporting. Staff received support and debriefing after incidents. However, staff demonstrated a lack of awareness of trust procedures for recording and reporting medication errors. This was particularly apparent in IDTs.
- Most service managers were able to produce details of serious incidents during the inspection, and demonstrate where changes to practice had been implemented. Examples of this included reviews of trust policies and local protocols.
- Service managers had signed off incidents and safeguarding concerns as recorded on the trust's electronic recording system.
- Staff told us they received support from managers where incidents had occurred relating to patients on their caseloads. However, some staff reported the level of support and quality of advice to be inconsistent, particularly in relation to guidance on writing reports for submission to the coroner court.

Are services effective?

Requires improvement

By effective, we mean that people's care, treatment and support achieves good outcomes, promotes a good quality of life and is based on the best available evidence.

Our findings

Assessment of needs and planning of care

- We examined 89 care and treatment records. Most contained detailed comprehensive assessments, and documented involvement from the patient, carers and family members as well as interagency working in the management of risks. However, there were 17records with no care plan or ones that were out of date.
- Considerable gaps in the recording of physical health care monitoring was found; with 26 records with no or very limited information recorded. We found medication cards without drug sensitivities recorded at Central and Ipswich IDTs and examples of depot injections given to patients without completion of physical health checks prior to administration at Waveney CMHS. Staff identified that patients would access medical checks through their GPs, and from the records examined, patients received a thorough physical health care checks during hospital admissions rather than as standard in the community.
- Staff recorded consent to the sharing of information in patient records. Mental Capacity Act assessments were not clearly recorded where relevant.
- Services used the same electronic records system throughout the trust. This offered consistency of information sharing for example, if patients moved between teams or were seen by the out of hours service. The system enabled staff to review patient's historic risks.
- Paper records were stored securely at each service location; with the exception of Bury South IDT.

Best practice in treatment and care

- Staff discussed the use of the national institute for health and care excellence (NICE) guidelines when prescribing medication. Patients reported to have meetings with their consultant or named nurse to discuss any medication side effects.
- Due to time and workload pressures, staff acknowledged that patients were not consistently receiving routine health care checks. From the 89 patient records reviewed, we identified considerable gaps in the recording of physical health care monitoring; with 26 records with no or very limited information recorded.
- Patients prescribed lithium or specific antipsychotic medication accessed blood testing and monitoring through their GP surgery.
- Some patient records contained health of the nation outcome scales and mental health clustering tools were utilised to assess risks and identify needs.
- Services held waiting lists that included patients awaiting psychology initial assessments and those awaiting treatment particularly on a one to one basis. We found one patient had been waiting for an assessment since June 2016. Staff encouraged patients where appropriate to attend therapy groups as these tended to run at regular intervals throughout the year and offer patients the opportunity to broaden their social networks. West Norfolk CMHS psychology service was not commissioned to provide trauma work with patients.
- Patients allocated to care services were able to access psychological therapies as recommended in NICE guidelines, in the care and treatment of patients with mental health conditions, including personality disorders and for those patients experiencing early onset psychosis. Therapies included use of dialectical behaviour therapy, cognitive behavioural therapy, cognitive analytic therapy, emotional regulation groups and mindfulness. Some psychology staff told us that due to service pressures, they were unable to provide the level of treatment sessions recommended as good practice in the NICE guidelines.
- Staff reported to use outcome measures including patient reported outcome measure (PROM). The peer support navigator at Central South CMHS services sent out questionnaires on completion of intervention with patients to source feedback on their experiences. The service was working with the support workers to look to develop the navigator role across the trust.
- A variety of group activities were available to encourage patient reintegration into the local community, with some groups run collaboratively by patients and peer support workers. These included walking, craft and allotment groups. Aims and objectives for sessions were

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set out so patients were clear of the expectations. Risk assessments were completed before patients attended these groups, and these were reviewed in light of any incidents or changes in patient presentation.

- One of the clinical team leaders for Central South in Norfolk was taking a lead role within community teams for developing services and support for pregnant patients and patients with children. They were responsible for disseminating information to all adult community services in the trust and collating case examples to be discussed at trust meetings, working collaboratively with children services and other agencies. This project and associated changes and development of policies and procedures was linked to the lessons learnt and analysis of serious incidents within the trust.
- Where patients required assistance with sourcing employment, housing or welfare benefits, there was an independent service that patients could work with as well as support provided by staff. The Waveney CMHS had started a community hub where patients could seek assistance with completing application paperwork for benefits and getting support and advice with rehousing. Staff gave examples of patients who attended the community hub, accessed information in a timely way that resulted in them no longer needing to see the mental health service as the root cause of their concerns were addressed.
- Frontline staff could not provide examples of their involvement in clinical audits. Service managers gave examples of audits completed; these included patient records and told us there was a recent audit on retrospective entries in records. Community services were not consistently completing medication and clinic room audits. We identified that community services received limited oversight from the trust pharmacy service. We were advised that the trust's pharmacy service was primarily responsible for inpatient services, and was not commissioned to provide cover to community services.
- City 1, 2 and 3 teams and Coastal IDT gave examples of patient and carer forums held regularly to seek feedback and to use the information received to inform service development and team priorities.

Skilled staff to deliver care

- Community services for adults of working age across Norfolk and Suffolk contained a full range of mental health disciplines working collaboratively with the responsible clinician usually a consultant psychiatrist. These included nurses and psychologists and some teams had occupational therapists. Services in Suffolk had a section 75 agreement in place with the local authority. Staff spoke positively about the benefits of being co-located for their own working practices and outcomes for patients. Services in Norfolk identified there could be time delays for accessing social care assessments through the local authority. City 1, 2 and 3 CMHS had workers from the charity MIND in their service.
- Teams consisted of skilled and experienced staff who worked in partnership to manage and assess patient needs and risks. Where new staff joined the team, they received a thorough induction and shadowing opportunities with colleagues. Where applicable, new staff completed preceptorship programmes. The induction programme for new support workers aligned to the care certificate standards.
- The trust had implemented a new computer system for recording supervision and appraisal compliance. Service managers told us staff struggled to use the system, and that the data collected did not give a true reflection of compliance. Service managers were unable to consistently assure us through data recorded that staff received regular supervision or that performance issues were robustly monitored and addressed. Some service managers held spreadsheets as an interim measure to monitor completion. The trust did not provide data relating to supervision rates prior to the inspection.
- However, frontline staff reported to have received regular clinical and managerial supervision. Most teams structured their supervision so staff received clinical supervision in a group setting and managerial supervision on a one to one basis. The trust policy for supervision was for staff to receive 10 sessions in a 12 month period to allow for leave. Clinical supervision was held on a set day each month, and was facilitated by senior nurses or psychology clinicians. The trust provided additional profession specific supervision and forums in line with professional registration requirements. Staff that attended these forums reported

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to find sessions beneficial and assist with the development of professional networks. Service managers highlighted the difficulties of holding clinical supervision in groups, as this was booked for the same day each month, and could result in staff non-attendance.

- Service managers told us that it was the responsibility of the individual clinician to record clinical supervision outcomes in their own patient's record.
- From data provided by the trust prior to the inspection, overall appraisal rates for community adult services in Norfolk and Suffolk was 59% for non-medical staff and 93% for medical staff. Completion compliance ranged from 31% for Central City 1 CMHS to 81% for Great Yarmouth Adult FACT CMHS and between 27% for Bury South ECP and 78% Bury North IDT Adult team. Service managers told us some gaps in appraisal completion related to staff sickness or new starters as the appraisal year ran from employment start dates. As with supervision, collection and recording of appraisal completion rates was inconsistent across adult community services.

Multi-disciplinary and inter-agency team work

- Services held regular multi-disciplinary and interagency meetings to manage the needs of patients and assessment of individual risks. Those teams with waiting lists reviewed patients waiting through telephone and written contact and liaised with other services involved in their care where appropriate such as the GP surgery. The teams using the FACT model discussed patient risks and areas of concern on a daily basis, and highlighted those patients needing increased levels of support and contact. From attending FACT and multi-disciplinary meetings, staff provided updates on joint visits and meetings attended with other agencies. This included meetings with the police, housing services, health visiting teams, education and social care staff. Where patients had a history of substance misuse or long-term health conditions, staff liaised with specialist services and GPs.
- Most teams had carer leads that completed specialist assessments, and supported those caring for patients with mental health needs to link with community services and charitable sector organisations offering practical advice and information.
- Relationships with crisis and out of hours services varied across community services in Norfolk and Suffolk. Staff appeared unclear what level of support could be sourced for patients through these services, and what level of contact would be provided. Service managers reported to liaise with crisis and out of hours service managers to seek resolution when it was unclear which service should take lead responsibility for a patient's care.
- The quality of risk assessments and care plans examined could make it difficult for out of hours staff to take on patients and be fully aware of all known and historic risks. Guidance and signposting information for patients in the event of a crisis or change in their condition did not consistently include contact details for the trusts out of hours and crisis services.

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

- Staff completed mandatory MHA training as part of their induction, then regular refresher courses. Completion compliance ranged from 54% for Central North West CMHS and 100% West Norfolk CMHS and 69% for Bury South IDT and 100% for Bury North IDT.
- The trust Mental Health Act (MHA) administration office oversaw MHA paperwork, and had responsibility for completion of regular quality audits. However, staff at Bury South IDT and Central IDT reported minimal support or involvement in paperwork audits by the MHA administration team.
- Staff could contact the office for advice and guidance when required. MHA administration team confirmed that hard copies of MHA paperwork were sent to each team in addition to a copy being scanned onto the patient's electronic care records. However, from the 99 medication cards examined we found 20 did not have a copy of the patient's MHA paperwork with it. This is not in line with MHA code of practice of ensuring MHA paperwork is kept with medication cards 'to minimise the risk of the patient being given treatment in contravention of the provisions of the Act.'
- From the 89 patient records viewed there were 20 patients receiving care under a community treatment order (CTO). Some CTO records did not contain details of consent to treatment discussion and associated mental capacity assessments.

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.

- Two patients had their CTOs recalled during the inspection. We observed staff following the trust's procedure to source an inpatient bed, and working with the patient, responsible clinician and other professionals involved.
- The CQC mental health act review team completed a review of CTO paperwork in community services and identified an invalid CTO in place at Ipswich IDT. This matter was escalated to the trust's MHA administration team who liaised with the service manager and patient involved.
- Information on independent mental health advocacy services was displayed in patient waiting areas, and was included in the welcome letter sent to patients when referred to the team.
- Data provided prior to the inspection indicated one recorded use of restraint in adult community services. We identified this related to an incident at Central North East service where a community patient required support to transfer to the 136 suite on site. Staff had used recognised safe holds with no use of the prone position during this incident.

Good practice in applying the Mental Capacity Act

- Staff had completed Mental Capacity Act (MCA) mandatory training. They were aware of the five statutory principles. Completion of training ranged from 56% for South East CMHT and 100% City 3 Team and between 67% for Central IDT and 100 Bury North IDT. The Trust training compliance target was 90%.
- From the 89 care and treatment records examined, staff recorded consent to the sharing of information in patient records. Mental Capacity Act assessments were not clearly recorded where relevant.

Good

Are services caring?

By caring, we mean that staff involve and treat people with compassion, kindness, dignity and respect.

Our findings

Kindness, dignity, respect and support

- Staff interacted with patients and their family members with care and compassion. Staff spoke about the patients on their caseloads with knowledge of their needs, social and medical histories. Staff offered practical and emotional support to carers and family members.
- Staff treated patients with respect, and showed professionalism when handling challenging situations.
- Patients told us that staff were responsive to their needs, were caring and treated them politely. Patients gave examples of where staff had offered support and encouragement to attend groups and reintegrate into their local community, and offered support in times of crisis.
- The trust implemented the triangle of care scheme, with carer assessors taking a lead role within teams to train staff and ensure the needs of carers were a shared priority with the needs of patients when completing assessments.

The involvement of people in the care that they receive

- Some patients reported to have been involved in the development of their care plans and spoke about the value placed on this by staff. The patient records reviewed during the inspection contained variable recorded evidence of patient and family involvement. The electronic recording system did not indicate where copies of care plans had been offered.
- Patient records demonstrated involvement in care programme approach reviews, and staff confirmed these were consistently completed face to face, involving patients, carers and family members.
- Patients confirmed medication side effects were explained to enable them to make informed decisions.
- All services in Norfolk had peer support workers or peer support navigators. These staff members had personal experience of accessing services. They utilised their skills to aid service development, and offered patient's practical advice and support in relation areas such as community reintegration and preparing for discharge from the service.
- Some carers expressed frustration at the lack of recognition they received for the level of support they gave to patients and their families.
- Central City 1, 2, and 3 and Coastal IDT were examples of teams who actively encouraged feedback from patients, carers and family members holding regular forums and community events.
- The trust scored 93% in the May 2017 friends and family test, with 5% of respondents reporting they would not recommend the trust. 88 out of a total of 122 respondents indicated they would be extremely likely to recommend, with 26 likely and 6 extremely unlikely to recommend.

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

- Waiting lists for services ranged from three patients (City 2 CMHS) to 141 patients (West Norfolk CMHS). Central IDT and Bury North IDT did not have waiting lists at the time of the inspection. There were inconsistent practices for the management of risks associated with waiting for treatment and allocation to a care coordinator. Based on waiting list numbers provided during the inspection, there were approximately 473 patients on waiting lists who did not have an allocated care coordinator.
- Urgent referrals or patients experiencing crisis received priority with visits and telephone support offered by the team duty workers.
- The inspection team observed incidents where patients had contacted the duty teams in distress, or to report feeling suicidal or experiencing a deterioration in their mental health. Staff dealt with these incidents immediately, managers were kept updated on situations as they developed and where appropriate, appointments were moved forward.
- Staff drew on professional experiences and knowledge of their patients to engage with patients who found it difficult to work with services. Staff offered appointments at times and in locations to try to suit patients and carers needs and their additional commitments.
- Services held regular allocation meetings. For those teams without a waiting list, cases tended to be allocated once all risk screening had been completed. Where applicable, patients moved onto FACT and were RAG rated and details placed in a folder that duty workers were responsible for maintaining contact at agreed intervals with those individuals.
- New patients referred to all teams received a welcome letter, which included details of out of hours support services. Patients were encouraged to access additional community resources such as local charities offering telephone and face-to-face support.
- Some staff lacked confidence in discharge planning for community patients on their caseloads, expressing concerns that patients could deteriorate, this was particularly apparent in the IDTs. This related to IDTs not using case load management tools during managerial supervision. Staff in some CMHS received sessions with the clinical nurse specialists aligned to their team to offer a review of their caseloads, considering risks, medication management and discharge planning. This offered staff clinical support on a one to one basis, from a staff member that was not their supervisor. Through use of caseload weighting tools and monitoring of referral rates, Norfolk services identified they were 28% over capacity in relation to volume of referrals, staffing levels and caseloads.
- Service managers in the IDTs recognised the need to implement caseload management tools to aid throughput of cases and to enable the service to identify pressure points and a clearer indication of staffing capacity levels.
- If patients missed appointments, staff would support them by attending appointments jointly. Staff would complete welfare check visits to patient's homes or liaise with the Police, alerting their managers to any concerns. However, we found examples in patient records and from clinical discussions observed during attendance at FACT meetings where staff had not followed the trust's 'non- access visits and missed/ cancelled appointments' policy. Examples included staff attempting contact patients for over five days before requesting welfare checks. In some cases, staff had cold called the patient's home address, not had a reply and still not requested a welfare check even though the patient had a high risk profile.

The facilities promote recovery, comfort, dignity and confidentiality

- All sites visited contained a range of clinic and meeting rooms, with medical and therapeutic equipment used for assessment and treatment sessions. Most clinic rooms were used for administration of depot injections however; inspectors identified concerns regarding the condition and suitability of some clinic rooms.
- Staff raised concerns in relation to room availability at some sites and we identified use of clinic room space at Central IDT for one to one sessions due to consultation room shortages.

Are services responsive to people's needs?

Requires improvement

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

- Rooms at West Norfolk CMHS had insufficient sound proofing potentially impacting on patient privacy and dignity. The use of the room was ceased during the inspection.
- Patient waiting areas contained information leaflets and posters on support services, treatment options and conditions. There was information for carers, and advice on mental health act rights, how to complain to the trust and local charities and organisations providing community based support services. However this information was only available in English.

Meeting the needs of all people who use the service

- Facilities were accessible for patients and visitors with disabilities. There were lifts in place and accessible toilets. Ipswich IDT had an allocated car parking area under the building to aid independent access. Equipment was available to support patients with hearing impairment. Staff reported to contact a service to have leaflets and information produced in large print.
- Assistance pull alarm cords in the accessible toilet at Bury South IDT were tested during the inspection. Staff were observed to walk past the toilet multiple times, comment on the noise but had not check if there was a patient in the toilet requiring assistance for over six minutes. Inspectors pulled all five assistance alarm cords in the accessible toilets at West Norfolk CMHS none of these worked. This was bought to the immediate attention of senior managers.
- We noted that some buildings with wheelchair access had the buttons for the door entry intercom systems positioned at standing height affecting ease of use.
- Posters and information leaflets in patient waiting areas were mainly in English, it was unclear how patients could easily access information in alternative formats without knowing what to ask for.
- The trust had a procedure in place for staff to access interpreters and signers to support with treatment and interaction with patients where needed.

Listening to and learning from concerns and complaints

- Patient waiting areas had posters and leaflets explaining the complaints process. Patients interviewed mainly reported to understand how to make a complaint. Where patients had complained, they reported to have had their concerns handled sensitively and be satisfied with the outcome.
- From data provided prior to the inspection, there were a total of 200 complaints made to the trust regarding community services for adults across Norfolk and Suffolk. 43 related to 'staff attitude', nine relating to 'communication' both written and oral and three relating to 'privacy and dignity of patients'. Staff demonstrated awareness of the trust complaints policy and had supported patients to raise concerns.
- From data provided by the trust prior to the inspection and dated 4 May 2017, South Central CMHS had the highest number of complaints with 25, City 2 and City 3 the lowest both with three. Ipswich IDT had 14 complaints and Bury North IDT had one for the same reporting period. The trust's data indicated that no complaints went to the ombudsman. However, CQC received a report from the Parliamentary Health Service Ombudsman indicating one complaint had been upheld in May 2017 regarding access to therapy services.
- Staff received feedback on complaints and investigation findings in business and governance meetings and through supervision. We saw evidence of information sharing in meeting minutes.
- The services had received verbal and written compliments, including thank you cards which were displayed on team notice boards. Feedback from compliments was discussed in team meetings. Service managers escalated compliments received by the teams to the senior management team.

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

Vision and values

- Most staff knew and demonstrated the vision and values of the trust in their treatment practices and approach to patients, speaking 'positively', 'respectfully and working together with patients, carers and colleagues.
- Staff knew who the senior managers within the trust were, and reported that these managers were present at trust inductions and held lead roles within the organisation linking to aspects of clinical practice aligned with the CQC action plan. Some patient waiting areas contained posters with pictures of senior managers on to aid recognition.
- The trust scored 93% in the May 2017 friends and family test for patients who would recommend the service. This was an improvement from the previous year when the trust scored 62%.

Good governance

- Managers reported that they completed regular quality audits of care plans and patient records and discussed issues during supervision; however the quality of care plans, crisis plans and risk assessments varied across the teams and did not reflect robust quality assurance processes in place.
- Staff received annual appraisals. Data provided prior to the inspection, overall appraisal rates for community adult services in Norfolk and Suffolk was 59% for non-medical staff and 93% for medical staff. Completion compliance ranged from 31% for Central City 1 CMHS to 81% for Great Yarmouth Adult FACT CMHS and between 27% for Bury South ECP and 78% Bury North IDT Adult team. Service managers identified the need for staff sickness and new members of staff to be taken into consideration in relation to service compliance data. Appraisal dates ran from employment start date, therefore completion rates varied for each staff member across the service.
- Service managers told us that where they identified issues relating to staff performance, they addressed these in partnership with the trust's HR department. However, service managers were unable to access meaningful data relating to staff compliance with supervision and appraisals. As such the inspection team were unable to seek assurances that robust proactive procedures were in place to identify performance issues or individual development and training needs.
- Services reported to offer group clinical supervision and managerial supervisor on a one to one basis for all staff. Service managers told us it was the responsibility of the clinician to document clinical decisions made in supervision in patient's records. The trust was unable to provide data relating to rates of staff managerial and clinical supervision. Staff gave assurances that they received regular supervision, and the trust had implemented a new recording system prior to the inspection. Due to the timescales of implementation, very limited amounts of data had been added to the new system, and services managers reported that some data was inaccurate, or incorrectly recorded as staff needed to familiarise themselves with the new system.
- Norfolk community services identified they were 28% over capacity for the number of referrals teams received in relation to staffing levels to assess and care co-ordinate patients. These concerns were on the trust's risk register and we viewed a copy of the report entitled 'community service line pressures report' that service managers for Norfolk had jointly submitted to the trust board. At the time of the inspection, these concerns had not been addressed. The trust need to review this report and support service managers and staff to implement feasible working practices that ensure the safety of patients awaiting allocation of a care coordinator and active treatment.
- Service managers and team leaders mainly reported to be well supported and had sufficient authority and administration support to meet the demands of their role, however some team leaders did report feeling overwhelmed with the amount of tasks they were expected to complete, and the associated pressures of their roles.
- Service managers added team related risks such as waiting lists, workload capacity and staff vacancy levels to the trust risk register.

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.

- The trust had provided IDTs had protected time one day per month. The morning was a staff meeting, with training and case discussion and the afternoon was for staff to complete paperwork and training course. However, this practice was not in place in Norfolk CMHS.
- The trust's training completion target was 90%. From data provider prior to the inspection, CMHS overall training compliance ranged from 80% to 92% and between 79% and 91% for Suffolk IDTs. Only four teams achieved overall compliance ratings of 90% or above.
- The trust had not addressed the identified concerns relating to the condition of treatment environments and ligature risks across at all services where patients attended for treatment (City 1, 2, and 3 did not see patients in their office building).
- The trust had not completed thorough service based risk assessments in relation to the decision made to remove automated external defibrillators (AED) from clinic rooms at Central South East and West CMHS, Great Yarmouth CMHS, Waveney CMHS, West Norfolk CMHS, Ipswich IDT, Coastal IDT and Bury South IDT. The trust informed us subsequently that automated external defibrillators were in place for in-patient services. Community staff were not aware that they could access these if needed.

Leadership, morale and staff engagement

- Staff reported to enjoy their roles, whilst acknowledging the challenges they faced working with complex patients and managing risks in the community. Most staff reported to be listened to and encouraged to give feedback to develop their service for the benefit of the patients. However, morale varied within teams and some staff told us they had experienced incidents of bulling or harassment.
- Some staff told us they would not be comfortable raising concerns and giving feedback for fear of reprisals. However, staff were aware of the trust's speak up guardian, and staff reported positive experiences when they had consulted with this staff member.
- There were no whistleblowing cases reported to be under investigation at the time of the inspection.
- Staff supported each other, and shared clinical expertise when managing complex patients. Systems were in place such as protected clinical time and regular team meetings to offer staff opportunities to discuss findings from incident investigations and lessons learnt.
- We did not find examples of staff involvement in clinical audits.
- There was effective mentorship programmes in place including shadowing opportunities with colleagues to gain practice experience when required. Teams offered student nurse and occupational therapy placements.
- Core service sickness rates were below the trust average of 5% and turnover rates were in line with the trust average of 12%.Service managers advised that agency staff had block contracts to offer consistency for patients and the team.
- The trust were aware of vacancy levels within these teams but progress with recruitment and encouraging active staff retention was slow and many posts remain unfilled.
- Results from the NHS National Staff Survey 2016 for the whole trust indicated that 57% of staff reported recent experiences of harassment, bullying or abuse. 46% of staff reported feeling unwell due to work related stress. 71% of staff reported to be working extra hours. However, 85% of staff reported that their role made a difference to patients.

Commitment to quality improvement and innovation

- The service manager for Coastal IDT had designed and implemented an intranet page only accessible to their service staff. This contained links to policies, local community resources and minutes from meetings. Designed to support staff to keep abreast of information and service development without overloading them with multiple emails.
- The peer support worker role was imbedded into teams in Norfolk since the 2016 inspection, with staff reporting to feel integrated within the service. A new 'peer support navigator' role was in place at Central South CMHS. This offered patients up to six sessions with the staff member to prepare for discharge from the CMHS and aid reintegration into their local community.

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.

- One of the clinical team leaders for Central South in Norfolk was taking a lead role within community teams for developing services and support for pregnant patients and patients with children. This project and associated changes and development of policies and procedures were linked to the lessons learnt and analysis of serious incidents within the trust.

This section is primarily information for the provider

Requirement notices

Action we have told the provider to take

The table below shows the legal requirements that were not being met. The provider must send CQC a report that says what action they are going to take to meet these requirements.

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Treatment of disease, disorder or injury	Regulation 11 HSCA (RA) Regulations 2014 Need for consent • The trust had not ensured that a copy of all relevant mental health act paperwork was attached to medication cards to ensure staff administered medication in lines with the MHA Code of Practice. • The trust had not ensured that staff documented thorough mental capacity assessments in patient's records where an assessment had been completed. **This was a requirement notice from the 2016 inspection. This was a concern identified in the 2014 inspection.** This is a breach of Regulation 11.

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Treatment of disease, disorder or injury	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment • The trust had not ensured all services had detailed ligature risk audits in place. **This was a requirement notice from the 2016 inspection. This was a concern identified in the 2014 inspection.** • The trust had not ensured that all staff had access to working personal alarms, and that systems were in place staff to know how to respond in the event these were activated. **This was a requirement notice from the 2016 inspection. This was a concern identified in the 2014 inspection.** • The trust had not ensured that all clinic rooms were equipped with emergency medication for use on site and in the community.

This section is primarily information for the provider

Requirement notices

- The trust had not ensured alternative procedures were implemented in relation to the decision for AED equipment to be removed from services. This linked to staff training and dissemination of procedures for staff to follow in the event of an emergency.
- The trust had not ensured that clinic room temperatures were consistently monitored across all sites and staff did not liaise with pharmacy services to seek advice in relation to medication storage and efficacy. **This was a requirement notice from the 2016 inspection.**
- The trust had not ensured robust systems were in place for the management of waiting lists, and ensuring consistent approaches across Norfolk and Suffolk for management of patient risk.
- The trust must review the unallocated cases in community services and ensure that there is an allocated care coordinator. **This was a concern identified in the 2014 inspection.**
- The trust had not ensured that patients received regular physical health care monitoring, and that systems were in place for this information to be recorded, including where a patient declined.
- The trust had not ensured consistent quality standards in relation to levels of detail recorded in patient risk assessments, care plans and crisis plans. **This was a requirement notice from the 2016 inspection. This was a concern identified in the 2014 inspection.**
- The trust had not ensured that all clinical staff and managers were familiar with procedures to follow in the event of a medication error or incident.
- The trust had not ensured that regular audits were completed of clinic room equipment and medication and comprehensive measures were implemented to ensure issues such as equipment requiring calibration were addressed.
- The trust had not ensured that staff were consistently adhering to the non –access visits and missed/ cancelled appointments policy and that all attempts and contact with patients were documented.

This section is primarily information for the provider

Requirement notices

- The trust had not ensured that all pull alarm cords in accessible toilets were in working order and that staff knew how to respond in the event of activation.

This is a breach of Regulation 12.

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Treatment of disease, disorder or injury	Regulation 17 HSCA (RA) Regulations 2014 Good governance • The trust had not ensured that all service managers and team leaders had training and support to enable them to access information on staff compliance with appraisals, supervision and training. This is a breach of Regulation 17.

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Treatment of disease, disorder or injury	Regulation 18 HSCA (RA) Regulations 2014 Staffing • The trust had not ensured that effective systems were in place for the monitoring and recording of clinical and managerial supervision for all staff. **This was a requirement notice from the 2016 inspection. This was a concern identified in the 2014 inspection.** • The trust had not ensured that effective systems were in place for the monitoring and recording of staff appraisals. **This was a requirement notice from the 2016 inspection. This was a concern identified in the 2014 inspection.** • The trust had not ensured staff were up to date with all mandatory training courses, and that adequate systems were in place for training compliance to be recorded. **This was a requirement notice from the 2016 inspection. This was a concern identified in the 2014 inspection.** • The trust had not ensured consistent use of caseload management tools. This is a breach of Regulation 18.