Norfolk and Suffolk NHS Foundation Trust

Inspection report

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We plan our next inspections based on everything we know about services, including whether they appear to be getting better or worse. Each report explains the reason for the inspection.

This report describes our judgement of the quality of care provided by this trust. We based it on a combination of what we found when we inspected and other information available to us. It included information given to us from people who use the service, the public and other organisations.

This report is a summary of our inspection findings. You can find more detailed information about the service and what we found during our inspection in the related Evidence appendix.

Ratings

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

We rated well-led (leadership) from our inspection of trust management, taking into account what we found about leadership in individual services. We rated other key questions by combining the service ratings and using our professional judgement.

Summary of findings

Background to the trust

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

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

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

Norfolk and Suffolk NHS Foundation Trust has a total of 12 locations registered with CQC and has been inspected 20 times since registration in April 2010.

When we inspected the trust in July 2017 under CQC's comprehensive inspection programme the trust was rated inadequate overall and was placed in special measures by NHS improvement following recommendation by CQC.

During the inspection of July 2017, we reviewed the five CQC key questions of safe, effective, caring, responsive and well led. We also considered all areas of previous non-compliance. A number of areas of further non-compliance were identified. We made the following requirements:

- The trust must ensure that all services had access to a defibrillator and that staff are aware of arrangements for life support in the event of an emergency
- The trust must ensure that action is taken to remove identified ligature anchor points and to mitigate risks where there are poor lines of sight.
- The trust must ensure that all mixed sex accommodation meets Department of Health and Mental Health Act code of practice guidance and promotes safety and dignity.
- The trust must review the continued use of bed bays in the acute wards and work with commissioners to provide single room accommodation.
- The trust must ensure that seclusion facilities are safe and appropriate and that seclusion and restraint are managed within the safeguards of national guidance and the Mental Health Act Code of Practice.
- The trust must fully implement guidance in relation to restrictive practices and reduce the number of restrictive interventions
- The trust must ensure there are enough personal alarms for staff and that patients have a means to summon assistance when required.
- The trust must ensure there are sufficient staff at all times, including medical staff and other healthcare professionals, to provide care to meet patients' needs.
- The trust must ensure all relevant staff have completed statutory, mandatory and where relevant specialist training, particularly in suicide prevention and life support.

Summary of findings

- The trust must ensure that all risk assessments, crisis plans and care plans are in place, updated consistently in line with multidisciplinary reviews and incidents and reflect the full and meaningful involvement of patients.
- The trust must ensure that the prescribing, administration and monitoring of vital signs of patients are completed as detailed in the NICE guidelines [NG10] on violence and aggression: short-term management in mental health, health and community settings.
- The trust must ensure that the temperature of medicines storage areas is maintained within a suitable range, and that the impact on medicines subject to temperatures outside the recommended range is assessed and acted on.
- The trust must ensure that all staff have access to clinical records and should further review the performance of the electronic system
- the trust must ensure that there is full and clear physical healthcare information and that patients physical healthcare needs are met
- The trust must ensure that all staff receive regular supervision and annual appraisals, and that the system for recording levels of supervision is effective and provides full assurance to the trust board
- The trust must ensure that patients are only restricted within appropriate legal frameworks.
- The trust must ensure that people receive the right care at the right time by placing them in suitable placements that meet their needs and give them access to 24-hour crisis services.
- The trust must minimise disruption to patients during their episode of care and ensure that discharge arrangements are fully effective
- The trust must ensure that there are clear targets for assessment and that targets for waiting times are met. The trust must ensure that people have an allocated care co-ordinator
- The trust must ensure that they fully address all areas of previous breach of regulation
- The trust must ensure that data is being turned into performance information and used to inform practices and policies that bring about improvement and ensure that lessons are learned

Following the inspection in July 2017, we served a warning notice under Section 29A of the Health and Social Care Act 2008 regarding our key concerns. Requirement notices were set across services regarding the additional concerns.

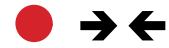
In May 2018, we conducted a focused inspection to look at the areas within the warning notice. While the trust had made some improvement in some areas we remained concerned about risk management, waiting lists, staffing and seclusion practice. A further warning notice was served under Section 29A of the Health and Social Care Act 2008. We told the trust that they must meet this by 3 September 2018.

In September 2017, the chief executive retired and was replaced by the director of finance. A substantive chief executive took up post in May 2018. The director of nursing resigned in October 2017. Since that time, the deputy director of nursing has been interim director of nursing. A new chief nurse will also join the trust in December 2018. In August 2018 a substantive chief operating officer and director of human resources and organisational development joined the trust. There is an interim director of finance.

Since the 2017 inspection, NHS Improvement have placed an improvement director with the trust and another trust is supporting the improvement programme. Multi-stakeholder overview and assurance group meetings take place monthly to monitor the trust's performance.

Summary of findings

Overall summary

Our rating of this trust stayed the same since our last inspection. We rated it as Inadequate 

What this trust does

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

Key questions and ratings

We inspect and regulate healthcare service providers in England.

To get to the heart of patients' experiences of care and treatment, we ask the same five questions of all services: are they safe, effective, caring, responsive to people's needs, and well-led?

Where we have a legal duty to do so, we rate the quality of services against each key question as outstanding, good, requires improvement or inadequate.

Where necessary, we take action against service providers that break the regulations and help them to improve the quality of their services.

What we inspected and why

We plan our inspections based on everything we know about services, including whether they appear to be getting better or worse.

We inspected eleven complete services:

Mental health wards:

- Acute wards for adults of working age and psychiatric intensive care units
- Forensic Inpatient/Secure wards
- Wards for older people with Mental Health problems
- Long stay/rehabilitation mental health wards for working age adults
- Wards for people with learning disabilities or autism
- Child & Adolescent Mental Health Wards

Community-based mental health and crisis response services:

- Specialist Community Mental health services for children and young people
- Community-based mental health services for adults of working age
- Community-based mental health services for older people
- Community Mental Health services for people with learning disabilities or autism
- Crisis and health based paces of safety

Summary of findings

Our comprehensive inspections of NHS trusts have shown a strong link between the quality of overall management of a trust and the quality of its services. For that reason, all trust inspections now include inspection of the well-led key question for the trust overall. What we found is summarised in the section headed Is this organisation well-led?

What we found

Overall trust

Our rating of the trust stayed the same. We rated it as inadequate because:

- The trust board and senior leadership team were in transition and had not formed to deliver a service that provided high-quality sustainable care. At our inspection of 2017, we had significant concerns about the safety, culture and leadership at the trust. We told the trust that they must urgently address concerns and meet regulation. At this inspection, we found that some of our significant concerns, some that we had raised with the trust in 2014, had not yet been fully addressed. We found that the board had not driven effective change at a pace and with sufficient traction to bring about improvements needed to resolve the failings in safety and to bring about sustained improvement.
- When we last inspected, we told the trust leadership that they did not demonstrate a safety narrative running through the organisation and that that they should ensure that learning was captured from incidents and concerns. At this inspection, we found that the safety culture has not yet fully developed. Managers did not ensure that learning from incidents was shared and embedded across the trust. Not all ward and community environments were safe. The quality of environmental risk assessments varied across services. Not all clinical risks were managed. Staff did not manage medicines and equipment in a safe way. Patients in seclusion did not always have access to the appropriate reviews of their treatment. Vacancies remained high particularly for nursing and medical staff. The trust had not ensured there were enough staff in some community services to meet the needs of patients. All of these issues had been raised with the trust during previous inspections.
- We found widespread low morale across services. This was attributed to a “do unto” attitude staff felt came from senior management and directors.
- The trust was attempting to take a systematic approach to governance but this had not fully succeeded in bringing about an improvement to the quality of services or ensured that these delivered a high standard of care. The trust had developed systems for identifying risks and was planning to eliminate or reduce them, but these were not yet effective in coping with both expected and unexpected risks. At this inspection we found that key risks that were considered closed or mitigated had not been fully addressed. In some cases, work undertaken had created new risks. These included ligature point management, care planning, access and waiting lists, staffing levels and seclusion practice and environments. It is concerning that the trust’s own assurance process had indicated more progress in some areas than we found at this inspection.
- We were very concerned about access to services and the management of the many patients who are on waiting lists. Not all services were meeting their targets for assessment. We were not assured that the trust responded appropriately to emergency or urgent referrals. Too many referrals were handed off inappropriately or refused and downgraded from urgent to routine without due care. We found many instances of people who had significant needs who were denied a service. Records showed that some patients had harmed themselves while waiting for contact from clinical staff'. Bed management remained challenging particularly in acute services. The planning of patients’ discharges did not always contribute to people staying out of hospital.

However:

Summary of findings

- Staff treated patients with compassion and kindness. They respected patients' privacy and dignity, and supported their individual needs. We observed positive interactions and saw staff responding to individual patient need. Staff usually involved patients and those close to them in decisions about their care and treatment.
- The service provided mandatory training in key skills to all staff and made sure everyone completed it. Managers made sure they had staff with a range of skills needed to provide high quality care. They supported staff with appraisals, supervision, and opportunities to update and further develop their skills.
- Staff assessed the mental health and physical health of patients on admission. Staff supported patients with their physical health and encouraged them to live healthier lives.
- Access to the clinical information system had improved. Work was underway to improve the forms and assessment documents that staff needed to complete for patients.
- The trust has committed to improving services by learning from when things went well and when they went wrong, and has begun to promote training, research and innovation. The trust had participated in some national improvement and innovation projects and undertook a wide range of quality audits and research.

Are services safe?

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

- Not all wards were safe and fit for purpose. The quality of environmental risk assessments varied across the wards. Managers used vague language on risk assessments and staff's knowledge of risk areas differed across wards. We found blind spots on wards and closed-circuit television (CCTV) coverage was poor in places. Staff did not record this on assessments, along with ligature anchor points. The trust made changes to services without due regard for the impact on people's safety. Managers had not completed accurate ligature assessments at some community services. The ligature assessments did not fully capture risks for newly refurbished toilets. This meant staff would not be aware of the higher risk areas which needed more supervision.
- There were not enough nursing and medical staff in all services to keep people safe from avoidable harm. Vacancies remained high particularly for nursing and medical staff. The trust had not ensured there were enough staff in some community services to meet the needs of the service. This meant patients often waited a long time before receiving triage, assessment and treatment. Many patients had not been allocated a care co-ordinator. This posed a risk to the patients' safety. We found examples where patients' situations had deteriorated and they needed urgent support as they posed a risk to themselves or others. The trust was not meeting its own safer staffing levels at some wards.
- Staff did not always complete and update risk assessments for each patient or use these to understand and manage risks individually. Staff at some community services did not always record their risk assessment of patients following allocation. Staff had not completed crisis plans or advanced decisions for some patients. It was not clear how staff were monitoring and reviewing incidents for patients on their waiting lists. Since the last inspection the trust had implemented a system to RAG rate patient's risk. However, they had not ensured that all red rated cases were allocated a care coordinator immediately. We found patients whose care and treatment needs had changed in risk but staff had not changed the RAG rating to reflect this. We were less concerned about the quality of staff's risk assessment of inpatients. Staff in these services had completed detailed risk assessments for patients and updated these regularly with input from patients.
- Staff did not seclude patients in a safe way that met the standards outlined in the Mental Health Act Code of Practice. There were gaps in records relating to patient observations, medical reviews and what items patients took in to the seclusion room. Staff secluded patients and did not record it in seclusion paperwork. Medical staff did not complete reviews on time. Staff used judgemental language in seclusion records and failed to inform carers and relatives when they secluded patients. There also remained environmental risk issues in some seclusion facilities.

Summary of findings

- Staff did not always follow best practice when storing, dispensing, and recording medication. The management of medicines was not safe at all services. Qualified staff did not sign when they dispensed controlled drugs on one ward. Staff lacked knowledge about the process for the storage and safe disposal of controlled drugs. Stock medications and clinical equipment had expired. We found out of date medicines and medical equipment at forensic wards. We found staff had administered as required medicines above prescription limits and had not always completed medicine administration records. Medication audits had raised concerns at some services however these had not subsequently been addressed.
- We found significant issues with resuscitation equipment on some wards, despite staff recording resuscitation equipment as checked and safe. Staff had not ensured that wards were fully equipped with accessible resuscitation and emergency equipment. Staff had not checked emergency bags and resuscitation equipment in line with trust policy on some wards.
- The Trust missed opportunities to prevent or minimise harm. Senior managers did not share lessons learned from incidents effectively across the services. Staff were not aware of incidents on other services that could be relevant to their service. This included incidents with ligature anchor points and with fire setting. At acute wards there were significant issues with patients having access to ignition sources, mainly lighters. We witnessed more than one patient smoking in the outside spaces, despite the trust being smoke free and staff restricting access to lighters. Staff completed pat down searches but did not have access to other equipment to support the searching of patients.

However:

- Most of the premises that we visited were clean, well equipped, well-furnished and well maintained. There were, however, concerns about delays to repairs at some community services.
- The trust had in place an electronic clinic room temperature monitoring system. The trust system alerted staff via email if there was a concern, and staff responded accordingly.
- The service provided mandatory training in key skills to all staff and made sure everyone completed it.
- Staff understood how to protect patients from abuse and the service worked well with other agencies to do so. Staff had training on how to recognise and report abuse and they knew how to apply it.
- Access to the clinical information system had improved. Work was underway to improve the forms and assessment documents that staff needed to complete for patients.

Are services effective?

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

- Care plans were not always in place or updated when needed. Not all patients had a care plan in place that was comprehensive or reflected their needs at acute and learning disability wards and some community teams. Staff did not complete individualised, person centred care plans with patients. Acute wards used templates for care plans which meant all patients had the same goals. Staff recorded the same actions and interventions required to meet goals. Staff recorded goals that were not relevant to the individual, for example carer support when there were no identified people involved in their care. The learning disability wards did not routinely create positive behavioural support plans for patients and care plans did not document mental capacity assessments or best interest decisions.
- Not all teams provided a range of treatment and care for patients based on national guidance and best practice. Some community services had significant waiting times for psychological therapies. Teams lacked sufficient psychology staff to provide the range of care recommended by the National institute for Health and Care Excellence guidelines.

However:

Summary of findings

- Staff assessed the mental health and physical health of patients on admission. Staff supported patients with their physical health and encouraged them to live healthier lives.
- Managers made sure they had staff with a range of skills needed to provide high quality care. They supported staff with appraisals, supervision, and opportunities to update and further develop their skills.
- Staff from different disciplines worked together as a team to benefit patients. Most services had a full range of mental health disciplines and workers who provided input into patient care. Staff held multidisciplinary meetings: patients and carers and were invited to these. Teams worked closely with external parties and other service providers for the benefit of patients.
- Staff understood their roles and responsibilities under the Mental Health Act 1983 and the Mental Health Act Code of Practice. Staff had knowledge of the Mental Health Act and applied the principles well in their work. Staff explained rights under the Mental Health Act to patients, regularly and in a way, that they understood. Staff knew how to access support and advice on Mental Health Act issues.
- At most services staff supported patients to make decisions on their care for themselves. They understood the trust policy on the Mental Capacity Act 2005 and assessed and recorded capacity clearly. However, this was not the case at the learning disability inpatient services. Patients who lacked capacity to give consent to treatment were being given antipsychotic medicines without a best interest decision being documented.

Are services caring?

Our rating of caring stayed the same. We rated it as good because:

- Staff treated patients with compassion and kindness. They respected patients' privacy and dignity, and supported their individual needs. We observed positive interactions and saw staff responding to individual patient need. Staff we spoke with knew the needs of their patients and the most effective ways of offering support for that person.
- Staff supported patients to understand and manage their own care, treatment and condition, for example by giving leaflets, books and talking to patients about medication and side effects. Staff understood and respected the individual needs of the patient's receiving treatment.
- Staff usually involved patients and those close to them in decisions about their care and treatment. Staff gave patients opportunities to provide feedback via community meetings. Staff supported patients to raise concerns and provided access to advocacy if required.

However:

- In acute and learning disability wards staff did not involve patients in care plans. Patients could not describe the contents of their care plan. Staff wrote care plans in formal language and plans lacked the patients voice. In learning disability wards documentation did not show that patients with communication difficulties were being supported to make decisions about their care.
- Staff at acute services did not always keep carers and involved people up to date with patients progress and information about their care.

Are services responsive?

Our rating of responsive went down. We rated it as inadequate because:

Summary of findings

- Patients found it difficult to access some of the service provided by the trust. Not all services were meeting their targets for assessment. In July 2018, the trust was not meeting the targets for four-hour emergency assessment at 93% or routine referrals seen with 28 days at 78%. In the Suffolk childrens' and young people's mental health services, 394 patients were awaiting triage at 13 September 2018 and it was taking staff on average 28 days to contact patients and then direct them to the right service.
- We were not assured that the trust responded appropriately to emergency or urgent referrals. Staff did not always manage referrals according to the level of urgency identified by the referrer. We found that staff were downgrading a high proportion of the emergency and urgent referrals; resulting in some urgent referrals waiting for up to and exceeding 28 days for a telephone contact. Data showed overall between January 2016 and May 2018, 46% of all emergency referrals and 55% of all urgent referrals in Suffolk received for adult patients were downgraded. Staff had not maintained clear records to support the decisions made and we found records were often incomplete and difficult to follow. Too many referrals were handed off inappropriately or refused and downgraded from urgent to routine without due care. We saw many situations where people were not offered a service yet had been in significant need. Records showed that, in some cases, patients had self-harmed or taken overdoses whilst waiting for contact.
- We did not find that the trust could be sure that in crisis services that staff prioritised face to face assessments over telephone contact within the four-hour emergency target as recommended within the Crisis Care Concordat 2014.
- Waiting times from referral to treatment were a serious concern. Almost 2400 adult patients across the trust had not been allocated a care coordinator in community mental health services for adults. A further 636 patients were waiting for treatment as of 20 September 2018 in childrens' and young people's mental health services CAMHs. Waiting lists across services were a serious issue. In July 2018, over 220 people had been waiting more than 18 weeks for treatment. We were concerned about the length of waiting lists and about patient safety and a lack of management of risks whilst waiting. We were also surprised to see that some services were seemingly obfuscating the size and length of waiting lists by allocating patients to staff or running several lists whilst agreeing that nothing would be offered until space was available.
- The planning of patients' discharge did not always contribute to people staying out of hospital. In acute services staff created discharge plans that lacked personalisation and detailed information. In crisis services we saw patient records that contained poor contingency plans for people who recently been inpatients. Patients expressed concerns over their discharge plans. The acute wards reported 253 readmissions within 28 days between 1st June 2017 and 31st May 2018. Of these there was an average of 11 days between discharge and readmission. Staff admitted 18 of these patients the day following discharge.
- Bed management remained challenging particularly in acute services. Staff rated beds of patients on leave using a red, amber and green system. If a bed was red, this meant staff should not admit to it. This did not always happen due to the pressure staff felt to admit patients requiring treatment. Not all wards functioned as the trust designed. For example, Thurne ward, an assessment ward, had an average length of stay of 40 days. This had increased due to problems moving patients to other wards within the trust. Some patients admitted to Thurne had been on the ward for over 12 months.
- The trust did not have adequate resources to support patients with attention deficit hyperactivity disorder. These patients often faced longer waits due to limited resources and system backlogs. West Suffolk IDT had 86 patients on the waiting list for assessment, of these 59 were waiting over 18 weeks. The longest wait for the service was from 22 March 2017.
- Staff in CAMHs were not always able to give patients help, emotional support and advice when they needed it due to the long waiting list for triage, assessment and treatment of patients. Two patients and four carers raised concerns about the length of time it took to access the service. Four patients said that the trust gave a limited service. The trust had received five complaints from June to August 2018 about waiting list times.

Summary of findings

- The board agreed in October 2017 to increase the contact with complainants during the investigation process. However, we did not see this in practice and this remains a significant concern where deadlines are missed. We found there had been significant delays in investigating some cases. In August 2018, there was an average of 61 days to respond to complaints. In some cases, there had been no correspondence to the complainant to explain the reason for this. Complaints information was also looked at services we visited. Generally, complaints had been appropriately investigated and included recommendations for learning. However, we also heard at some teams that staff did not record or share information about informal complaints.

However:

- The design, layout, and furnishings of the wards supported patients' treatment, privacy and dignity. Wards provided appropriate space for patients to engage in activities, therapy and to see visitors. Facilities meant patients could talk to families and other people in private. Staff supported patients to personalise their bedrooms. Staff made arrangement for patients to take part in activities that supported any spiritual and religious needs.
- Staff supported patients with diverse needs such as providing visual information or interpreters to aid with communication, and considering how to improve accessibility for patients using a wheelchair or who had mobility difficulties. Staff gave examples of supporting patients with lesbian, gay, bisexual and transgender or disability needs. Community facilities were accessible to all who needed it and took account of patients' individual needs. Staff helped patients with communication, advocacy and cultural support.
- Staff supported patients with activities outside of the services, such as work, education and family relationships.

Are services well-led?

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

- The trust board and senior leadership team were in transition and had not formed to deliver a service that provided high-quality sustainable care. At our inspection of 2017, we had significant concerns about the safety, culture and leadership at the trust. We told the trust that they must urgently address concerns and meet regulation. At this inspection, we found that some of our significant concerns, some that we had raised with the trust in 2014, had not yet been fully addressed. We found that the board had not driven effective change at a pace and with sufficient traction to bring about improvements needed to resolve the failings in safety and to bring about sustained improvement. Staff told us that their local managers were supportive and some leaders were approachable, but they did not know or feel engaged with the senior leadership team.
- The trust had a vision for what it wanted to achieve that had been developed in 2015 with involvement from staff, patients, and key groups representing the local community but urgent and sustained action was needed to ensure this had meaning for staff and patients. However, a number staff told us that managers and leaders did not always model the values and behaviours of the trust. While strategies were in place these had not always led to action.
- We found widespread low morale across services. This was attributed to a "do unto" attitude staff felt came from senior management and directors. Staff told us that they felt let down by senior management. In the 2017 NHS Staff Survey the trust had worse results than other similar trusts in 26 key findings. Key findings included staff's motivation at work, the percentage of staff reporting good communication between senior management and staff, satisfaction with the level of responsibility and involvement and staff's recommendation of the organisation as a place to work or receive treatment. Latest data from the Friends and Family test staff results showed the scores had declined and the percentage of staff who would recommend the trust as a place to work was worse than the England average.

Summary of findings

- Despite improved recruitment outcomes we remain concerned about staffing levels in some core services. We remain concerned that nursing staff vacancies remain very high in wards. Medical vacancies were also high at 21%. In August 2018, the trust was not meeting it target for nursing staff fill rates at 88%. We found that this impacted on patient care. In community services, while recruitment had improved against set staffing levels this had not brought about significant changes to address waiting lists and some team's caseloads.
- The trust was attempting to take a systematic approach to governance but this had not fully succeeded in bringing about an improvement to the quality of services or ensured that these delivered a high standard of care. The trust had recently reviewed its governance structure to streamline assurance processes and provide a clearer line of sight from the board to ward. Local governance groups had been reorganised to place a stronger emphasis on accountability and assurance from service managers. A standardised integrated performance dashboard had been developed and was used at board and locality level meetings to ensure a common set of performance indicators across the organisation. We recognise that significant work has been undertaken to rationalise the governance structure and systems had been put in place to provide better assurance, but this has not yet addressed all our concerns or brought about improvements to the quality of its services. It is concerning that the trust's own assurance process had indicated more progress in some areas than we found at this inspection.
- The trust had developed systems for identifying risks and, but these were not effective in coping with both expected and unexpected risks. At this inspection we found that key risks that were considered closed or mitigated had not been fully addressed. These included ligature point management, care planning, access and waiting lists, staffing levels and seclusion practice and environments. In some cases, work undertaken had created new risks. This long list of outstanding safety issues is unacceptable and shows that the trust does not yet have a thread of safety running through the organisation to protect patients from harm. The board has not ensured, within a reasonable timeframe, that the environments and practices promote safe care and treatment and comply with regulations. Further work is required to ensure that all risks are fully captured and understood by the board. We were concerned that while the trust's own governance system had highlighted some of these issues, the trust was yet to fully address these across all services.
- During this inspection we looked in detail at the actions the trust had taken in response to serious incidents. We found that work had begun on required actions, but further work was needed to ensure that there were not missed opportunities. Where serious incidents had happened, we saw that investigations were usually carried out, but this needed to be improved to include all serious incidents. The trust had improved the quality of investigations, but some actions arising from the investigation were not always specific and we could not see that actions had been completed comprehensively or in a timely way. We were not able to evidence that appropriate learning had been shared in each case. Teams generally confirmed clinical and other incidents were reviewed and discussed by the management team and shared with front line staff. However, many staff did not know of incidents that had occurred in similar services to their own.
- The trust collected and used information and data to consider its performance, but this was not always reliable. There were secure systems in place for recording and accessing confidential information. Work had been undertaken to improve the quality and accuracy of performance data since our last inspection. A chief clinical information officer had been appointed to lead on digital development. The trust had reviewed the integrated performance dashboards at board and locality level to ensure a common set of performance indicators across the organisation. However, the senior team acknowledged that data sets required further refinement and that further work was required to ensure that other key information, such as the board assurance framework, risk registers and the audit report were accurate and fully highlighted risks. During service visits team managers told us that they did not have all the performance data they required to fully manage their service.
- Several staff raised a concern with us regarding how they recorded contacts with patients on the electronic records system. Staff completing initial telephone contacts with patients completed and recorded these contacts differently

across teams. Staff were required to identify a level of 'treatment' with each contact. We were not assured that all staff had clear guidance on how to record contacts or that the trust could be sure that all patients were receiving an element of treatment during these telephone conversations. The trust confirmed they were looking at this issue as part of work to address waiting lists.

- The trust had a strategy in place to engage with patients, staff and stakeholders, but urgent work was needed to embed this agenda and turn the strategy into action. During this inspection we heard from many service users, carers and local user groups about their experience of care. Most people that we spoke with were positive about their, or their loved ones, care and treatment and the service that had been received. However, a significant number of people were unhappy with the service they or their loved one had received. We particularly heard about delays in accessing services and that communication was poor during these waits. Some people did not feel involved in their care or listened to by the trust. We were disappointed that in our interactions with some key staff that there was limited focus on patient's experience. We believe that the trust has a lot to do at all levels to ensure that patients are at the centre and forefront of the purpose of NSFT.

However:

- The trust had a freedom to speak up guardian whose role was to provide independent and confidential advice and support to staff who raise a concern. This service was well used and had escalated cases to the right level so that they can be resolved efficiently.
- The trust had met its duty of candour obligations required to be open and transparent with people who use services and other 'relevant persons' in relation to care and treatment and particularly when things go wrong.
- The trust had significantly improved its training, appraisal and supervision compliance since our last inspection. However, further work was needed to ensure compliance with clinical supervision and ensure the quality of supervision and appraisal.
- The trust had completed the information governance toolkit assessment. The information toolkit had achieved compliance of 93% in March 2018. The trust had robust information governance systems in place including the confidentiality of patient records in line with best practice. The General Data Protection Regulation (GDPR) has been rolled out successfully. The trust could demonstrate effective information security through the management of a recent phishing attempt which was identified and actioned within a very short space of time.
- When we previously inspected the trust, we were very concerned about the performance of the electronic patient information system. Since then, the trust had undertaken various improvement initiatives. Staff confirmed that the system was more usable and accessibility had improved. Additional work was planned to rationalise the risk forms that staff needed to complete.
- The trust has committed to improving services by learning from when things went well and when they went wrong, and has begun to promote training, research and innovation. The trust had participated in some national improvement and innovation projects and undertook a wide range of quality audits and research. The trust had participated in the two national enquiries applicable to them. The trust has been awarded a second gold star in recognition of its commitment to ensuring carers are fully supported and involved in decisions about care and for successfully achieving the second stage of the Triangle of Care. At the most recent Green Light Toolkit audit the trust had met all standards and was above the national average for 25 of 27 standards.

Ratings tables

The ratings tables show the ratings overall and for each key question, service type, and for the whole trust. They also show the previous ratings for services or parts of them not inspected this time. We took all ratings into account in deciding overall ratings. Our decisions on overall ratings also took into account factors including the relative size of services and we used our professional judgement to reach fair and balanced ratings.

Summary of findings

Outstanding practice

We found examples of outstanding practice at some services. For more information, see the outstanding practice section of this report.

Areas for improvement

We found areas for improvement including six breaches of legal requirements that the trust must put right. We found 23 things that the trust should improve to comply with a minor breach that did not justify regulatory action, to prevent breaching a legal requirement, or to improve service quality.

For more information, see the Areas for improvement section of this report.

Action we have taken

We issued seven requirement notices to the trust. Our action related to breaches of 61 legal requirements in nine core services. That meant the trust had to send us a report saying what action it would take to meet this requirement.

For more information on action we have taken, see the sections on Areas for improvement and Regulatory action.

What happens next

We will check that the trust takes the necessary action to make the improvement we have identified. We will continue to monitor the safety and quality of services through our continuing relationship with the trust and our regular inspections.

Outstanding practice

Child and adolescent mental health wards

- Staff were strongly encouraged in their personal and professional development for the benefit of staff and patients. Visits were made to other providers to learn from, and share best practise. Staff innovation was encouraged and supported, for instance since the last inspection staff had developed the CPOC role, positive behaviour practise, and were due to visit a flagship eating disorder service the following week. The unit manager had secured funding for specialist in-house training from the Anna Freud Centre in London.
- Staff were described by patients and staff as being genuinely caring without exception. Patients felt respected, supported and treated as individuals. Staff gave up their free time for the benefit of patients and were passionate about making a difference.
- The family therapist, psychologists, and the social worker worked both in the ward and in the community, and services were tailored to meet the needs of individual young people and delivered in a way to ensure flexibility, choice and continuity of care.
- A wide range of therapeutic activities were offered into the evenings and at weekends. Young people benefitted from input from a chaplain, fitness instructor, social worker and family therapist as well as the psychologists and occupational therapists. Education provision was good, with effective liaison between the unit and local schools and colleges.

Community mental health services for people with a learning disability or autism

Summary of findings

- The manager of the child and adolescent community service, Mariner House had adapted a case load management tool to support the team. The tool factored in the number of patients on the case load, the level of risk of each patient and additional work that staff undertook. For example, lead roles. This tool then scored the staff members work load out of 235. This allowed the manager to look to assess the individual staff members workload and assign newly referred patients or additional roles to the member of staff without placing excessive amounts of work on them.
- The manager of the child and adolescent learning disability service at Mariner House had developed an additional six months role in depth induction to run alongside staff probation. This was specific to child and adolescent learning disabilities. The manager had ensured that the first part of the induction included basic information and orientation to the service. This then progressed on to continuing professional development in relation to learning disability child and adolescent mental health. This included a competency framework which was in line with the learning disability care skills framework. The manager reviewed staff progress in monthly management supervision.
- The manager at Mariner House adult learning disability team had set up and held weekly multidisciplinary meetings with the social community care team and GP liaison nurses to discuss all patients and improve the interagency team working. We saw minutes of these meetings which showed multi agency assessments had taken place. This improved the patients access to right support in a quicker timeframe.

Areas for improvement

Action the trust MUST take is necessary to comply with its legal obligations. Action a trust SHOULD take is to comply with a minor breach that did not justify regulatory action, to prevent it failing to comply with legal requirements in future, or to improve services.

We told the trust that it must take action to bring services into line with seven regulations in respect of sixty-one breaches of legal requirements. This action related to nine services.

Action the trust MUST take to improve:

Acute wards for adults of working age and psychiatric intensive care units

- The trust must ensure staff involve patients in care planning and their individual needs are recorded appropriately.
- The trust must ensure all environmental risks are identified and mitigated against.
- The trust must ensure the safe management of medicines.
- The trust must ensure that during periods of seclusion and segregation they protect patient's dignity and privacy at all times.
- The trust must ensure that equipment used by staff is regularly and accurately checked.
- The trust must ensure that staff consistently apply and record appropriate elements of the seclusion policy in line with the Mental Health Act Code of Practice.
- The trust must assess, monitor and improve the quality and safety of the services provided to ensure actions from the CQC's inspections in 2014, 2016 and 2017 have been completed.
- The trust must ensure that robust audit and governance systems are in place to monitor clinical practice and risk within the service.
- The trust must deploy sufficient numbers of suitably qualified, competent, skilled and experienced staff to ensure they can meet patient's care and treatment needs.

Summary of findings

Long stay or rehabilitation mental health wards for working age adults

- The trust must ensure that maintenance work is carried out when requested.
- The trust must ensure that when lessons are shared, any actions are implemented.
- The trust ensure staff have the necessary skills to keep themselves safe and if unable to attend personal safety training there is a system in place to mitigate the risk.
- The trust must ensure all environmental risk are identified and plans put in place to reduce those risks.
- The trust must review the operational policy and ensure it reflects best practice guidance.

Forensic inpatient or secure wards

- The trust must ensure learning from serious incidents is shared across services and at ward level.
- The trust must ensure action is taken to mitigate against identified risks.
- The trust must ensure clear governance procedures are embedded to ensure the safe management of medicines, medical equipment and emergency equipment.
- The trust must ensure details of serious incidents are handed over to staff and recorded in patient's progress notes and risk assessments.
- The trust must ensure seclusion rooms are free from hazards.
- The trust must ensure staff follow the Mental Health Act code of practice for patients in seclusion and instigate seclusion processes for all incidents of seclusion.

Wards for older people with mental health problems

- The trust must ensure they assess the risks to health and safety of patients while they are receiving treatment and care, and do all that is reasonably practical to mitigate any such risks, including ligature reduction work on the wards.
- The trust must ensure that they assess, prevent and reduce the risk associated with the control of infections, including those that are health care associated.
- The trust must ensure they seek and act on feedback from patients and carers for the purposes of continually evaluating and improving services.

Wards for people with a learning disability or autism

- Staff must ensure that all patients have a detailed positive behaviour support plan or equivalent.
- Staff must ensure that best interest decisions are clearly documented for patients who lack capacity to consent.
- Staff must ensure that Deprivation of Liberty Safeguards paperwork is completed correctly.

Community-based mental health services of adults of working age

- The trust must ensure that all services have detailed ligature risk audits in place and that risks are fully known and mitigated.
- The trust must ensure that there as full and clear physical healthcare information and that physical healthcare needs are met and a system in place in all services for this information to be recorded.
- The trust must ensure all equipment in clinic rooms had been calibrated.
- The trust must ensure all medical supplies are in date.

Summary of findings

- The trust must not ensure that all patients risks are assessed and managed, and that risk assessments and care plans are in place and updated consistently in line with changes to patients needs or risks.
- The trust must ensure all patients are allocated a care coordinator and provided with timely access to services or treatment
- The trust must ensure staff have the necessary training to keep themselves and patients safe.
- The trust had must ensure that audit outcomes and needs identified are addressed.
- The trust had must ensure that effective systems are in place for the monitoring and recording of clinical supervision for all staff.

Mental health crisis services and health-based places of safety

- The trust must ensure that staffing levels out of hours are sufficient to meet local need.
- The trust must ensure that all premises are safe for their intended purpose.
- The trust must ensure that all ligature risks are identified and appropriate plans in place to reduce risk.
- The trust must ensure that processes are in place to ensure that lessons learned are shared across all crisis, home treatment and acute liaison services.
- The trust must ensure that all teams comply with the 4-hour emergency assessment target for referral to assessment.
- The trust must ensure that all teams are aware of their responsibilities for assessing patients presenting in emergency departments in crisis.
- The trust must ensure that staff are consulted and involved in service planning.
- The trust must ensure that lessons learned and improvements to practice are shared and implemented, where appropriate, across all services.
- The trust must ensure that systems accurately reflect the nature of patient contacts within their electronic patient record system in order to monitor the effectiveness of the assessment and treatment delivered to patients.
- The trust must ensure that all repairs to environments are completed in a timely manner to protect the privacy and dignity of patients.

Specialist community mental health services for children and young people

- The trust must ensure there is effective leadership of the children and young person service across Norfolk and Suffolk.
- The trust must review their governance systems to ensure their compliance with actions from past CQC inspections.
- The trust must review their systems for assessing and monitoring risks for patients on waiting lists for triage, assessment and treatment and provide a consistent approach to this across the children and young person service Norfolk and Suffolk.
- The trust must review their recruitment processes and ensure there is adequate staff available to reduce the patient waiting lists for triage, assessment and treatment in the children and young person service.
- The trust must ensure they have accessible and comprehensive data/systems for the children and young person service teams to measure their performance and risks.
- The trust must review their process for identifying risks on their register.

Summary of findings

- The trust must review their policy and process for ligature risk assessment in community teams, to ensure ligature risks are identified and managed.
- The trust must ensure children and young person service staff follow the trust's infection control procedures and processes.
- The trust must review their systems to ensure that patients have risk assessments and care plans in the children and young person service.
- The trust must review their service provision for the children and young person service patients with attention deficit hyperactivity disorder and reduce service waiting times.
- The trust must review and improve their systems for engaging staff in development of the children and young person service in Suffolk.
- The trust must ensure that all staff understand and follow the trust's complaints policy in the children and young person service.
- The trust must ensure that staff receive regular line management, clinical supervision and appraisal in the children and young person service.

Community-based mental health services for older people

- The trust must ensure that environmental risk assessments including ligature risks are completed and any identified risks mitigated against.
- The trust must ensure that all clinic rooms have emergency medication for use on site or in the community.
- The trust must ensure that they have a full range of staff to deliver psychological therapies and occupational health assessments.

Action a trust SHOULD take is to comply with a minor breach that did not justify regulatory action, to prevent it failing to comply with legal requirements in future, or to improve services.

Action the trust should take to improve:

Acute wards for adults of working age and psychiatric intensive care units

- The trust should ensure that all clinic rooms are cleaned regularly
- The trust should ensure that it provides a culture where staff feel listened to, supported by senior management, connected to the organisation and able to provide feedback.

Long stay or rehabilitation mental health wards for working age adults

- Review the system for logging, reviewing and learning from local complaints.

Forensic inpatient or secure wards

- The trust should ensure all furniture used by patients is fit for purpose and does not pose an infection control risk.
- The trust should ensure all patients have access to psychology.
- The trust should promote patients comfort and dignity by ensuring there are sufficient toilet and bathroom facilities on wards.

Wards for older people with mental health problems

Summary of findings

- The trust should ensure that they address the culture of the organisation to ensure that staff feel motivated and are active partners in development and delivery of change.
- The trust should ensure that the female only lounge on Laurel ward is easily accessible for female patients on that ward.
- The trust should ensure that staff meet medicines management guidance on controlled drugs storage, by keeping the controlled drugs keys on a separate key ring.
- The trust should ensure that staff store copies of any completed carers assessments within the patients care records.
- The trust should ensure that there are processes in place for the sharing of good practice across the whole of the Trust.
- The trust should ensure that all signage in this service is dementia friendly and easy read

Wards for people with a learning disability or autism

- Staff should ensure that patients are supported to make decisions about their care and this is documented in their notes.
- Staff should ensure that patients with communication difficulties are involved in the planning of their care.

Specialist community mental health services for children and young people

- The trust should consider reviewing their systems to improve communication between Norfolk and Suffolk teams in the children and young person service.
- The trust should consider ensuring they have plans in place with clear timescales to address environmental risks at locations.
- The trust should consider having a clear system in place to capture staff's clinical supervision attendance.
- The trust should ensure staff document their consultation with patients (or carers) in record's.

Community-based mental health services for older people

- The trust should ensure that they have the systems in place to monitor waiting lists for access to psychology assessments and therapies.
- The trust should ensure that team managers have access to systems and dashboards within a timely manner.

Community mental health services for people with a learning disability or autism

- The trust should consider making changes to rooms in the services to ensure they meet the needs of the learning disabilities patients who use them.
- The trust should ensure that they act in a timely way when managers' report any risk issues in relation to their services.

Summary of findings

Is this organisation well-led?

Our comprehensive inspections of NHS trusts have shown a strong link between the quality of overall management of a trust and the quality of its services. For that reason, we look at the quality of leadership at every level. We also look at how well a trust manages the governance of its services – in other words, how well leaders continually improve the quality of services and safeguard high standards of care by creating an environment for excellence in clinical care to flourish.

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

- The trust board and senior leadership team were in transition and had not formed to deliver a service that provided high-quality sustainable care. At our inspection of 2017, we had significant concerns about the safety, culture and leadership at the trust. We told the trust that they must urgently address concerns and meet regulation. At this inspection, we found that some of our significant concerns, some that we had raised with the trust in 2014, had not yet been fully addressed. We found that the board had not driven effective change at a pace and with sufficient traction to bring about improvements needed to resolve the failings in safety and to bring about sustained improvement. Staff told us that their local managers were supportive and some leaders were approachable, but they did not know or feel engaged with the senior leadership team.
- The trust had a vision for what it wanted to achieve that had been developed in 2015 with involvement from staff, patients, and key groups representing the local community but urgent and sustained action was needed to ensure this had meaning for staff and patients. However, a number staff told us that managers and leaders did not always model the values and behaviours of the trust. While strategies were in place these had not always led to action.
- We found widespread low morale across services. This was attributed to a “do unto” attitude staff felt came from senior management and directors. Staff told us that they felt let down by senior management. In the 2017 NHS Staff Survey the trust had worse results than other similar trusts in 26 key findings. Key findings included staff’s motivation at work, the percentage of staff reporting good communication between senior management and staff, satisfaction with the level of responsibility and involvement and staff’s recommendation of the organisation as a place to work or receive treatment. Latest data from the Friends and Family test staff results showed the scores had declined and the percentage of staff who would recommend the trust as a place to work was worse than the England average.
- Despite improved recruitment outcomes we remain concerned about staffing levels in some core services. We remain concerned that nursing staff vacancies remain very high in wards. Medical vacancies were also high at 21%. In August 2018, the trust was not meeting it target for nursing staff fill rates at 88%. We found that this impacted on patient care. In community services, while recruitment had improved against set staffing levels this had not brought about significant changes to address waiting lists and some team’s caseloads.
- The trust was attempting to take a systematic approach to governance but this had not fully succeeded in bringing about an improvement to the quality of services or ensured that these delivered a high standard of care. The trust had recently reviewed its governance structure to streamline assurance processes and provide a clearer line of sight from the board to ward. Local governance groups had been reorganised to place a stronger emphasis on accountability and assurance from service managers. A standardised integrated performance dashboard had been developed and was used at board and locality level meetings to ensure a common set of performance indicators across the organisation. We recognise that significant work has been undertaken to rationalise the governance structure and systems had been put in place to provide better assurance, but this has not yet addressed all our concerns or brought about improvements to the quality of its services. It is concerning that the trust’s own assurance process had indicated more progress in some areas than we found at this inspection.

Summary of findings

- The trust had developed systems for identifying risks and, but these were not effective in coping with both expected and unexpected risks. At this inspection we found that key risks that were considered closed or mitigated had not been fully addressed. These included ligature point management, care planning, access and waiting lists, staffing levels and seclusion practice and environments. In some cases, work undertaken had created new risks. This long list of outstanding safety issues is unacceptable and shows that the trust does not yet have a thread of safety running through the organisation to protect patients from harm. The board has not ensured, within a reasonable timeframe, that the environments and practices promote safe care and treatment and comply with regulations. Further work is required to ensure that all risks are fully captured and understood by the board. We were concerned that while the trust's own governance system had highlighted some of these issues, the trust was yet to fully address these across all services.
- During this inspection we looked in detail at the actions the trust had taken in response to serious incidents. We found that work had begun on required actions, but further work was needed to ensure that there were not missed opportunities. Where serious incidents had happened, we saw that investigations were usually carried out, but this needed to be improved to include all serious incidents. The trust had improved the quality of investigations, but some actions arising from the investigation were not always specific and we could not see that actions had been completed comprehensively or in a timely way. We were not able to evidence that appropriate learning had been shared in each case. Teams generally confirmed clinical and other incidents were reviewed and discussed by the management team and shared with front line staff. However, many staff did not know of incidents that had occurred in similar services to their own.
- The trust collected and used information and data to consider its performance, but this was not always reliable. There were secure systems in place for recording and accessing confidential information. Work had been undertaken to improve the quality and accuracy of performance data since our last inspection. A chief clinical information officer had been appointed to lead on digital development. The trust had reviewed the integrated performance dashboards at board and locality level to ensure a common set of performance indicators across the organisation. However, the senior team acknowledged that data sets required further refinement and that further work was required to ensure that other key information, such as the board assurance framework, risk registers and the audit report were accurate and fully highlighted risks. During service visits team managers told us that they did not have all the performance data they required to fully manage their service. Several staff raised a concern with us regarding how they recorded contacts with patients on the electronic records system. Staff completing initial telephone contacts with patients completed and recorded these contacts differently across teams. Staff were required to identify a level of 'treatment' with each contact. We were not assured that all staff had clear guidance on how to record contacts or that the trust could be sure that all patients were receiving an element of treatment during these telephone conversations. The trust confirmed they were looking at this issue as part of work to address waiting lists.
- The trust had a strategy in place to engage with patients, staff and stakeholders, but urgent work was needed to embed this agenda and turn the strategy into action. During this inspection we heard from many service users, carers and local user groups about their experience of care. Most people that we spoke with were positive about their, or their loved ones, care and treatment and the service that had been received. However, a significant number of people were unhappy with the service they or their loved one had received. We particularly heard about delays in accessing services and that communication was poor during these waits. Some people did not feel involved in their care or listened to by the trust. We were disappointed that in our interactions with some key staff that there was limited focus on patient's experience. We believe that the trust has a lot to do at all levels to ensure that patients are at the centre and forefront of the purpose of NSFT.

However:

Summary of findings

- The trust had a freedom to speak up guardian whose role was to provide independent and confidential advice and support to staff who raise a concern. This service was well used and had escalated cases to the right level so that they can be resolved efficiently.
- The trust had met its duty of candour obligations required to be open and transparent with people who use services and other 'relevant persons' in relation to care and treatment and particularly when things go wrong.
- The trust had significantly improved its training, appraisal and supervision compliance since our last inspection. However, further work was needed to ensure compliance with clinical supervision and ensure the quality of supervision and appraisal.
- The trust had completed the information governance toolkit assessment. The information toolkit had achieved compliance of 93% in March 2018. The trust had robust information governance systems in place including the confidentiality of patient records in line with best practice. The General Data Protection Regulation (GDPR) has been rolled out successfully. The trust could demonstrate effective information security through the management of a recent phishing attempt which was identified and actioned within a very short space of time.
- When we previously inspected the trust, we were very concerned about the performance of the electronic patient information system. Since then, the trust had undertaken various improvement initiatives. Staff confirmed that the system was more usable and accessibility had improved. Additional work was planned to rationalise the risk forms that staff needed to complete.
- The trust has committed to improving services by learning from when things went well and when they went wrong, and has begun to promote training, research and innovation. The trust had participated in some national improvement and innovation projects and undertook a wide range of quality audits and research. The trust had participated in the two national enquiries applicable to them. The trust has been awarded a second gold star in recognition of its commitment to ensuring carers are fully supported and involved in decisions about care and for successfully achieving the second stage of the Triangle of Care. At the most recent Green Light Toolkit audit the trust had met all standards and was above the national average for 25 of 27 standards.

Ratings tables

Key to tables					
Ratings	Not rated	Inadequate	Requires improvement	Good	Outstanding
Rating change since last inspection	Same	Up one rating	Up two ratings	Down one rating	Down two ratings
Symbol *	➔➔	↑	↑↑	↓	↓↓
Month Year = Date last rating published					

* Where there is no symbol showing how a rating has changed, it means either that:

- we have not inspected this aspect of the service before or
- we have not inspected it this time or
- changes to how we inspect make comparisons with a previous inspection unreliable.

Ratings for the whole trust

Safe	Effective	Caring	Responsive	Well-led	Overall
Inadequate ➔➔ Sept 2018	Requires improvement ➔➔ Sept 2018	Good ➔➔ Sept 2018	Inadequate ↓ Sept 2018	Inadequate ➔➔ Sept 2018	Inadequate ➔➔ Sept 2018

The rating for well-led is based on our inspection at trust level, taking into account what we found in individual services. Ratings for other key questions are from combining ratings for services and using our professional judgement.

Ratings for mental health services

	Safe	Effective	Caring	Responsive	Well-led	Overall
Acute wards for adults of working age and psychiatric intensive care units	Inadequate ➔➔ Sept 2018	Requires improvement ➔➔ Sept 2018	Requires improvement ↓ Sept 2018	Inadequate ↓ Sept 2018	Inadequate ➔➔ Sept 2018	Inadequate ➔➔ Sept 2018
Long-stay or rehabilitation mental health wards for working age adults	Requires improvement ➔➔ Sept 2018	Good ↑ Sept 2018	Good ➔➔ Sept 2018	Good ➔➔ Sept 2018	Requires improvement ➔➔ Sept 2018	Requires improvement ➔➔ Sept 2018
Forensic inpatient or secure wards	Requires improvement ➔➔ Sept 2018	Good ➔➔ Sept 2018	Good ➔➔ Sept 2018	Good ➔➔ Sept 2018	Good ➔➔ Sept 2018	Good ➔➔ Sept 2018
Child and adolescent mental health wards	Good ➔➔ Sept 2018	Outstanding ➔➔ Sept 2018	Outstanding ➔➔ Sept 2018	Outstanding ➔➔ Sept 2018	Outstanding ↑ Sept 2018	Outstanding ➔➔ Sept 2018
Wards for older people with mental health problems	Requires improvement ➔➔ Sept 2018	Good ↑ Sept 2018	Good ➔➔ Sept 2018	Good ➔➔ Sept 2018	Requires improvement ↓ Sept 2018	Requires improvement ➔➔ Sept 2018
Wards for people with a learning disability or autism	Requires improvement ➔➔ Sept 2018	Requires improvement ↓ Sept 2018	Requires improvement ↓ Sept 2018	Good ➔➔ Sept 2018	Requires improvement ↓ Sept 2018	Requires improvement ↓ Sept 2018
Community-based mental health services for adults of working age	Inadequate ➔➔ Sept 2018	Requires improvement ➔➔ Sept 2018	Good ➔➔ Sept 2018	Inadequate ↓ Sept 2018	Inadequate ➔➔ Sept 2018	Inadequate ➔➔ Sept 2018
Mental health crisis services and health-based places of safety	Requires improvement ➔➔ Sept 2018	Good ↑ Sept 2018	Good ➔➔ Sept 2018	Requires improvement ➔➔ Sept 2018	Inadequate ➔➔ Sept 2018	Requires improvement ➔➔ Sept 2018
Specialist community mental health services for children and young people	Inadequate ↓ Sept 2018	Good ↑ Sept 2018	Good ➔➔ Sept 2018	Inadequate ↓ Sept 2018	Inadequate ↓ Sept 2018	Inadequate ↓ Sept 2018
Community-based mental health services for older people	Requires improvement ↑ Sept 2018	Requires improvement ➔➔ Sept 2018	Good ➔➔ Sept 2018	Requires improvement ↓ Sept 2018	Requires improvement ➔➔ Sept 2018	Requires improvement ➔➔ Sept 2018
Community mental health services for people with a learning disability or autism	Good ➔➔ Sept 2018	Good ➔➔ Sept 2018	Good ➔➔ Sept 2018	Good ➔➔ Sept 2018	Good ↑ Sept 2018	Good ➔➔ Sept 2018
Overall	Inadequate ➔➔ Sept 2018	Requires improvement ➔➔ Sept 2018	Good ➔➔ Sept 2018	Inadequate ↓ Sept 2018	Inadequate ➔➔ Sept 2018	Inadequate ➔➔ Sept 2018

Overall ratings for mental health services are from combining ratings for services. Our decisions on overall ratings take into account the relative size of services. We use our professional judgement to reach fair and balanced ratings.

Community mental health services for people with a learning disability or autism

Good 

Key facts and figures

Community mental health services for people with learning disabilities or autism provide care for adult and child patients across Suffolk at a variety of accessible bases, as part of the wider integrated delivery teams (IDTs). All patients lived at home or in residential care, with home visit support from a care co-ordinator and/or outpatient appointment. These services operated from 9am until 5pm, Monday to Friday.

The trust had worked within the principles of the transforming care agenda. The trust closed several wards and the services were more focussed in the community. The inpatient and community teams are part of the same service and work as one team.

The trust did not provide any community mental health services for people with learning disabilities or autism in Norfolk.

Adult services offered care to people from the age of 18 upwards, except for Lothingland where adult services were offered from aged 25 years. In general, caseloads varied from 11 to 18 people per care co-ordinator.

People supported by the Suffolk Child and Adolescent Learning Disability team attended outpatient appointments with the consultant psychiatrist in the East of the county at Walker Close and in West Suffolk at the Child Health Centre in Bury St. Edmunds. The age range of people who used this service ran from 0 years to 25 years.

We inspected the Suffolk intensive support at home team as part of the community services. Based at Walker Close, Ipswich this team offered advice and extra support to families and carers through observation and formulation to avoid a hospital admission when the needs of the patients changed. The intensive support at home team operated from 7am until 9pm each day of the week.

The trust is registered with the CQC for the following regulated activities:

Assessment or medical treatment for persons detained under the Mental Health Act 1983

Treatment of disease, disorder, or injury.

At the last inspection in July 2017, the overall rating for this service was good. The safe, effective caring and responsive domains were rated as good; the well-led domain was rated as requires improvement.

The following areas were identified as actions the provider must take to improve:

- The trust must ensure that patients do not have excessive waiting times to access speech and language therapy, including a dysphagia assessment.

The following areas were identified as actions the provider should take to improve:

- The trust should ensure that staff at the Waveney bases are provided with personal alarms when working on a one to one basis with patients or be able to summon help via alarms fitted in the interview rooms.
- The trust should work towards providing equity in care to patients by ensuring the same access to therapies is available across the integrated delivery teams.
- The trust should ensure that all staff clearly document physical health and annual health checks in the patient notes.

Community mental health services for people with a learning disability or autism

- The trust should provide clear guidance on what action staff should take to ensure that the efficacy of depot medication is unaffected by a rise in temperature.
- The trust should ensure that sufficient detail is provided in patient notes that shows patient centre care is being provided.
- The trust should ensure that access to mandatory training is improved

Our inspection was announced (staff knew we were coming) to ensure that everyone we needed

to talk to was available. We inspected sites at Lowestoft, Stowmarket and Ipswich and looked at all key questions.

This inspection has found that the trust had met the requirement notice from the previous inspection regarding patients having access to speech and language therapy, including a dysphagia assessment.

Before the inspection visit, we reviewed information that we held about these services and information requested from the trust. During the inspection visit, the inspection team:

- spoke with the manager of the adult services and the manager of the child and adolescent service
- spoke with 23 other staff members, including nurses, clinical support workers, occupational therapists, psychologists and behavioural therapists
- examined medicine management across the service and medication charts
- reviewed 29 patient care records
- observed one multidisciplinary meeting
- observed one episode of care (activity group).
- After the inspection visit, the inspection team:
- Spoke with three patients who were using the service and six carers.

Summary of this service

Our rating of this service stayed the same. We rated it as good because:

- All areas were clean and well maintained, with suitable furnishings. The trust had fitted all interview rooms with alarms and staff were available to respond to alarms if required. Staff also had personal alarms when visiting patients in the community. Staff followed the trust wide lone working policy which included clear personal safety protocols.
- Managers calculated staffing levels to ensure that the service had enough staff with the right skills, qualifications and experience to meet the needs of the patients. The service had sufficient staff to support the patients who used this service which included a psychiatrist. Managers assessed the size of the caseloads of individual staff regularly and helped staff manage the size of their caseloads. At the time of the inspection the service did not have a waiting list for patients accessing the service.
- Managers identified training needs their staff had and gave them the time and opportunity to develop their skills and knowledge. Staff had completed and were up to date with their mandatory training which included the Mental Health Act, the Mental Health Act Code of Practice and the Mental Capacity Act. Staff received training in safeguarding that was appropriate for their role. Staff could give clear examples of how to protect patients from harassment and discrimination and knew how to make a safeguarding referral and who to inform if they had concerns.

Community mental health services for people with a learning disability or autism

- Care plans and risk assessments were comprehensive. Staff completed and regularly updated thorough risk assessments for most patients using the service using a trust wide risk assessment tool. Staff embedded completed crisis plans in the risk assessment tool that identified individual patients needs if a crisis occurred. Staff completed comprehensive, personalised, holistic and recovery-orientated care plans, considering the views of the patients, their family or carers. Staff completed a comprehensive mental health assessment for each patient using the service. Staff ensured that patients had regular physical health checks and staff recorded the patients' physical health problems within the patients care plans and risk assessments. Staff made sure patients had support for their physical health needs, either from their GP or consultant psychiatrist. Staff knew what incidents to report and how to report them. Managers investigated incidents across the trust and if required managers and staff would make changes to practice as a result of incidents and feedback. Managers debriefed and supported staff after any serious incident and fully understood duty of candour.
- Staff were discreet, respectful, and responsive when caring for patients and their family and maintained confidentiality at all times. Staff gave patients, families and carers help, emotional support and advice when they needed it. Staff supported them to understand and manage their care in their preferred communication method. Staff ensured that easy read documentation and pictorial positive behaviour support plans were in place to support the engagement of the patients and their families or carers.
- Staff involved patients in decisions about the service. Patients could give feedback on the service and their treatment and staff supported them to do this. Staff enabled families and carers to give feedback on the service they received at individual appointments with patients and via the friends and family test. Feedback from people who use the service, those who are close to them and stakeholders was continually positive about the way staff treated patients. Patients told us that staff were always friendly and welcoming, there was always someone available to offer support and guidance, they felt staff went the extra mile and the care they receive exceeded their expectations.
- The service met the referral to assessment target in three out of the 13 of the community learning disabilities team. The service met the referral to treatment target in10 out of the 13 teams. The team responded promptly to urgent referrals, we saw examples in care records of patients had been seen on the same day as the referral was made due to them being in crisis.
- The team tried to engage with people who found it difficult, or were reluctant, to seek support from mental health services. Staff supported patients to maintain contact with their families and carers. Staff told us that carers were central to the care plan for patients and they were often actively involved in patient care. This was evidenced in the patient notes we reviewed.
- Managers had systems in place to monitor the waiting lists. At the time of the inspection there were no patients waiting longer than 18 weeks for treatment. At the weekly multi agency or multidisciplinary meetings all patients including new referrals were discussed and decisions made on what action needed to be taken for patients to be assessed.
- Leaders had a good understanding of the services they managed. They could explain clearly how the teams were working to provide high quality care. Local managers had systems and procedures to ensure that the premises were safe and clean; staff received training and supervision staff assessed patients and treated them well; referrals and waiting times were managed well; incidents and complaints were reported, investigated and learned from with findings shared with all staff.
- Managers understood their teams and identified when staff needed extra support. They discussed with the staff member what they could do to enable the individual staff member to perform their job well. Managers supported staff through regular supervision and appraisals and held monthly staff team meetings. In addition to this, managers

supported staff during their appraisals and discussed career progression and development during management supervision. Managers used team meetings and protected time to allow staff to discuss how to improve the service and innovative ways of working. This resulted in managers developing the weekly multiagency meetings and changes to the environment.

However:

- Some staff that we spoke with did not feel the same support or respect from the senior management team across the trust. Staff told us that they felt they were 'left alone' to get on with their work. They felt senior management were not aware of the positive work and changes they had made in order to improve the service for patients. In addition to this staff reported that the did not feel included in discussion about changes outside of this service and across the trust.
- We were concerned that these issues when reported to the trust's senior management were not acted on in a timely manner.

Is the service safe?

Good 

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

- All areas were clean and well maintained, with suitable furnishings. The trust had fitted all interview rooms with alarms and staff were available to respond to alarms if required. Staff also had personal alarms when visiting patients in the community. Staff followed the trust wide lone working policy which included clear personal safety protocols. Staff ensured that all clinic rooms had the necessary equipment for patients to have thorough physical examinations.
- Managers calculated staffing levels to ensure that the service had enough staff with the right skills, qualifications and experience to meet the needs of the patients, despite the service having vacancies. Members of the team picked up each other's caseloads when colleagues were off due to sickness and absence. Managers assessed the size of the caseloads of individual staff regularly and helped staff manage the size of their caseloads. At the time of the inspection the service did not a waiting list for patients accessing the service.
- The service had sufficient staff to support the patients who used this service which included a psychiatrist. Staff responded promptly to sudden deterioration in a patient's health. Doctors prescribed medication and staff reviewed the effects of each patient's medication on their physical health according to National Institute for Health and Care Excellence guidance.
- Staff had completed and were up to date with their mandatory training. Managers and staff received electronic alerts so they knew when to update or complete training modules. Staff received training in safeguarding that was appropriate for their role. Staff could give clear examples of how to protect patients from harassment and discrimination and knew how to make a safeguarding referral and who to inform if they had concerns.
- Staff completed and regularly updated thorough risk assessments for most patients using the service using a trust wide risk assessment tool. Staff embedded complete crisis plans in the risk assessment tool that identified individual patients needs if a crisis occurred.
- Staff knew what incidents to report and how to report them. Managers investigated incidents across the trust and if required managers and staff would make changes to practice as a result of incidents and feedback. Managers debriefed and supported staff after any serious incident and fully understood duty of candour.

Community mental health services for people with a learning disability or autism

Is the service effective?

Good 

Our rating of effective stayed the same. We rated it as good because:

- Staff completed comprehensive, personalised, holistic and recovery-orientated care plans, considering the views of the patients, their family or carers. Staff assessed the patient's capacity at the beginning of every appointment and this was recorded within the patient's care plan and risk assessment. Staff completed a comprehensive mental health assessment each patient using the service.
- Staff ensured that patients had regular physical health checks and staff recorded physical health problems within care plans and risk assessments. Staff made sure patients had support for their physical health needs, either from their GP or consultant psychiatrist.
- The service had access to a full range of specialists, including speech and language therapists and psychologists who adhered to best practice and followed the National Institute for Health and Care Excellence guidance when caring for patients to meet their needs.
- Experienced staff had the right skills and qualifications to meet the needs of the patients in their care. Managers gave each new member of staff a full induction to the service before they started work. Managers identified any training needs their staff had and gave them the time and opportunity to develop their skills and knowledge. Managers supported staff through regular supervision and appraisals and held monthly staff team meetings.
- Staff received training in, and had a good understanding of the Mental Health Act, the Mental Health Act Code of Practice and the Mental Capacity Act.
- Staff made sure they shared clear information about patients and any changes in their care during multidisciplinary meetings. Managers held weekly allocation meetings, weekly behaviour planning meetings and monthly bring it forward meetings.
- Staff knew and had access to administrative support and legal advice on implementation of the Mental Capacity Act, the Mental Health Act and its Code of Practice. The mental health administration team completed regular audits to make sure they applied the Mental Health Act correctly. The trust had clear, accessible, relevant and up-to-date policies and procedures that reflected all relevant legislation including the Mental Capacity Act and the Mental Health Act Code of Practice.

Is the service caring?

Good 

Our rating of caring stayed the same. We rated it as good because:

- Staff were discreet, respectful, and responsive when caring for patients and their family and maintained confidentiality at all times. Staff we spoke with were compassionate, caring and respectful to the individual needs of patients, including their personal, cultural, social and religious needs.
- Staff gave patients, families and carers help, emotional support and advice when they needed it and supported them to understand and manage their care in their preferred communication method. Staff ensured that easy read documentation and pictorial positive behaviour support plans were in place to support the engagement of the patients and their families or carers.

- Staff supported patients and carers to understand and manage their care. Carers could not speak highly enough of the level of care provided to them.
- Staff directed patients to other services and supported them to access those services if they needed help. Staff ensured that patients could access advocacy when required.
- Staff involved patients in decisions about the service. Patients could give feedback on the service and their treatment and staff supported them to do this. Staff enabled families and carers to give feedback on the service they received at individual appointments with patients and via the friends and family test. Feedback from people who use the service, those who are close to them and stakeholders was continually positive about the way staff treated patients. Patients told us that staff were always friendly and welcoming, there was always someone available to offer support and guidance, they felt staff went the extra mile and the care they receive exceeded their expectations.

Is the service responsive?

Good 

Our rating of responsive stayed the same. We rated it as good because:

- The service met the referral to assessment target in three out of the 13 of the community learning disabilities team. The service met the referral to treatment target in 10 out of the 13 the teams. The team responded promptly to urgent referrals, we saw examples in care records of staff seeing patients on the same day they received the referral due to them being in crisis. Managers had systems in place to monitor the waiting lists. At the time of the inspection there were no patients waiting longer than 18 weeks for treatment, although there had been patients waiting longer in the the period preceding the inspection. At the weekly multi agency meeting all patients including new referrals were discussed and decisions made on what action needed to be taken for patients to be assessed.
- The team tried to engage with people who found it difficult, or were reluctant, to seek support from mental health services. Staff continually tried to build a therapeutic alliance until the patient engaged with the service. Staff did not discharge patients due to not attending set appointments and the team tried to contact patients and family if appropriate to offer support.
- Where possible, staff offered patients flexibility in the times of appointments. Staff cancelled appointments only when necessary and when they did, they explained why and helped patients to access treatment as soon as possible.
- Patients and their families knew how to complain or raise concerns. Staff knew how to handle complaints appropriately. The trust investigated complaints and fedback to patients after the investigation. Managers shared the outcome of complaints with staff in monthly team meetings. We saw in all the services that we inspected a high number of compliments, cards and letters from families and carers.

However:

- The service had rooms at each location for meeting with patients and their carers, but they did not fully support the treatment and care of the patients. For example, the lights within the room came on as soon as patients walked in to the room. Due to some patients' sensory needs they would not be able to tolerate the brightness of the room and staff had no way of adjusting the lights. However, we acknowledged that most patients were seen in their own homes and therefore the facilities were not an issue for the majority of patients.

Community mental health services for people with a learning disability or autism

Is the service well-led?

Good ↑

Our rating of well-led had improved. We rated it as good because:

- Leaders had a good understanding of the services they managed. They could explain clearly how the teams were working to provide high quality care. Leaders had the right skills, knowledge and experience to lead their teams and perform their roles. Staff told us that leaders were visible in the service, approachable, and operated an open-door policy.
- The trust gave opportunity for leaders to develop their skills and for other staff to develop leadership skills. Managers reported that the trust had developed a leadership programme which they found invaluable.
- Staff felt able to raise concerns without fear of retribution. Staff knew how to use the whistle-blowing process and about the role of the Freedom to Speak Up Guardian.
- Managers understood their teams well. They identified when staff needed extra support and discussed with the staff member what they could do to enable the individual staff member to perform their job well. Managers supported staff during their appraisals and discussed career progression and development during management supervision. Managers used team meetings and protected time to allow staff time and support to discuss how think about how to improve the service and innovative ways of working. This had resulted in managers developing the weekly multiagency meetings and changes to the environment.
- Local managers had systems and procedures to ensure that the premises were safe and clean; staff were trained and supervised; patients were assessed and treated well; referrals and waiting times were managed well; incidents were reported, investigated and learned from with findings shared with all staff.
- Patients and carers had opportunities to give feedback on the service they received in a way that reflected their individual needs. Managers and staff had access to the feedback from patients, carers and staff and used it to make improvements.

However:

- Staff reported that they did not feel included in discussion about changes outside of this service and across the trust.
- Some staff did not feel the same support or respect from the senior management team across the trust. Staff told us that they felt they were 'left alone' to get on with their work and that the senior management were not aware of the positive work and implemented changes they had made to improve the service for patients.
- Managers and staff maintained and had access to the risk register either at a team and directorate level and could escalate concerns when required from a team level. Staff escalated concerns through regular supervision and team meetings. However, we were concerned that these issues when reported to the trusts senior management were not always acted on in a timely manner.

Community-based mental health services of adults of working age

Inadequate 

Key facts and figures

Norfolk and Suffolk foundation Trust provides community-based mental health services for adults of working age. The service was last inspected in July 2017. They received an overall rating of inadequate, with requires improvement for effective and responsive domains and a rating of good for caring.

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.

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.

In Norfolk the services were known as Community Mental Health Teams (CMHT) and in Suffolk as Integrated Delivery Teams (IDTs). In Norfolk, the CMHT comprised of professionals solely working in the adult community mental health pathway. Patients assessed to require a high level of contact during 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. 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.

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.

At this inspection we found that this core service had not fully met or addressed actions from our inspection in July 2017. We found continued breaches of the following:

- Regulation 12 HSCA (RA) Regulations 2014 Safe care and Treatment
- Regulation 18 HSCA (RA) Regulations 2014 Staffing

The trust had addressed some findings of the inspection in July 2017

- Regulation 11 HSCA (RA) Regulations 2014 Need for consent
- Regulation 17 HSCA (RA) Regulations 2014 Good Governance

Community-based mental health services of adults of working age

The trust is registered for the following regulated activities:

- Assessment or medical treatment for persons detained under the Mental Health Act 1983
- Treatment of disease, disorder or injury.

The inspection team visited 13 community teams across Norfolk and Suffolk between 03 September and 12 September. During the inspection we visited the following teams and look at all five key questions:

- Northgate Hospital resource centre Early Intervention
- Waveney CMHT Victoria House
- Mariner House Ipswich
- Norwich CMHT, The Anchorage
- Northgate Hospital Early Intervention
- Bury North Integrated Delivery Team (IDT)
- Bury South Integrated Delivery Team (IDT)
- Coastal Integrated Delivery Team (IDT)
- Early Intervention Team, West Norfolk Early Intervention
- West Norfolk CMHT
- South Norfolk CMHT, Gateway House
- North Norfolk CMHT Peddars Centre
- Suffolk Access and Assessment Team

Our inspection was announced (staff knew we were coming) to ensure that everyone we needed to talk to was available. Before the inspection visit we reviewed information that we held about these services and information requested from the trust. We inspected all five key questions for this core service.

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 and carers at focus groups.

During the inspection visit, the inspection team:

- visited 13 of the teams, looked at the quality of the care and observed how staff were caring for patients
- spoke with 17 managers including team managers
- interviewed 41 staff including nurses, occupational therapists, psychiatrists, psychologists, health care support workers, administration and reception staff
- reviewed 98 care records of patients
- spoke with 18 patients who were using the service
- spoke with 17 carers of patients who were using the service
- attended and observed 7 meetings and activities including carers and patients' groups, a handover meeting and multi-disciplinary meetings

Community-based mental health services of adults of working age

- carried out a specific check of the medication management in all teams looked at policies, procedures and other documents relating to the running of the service.

We also returned unannounced to the West Norfolk CMHT and the Bury South Integrated Delivery Team between 20 and 26 September.

Summary of this service

Our rating of this service stayed the same. We rated it as inadequate because:

- During this inspection we found major concerns about access to services. We were not assured that the adult community mental health services responded appropriately to urgent referrals. We found that staff in Suffolk access and assessment team were downgrading a high proportion of the emergency and urgent referrals. We saw numerous situations where people were not offered a service yet had been in significant need. Records showed that, in some cases, patients had self-harmed or taken overdoses whilst waiting for contact. The trust did not consistently meet the target to see patients from referral stage to assessment. For routine referrals, this was 78% against a target of 95%. From assessment to treatment the target was 18 weeks. At the time of the inspection, there were 224 people waiting longer than 18 weeks for treatment.
- We were particularly concerned about the risk management of community adult patients awaiting allocation of a care co-ordinator. At the time of inspection, a total of 2390 patients were without a care coordinator or lead professional across adult services. During this waiting period patients only received telephone calls and no face to face contact. This meant there was very little support for those patients for varying lengths of time, and the impact of these arrangements raised serious safety issues for patients in this position. Since the last inspection, the trust had implemented a system that required that all red rated cases were allocated a care coordinator immediately and not held on the waiting list. However, at one service we found unallocated patients on the waiting list for a care coordinator and they were red status. Three patients care and treatment records had changed in risk, and staff had not changed the RAG rating to reflect this. We found a patient who had been raised to amber however, staff had not documented why, and there had been no contact from April to July 2018.
- There was a lack of oversight of adult community mental health services by the wider trust. For example, we found a gap in shared feedback and learning from incidents across the whole trust. Since June 2018, there had been further deaths. We found evidence that recommendations had been made following many investigations at the trust but there was a lack of evidence that the trust had acted on all recommendations. This was in relation to risk assessments and care plans not completed and up to date and the number of people on waiting lists for allocation of a care co-ordinator. We found evidence that these problems were still present despite these recommendations
- Staff told us that information was cascaded down to service level from the trust board without engagement. Staff told us that there was poor leadership above local manager level and that recognition and acknowledgement for good work was poor. Staff did not feel that they could contribute to the trust strategy. Some community services said they felt isolated from the rest of the trust. Patients and carers we spoke with told us that the senior leadership was detached from local services and did not involve them or listen to their views.
- The trust had not fully carried out its intention to assess ligature risk in community bases and, despite raising it at the last inspection, staff were not fully assessing risk. Not all community settings had an adequate ligature point risk assessment. This meant staff at these locations were not aware of specific risks. Additional risks had been introduced in patient's toilets following works to make the environment safer.

However:

Community-based mental health services of adults of working age

- Staff were very clear about the personal safety protocols within the community teams, and the trust policy for lone working. Staff could explain to us the system to ensure administration teams were aware of their location. Staff at all sites visited had personal alarms in working order, and regular checks of the equipment carried out and documented.
- Ninety four percent of staff had received training in safeguarding that was appropriate for their role. Staff demonstrated clear knowledge of trust safeguarding processes and procedures, and recognised the different types of potential abuse.
- Statutory records inputted by staff were complete and in order on the electronic system. We examined 51 medication records. Medication records for the 18 patients with a community treatment order, were in place. These areas had improved since the last inspection.
- Managers identified any specialist training needs their staff had and gave them the time and opportunity to develop their skills and knowledge. Managers made sure staff received any specialist training for their role. For example, the nurse training pathway, psychology, mental health professionals and trauma training was ongoing by staff at community services.
- We observed and heard staff treating patients with kindness, dignity, respect and support. Staff demonstrated commitment and were caring towards patients. Staff offered practical and emotional support to family's and carers. Patients we spoke with were complimentary about their care coordinators. We saw evidence of information given to patients to help them understand their acre and treatment needs, we saw medicine and conditions advice in easy read formats for patients to understand.
- Managers and staff at community services made "your service your say" and "help us to help you" feedback leaflets easily accessible to patients across community sites in waiting areas.

Is the service safe?

Inadequate  

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

- We were not assured that the adult community services responded appropriately to urgent referrals. Staff did not always manage referrals according to the level of urgency identified by the referrer. We found that staff in access and assessment teams were downgrading a high proportion of the emergency and urgent referrals resulting in some urgent referrals waiting for up to and exceeding 28 days for a telephone contact. Staff had not maintained clear records to support the decisions made and we found records were often incomplete and difficult to follow. Too many referrals were handed off inappropriately or refused and downgraded from urgent to routine without due care. We saw numerous situations where people were not offered a service yet had been in significant need. Records showed that, in some cases, patients had self-harmed or taken overdoses whilst waiting for contact.
- Staff at community services continued to triage new referrals and RAG rated their risk to red, amber and green. Since the last inspection the trust had implemented a system intended to ensure that all red rated cases were allocated a care coordinator immediately. However, we found three patients' care and treatment records had changed in risk, and staff had not changed the RAG rating to reflect this. We found a patient who had been raised to amber, but staff had not documented why, and there had been no contact from April to July 2018. At one service we found unallocated patients on the waiting list for a care coordinator and they were red status.

Community-based mental health services of adults of working age

- During this inspection we found evidence that access and assessment teams were completing core assessments and risk assessments for the patient then once referred to the adult community service these were being reassessed. The adult community service did not trust the assessments done by access and treatment teams and they believe that some patients not appropriate for services were being referred. The impact of this was adding to waiting time for patients to receive the correct support and treatment.
- We reviewed 98 care and treatment records during this inspection and found the trust were not appropriately managing patient risks which was also raised as a serious concern during the previous inspections in July 2017 and May 2018. Throughout this inspection we found four records were without a core risk assessment, six records did not have a risk assessment, and nine patients were without a care plan required to address known risks. Three patients had alerts regarding risk to others, these had not been recorded on the system which meant staff were not fully aware of the patients' risks. We found further evidence that staff had not updated patients' risk appropriately.
- Recruitment had improved and the adult community services had almost met its own set staffing levels, but there was not enough staff with the right skills, qualifications and experience for each team to meet the needs of all patients. At the time of this inspection there was a total of 2390 adult patients on waiting lists who were not allocated a care coordinator or lead professional.
- The trust had implemented a standardised ligature risk assessment for all community adult services. This comprised of a heat map of all areas (a heat map is a plan of the premises identifying levels of risk by an amber or red rating), and a rag rating for individual rooms with specific guidelines to mitigate risk. However, at Bury South IDT the ligature risk assessment was not the same as the rest of the trust, no heat map was available on request, rooms were not rag rated or assessed individually. This did not include individual rooms. Wymondham had ligature assessments for each floor. This meant staff at these locations were not aware of specific risks. Additional risks had been introduced in patient's toilets following works to make the environment safer. The fire risk assessment at Bury South was out of date and in February 2018 the system was assessed as not fit for purpose. However, in July 2018 the new system was installed, but records did not reflect this.
- Across most community team's clinic rooms, equipment was tested and in date. However, Staff at Norwich CMHT had not ensured calibration of the clinic room equipment. West Norfolk Early intervention team did not have a blood monitoring machine available. Mariner House had two first aid boxes which contained out of date products. The evacuation chair check was due in May 2018, and this had not been completed.
- Medication was not always appropriately managed. Bury south IDT had a newly prescribed depot injection which had not been administered and was two weeks over the prescribed date, two patients' medication cards were missing, and no explanation could be given. This meant that some areas of medication administration were poor.
- Mandatory training compliance rates at community services across the trust were mostly above the trust target of 85%. However, Waveney had basic life support training at 50%. Early Intervention team in Kings Lynn had basic life support at 42.9% and personal safety was at 57.1% and Coastal IDT basic life support was at 66.7%.

However

- The trust had in place an electronic clinic room temperature monitoring system. The trust system alerted staff via email if there was a concern, and staff responded accordingly
- Staff at all sites visited had personal alarms in working order, and regular checks of the equipment carried out and documented.
- The services we visited all had access to a psychiatrist. Appointments were planned and emergency appointments were accommodated if risk had changed. Staff told us Psychiatrists were responsive to needs of patients

Community-based mental health services of adults of working age

- Staff were very clear about the personal safety protocols within the community teams, and the trust policy for lone working. Staff could explain to us the system to ensure administration teams were aware of their location.
- Ninety four percent of staff had received training in safeguarding that was appropriate for their role. Staff demonstrated clear knowledge of trust safeguarding processes and procedures, and recognised the different types of potential abuse.

Is the service effective?

Requires improvement 

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

- There were waiting lists across community sites for the psychological therapies. This varied from an eight to 12 month wait. There were also waiting lists across sites for dialectical behaviour therapy, patients were waiting up to three months for this. Some of the psychologists held low caseload numbers and staff said that they would not take on additional patients as they needed support but were yet to be allocated to a care co-ordinator. Specifically, King's Lynn had a team of psychologists but only five patients on their caseload whilst there was a waiting list for patients to access the service. This meant that services were not always patient focused or interventions available.
- The trust had no standard measure to collate data for clinical supervision for the trust, but staff told us that they received supervision. This was identified on previous inspections.
- There was a gap between GP physical health checks carried out by GPs and the recording of the information on the patient record. Which meant that information was not always timely.
- Issues identified in clinical audits, benchmarking and quality improvement initiatives had not been dealt with. These included environment, medication, caseload weighting, care planning and risk assessments.
- Staff reported to us that relationships with crisis teams varied across community services in Norfolk and Suffolk. Staff raised concerns that crisis assessment of risks varied greatly from that of community services and felt there was not enough good links between the two services. Bury South IDT service felt the referral system and links between their service and the access and assessment team were poor, and felt this impacted on patients receiving the support required in a timely manner.

However:

- We examined 51 medication records. Medication records for the 18 patients with a community treatment order, were in place. This is an area which has improved since the last inspection.
- Statutory records inputted by staff were complete and in order on the electronic system. This is an area which has improved since the last inspection.
- Managers identified any specialist training needs their staff had and gave them the time and opportunity to develop their skills and knowledge. Managers made sure staff received any specialist training for their role. For example, the nurse training pathway, psychology, mental health professionals and trauma training was ongoing by staff at community services.
- Staff shared updates with other agencies. This included primary and social care staff, housing services, local authorities and access to education opportunities. Some community services in Norfolk had set up a recovery information centre to support this need, which provides housing advice, peer support, debt management, benefits advice.

- Groups were offered on various sites visited including mindfulness, emotional regulation group, and open space. Patients referred to the recovery college could access courses for personality disorder, managing anxiety and depression as part of their treatment and care.

Is the service caring?

Good 

Our rating of caring stayed the same. We rated it as good because:

- We observed and heard staff treating patients with kindness, dignity, respect and support. Staff demonstrated commitment and were caring towards patients. Staff offered practical and emotional support to family's and carers. Patients we spoke with were complimentary about their care coordinators.
- Staff supported patients to understand and manage their own care, treatment or condition. We saw evidence of information given to patients to help them understand this, Patients we spoke with were very positive about the support provided to them. We spoke with 18 patients who spoke highly of their care coordinators in the service and said that they received regular visits. Patients felt involved in their care and said that appointments were flexible when needed. One patient stated the service was lifesaving. Patients said the recovery college was a valuable resource for patients, it made a real difference to patients' lives.
- Managers and staff at community services made "your service your say" and "help us to help you" feedback leaflets easily accessible to patients across community sites in waiting areas.
- Staff involved families and carers appropriately. Through the trust mental health team's carers were provided a range of support. For example, The Suffolk Carers Improvement Plan meeting was held monthly. Access to on line forums. Central City 1,2 and 3 and Coastal IDT held regular forums and carers events. There was a carers matter eLearning portal to help develop skills and knowledge in topics such as mental health, dementia, nutrition and hydration and managing behaviour.

However:

- One carer said they had found some systems to be complicated. One carer we spoke with felt staff had withdrawn their services and reduced contact, and felt the adult community services were having too many changes. Two carers spoken with stated that needs were identified but services just did not deliver, this has led to discharge from the service without adequate support. The impact of this was patients were referred back to the service.
- We found some records which did not reflect evidence of patient and carer involvement. We found that the levels of involvement in care plans was variable across teams.

Is the service responsive?

Inadequate 

Our rating of responsive went down. We rated it as inadequate because:

- The system for managing referrals was ineffective. The trust did not consistently meet the target to see patients from referral stage to assessment. The trust had set a target for time from referral to triage of five days for urgent referrals and 28 days for routine referrals. At the time of the inspection we were unable to establish the overall performance for urgent referrals. For routine referrals, this was 78% against a target of 95%. Yarmouth and Waveney adult team reported routine referrals waiting time as up to 56 days. From referral to treatment the target was 18 weeks. At the

time of the inspection, there were 224 people waiting longer than 18 weeks for treatment. There were waiting lists for the allocation of care coordinators at most of the services we inspected. For example, at the 1 September 2018 at West Norfolk adult team there were 327, Waveney adult team there were 266, and Great Yarmouth there were 236. Overall, there were 2390 patients waiting for allocation of a care co-ordinator across adult services.

- We were not assured that the adult community services responded appropriately to urgent referrals. Staff did not always manage referrals according to the level of urgency identified by the referrer. We found that staff in access and assessment teams were downgrading a high proportion of the emergency and urgent referrals; resulting in some urgent referrals waiting for up to and exceeding 28 days for a telephone contact. Data for the Suffolk assessment and treatment team showed overall between January 2016 and May 2018, 46% of all emergency referrals and 55% of all urgent referrals received for adult patients were downgraded. This impacted on the length of time people waited for a service.
- There were still gaps in the process to engage with patients and we found two significant gaps in contact times which we raised at the time of inspection.

However:

- Staff interviewed said that patients' appointments ran on time and staff informed patients when they did not. Patients we spoke with agreed with this and stated that if their care coordinator was ill they would receive a call to inform them of this.
- Staff supported patients during referral and transfers between services. Mangers told us they would be referred to another service and would stay with both services until a joint handover meeting of the patient had taken place.

Is the service well-led?

Inadequate 

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

- We are concerned that since the last inspection there had not been improvement in the safety and responsiveness of adult community mental health services.
- Staff reported a disconnect between them and higher senior management. Some community services staff said that they felt isolated from the rest of the trust and communication was poor. Staff believed there was still a lack of cascading much needed information to move forward. Staff felt that progress was slow and wider learning for the trust was not being communicated to them. This had led to staff lacking trust that improvements could be made.
- Managers at local level reported there was poor leadership above their role and that recognition for good work and acknowledgment was poor.
- There was a lack of oversight of adult community mental health services by the wider trust. For example, we found a gap in shared feedback and learning from incidents across the whole trust. Since June 2018, there had been further deaths. We found evidence that recommendations had been made following many investigations at the service but there was a lack of evidence that they had acted on recommendations. This was in relation to risk assessments and care plans not being completed and kept up to date and the number of people on waiting lists for allocation of a care co-ordinator. This was still a concern and was reoccurring despite recommendations.
- Issues identified in clinical audits, benchmarking and quality improvement initiatives had not been dealt with by managers. These included environment, medication, caseload weighting, care planning and risk assessments.

Community-based mental health services of adults of working age

- Patient and carers felt trust leaders were detached from local services and did not involve patients and carers in listening to their views, and did not have the opportunity to meet with the senior leadership team to give feedback.

However:

- Staff understood the trust's arrangements for working with community and external teams both inside and outside the trust. For example, we observed a section 75 agreement meeting held with the county council. This was a multiagency collaborative meeting and was chaired by the director for Suffolk, who discussed risk and the need to balance resources and requirements.
- Staff told us they felt respected, support and valued by their team and local management.
- Managers supported staff during their appraisals and discussed career progression and development. Staff understood the whistle-blowing policy and knew how to access the speak up guardian. However, during staff interviews some staff said they felt uncomfortable to talk openly about their day to day work and concerns they had.

Acute wards for adults of working age and psychiatric intensive care units

Inadequate 

Key facts and figures

Norfolk and Suffolk NHS Foundation Trust provides acute and psychiatric intensive care support across eleven inpatient wards at five locations across Norfolk and Suffolk.

There are 190 beds in total.

Wards are located at:

The Fermoy Unit, King's Lynn:

Churchill ward is a mixed sex ward with 16 beds for acutely unwell patients.

Hellesdon Hospital, Norwich:

Thurne ward is a 15 bedded mixed sex admission and assessment ward.

Waveney is a 20 bedded female acute admission ward.

Glaven is a 20 bedded male acute admission ward.

Rollesby ward is a 10 bedded mixed sex psychiatric intensive care unit.

Coastlands-Northgate, Great Yarmouth:

Yarmouth Acute Ward is a mixed sex 20 bedded ward for acutely unwell patients.

Wedgwood House, Bury St Edmunds:

Northgate is a 21 bedded mixed sex acute admission ward.

Southgate is a 16 bedded mixed sex acute admission ward.

Woodlands Ipswich:

Avocet is a 21 bedded mixed sex acute ward

Poppy is a 21 bedded mixed sex acute ward.

Lark ward is a 10 bedded mixed sex psychiatric intensive care unit. This ward was closed at the time of the inspection and was not visited.

This was an announced comprehensive inspection.

The service was last inspected in May 2018 when an unannounced inspection took place to review actions required from previous inspections. A warning notice was issued to the Trust, following the inspection in May 2018, for the following regulatory breaches:

- Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment
- Regulation 13 HSCA (RA) Regulations 2014 Safeguarding service users from abuse and improper treatment
- Regulation 17 HSCA (RA) Regulations 2014 Good governance
- Regulation 18 HSCA (RA) Regulations 2014 Staffing

Acute wards for adults of working age and psychiatric intensive care units

Before the inspection visit, we reviewed information that we held about these services and information requested from the trust.

During the inspection visit, the inspection team:

- spoke with 40 patients who were using the service and three carers
- spoke with the managers/leaders for each of the wards
- spoke with 56 other staff members; including doctors, nurses, healthcare assistants, occupational therapists and discharge co-ordinators
- observed two meetings and one episodes of care
- reviewed documentation relating to the service, including policies and procedures and meeting minutes
- Reviewed 39 records relating to patient risk assessments, physical health and care plans, and 19 patient prescription charts. We reviewed 38 records relating to episodes where staff secluded patients.

Summary of this service

Our rating of this service stayed the same. We rated it as inadequate because:

- Safety was not a sufficient priority. The trust had failed to address all issues raised from previous inspections dating back to 2014. Not all ward environments were safe. The quality of environmental risk assessments varied across wards. Managers had not identified all the risks contained within their environments. Staff did not manage medicines and equipment in a safe way. The trust missed opportunities to prevent or minimise harm. Senior managers did not share lessons learned effectively and there was a lack of addressing themes from incidents quickly. Wards worked below the established numbers of staff required to keep patients safe. Patients in seclusion did not always have access to the appropriate reviews of their treatment, or the appropriate staff to maintain their dignity.
- Patients were at risk of not receiving individualised treatment. Staff did not involve all patients in their care plans. Twenty-three patients could not describe what their care plan said and what goals they were working towards. Staff used templates for care plans which meant goals, actions and interventions were the same for patients. Care plans were not person centred and lacked patient voice. Not all patients had access to a copy of their care plan. Staff did not always involve people patients identified as important to them in their care. On 20 occasions staff did not update families and carers when they secluded patients. We specifically requested one carer be updated about their loved one's care when we identified inappropriate delays.
- Staff did not plan patient's discharge from hospital effectively. Staff created discharge plans that did not provide robust detail and patients expressed concerns about their discharge plans. The service reported 253 readmissions within 28 days between 1st June 2017 and 31st May 2018. Of these there was an average of 11 days between discharge and readmission. Staff admitted 18 of these patients the day following discharge.
- The leadership, governance and culture of the organisation did not assure the delivery of high quality care. There continued to be issues raised from previous inspections that the trust had failed to address. Staff in services reported a distinct lack of connection to the wider organisation. Staff described a lack of collaboration in decisions that affected their wards and felt the trust priority was not patient care. Staff reported a lack of visible leadership from the most senior managers in the organisation. The trust did not have sufficient oversight of key risk issues and failed to identify key themes and trends to prevent serious incidents from re-occurring. The trust did not learn from previous lessons and did not share information about incidents effectively. Assurance tools, such as clinical audits, were not accurate.

Acute wards for adults of working age and psychiatric intensive care units

However:

- Local ward staff demonstrated passion and commitment to their roles. Teams created ways to support each other, despite challenging circumstances with staffing and morale. Managers ensured staff had access to regular supervision and appraisals to discuss their workload, training and development needs. Staff had the right qualifications and experience required to support patients and we observed positive and caring interactions.
- Staff ensured that patients had access to appropriate physical healthcare. Physical healthcare nurses worked with teams to meet the physical healthcare needs of patient's and to provide ongoing monitoring of physical health conditions.
- Local ward staff gave patients the opportunity to provide feedback through community meetings and ward forums. Where patients needed support to express their views, staff referred them to advocacy services.

Is the service safe?

Inadequate  

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

- Not all ward environments were safe. The quality of environmental risk assessments varied across the wards. Managers used vague language on risk assessments and staff's knowledge of risk areas differed across wards. We found blind spots on wards that staff did not record on assessments, along with ligature anchor points that staff had not recorded or mitigated against. The trust made changes to services without due regard for the impact on people's safety. The trust had replaced soap and hand towel dispensers following our last inspection. Unfortunately, this had increased risk to patients as the new dispensers were screwed to the wall, causing a new ligature anchor point. Closed-circuit television (CCTV) coverage was poor on some wards, the quality of images was poor and staff could not see all areas of the wards due to the placement of CCTV.
- The management of medicines and equipment was not safe. We found significant issues with resuscitation equipment on one ward, despite staff recording resuscitation equipment as checked and safe. Staff did not clean clinic rooms regularly. Qualified staff did not sign when they dispensed controlled drugs on one ward. Staff lacked knowledge about the process for the safe disposal of controlled drugs. Stock medications and clinical equipment had expired. We requested staff remove the items and order replacements.
- The Trust missed opportunities to prevent or minimise harm. Senior managers did not share lessons learned from incidents effectively across the wards. Staff were not aware of incidents on other wards that could be relevant to their ward. This included incidents with ligature anchor points and with fire setting. There were significant concerns about patients having access to ignition sources, mainly lighters. We witnessed more than one patient smoking in the outside spaces, despite the trust being smoke free and staff restricting access to lighters. Staff completed pat down searches and did not have access to other equipment to support the searching of patients.
- Wards frequently worked with fewer staff than planned. There was a vacancy rate of 24% for registered nursing staff and 9% for healthcare support workers. Between June 2017 and May 2018 10% of available shifts were not filled by bank or agency staff for qualified staff and 12% for healthcare support workers. Managers did not record when staff moved between wards due to shortages, therefore rotas did not accurately reflect the numbers of staff present on the ward. Staff described the impact of staffing levels on patients. Staff had to reduce the time patients could take leave, or re-book leave for different times. Staff reported 139 incidents relating to staff shortages from April 2018 to September 2018. The highest figures related to August 2018 where staff reported 39 incidents, 15 relating to Avocet ward. Nurses could not always complete nursing reviews of patients in seclusion due to shortages of qualified staff.

Acute wards for adults of working age and psychiatric intensive care units

- Staff did not seclude patients in a safe way that met the standards outlined in the Mental Health Act Code of Practice. There were gaps in records relating to patient observations, medical reviews and what items patients took to the seclusion room. Staff secluded patients and did not record it in seclusion paperwork. Medical staff did not complete reviews on time. Staff used judgemental language in seclusion records and failed to inform carers and relatives when they secluded patients.

However:

- Staff knew what to report if they felt a patient was at risk of abuse. Staff understood the trust policy for safeguarding and 99% of staff received training in safeguarding adults and children. Eighty seven percent of staff received safeguarding training at a higher level, level three. Staff considered safeguarding when supporting patients and worked effectively with the appropriate agencies.
- Staff had undertaken some initiatives to improve patient risk and care. These included floor walking, board rounds, dedicated team days, safety folders, bespoke seclusion training, safe ward initiatives, time to shine and 'red to green'.

Is the service effective?

Requires improvement ● →←

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

- Staff did not complete individualised, person centred care plans with patients. Wards used templates for care plans which meant all patients had the same goals. Staff recorded the same actions and interventions required to meet goals. Staff recorded goals that were not relevant to the individual, for example carer support when there were no identified people involved in their care.

However:

- Patients had access to a wide variety of staff to support their treatment. Staff were suitably qualified and experienced to deliver care in line with best practice guidelines. Managers supported staff to develop their skills through individual supervision and appraisal.
- Teams reviewed patient care regularly, ensured patients had access to physical health care and involved other agencies in patient care, where appropriate.
- Staff demonstrated understanding of the Mental Health Act and Mental Capacity Act. Staff upheld the principles of the Acts, ensuring patients received care and treatment in line with legislation.

Is the service caring?

Requires improvement ● ↓

Our rating of caring went down. We rated it as requires improvement because:

- Staff did not involve patients in care plans. Twenty-three patients could not describe the contents of their care plan. Staff wrote care plans in formal language and plans lacked the patients' voice. Staff recorded dates of care plan updates that did not match with records of seeing patients for one to one sessions.
- Staff did not always keep carers and involved people up to date with patients' progress and information about their care. We raised one issue with managers that required urgent action due to significant delays in updating a family member. We found 20 occasions' where staff did not inform families and carers when they secluded a patient.

However

- Staff treated patients with kindness, respect and treated them as individuals. We observed positive interactions and saw staff responding to individual patient need. Staff we spoke with knew the needs of their patients and the most effective ways of offering support for that person.
- Staff gave patients opportunities to provide feedback via community meetings. Staff supported patients to raise concerns and provided access to advocacy if required.

Is the service responsive?

Inadequate 

Our rating of responsive went down. We rated it as inadequate because:

- The planning of patients' discharge did not always contribute to people staying out of hospital. Staff created discharge plans that lacked personalisation and detailed information. Patients expressed concerns over their discharge plans. The service reported 253 readmissions within 28 days between 1st June 2017 and 31st May 2018. Of these there was an average of 11 days between discharge and readmission. Staff admitted 18 of these patients the day following discharge.
- Not all wards functioned as the trust intended. On Thurne ward, the average length of stay, at the time of inspection was 40 days. Thurne ward was an assessment ward. Length of stay increased due to problems moving patients to other wards within the trust. Some patients admitted to Thurne had been on the ward for over 12 months.
- Bed management was challenging. Nine wards reported occupancy over 85% with two over 100% and two at 100%. Staff rated beds of patients on leave using a red, amber and green system. If a bed was red, this meant staff should not admit to it. This did not always happen due to the pressure staff felt to admit patients requiring treatment.

However:

- Patients knew how to complain and felt that staff supported them to do so, without fear of victimisation or reprisals. Managers reviewed complaints and shared outcomes with the wards teams.
- Wards provided appropriate space for patients to engage in activities, therapy and to see visitors. Facilities meant patients could talk to families and other people in private. Staff supported patients to personalise their bedrooms. Staff made arrangement for patients to take part in activities that supported any spiritual and religious needs.

Is the service well-led?

Inadequate 

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

- Concerns raised at previous inspections dating back to 2014 had not been addressed. This included issues raised in a warning notice issued in May 2018.
- There was minimal engagement from senior leaders with staff and teams working on the wards. Staff described a lack of visibility from senior managers and felt disconnected to the wider organisation. There were low levels of satisfaction with the organisation. Staff felt excluded from decisions that affected their wards and described the

organisations focus as getting good CQC ratings. Decisions made by leaders in the organisation directly affected the quality and safety of the services. Staff described being 'done unto' and felt there was poor collaboration between local teams and senior managers. Staff described delays in the trust responding to facilities issues which contributed to their frustration as it impacted the safety of their ward environments.

- The trust did not identify, investigate and attempt to reduce significant issues that threatened the delivery of safe care and treatment. We found serious incidents relating to fire setting at acute wards. The trust had not identified links between incidents to identify wider trust learning. Incidents had similar themes, including patient access to lighters, risk assessment and the searching of patients that had not been considered organisationally. Risk captured at organisational levels were not accurate. There were discrepancies between audit tools and incidents taking place on the ward. This was particularly relevant to monitoring and recording of seclusion.

However:

- Local ward teams had improved morale and created ways to support each other. Staff described commitment and dedication on wards and a desire to do the best job, despite challenging circumstances. Staff praised local ward managers for their visibility, support and commitment to their wards.

Long stay or rehabilitation mental health wards for working age adults

Requires improvement 

Key facts and figures

The rehabilitation ward is a community rehabilitation unit and is part of the trust's mental health services for adults of working age. The service aims to provide specialist assessment, treatment and support to patients with severe and enduring mental health needs. Suffolk Rehabilitation and Recovery Service provided 10 beds for both men and women. The ward is situated in Suffolk. There was no rehabilitation service in Norfolk. At the time of inspection, there were four male patients and two female patients admitted to the ward. The ward was located over two floors.

The ward aimed to help individuals who had severe and enduring mental illness build functional living skills to enable them to move from an inpatient to a community based setting. The expected length of stay is between six months and two years.

The ward accepted patients detained under the Mental Health Act 1993.

The trust is registered for the following regulated activities:

Assessment or medical treatment for persons detained under the Mental Health Act 1993

Diagnostic and screening procedures

Treatment of disease, disorder or injury

During this inspection we found the trust had acted to address the previous requirements specific to the rehabilitation ward in 2017, which were:

Regulation 11 HSCA (RA) Regulations 2014 Need for consent

- The trust had not ensured that consent to treatment forms were completed correctly and updated in line with the procedures and safeguards required under the Mental Health Act Code of practice.

Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment

- The trust had not done all that is reasonably practicable to mitigate against the risks identified on the ligature risk audit.
- The trust had not ensured that all staff used personal alarms and had a means to summon assistance if required.
- The trust had not ensured that only patients whose needs could be safely met had been admitted to St Catherine's. (This service now closed)

Regulation 18 HSCA (RA) Regulations 2014 Staffing

- The trust did not always deploy sufficient numbers of suitable qualified, competent, skilled and experienced staff to ensure they could meet patient's care and treatment needs.
- The trust did not ensure that all staff received appraisals and supervision.

Our inspection was announced (staff knew we were coming) to ensure that everyone we needed to talk to was available. We inspected the whole service and looked at all key questions.

Before the inspection visit, we reviewed information that we held about these services and information requested from the trust.

Long stay or rehabilitation mental health wards for working age adults

During the inspection visit, the inspection team:

- spoke with three patients who were using the service
- spoke with the manager
- spoke with 5 other staff members, including occupational therapists, nurses, recovery workers, administrative staff and occupational therapists
- carried out a specific check of the medication management arrangements and 6 medication cards
- reviewed four patient care records
- observed a staff handover, sharing meeting and safety huddle
- examined the clinic room
- reviewed a range of policies, procedures and other documents relating to the running of the ward.

Our inspection of findings

Summary of this service

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

- We observed a lack of learning from lessons or action taken from audit or incidents. There had been overall improvement in collating raw data, but this was not always translating into improving standards. We saw audit had been completed but conclusions and findings of the audits were not always turned into action.
- The ward only accepted patients with low risk of self-harm or violence onto the ward. This was not the criteria reflected in the operational policy of the trust. It was not clear how the needs of the higher risk patient group were met, if rehabilitation was an identified clinical need. The policy referred to the service as an open rehabilitation environment but failed to specify the type of service as per best practice guidance. The operational policy required review.
- We continued to see information stored in different places in the electronic care records. This meant that staff had to spend a lot of time finding the information they needed to do their jobs. We saw the trust had invested to improve capacity and efficiency and although the system froze fewer times than during previous inspections, it remained a concern.

However:

- Staff were pro-active in discharge planning and ensured patients views were at the centre of the process. This was an improvement from previous inspections.
- We saw that patients had access to local community services and were actively encouraged to access work and educational courses. There was also a strong occupational therapy presence to support patients with activities of daily living.

Is the service safe?

Requires improvement 

Long stay or rehabilitation mental health wards for working age adults

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

- Not all potential ligature points were identified on the risk assessment. For instance, the ensuite bedroom doors had not been added. This was despite a serious incident in another part of the trust relating to this specific risk. This raised concerns that lessons may not always be learned.
- The trust had replaced soap and hand towel dispensers without consultation with staff. This had added a further ligature risk due to the way they were fixed to the wall. Staff did not understand how this decision was made.
- Maintenance had signed work as completed when clearly it hadn't been. This meant identified issues were not resolved and continued to be a risk to the patient. Staff knew of this error but had not acted on it.
- The percentage of staff who completed personal safety training was 74. This fell below the trust own target of 85%. Failure to comply with this training could put staff safety at risk.
- Psychiatrist cover was provided for just two afternoons a week, once by the Consultant and once by a specialist registrar. We observed staff drive 45 minutes each way to get a prescription chart signed by a doctor.

However:

- Mandatory training compliance exceeded the trust's own target in most subjects.
- Staff carried out risk assessments and reviews.
- A floor walker had been introduced to increase staff presence on the ward.
- We saw patients actively engaging in community activities, activities of daily living and access to training and educational opportunities.

Is the service effective?

Good ↑

Our rating of effective improved. We rated it as good because:

- Staff completed a comprehensive mental health assessment prior to admission and upon admission.
- Staff carried out a rehabilitation functional assessment with the patient on admission. This was then repeated every two months to assist in tracking changes to patients' functional ability during admission.
- We saw that access to community activities had improved. For instance, some patients accessed a local farm for work experience and at the end of their placement received a job reference.
- Staff had access to training, received management supervision and had had an annual appraisal. Staff also accessed reflective practice sessions on the ward.
- There was a strong occupational therapy presence on the ward supporting patients to gain skills to live independently.

However:

- Evidence of learning from audit lacked detail, particularly linked to the medication management audit findings. The ward manage acknowledged further action was required to address this area of concern.

Long stay or rehabilitation mental health wards for working age adults

Is the service caring?

Good  

Our rating of caring stayed the same. We rated it as good because:

- Staff had detailed knowledge of each patients' individual needs and responded accordingly.
- We saw kind, patient, positive interactions that were respectful and responsive to patients' requests.
- There was evidence of staff involving patients in the development of their care plans and supported patients to create their own visual discharge pathway.
- The ward had developed a carer clinic which the lead member of staff had protected time to organise and run.
- Patients told us staff were kind and the felt listened to.

Is the service responsive?

Good  

Our rating of responsive stayed the same. We rated it as good because:

- Patients were supported to access work experience, education and local amenities. One patient also utilised the recovery college. Within the ward, patients were supported to complete every day activities such as budgeting and cooking.
- Patients had key cards to the front door and bedrooms for easy access. The key cards were programmed to ensure access could not be gained by the opposite sex into the bedroom areas.
- We saw evidence of patient involvement in their own discharge planning. This included encouraging and supporting patients to develop a visual discharge pathway which was displayed on their own bedroom walls. There were no delays

However:

- The process of referral and transfer was lengthy. There was a monthly panel meeting to consider referrals. If a patient was referred the day after a panel meeting, it would be a further month before a decision was made. This could delay patients receiving the correct care at the right time, and it could delay a bed becoming free from the referring ward. It was unclear if the time it took to transfer was for patient benefit or because there had not been a review of how effective the process was.
- The manager was unable to show an effective system of reviewing complaints made on the ward.

Is the service well-led?

Requires improvement  

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

Long stay or rehabilitation mental health wards for working age adults

- The operational policy for this service required review. The admission criteria within the policy did not reflect what was happening on the ward. Patients displaying medium or high risk of self-harm were excluded from accessing the service but this was not reflected in the policy. The policy referred to the service as an open rehabilitation environment but failed to specify the type of service using best practice guidance.
- Systems to ensure appropriate learning from incidents required further consideration. We saw that managers collated and shared information but there lacked a system to ensure that lessons were learned and changes made. At ward level, we saw review and learning from incidents that had occurred on the ward, however there was limited learning from incidents that occurred in other areas of the trust. We saw an overall improvement in collating data at ward level, but this had not always translated into improved standards.

However;

- Frontline staff were supported to access clinical training and leadership courses which was identified via the supervision and appraisal process.
- The local manager used available information such as dashboards to monitor ward performance.
- There was a monthly meeting held with the ward manager where senior managers reviewed the ward performance and discussed actions.

Mental health crisis services and health-based places of safety

Requires improvement 

Key facts and figures

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

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

In Norfolk there are three crisis resolution and home treatment teams. They are based at Hellesdon hospital in Norwich, Northgate hospital in Great Yarmouth and Fermoy unit in King's Lynn. In Suffolk there are two home treatment teams based at Wedgewood House in Bury St Edmunds and Woodlands unit in Ipswich. Two crisis resolution teams have been recently developed by the trust following a service redesign and these were collocated with the home treatment teams. Emergency referrals for assessment are passed directly to the Norfolk based teams by the Single Point of Access service and to the Suffolk based teams by the Access and Assessment service.

An acute mental health liaison service is provided for people who present to James Paget hospital in Great Yarmouth, Norfolk and Norwich University hospital in Norwich, Queen Elizabeth hospital in King's Lynn, West Suffolk hospital in Bury St Edmunds and Ipswich hospital in Ipswich. These teams aim to provide prompt assessment of a patient's needs and signpost care appropriately.

The health-based place of safety (HBPoS) is a place where someone who may be suffering from a mental health problem can be taken by police officers, using the Mental Health Act, to be assessed by a team of mental health professionals. There are five health-based places of safety. These are at Northgate hospital in Great Yarmouth, Hellesdon hospital in Norwich, Fermoy unit in King's Lynn, Woodlands unit in Ipswich and Wedgewood house in Bury St Edmunds.

This was an announced comprehensive inspection.

The service was last inspected in May 2018 when an unannounced inspection took place to review actions required from previous inspections. A warning notice was issued to the Trust, following the inspection in May 2018, for the following regulatory breaches:

- Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment
- Regulation 13 HSCA (RA) Regulations 2014 Safeguarding service users from abuse and improper treatment
- Regulation 17 HSCA (RA) Regulations 2014 Good governance
- Regulation 18 HSCA (RA) Regulations 2014 Staffing

Before the inspection visit, we reviewed information that we held about these services and information requested from the trust.

During the inspection visit, the inspection team:

- spoke with 11 patients who were using the service and three carers
- spoke with 16 managers/leaders

Mental health crisis services and health-based places of safety

- spoke with 51 other staff members; including doctors, nurses, healthcare assistants, psychologists and pharmacists
- observed eight telephone triage/support calls with patients
- attended three staff handover meetings
- reviewed documentation relating to the service, including policies and procedures and meeting minutes
- reviewed 62 care records of patients using three crisis services
- reviewed 26 records for patients detained under Section 136 Mental Health Act 1983 in a HBPoS.
- reviewed medication management.

Summary of this service

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

- The trust did not have sufficient oversight of key risks and issues for this service. Environmental risk assessments did not identify all risks and some identified risks in assessments rooms and the HBPoSs had not been removed or reduced. Staff awareness of environmental risks varied. Repairs were needed to ensure one of the assessment rooms provided privacy and dignity for patients. Staff had identified this risk and reported this repeatedly but repairs were still awaited at the time of our inspection.
- Staff did not always manage referrals according to the level of urgency identified by the referrer, or keep accurate records to support the decisions made. Within the Suffolk services, we found that staff were downgrading a high proportion of the emergency and urgent referrals; resulting in some urgent referrals waiting for up to and exceeding 28 days for a telephone contact. Staff had not maintained clear records to support the decisions made and we found records were often incomplete and difficult to follow. The trust had not consistently met its target times for four-hour emergency referrals.
- Some services still had staffing shortages, particularly at night. There was no oversight of the sharing of lessons learned from when something goes wrong between teams or localities and key recommendations from serious incident reports did not translate into trust wide learning. Senior managers were unable to demonstrate any evidence of how lessons learnt are shared between teams.
- The lack of strategic direction for the core service identified in our inspections in 2014, 2017 and 2018 remained. Despite the introduction of a standard operating procedure for crisis resolution and home treatment teams, differing practices, staffing levels and inequitable delivery of services were observed between teams. For example, patients received a different response for the four-hour emergency assessment between Norfolk and Suffolk services. We were concerned that patients residing in Norfolk did not receive an equitable service to those residing in Suffolk.
- Issues raised in our previous inspections relating to leadership and engagement remained. Some staff reported a recent increase in the visibility of senior leaders in some services but most staff we spoke with told us that the senior leaders were out of touch with what was happening on the front line and did not understand the risks and issues experienced by the staff themselves. Staff told us they had not had the opportunity to contribute to discussions about changes to their services.

However

Mental health crisis services and health-based places of safety

- Staff were caring and all patients told us that they felt positive about the care they received from staff. Leaders at a local level had the right skills, knowledge and experience to lead their teams. They had a clear understanding of the service they managed and displayed passion for their services.
- Staff completed a comprehensive mental health assessment of each patient. Overall, care plans were up to date, personalised, holistic, recovery orientated and considered physical health needs.
- Improvements had been made in the number of staff who had had appraisals and mandatory training since our last inspection. Improvements had also been made in staffing levels at the HBPoS and staff working there had received specific training on their role and were knowledgeable about their roles and responsibilities.

Is the service safe?

Requires improvement 

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

- Environmental risk assessments did not identify all risks and some identified risks had not been removed or reduced. Staff awareness of environmental risks varied. The doors of the assessment room used by the crisis resolution and home treatment team opened inwards and could be barricaded. One of the two exit doors was locked in the assessment room used by the acute liaison service in King's Lynn so staff could not use this to exit the room if needed. This risk was identified in the last two inspections of this service. This was also the case in the secure assessment room used by the acute liaison service in Great Yarmouth and there were no viewing panels in either door preventing observation from outside the room. The assessment room used by the acute liaison service in Ipswich had potential ligature anchor points, lightweight furniture and could not be observed from outside. Blind spots were identified in the HBPoS at Hellesdon hospital and at Woodlands in Ipswich where some furniture was not weighted and could be thrown or used as a weapon. All HBPoS and the crisis resolution and home treatment team in Norwich had towel/soap/toilet roll dispensers that could be used as a ligature anchor point.
- Some services still had staffing shortages, particularly at night. Although staffing levels had improved in the crisis resolution and home treatment team in King's Lynn, there were insufficient staff numbers to have a registered nurse on shift overnight at all times. On these occasions the registered nurse in the acute liaison team provided the crisis service in addition to assessments in the emergency department of the Queen Elizabeth hospital. Staff sickness in the acute liaison team meant registered nurses from the crisis resolution and home treatment team were providing both services at times. There was still one registered nurse and one support worker at night at the crisis resolution and home treatment team in Great Yarmouth to respond to crisis calls, make gatekeeping assessments for admissions to the inpatient wards and assessments in the emergency department of James Paget hospital, some 25 minutes away. This was identified in the last two inspections of this service.
- The trust did not always respond to patient risks identified by the referrer appropriately. Staff had downgraded a significant proportion of both emergency and urgent referrals. Records reviewed showed some instances where patients had self-harmed whilst awaiting contact from the trust.
- Lessons learned from when something goes wrong were not communicated widely to support improvement where relevant. Managers and staff were not aware of some of the learning from incidents in other crisis resolution and home treatment teams in the trust. For example, three days of home treatment for each patient discharged from Northgate in Great Yarmouth had been implemented as a result of learning from a serious incident but managers and staff in other services were unaware of this.

However:

Mental health crisis services and health-based places of safety

- Some improvements had been made in the environments in assessment rooms and HBPoS. All areas of the service were clean when we visited.
- Improvements had been made in staffing levels at the acute liaison team in Norwich and in the HBPoS in in Norwich and King's Lynn since our last inspection.
- Staff had completed and were up to date with their mandatory training. The compliance for mandatory and statutory training courses at 31 May 2018 was 91% against the trust target of 85%.

Is the service effective?

Good ↑

Our rating of effective improved. We rated it as good because:

- Staff completed a comprehensive mental health assessment of each patient. We looked at 62 care plans. Overall, care plans were up to date, personalised, holistic, recovery orientated and considered physical health needs.
- Staff made sure that patients had a full physical health assessment and knew about any physical health problems. Physical health monitoring was taking place across all services with timely correspondence and discussion with the patient's GP.
- Staff we spoke with told us they received monthly supervision and attended regular supervision, training and reflective practice days. Improvements had been made in the number of staff who had had appraisals since our last inspection. The trust's target rate for appraisal compliance was 89%. This year so far, the overall appraisal rate was 93% (as at 31 May 2018).
- The service had (access to) a full range of specialists to meet the needs of the patients. Staff provided a range of treatments and support to patients who accessed the service. They were experienced and knowledgeable and had the essential skills to meet the needs of the patients group. Some specialist training was available.
- Staff working in the HBPoS had received specific training on their role and were knowledgeable about their roles and responsibilities. Patients were given oral and written information about their rights under the Mental Health Act.

However:

- Two care records at west crisis resolution and home treatment team in King's Lynn and one care record at West Suffolk home treatment team in Bury St Edmonds did not have a care plan. We raised this with managers at the time of our inspection and action was taken to address these gaps.
- Staff working in the HBPoS told us that registered nurses were available to assess the patient and provide oversight of their care but there was limited evidence of nursing input in the 26 records reviewed. Five records did not have information about whether rights had been explained or not. Physiological observations and early warning score charts had been completed for 20 of these patients and there was no recorded reason for the remaining patients not having received these.

Is the service caring?

Good →←

Our rating of caring stayed the same. We rated it as good because:

Mental health crisis services and health-based places of safety

- Staff were discreet, respectful, and responsive towards patients. They were caring, warm, empathic and supported patients to understand their treatment needs and manage their own care and treatment.
- All patients told us that they felt positive about the care they received from staff. They told us staff were caring, compassionate and they listened to them and their individual needs.
- Staff involved patients and gave them access to their care plans. Patients were involved in managing their risks and planning their care and had either received or refused a copy of their care plan.
- Staff provided all patients and carers the opportunity to give feedback on the service that they received and made sure they could access advocacy services.
- Patients and carers we spoke with told us that carers were appropriately involved in care planning. Carers told us they were kept up to date and offered support.

Is the service responsive?

Requires improvement 

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

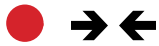
- The trust had introduced a standard operating procedure for crisis resolution and home treatment teams since our inspection in July 2017. However, patients received a different response for the four-hour emergency assessment between Norfolk and Suffolk services. Patients almost exclusively received telephone contact in Norfolk whilst four-hour emergency assessments were completed face to face in Suffolk following a one hour requirement for telephone triage. There were different practices for assessing patients of the crisis resolution and home treatment teams who presented to the emergency department of an acute hospital.
- We were not assured that the trust responded appropriately to emergency or urgent referrals. Staff did not always manage referrals according to the level of urgency identified by the referrer, or keep accurate records to support the decisions made. Within the Suffolk services, we found that staff were downgrading a high proportion of the emergency and urgent referrals; resulting in some urgent referrals waiting for up to and exceeding 28 days for a telephone contact. Data showed overall between January 2016 and May 2018, 46% of all emergency referrals and 55% of all urgent referrals received for adult patients were downgraded. Records showed in some cases, patients had self-harmed whilst waiting for contact. Staff had not maintained clear records to support the decisions made and we found records were often incomplete and difficult to follow.
- The trust had not consistently met its target times. The west crisis resolution and home treatment team in King's Lynn met the four-hour emergency assessment for 89% of cases in June 2018 and 72% of cases in July 2018 against a target of 95%. The acute liaison team at Norfolk and Norwich University hospital in Norwich met the one-hour response time in 88% of cases in April 2018, 87% of cases in May 2018 and 88% of cases in June 2018 against a target of 95%. Overall the trust met the four-hour emergency assessment target for 93% of cases in July 2018 against a target of 95%.
- One of the assessment rooms used by the West Suffolk crisis resolution and home treatment teams had no door due to the previous door becoming unsafe. This had been reported by staff in June 2018 and escalated but repairs were still awaited at the time of our inspection.

However:

- The crisis resolution and home treatment teams took a proactive approach to engaging with patients who found it difficult or were reluctant to engage with mental health services.

- Patients told us that appointments generally ran on time and staff informed them when there were delays. Patients had some flexibility and choice in the appointment times available.
- The HBPoS met the 24-hour target for detention under Section 136 of the Mental Health Act and patients were discharged or moved to a suitable placement within this timeframe.
- Information for patients on the use of CCTV was clearly visible in the HBPoS at Fermoy in King's Lynn following our last inspection but there was no such information at the HBPoS at Northgate hospital in Great Yarmouth. A clock was visible by patients in all of the HBPoS.

Is the service well-led?

Inadequate 

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

- The service had failed to address issues raised by previous inspections dating back to 2014.
- The trust did not have sufficient oversight of key risks and issues for this service. There was no oversight of the sharing of lessons learned between teams or localities and key recommendations from serious incident reports did not translate into trust wide learning. Senior managers were unable to demonstrate any evidence of how lessons learnt are shared between teams.
- Some staff reported a recent increase in the visibility of senior leaders in some services but most staff we spoke with told us that the senior leaders were out of touch with what was happening on the front line and did not understand the risks and issues experienced by the staff themselves. Staff told us they had not had the opportunity to contribute to discussions about changes to their services.
- The lack of strategic direction for the core service identified in our inspections in 2014, 2017 and 2018 remained. The trust had introduced a standard operating procedure for crisis resolution and home treatment teams. However, differing practices, staffing levels and inequitable delivery of services were observed between teams. There was no cross county working between Norfolk and Suffolk services. Team managers were unaware of different practices in other teams and there was a lack of strategic oversight of these differences and clear direction for service development from senior leaders.
- Staff completing initial telephone contacts with patients referred for emergency assessments completed and recorded these contacts differently across teams. There was no clear guidance on how such contacts should be recorded within the electronic patient record system. We were not assured that all staff had clear guidance on how to record contacts or that the trust could be sure that all patients were receiving an element of treatment during these telephone conversations.
- Staff had access to equipment and technology that worked well and supported them to do their work. However, the acute liaison at West Suffolk hospital reported difficulties with two data systems (Lorenzo and E-Care). There were access issues which had the potential for staff not to be able to update systems in a timely manner. This had been reported as an issue to the trust several times, but there was no outcome to date.

However:

- Staff described local morale as positive and told us there was a good level of team working with staff happy to help each other out. Staff felt respected and valued in their roles by local managers.

Forensic inpatient or secure wards

Good

Key facts and figures

Norfolk and Suffolk Foundation trust provides forensic wards for adults of working age across six wards on three sites.

Medium secure wards are based at the Norvic clinic, Norwich;

- Catton ward is a nine bed admission ward for male patients.
- Thorpe ward is a 10 bed ward for male patients.
- Drayton ward is a 16 bed ward for male patients.

The service provides assessment and treatment for male patients detained under the Mental Health Act who required care in a medium secure setting. The patients may have a forensic history and require treatment over a prolonged period.

Low secure services were based at Hellesdon Hospital in Norwich and St Clements Hospital in Ipswich. At Hellesdon Hospital there were two wards:

- Yare ward was a 15 bed ward for male patients.
- Whitlingham ward was 12 bed ward for female patients.

At St Clements Hospital there was one ward:

- Foxhall house was an 11 bed ward for male patients.

The service took referrals from medium secure units, Ministry of Justice, National Offender Management Service and other wards within the trust. The team determined the best treatment based on risk reduction and assessment of individual patients.

We issued a section 29a warning notice following a focused inspection in July 2018. This inspection was carried out to check on actions taken following a section 29a warning notice issued following the comprehensive inspection of the service in July 2017. We identified areas for improvement and told the trust to take the following actions:

- The trust must ensure that all services have access to a defibrillator and that staff are aware of arrangements for life support in the event of an emergency.
- The trust must ensure that action is taken to remove identified ligature anchor points and to mitigate risks where there are poor lines of sight.
- The trust must ensure that seclusion facilities are safe and appropriate and that seclusion and restraint are managed within the safeguards of national guidance and the Mental Health Act Code of Practice.
- The trust must fully implement guidance in relation to restrictive practices and reduce the number of restrictive interventions.
- The trust must ensure there are enough personal alarms for staff and that patients have a means to summon assistance when required.
- The trust must ensure there are sufficient staff at all times, including medical staff and other healthcare professionals, to provide care to meet patients' needs.

Forensic inpatient or secure wards

- The trust must ensure all relevant staff have completed statutory, mandatory and where relevant specialist training, particularly in suicide prevention and life support.
- The trust must ensure that all risk assessments, crisis plans and care plans are in place, updated consistently in line with multidisciplinary reviews and incidents and reflect the full and meaningful involvement of patients.
- The trust must ensure that the prescribing, administration and monitoring of vital signs of patients are completed as detailed in the NICE guidelines [NG10] on violence and aggression: short-term management in mental health, health and community settings.
- The trust must ensure that the temperature of medicines storage areas is maintained within a suitable range, and that the impact on medicines subject to temperatures outside the recommended range is assessed and acted on.
- The trust must ensure that all staff have access to clinical records and should further review the performance of the electronic system.
- the trust must ensure that there is full and clear physical healthcare information and that patients physical healthcare needs are met.
- The trust must ensure that all staff receive regular supervision and annual appraisals, and that the system for recording levels of supervision is effective and provides full assurance to the trust board.
- The trust must ensure that patients are only restricted within appropriate legal frameworks.
- The trust must ensure that people receive the right care at the right time by placing them in suitable placements that meet their needs and give them access to 24 hour crisis services.
- The trust must minimise disruption to patients during their episode of care and ensure that discharge arrangements are fully effective.
- The trust must ensure that there are clear targets for assessment and that targets for waiting times are met. The trust must ensure that people have an allocated care co-ordinator.
- The trust must ensure that they fully address all areas of previous breach of regulation.
- The trust must ensure that data is being turned into performance information and used to inform practices and policies that bring about improvement and ensure that lessons are learned.

The service was rated as good following the comprehensive inspection in July 2017. However, the safe domain was rated as requires improvement due to breaches of regulation 12, safe care and treatment; regulation 15, equipment and premises and regulation 18, staffing. We identified areas for improvement and told the trust to take the following actions:

- The trust must ensure that they have set timescales to address the identified ligature points on wards.
- The trust must ensure that repairs to the seclusion rooms are carried out in a timely manner
- The trust must consistently maintain clinic rooms at correct temperatures on all wards.
- The trust must ensure all relevant staff have completed all mandatory training, particularly in suicide prevention and life support.
- The trust must ensure there are sufficient staff so that leave and activities are not cancelled.
- The trust should ensure that staff seeks advice from pharmacy when clinic room temperatures are out of range.

Forensic inpatient or secure wards

- The trust should ensure that all staff receive annual appraisals.

We have identified the issues which remain in this report. The trust had completed some but not all of the actions from the July 2017 and July 2018 inspections.

Our inspection, carried out between 3 – 14 September 2018, was comprehensive and announced (staff knew we were coming) to ensure that everyone we needed to talk to was available. Before the inspection visit we reviewed information that we held about this core service and information we had requested from the Trust.

During the inspection visit, the inspection team:

- spoke with 21 patients who were using the service
- spoke with the managers or deputies for each of the wards
- spoke with 22 other staff members; including doctors, nurses, healthcare assistants, occupational therapists, recreational workers and psychologists
- observed one meeting and two episodes of care
- reviewed 26 patient records relating to physical health
- reviewed 26 records relating to patient risk assessments and care plans, and 57 patient prescription charts.

Summary of this service

Our rating of this service stayed the same. We rated it as good because:

- Managers had completed detailed ligature audits and management plans. The trust had carried out work to reduce ligature risks on the wards.
- Staff had completed detailed, holistic and person-centred care plans and risk assessments in patient records reviewed. Staff completed full physical health checks for patients on admission and patients had care plans to meet physical health needs.
- Staff treated patients with kindness and respect. Patients told us that staff were very nice, helpful, open minded and friendly. We observed caring interactions between staff and patients. Staff involved patients in their care plans and risk assessments. Patients could give feedback on the service and their treatment and staff supported them to do this. Patients were involved in staff recruitment.
- Staff supported patients to meet their goals, and made sure patients had access to opportunities for education and work. Examples included a patient completing a business degree and another working as a volunteer in a café. Patients had access to a recovery college and to light industry workshops on and off site. Staff supported patients to access activities in the community, including sailing, rambling and dog walking.
- Managers of the service provided strong, local leadership. Managers used dashboard information to monitor and improve the performance of their teams. Team morale was positive. Managers ensured staff were supported in their roles through supervision, team meetings, reflective practice sessions and training.

However:

- The trust had not ensured robust recording and learning from serious incidents. The trust had not shared learning from a patient death in 2014. There was a patient death in the forensic service in 2017. Both patients died after using

the same style of ensuite door as a ligature anchor point. The trust were planning to pilot anti-ligature ensuite doors in new bathrooms but were not replacing existing ensuite doors. Staff had not recorded a serious incident that had occurred on Whitlingham ward in the patient's progress notes. Details of the incident were not handed over to the next shift. Staff had not updated the patient's risk assessment.

- Staff did not always manage medicines and equipment safely. We found out of date medicines and medical equipment on five out of six wards. We found staff had administered as required medicines above prescription limits on two wards and had not always completed medicine administration records on one ward. Staff did not ensure that wards were fully equipped with accessible resuscitation and emergency equipment. Staff were not checking emergency bags and resuscitation equipment in line with trust policy on five out of six wards.
- Seclusion was not always managed well. The trust had not ensured the seclusion room on Yare ward was free from hazards. Staff did not always follow the Mental Health Act code of practice for patients in seclusion and long term segregation. Reviews and observations were not carried out as required and staff had not instigated seclusion processes for a patient secluded in the courtyard.

Is the service safe?

Requires improvement 

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

- Staff did not always manage medicines safely. We found out of date medicines and medical equipment on five out of six wards. We found staff had administered as required medicines above prescription limits on two wards and had not always completed medicine administration records on one ward.
- Staff did not ensure that wards were fully equipped with accessible resuscitation and emergency equipment. Staff were not checking emergency bags and resuscitation equipment in line with trust policy on five out of six wards.
- Staff had not recorded a serious incident that had occurred on Whitlingham ward in the patient's progress notes. Details of the incident were not fully handed over to the next shift. Staff had not updated the patient's risk assessment.
- Staff did not always follow the Mental Health Act code of practice for patients in seclusion and long term segregation. Doctors had not completed the required medical reviews in four of 16 seclusion records checked. Nurses had not completed reviews in one seclusion record checked and an independent multi-disciplinary review had not taken place in two seclusion records. Staff had not completed 15-minute observations as required in one of the seclusion records checked. Staff had not instigated seclusion processes for a patient secluded in the courtyard. Staff and not completed hourly observations or informed relevant parties for all three episodes of long term segregation reviewed. Staff had not completed long term segregation care plans for one patient.
- Staff had not ensured all furniture was maintained. We noticed that the weighted metal chairs in the servery at the Norvic Clinic were rusty, with paint flaking off. This posed an infection control risk as patients could pick off the paint whilst eating.

However:

- Managers had completed detailed ligature audits and management plans. The trust had carried out work to reduce ligature risks on the wards.
- Managers ensured safe staffing by over staffing with non-registered staff and block booking agency staff.
- Staff had completed detailed risk assessments for patients and updated these regularly with input from patients.

Forensic inpatient or secure wards

- Teams were reducing the use of restrictive interventions, through positive behaviour plans and verbal de-escalation.

Is the service effective?

Good ➔➔

Our rating of effective stayed the same. We rated it as good because:

- Staff completed detailed, holistic and person-centred care plans in patient records reviewed. Staff completed full physical health checks for patients on admission and patients had care plans to meet physical health needs.
- The service had skilled staff to deliver care. Five of the six wards had a full range of specialists to meet the needs of the patients on the ward. Psychologists provided one to one and group therapies for patients.
- Managers ensured staff received supervisions and facilitated regular team meetings. The psychology team supported staff with reflective practice sessions and de briefs following incidents.

However:

- Foxhall House had no psychology input at the time of our visit. Managers were arranging cover whilst the post was recruited to.

Is the service caring?

Good ➔➔

Our rating of caring stayed the same. We rated it as good because:

- Staff treated patients with kindness and respect. Patients told us that staff were very nice, helpful, open minded and friendly. We saw caring interactions between staff and patients.
- Staff involved patients in their care plans and risk assessments. Patients could give feedback on the service and their treatment and staff supported them to do this. Patients were involved in staff recruitment.
- Staff involved carers in their relatives care and supported them to access carers assessments. Staff facilitated regular carers meetings.

Is the service responsive?

Good ➔➔

Our rating of responsive stayed the same. We rated it as good because:

- Staff worked with patients to plan their discharge. Staff supported patients to access support to help them move on, for example, one patient had accessed a grant to redecorate their flat as part of their discharge plan.
- Staff supported patients to meet their goals, examples included a patient completing a business degree and another working as a volunteer in a café. Staff made sure patients had access to opportunities for education and work. Patients had access to a recovery college and to light industry workshops on and off site. Staff supported patients to access activities in the community, including sailing, rambling and dog walking.

Forensic inpatient or secure wards

- Patients knew how to complain or raise concerns. Staff dealt with complaints in line with the trust policy. Managers investigated complaints and identified themes.
- Patients were able to personalise their bedrooms and had access to drinks and snacks.

However:

- The trust had not ensured facilities promoted comfort and dignity of patients on Drayton ward. There were only two bathrooms and two toilets for 16 patients and bedrooms were not ensuite. The manager had requested funds for work to be done to improve facilities and had been told there was no capital available.

Is the service well-led?

Good 

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

- Managers of the service provided strong, local leadership. Managers used dashboard information to monitor and improve the performance of their teams.
- Team morale was positive. Managers ensured staff were supported in their roles through supervision, team meetings, reflective practice sessions and training.
- Managers could raise issues in monthly clinical governance meetings. One manager had raised concerns about staff due to leave and the impact on his service. Senior managers had committed to provide staff from another service to support.

However:

- The trust had not ensured learning from serious incidents was shared at ward level. The trust had not shared learning from a patient death in 2014. There was a patient death in the forensic service in 2017. Both patients died after using the same style of ensuite door as a ligature anchor point. The trust was planning to pilot anti-ligature ensuite doors in new bathrooms but were not replacing existing ensuite doors.
- The trust had not embedded clear governance procedures to ensure the safe management of medicines and emergency equipment.
- The trust had not acted to ensure seclusion rooms were safe following the issuing of a section 29a warning notice in June 2018.

Specialist community mental health services for children and young people

Inadequate

Key facts and figures

Norfolk and Suffolk NHS Foundation Trust provides specialist community mental health services for children and young people for patients aged 0 to 25 years throughout Norfolk and Suffolk under one registered location: Hellesdon hospital.

We inspected six of the specialist community mental health services for children and young people

provided by this trust to look at those parts of the service that did not meet legal requirements and

as we received information giving us concerns about the safety and quality of the services.

Great Yarmouth and Waveney, Child, family and young people's service, Northgate Hospital, Great Yarmouth. Teams include, 0-14 years, 14-25 years youth and crisis teams.

West Norfolk Child, family and young people's service, Thurlow House, Kings Lynn (0-25 years) Teams include, 0-14 years, 14-25 years youth team and crisis teams.

Central Norfolk Child, Family and young Person Service, St Stephen's Road, Norwich (14 to 26 years) Teams include14-25 years youth and crisis teams.

Bury South Integrated delivery team, Hospital Road, Bury St. Edmunds (0-25 years). Includes, 0-14 years and 14-25 years youth teams.

Ipswich Integrated delivery team, Mariner House, Ipswich (0-25 years) Includes, 0-14 years and 14-25 years youth teams.

Emotional Wellbeing Hub Suffolk, Landmark House, Ipswich (0-25 years). Suffolk multi agency triage team for referrals.

We did not inspect all other specialist community mental health services for children and young people previously rated requires improvement. We are monitoring the progress of improvements to services and will re-inspect them as appropriate.

At this inspection we found that this core service had not fully addressed actions from our 2017 inspection. We found breaches of:

- Regulation 12 HSCA (RA) Regulations 2014 Safe care and Treatment
- Regulation 16 HSCA (RA) Regulations 2014 Receiving and acting on complaints
- Regulation 17 HSCA (RA) Regulations 2014 Good governance
- Regulation 18 HSCA (RA) Regulations 2014 Staffing

The trust had addressed some findings of the inspection in 2017 and was no longer in breach of:

- Regulation 10 HSCA (RA) Regulations 2014 Dignity and respect
- Regulation 13 HSCA (RA) Regulations 2014 Safeguarding service users from abuse and improper treatment

The CQC have registered the location Hellesdon Hospital (which this core service is under) for the following regulated activities:

Specialist community mental health services for children and young people

- Assessment or medical treatment for persons detained under the Mental Health Act 1983
- Treatment of disease, disorder or injury.

Our inspection of this core service in September 2018 was announced (staff knew we were coming) to ensure that everyone we needed to talk to was available.

Before the inspection visit, we reviewed information that we held about these services and information requested from the trust.

The inspection team visited community teams on 4, 5, 6, 11,12, and 20 September 2018.

During the inspection visit, the inspection team:

- visited teams to look at the environment
- spoke with seven patients who were using the service
- spoke with seventeen carers of patients who were using the service
- reviewed 22 comments forms received from patients or their carers
- spoke with three operational managers, one community services manager and eight clinical team leads
- spoke with 42 staff including nurses, support workers, doctors, occupational therapists, peer support worker, psychologists, social workers and administration staff
- observed four staff meetings or contacts with patients including a triage and multi-disciplinary team meeting, observation of a triage call and safeguarding case discussion
- reviewed 40 patient care and treatment records including, referral information, risk assessments and care plans.
- reviewed 24 staff records including supervision, appraisal and training records
- reviewed a range of policies, procedures and other documents relating to the running of the service.

Summary of this service

Our rating of specialist community mental health services for children and young people went down. We rated it as inadequate because:

- Not all issues reported at previous inspections had been addressed. We rated safe, responsive and well-led as inadequate. We rated effective as requires improvement and caring as good.
- The trust had not ensured adequate leadership and governance to address all actions from our 2017 inspection. These related to managing patient waiting times for allocation of care coordinators, risk plans, ligature assessment, supervision and ensuring all teams within the children's, family and young people's service were working to common goals and practices.
- The trust had not ensured a clear overarching strategy and development plan for children's, family and young people's services Twenty out of 53 staff raised concerns with us about the management and senior leadership of their service and a lack of understanding of children and young people's services at board level. This was particularly evident in Suffolk where many staff spoke to us about disconnection from trust decision making; not being involved in changes that affected them and the belief that the trust was Norfolk centred.

Specialist community mental health services for children and young people

- The service did not have adequate systems for monitoring, assessing and mitigating the risks to patients. The service did not have access to clear information about the number of patients waiting for triage, assessment and treatment across this service. The risk register did not capture all the risks for this service. The service did not consistently meet their target for under 18 routine referrals for assessment or their target for under 18 referrals for treatment. Teams had reported five incidents from June to August 2018 where they had not met commissioned targets for waiting times. There had been five complaints in June to August 2018 about waiting list times. Patients with attention deficit hyperactivity disorder often faced longer waits due to limited resources and system backlogs. Staff did not always record comprehensive risk assessment of patients as we could not find 13 out of 40 records. Staff had not completed crisis plans or advanced decisions for 22 patients. Staff had not developed comprehensive care plans, for nine out of 40 patients. Staff had not always reviewed and updated care plans when patient's needs changed. Trust data for July 2018 data showed teams were not achieving the trust target of 95% compliance for ensuring records were up to date.
- Managers did not have easy access to data, which posed a risk they would not have clear information to be able to check how their team was performing. They expressed concern that the systems did not accurately capture information for example data on appraisals, supervisions and staff turnover. Managers did not ensure that Bury South IDT staff received regular supervision. Systems showed 75% compliance with staff appraisal and 70% compliance for staff supervision. A sample of five staff records showed that supervision did not take place regularly with sufficient quality. The trust had not ensured that all staff understood or were following the trust's complaints policy at South Bury Integrated delivery team. There was no evidence of any trust response to a complainant.
- The trust had not ensured adequate staffing to meet the needs of the service. This meant patients often waited a long time before receiving triage, assessment and treatment. This posed a risk to patients' safety. We found examples where patients' situations had deteriorated and they needed urgent support as they posed a risk to themselves or others. The trust had set up in April 2018 a multi-agency 'emotional well-being hub'. This team triaged referrals for young people needing health or social care across Suffolk. They were under resourced and had 394 patients awaiting triage 13 September 2018 and it took staff on average 28 days to contact patients and then direct them to the right service. Additionally, the trust had difficulties gaining medical cover for Suffolk to meet patients' needs which had led to backlogs for appointments. Managers across the trust said there were difficulties recruiting staff. The staff vacancy rate for this core service was 8% as of 31 May 2018. This was higher than the 3% rate reported at the last inspection.
- The service did not have adequate oversight of ligature risk assessments for premises where staff saw patients. Managers had not completed accurate ligature assessments at four locations. The ligature assessments did not fully capture risks for newly refurbished toilets. This meant staff would not be fully aware of the higher risk areas which needed more supervision. Staff were not following trust processes for infection control as four sites did not have cleaning rotas for treatment rooms and toys. Great Yarmouth and Waveney site had four out of six threadbare chairs in a patient group room, which would be hard for staff to keep clean.

However:

- Staff were proud of their work and showed commitment to giving a good service for patients and their carers, despite the challenges they faced. Patients and carers told us that when staff gave care and treatment it was often excellent. Staff were non-judgemental and gave patients choices about their care and treatment. Carers gave examples of where staff had gone out of their way to get support for them as well as the patient.
- Staff delivered care in line with best practice and national guidance (from relevant bodies e.g. National Institute for Health and Care Excellence), for example family therapy, cognitive behavioural therapy and cognitive analytic therapy. Teams such as Great Yarmouth and Waveney youth team had identified clinical pathways and provided information packs to give patients support with trauma, emotional instability mindfulness, hearing voices, self-harm and unusual beliefs. Norfolk teams used 'patient outcome data' to check the effectiveness of their service. Staff used

technology such as tablets for patients to complete outcome measures such as the 'revised children's anxiety and depression scale' and 'clinical outcomes in routine evaluation'. The trust had identified research leads and had a research development programme. Staff produced reports sharing information with teams about research relevant to their work.

- The trust had provided a range of specialist services. These included a service in Suffolk for young people up to 18 years, who were adopted, looked after or in special guardianship, child arrangement or kinship care. This service also offered support to carers or families. The trust had developed a specialist community perinatal mental health service with midwives at Ipswich Hospital and West Suffolk Hospital. The trust had services for patients with an eating disorder or early psychosis. The trust had a youth justice team for patients in contact with criminal justice services. Staff said they had effective working relationships with other teams in and external to the organisation. Examples, included working with local acute hospital and paediatric teams, schools, colleges and universities. Staff made sure patients had access to opportunities for education and work. Staff liaised with schools regarding further observation and assessment to gain a better understanding of children's needs.
- The trust had ensured that most staff had completed and were up to date with their mandatory training when we visited. Teams achieved above 80% compliance. The trust had acted following our 2017 inspection to ensure that most staff were competent in the use of the electronic recording system, and staff reported they were confident in being able to use the systems. The emotional well-being hub had recruited a peer support worker and were developing peer support volunteers for 2019.

Is the service safe?

Inadequate 

Our rating of safe went down. We rated it as inadequate because:

- The trust did not have adequate systems for monitoring, assessing and mitigating the risks to patients. The service did not have access to clear information about the number of patients waiting for triage, assessment and treatment across this service. Norfolk and Suffolk teams had differing systems for monitoring the levels of risk for patients and the length of time they had been waiting for a service. The trust had not ensured that their risk register captured all the risks for this service as teams had varying entries for example about waiting times or staffing. Staff did not always record a risk assessment of patients as 13 of 40 patients care and treatment records did not have comprehensive risk assessments following allocation. Staff had not completed crisis plans or advanced decisions for 22 patients. It was not clear how staff were monitoring and reviewing incidents for patients on their waiting lists.
- The trust had not ensured there were enough staff to meet the needs of the service. This meant patients often waited a long time before receiving triage, assessment and treatment. This posed a risk to patient's safety. We found examples where patients' situations had deteriorated and they needed urgent support as they posed a risk to themselves or others. The trust had set up in April 2018 a multi-agency 'emotional well-being hub'. This team triaged referrals for young people needing health or social care across Suffolk. They were under resourced and had 394 patients awaiting triage 13 September 218 and it took staff on average 28 days to contact patients and then direct them to the right service. Additionally, the trust had difficulties gaining medical cover for Suffolk to meet patient's needs which had led to backlogs for patient appointments. Managers across the trust said there were difficulties recruiting staff. The staff vacancy rate for this core service was 8% as of 31 May 2018. This was higher than the 3% rate reported at the last inspection.
- Not all premises were clean and tidy and not all environmental risks were managed effectively. Infection control processes were not robust as most sites did not have cleaning rotas for treatment rooms and toys. Great Yarmouth and Waveney had four out of six threadbare chairs in one patient group room. Staff at Central Norfolk, St Stephen's

site stored items inappropriately, including near a fire escape route. Actions to address environmental risks were still required at Meridien House. Managers had not completed accurate ligature assessments at four locations. The ligature assessments did not fully capture risks for newly refurbished toilets. This meant staff would not be aware of the higher risk areas which needed more supervision.

However:

- The trust had identified the need for additional staffing to reduce waiting lists. Managers used a caseload weighting tool to support staff with their work. The trust had ensured that most staff had completed and were up to date with their mandatory training when we visited. Teams achieved above 80% compliance.
- The service had acted to address the safeguarding concern from our 2017 inspection regarding the patients' waiting area at Thurlow House. Staff had access to personal alarms when interviewing patients in rooms. West Norfolk, Thurlow House had set up a new clinic and treatment area. Staff at East Suffolk child treatment centre, Walker Close had developed a safety training pack.
- Managers investigated serious incidents, gave feedback to staff and shared learning from serious incidents outside their team. The trust had ensured that staff received training in safeguarding that was appropriate for their role. Staff knew how to recognise if children or adults were at risk of, or suffering harm and worked with other agencies to protect them.

Is the service effective?

Good ↑

Our rating of effective improved. We rated it as good because:

- Staff delivered care in line with best practice and national guidance (from relevant bodies e.g. National Institute for Health and Care Excellence), for example family therapy, cognitive behavioural therapy and cognitive analytic therapy. Teams such as Great Yarmouth and Waveney youth team had identified clinical pathways and provided information packs to give patients support with trauma, emotional instability, mindfulness, hearing voices, self-harm and unusual beliefs. The emotional well-being hub had recruited a peer support worker and were developing peer support volunteers for 2019.
- Norfolk teams used 'patient outcome data' to monitor the effectiveness of their service. Staff used technology such as tablets for patients to complete outcome measures such as the 'revised children's anxiety and depression scale' and 'clinical outcomes in routine evaluation'.
- Staff had effective working relationships with other teams in and external to the organisation. Examples, included working with local acute hospital and paediatric teams, schools, colleges and universities. Staff liaised with schools regarding further observation and assessment to gain a better understanding the children's needs.

However:

- The trust had not acted to complete all actions from our 2017 inspection. Managers had not ensured Bury South Integrated delivery team received regular supervision. Trust data systems showed 75% compliance with staff appraisal and 70% compliance for staff supervision. We checked a sample of five staff records which showed that supervision did not take place regularly with sufficient quality.

Specialist community mental health services for children and young people

Is the service caring?

Good 

Our rating of caring stayed the same. We rated it as good because:

- Seven patients and 14 carers of patients told us that when staff gave care and treatment it was often excellent. Staff were very kind, respectful, non-judgemental and responsive.
- Staff supported patients to understand and manage their own care, treatment and condition, for example by giving leaflets, books and talking to patients about medication and side effects. Staff understood and respected the individual needs of the patient's receiving treatment.
- Staff involved patients and gave them copies of care plans. Staff made sure patients understood their care and treatment. Staff involved patients in decisions about the service, when appropriate. Carers said that staff often gave them support or helped them to access their own support.

However:

- The trust had not ensured staff fully documented their consultation with patients (or carers) in records in 15 out of 40 records.

Is the service responsive?

Inadequate 

Our rating of responsive went down. We rated it as inadequate because:

- The service did not ensure that patients were receiving the service they needed in a timely way. Patients often waited a long time before receiving assessment and treatment. Thirty-two staff out of 52 staff raised concerns about waiting lists and the time it took to offer patients a service. Three hundred and ninety-four patients in Suffolk were awaiting triage at 13 September 2018 and it was taking staff on average 28 days to contact patients and then direct them to the right service. The trust stated 636 patients were waiting for treatment as of 20 September 2018. Information supplied during the inspection stated that the longest wait for patients was from May 2018. However, additional information provided showed that thirty-six patients had been waiting since referred in 2013. They could not give an accurate list for the number of patients waiting for assessment.
- They did not always meet their target for under 18 routine referrals assessed in 28 days. The target for under 18 referrals 'treatment within standard' (15 weeks) was not always met. Teams had reported five incidents from June to August 2018 where they had not met commissioned targets for waiting times.
- The service had not taken adequate measures to reduce the waiting time to allocate care co-ordinators to patients.
- The trust did not have adequate resources to support patients with attention deficit hyperactivity disorder. These patients often faced longer waits due to limited resources and system backlogs. West Suffolk IDT had 86 patients on the waiting list for assessment, of these 59 were waiting 18 weeks. The longest wait for the service was from 22 March 2017.
- Staff were not always able to give patients help, emotional support and advice when they needed it due to the long waiting list for triage, assessment and treatment of patients. Two patients and four carers raised concerns about the

length of time it took to access the service. Four patients said that the trust gave a limited service. The trust had received five complaints between June and August 2018 about waiting list times. The trust had not ensured that all staff understood or were following the trust's complaints policy. There was no evidence of any trust response to one complainant.

However:

- The trust had a range of specialist services. These included a service for young people up to 18 years in Suffolk, who were adopted, looked after or in special guardianship, child arrangement or kinship care. This service also offered support to carers or families. The trust had developed a specialist community perinatal mental health service with the midwives at Ipswich Hospital and West Suffolk Hospital. The trust had services for patients with an eating disorder or early psychosis. The trust had a youth justice team for patients in contact with criminal justice services. The trust had started a consultation exercise in Suffolk to look at an 'Under 18s Crisis Pilot Model' and the level of need for this service, to provide a similar service as they had for patients in Norfolk.
- The service had met their target of 95% compliance for staff assessing emergency referrals for patients under 18 years, within four hours as detailed in their 'Operational Performance Dashboard' August 2018. Staff were trying new approaches to reduce their workload. For example, West Norfolk, Thurlow House staff were setting up a 'discharge café' for staff to improve discharge planning for patients and increase throughput. The assessment and intensive support team had started an 'early help' short term intervention work with patients.

Is the service well-led?

Inadequate

Our rating of well-led went down. We rated it as inadequate because:

- The trust had not ensured adequate leadership and governance to address all actions from our previous inspections. These related to managing patient waiting times for allocation of care coordinators, risk plans, ligature assessment, supervision and ensuring all teams within the children's, family and young people's service were working to common goals and practices. Additionally, we found at this inspection that the trust oversight of infection control needed improvement.
- The trust had not ensured a clear overarching strategy and development plan for children's, family and young people's services. Twenty out of 53 staff raised concerns with us about the management and senior leadership of their service. They rarely had opportunities to meet together to share learning. This was particularly evident in Suffolk where many staff spoke to us about disconnection from trust decision making; not being involved in changes that affected them and the belief that the trust was Norfolk centred. Staff told us that the board did not evidence understanding of specialist community mental health services for children and young people. Not all staff felt respected, supported and valued by their team and wider management.
- The service did not have adequate systems for monitoring, assessing and mitigating the risks to patients. The service did not have access to clear information about the number of patients waiting for triage, assessment and treatment across this service. Trust data provided did not correlate with our findings on site for example about length of time on waiting lists and the number of patients identified as high risk. Managers did not have easy access to data, which posed a risk as they did not have clear information to be able to check how their team was performing. They expressed concern that the systems did not accurately capture information, for example, data on appraisals, supervisions and staff turnover. Managers often relied on others to find information for them. The trust had not ensured that all staff understood or were following the trust's complaints policy, for example in South Bury integrated delivery team in Suffolk.

Specialist community mental health services for children and young people

- The service had not audited or reviewed their systems following changes to the emotional wellbeing hub taking over triaging referrals for teams in Suffolk in April 2018. Staff experienced challenges trying to get through the volume of referrals.

However:

- Staff were proud of their work and were committed to giving a good service for patients and their carers, despite the challenges they faced.
- The trust had identified research leads and had a research development programme. Staff produced reports sharing information with teams about research relevant for their work.

Wards for older people with mental health problems

Requires improvement 

Key facts and figures

Norfolk and Suffolk NHS foundation Trust provides inpatient care to older patients in eight wards at four locations. There are 114 beds in total.

At Julian Hospital, Norwich in the Norfolk area there are four wards for older patients.

- Sandringham Ward is an acute admissions unit. It provides care and treatment to men and women with 'complexities in later life' including functional mental health diagnosis. It has 16 beds, at the time of inspection there were 14 patients.
- Beach ward is an acute admission ward for men with dementia. It offers assessment, and treatment for patients with acute care needs. It has 13 beds, at the time of inspection there were 12 patients.
- Rose Ward is a mixed gender, sub-acute treatment ward for men and women experiencing dementia. It has 13 beds, at the time of inspection there were 12 patients.
- Reed Ward is an acute admission ward for women with dementia. It offers assessment and treatment for patients with acute care needs. It has 12 beds, at the time of inspection there were 11 patients.

At Carlton Court, Lowestoft in the Great Yarmouth and Waveney area there is one ward, known as Laurel Ward. This ward is the combination of two former wards known as Foxglove and Fernwood wards.

- Laurel Ward is an 11 bedded mixed gender ward for patients with a diagnosis of dementia who require continuing assessment.

At Ipswich hospital in the East Suffolk area, there is one ward known as the Willows, it is divided into two distinct and separate areas for older adults.

- The Willows is a mixed gender admission, assessment and treatment unit. It provides assessment, care and treatment for men and women with 'complexities in later life' including functional mental health diagnosis and dementia. The ward has 21 beds, 11 beds for patients experiencing dementia, and 10 beds for patients experiencing functional mental illness. At the time of inspection there were 9 and 8 patients respectively.

At West Suffolk Hospital, Bury St Edmunds there is one ward for older patients known as Abbeygate, divided into two wards known as Laurel and Maple.

- Laurel Ward is a mixed gender acute admission and treatment ward for older people with dementia. It has 7 beds, and at the time of inspection there were 5 patients.
- Maple Ward is a mixed gender, acute admission and treatment ward for older people with functional mental illness diagnosis. It has 10 beds, and at the time of inspection there were 10 patients.

The last comprehensive inspection of this core service was in July 2017. At that time, we found the service had breached the following regulations: -

Regulation 12 - Safe care and Treatment.

- There were several medicines management issues. These included medicines being out of date, and opened creams and liquid medications that staff had not labelled with patient details or dates of opening.

Regulation 13 - Safeguarding service users from abuse and improper treatment.

Wards for older people with mental health problems

- Staff had made Deprivation of Liberty Safeguards applications for a number of patients. Out of 43 active applications only seven had been authorised. On six wards the urgent authorisation had expired and there was no evidence that staff had applied for an extension. On another ward staff had secluded a patient twice without a Deprivation of Liberty Safeguards authorisation in place.
- Staff had not completed seclusion records for one patient in line with the trust policy. Observations had not been recorded, there was no seclusion care plan for one episode and the name of the practitioner who authorised the second seclusion had not been recorded.

Regulation 15 – Premises and Equipment

- The seclusion room on Abbeygate did not comply with the Mental Health Act code of practice.

Regulation 18 – Staffing

- There were staff shortages across most wards. We saw evidence that wards often ran below established staffing levels.

At time of this inspection we found the Trust had addressed some of these issues by removing all seclusion rooms in the service. The Trust had carried out a review of staffing establishment across six of the eight wards, the remaining two wards due for review within the following month. Ward managers were ensuring that all staff were aware of their responsibilities to adhere to trust policy about medication management and storage, and we did not find any significant errors on this occasion. Managers had revised the processes for monitoring Deprivation of Liberty safeguard applications, and adherence to Mental Health Act and Mental Capacity administration.

Our inspection carried out between 3 – 14 September 2018, was comprehensive and announced (staff knew we were coming) to ensure that everyone we needed to talk to was available. Before the inspection visit we reviewed information that we held about this core service and information we had requested from the Trust.

The inspection team visited all eight wards in this core service. During the visit the inspection team:

- visited all eight wards, looked at the quality of the service environment and observed how staff were caring for patients
- spoke with 18 patients who were using the service
- interviewed eight ward managers or their equivalent, two matrons and two service managers
- spoke with 39 other staff members; including doctors, nurses, psychologists, occupational therapists, activity workers and healthcare assistants.
- attended and observed three multidisciplinary meetings, one handover meeting and one complex care planning group
- spoke with 9 carers of patients using the service
- looked at 32 treatment records of patients
- looked at 46 medication charts for patients using the service
- attended and observed three lunchtime groups
- looked at a range of policies, procedures and other documents related to the running of the service.

Summary of this service

Wards for older people with mental health problems

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

- The disconnect between local services and the senior leadership impacted on the ability of the service to offer a safe service. Staff did not feel connected to the wider trust, and the senior managers did not involve service staff in decisions about their services. Staff on wards, including ward level leaders, expressed frustration about senior leadership decisions and that they were not involved in the decision making when they had the specialist knowledge of their environments and risks. Examples of this included trust wide decisions relating to environmental works, such as replacement and reduction of ligature points. While reducing or replacing some ligature points in this service they had created others.
- Staff described visible local leadership to service manager level, but felt above that role there was a lack of visibility and understanding of the needs of their service. There was a lack of response about issues significant to their wards, such as not supporting ward managers to manage infection control.
- Ward staff gave examples supporting their opinion that the leadership team had unfairly blamed them for inadequacies on their wards that they had no control.
- On Laurel ward the controlled drugs keys were not kept safely. They were available to staff even if they were not authorised.
- There were no processes in place for the sharing of ideas and best practice across the Norfolk and Suffolk teams.

However:

- Managers had been successful in nurse recruitment for this service, with lower than trust average for vacancies.
- Staff who had received training in dementia awareness completed a comprehensive mental health assessment for each patient either on admission or soon after. Staff developed comprehensive care plans for each patient that met their mental, emotional, nutritional, and physical health needs. Managers encouraged staff to use new evidence based techniques and technologies to support the delivery of high quality care. Staff used recognised rating scales to assess and record the severity of patient conditions and care and treatment outcomes.
- Managers recognised the continuing development of staff skills, competence and knowledge as being integral to ensuring high quality care. The mandatory training rate for this service was 92% compared to 88% at the last inspection and higher than the trusts target of 85%. Where mandatory training was not older person specific, ward managers offered supplementary, bespoke training for their staff. Data provided at inspection showed this services' appraisal rate was 99%, and the supervision rate ranged between 93% and 100% across all wards. The trust target for appraisal and supervision was 89%.
- Staff treated patients with kindness and respect. Feedback from patients, those who were close to the patients and stakeholders was positive about the way staff treated people. We saw that most staff could anticipate patients' needs and were able to give help, emotional support and advice when they needed it. Staff supported patients to understand and manage their own care treatment or condition. Staff directed patients to other services as needed, including referral services such as podiatry and dentistry, and supported them to access those services if needed.
- Managers ensured beds were available when patients needed them. Patients only moved between wards during admission when there were clear clinical reasons or it was in the best interest of the patient. Staff did not move or discharge patients at night or very early in the morning. Managers ensured they did not discharge patients before they were ready.

Wards for older people with mental health problems

- Patients had personalised swipe wrist bands that staff had programmed to allow access to specific parts of the ward. The service had a full range of rooms and equipment to support treatment and care. The Patient-Led Assessments of the Care Environment (PLACE) score for ward food at two locations scored higher than similar trusts which was 91.5%. Willow ward was 99.5%, and Laurel 98.5%, while Rose, Reed, Beach and Sandringham scored 89.4%. The service received five times more compliments than complaints for the period 01 June 2017 to 31 May 2018.

Is the service safe?

Requires improvement 

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

- There were outstanding ligature reduction works on some wards, because the ligature work already carried out had created new ligature anchor points.
- There were potential infection control risks on most wards, specifically fabric covered chairs on most wards. On Sandringham ward most areas of the ward was carpet rather than waterproof floor coverings. Ward mangers expressed frustration that despite having had their requests for new furniture approved, the procurement process had taken a long time, and there were still delays and uncertainty about delivery dates. We saw evidence of how senior management had refused requests for replacement floor coverings for Sandringham ward, thereby allowing the ward to remain an infection control risk.
- On Laurel ward the controlled drugs keys were not just available to authorised staff only. Staff kept the controlled drugs keys on same key ring as the main clinic keys. Also, the staff member who held the keys at the time of inspection did not realise the controlled drugs should be on a separate key ring or why, though once the inspector had pointed this out the manager rectified the situation.

However:

- Wards were clean and tidy, staff cleaned ward areas regularly and kept cleaning records up to date. Patient-Led Assessments of the Care Environment (PLACE) scores for (2017), showed the locations scored higher than similar trusts for cleanliness and two locations scored higher than similar trusts for condition, appearance, and maintenance.
- Staff had reduced use of restrictive practice, supported by a management group leading the way in least restrictive practice implementation. Some wards, Abbeygate, Laurel and Willows had recently introduced positive behaviour support planning for patients. There were no seclusion rooms in this service, staff used effective de-escalation strategies and techniques. On the few occasions that seclusion had taken place staff carried out the process discreetly in quiet areas of the wards or occasionally patients' bedrooms. Staff reported all incidents of seclusion and correctly documented and monitored them in line with Mental Health Act code of practice.
- Staff completed patients' risk assessments and risk management plans were to a high standard. The assessments included, mental, physical, social, and emotional risks. Staff checked historical risk information with family and carers for accuracy and context. On most wards, when a patient had three or more falls this automatically triggered a multidisciplinary review of the patients' risks and treatment plans.
- Staff training was up to date. Mandatory training compliance for this service was 92% compared to 88% at the last inspection, and higher than the trust's target of 85%. Where mandatory training was not older person specific, ward managers offered supplementary, bespoke training for their staff using real time examples from their wards to aid this training.

Wards for older people with mental health problems

Is the service effective?

Good ↑

Our rating of effective improved. We rated it as good because:

- Staff completed a comprehensive mental health assessment for each patient either on admission or soon after. There was a holistic approach to assessing, planning, and delivering care and treatment. Managers actively encouraged staff to use safe innovative and pioneering approaches to delivering care and treatment. These included psychiatrists on Abbeygate sharing their knowledge of the Butterfly model (a research based, integrated approach to person centred dementia care planning) with other staff.
- Staff assessed all patients' physical health needs, including nutritional needs, on admission then regularly reviewed these during their time on the ward. Staff developed a comprehensive care plan for each patient that met the mental and physical health needs. Staff regularly reviewed and updated care plans when patients' needs changed. Staff used evidence based techniques and technologies.
- Managers proactively supported staff to gain new skills and share best practice. Examples included the development of an observation and engagement group open to all staff from wards at Julian Hospital. This group was facilitated and monitored by a ward manager, psychologists, and a project manager, bringing together highly experienced staff including dementia champions. The group formulated individualised care management plans to meet the needs of patients where traditional care planning strategies had not been effective. Psychology assistants monitored the care plans, evaluated, and wrote up the findings. Staff used the outcomes of to inform future care plans, staff learning and research.
- Staff used recognised rating scales to assess and record the severity of patient conditions and care and treatment outcomes. These included, model of human occupation screening tool, the pool activity level (a checklist providing guidance as to a person's ability in several different activities), Addenbrookes cognitive examination, Middlesex elderly assessment of mental state and Montreal cognitive assessment.
- Staff had a holistic approach to planning people's discharge, transfer or transition to other services. Staff planned discharge as early as possible. Arrangements fully reflect individual circumstances and preferences.
- Managers supported staff to deliver effective care and treatment, through meaningful and timely supervision, appraisal, training, and coaching. Data provided at inspection showed the appraisal rate was 99%. Supervision rates ranged between 93% and 100% across all wards, and the trust target for appraisal and supervision was 89%. On Abbeygate specialist training and coaching included a facilitated, and protected one hour per week reflective practice and training session. The ward manager checked who was attending these sessions to ensure that all staff had opportunity to attend at least two sessions per month.
- Managers ensured that they supported staff in their roles. We saw evidence of managers and mentors supporting relevant staff through the process of revalidation. There was a clear approach for supporting and managing staff when their performance was poor or variable.

However:

- There were no formal processes for sharing ideas and best practice across the Norfolk and Suffolk teams. However, Sandringham ward had a sharing best practice folder for staff, and managers had made attempts to share best practice across teams within their geographical area.

Wards for older people with mental health problems

Is the service caring?

Good ➔➔

Our rating of caring stayed the same. We rated it as good because:

- Staff treated patients with kindness and respect. Feedback from patients, those who were close to the patients and stakeholders was positive about the way staff treated people.
- Staff were discreet, respectful, compassionate, and responsive when caring for patients, including those times when helping with personal care and medication administration. We saw staff interacting with patients during the day and at lunchtimes, we saw that most staff anticipated patients' needs and were able to give help, emotional support, and advice when they needed it.
- Staff involved patients and gave them access to their care plans and risk assessments. Staff made sure patients understood their care and treatment, and found ways to communicate with patients who had communication difficulties. Staff involved patients in decisions about the service, when appropriate. Patients could give feedback on the service and their treatment and staff supported them to do this. Staff achieved this through a series of community meetings and council meetings.
- Staff supported patients to maintain and develop their relationships with those close to them, and their social networks in the community.
- Staff involved family and carers in the service. Family and carers received regular news letters about activities and ward news, from ward staff. A senior staff member contacted the main carer or next of kin 72 hours after admission to establish factual information such as patients' preferences, risk behaviours, and presentation at home prior to admission. Staff contacted family members before and after any multidisciplinary meetings, ward rounds or care program approach meetings.

However:

- We did not see any carers assessments in the patients' care notes, though staff had told us they usually offered all carers the opportunity of having a carers assessment.

Is the service responsive?

Good ➔➔

Our rating of responsive stayed the same. We rated it as good because:

- Managers ensured beds were available when patients needed them. The trust reported that for the period 01 June 2017 and 31 May 2018 bed occupancy for this service ranged from 75% on Laurel ward, 91% on Abbeygate, 98% on Beach, Willow and Reed wards, and 100% on Sandringham and Rose wards. The trust's benchmark during this period was 85%. At the time of inspection there were three out of area placements. When patients went on leave there was always a bed available when they returned. Patients only moved between wards during admission when there were clear clinical reasons or it was in the best interest of the patient. Staff did not move or discharge patients at night or very early in the morning. Staff could usually locate a psychiatric intensive care bed if a patient needed more intensive care and always tried to ensure that this was not far away from the patient's family and friends.
- At the time of inspection, the service had seven delayed transfers of care. In all cases the delays were due to lack of local authority funding or availability of placements. Ward staff were addressing this issue by closer liaison with

discharge teams, adult social care and in house early or supported discharge planning. Managers and staff ensured they did not discharge patients before they were ready. Managers on Sandringham ward and Abbeygate used a red to green tracking system to monitor patients' progress towards discharge. Staff ensured that patients or their carers had copies of all discharge paperwork including any aftercare plans.

- The trust ensured facilities promoted recovery, comfort and dignity. Each patient had their own bedroom that they could personalise and access at all times. Patients had personalised swipe wrist bands that staff had programmed to allow access to specific parts of the ward. For example, male patients could access the male bedroom corridors but not the female areas.
- The service had a range of rooms and equipment to support treatment and care, including assisted bathrooms, therapy rooms, clinics for examinations and treatments, and sensory rooms. Wards had equipment and resources available for patients who had regular falls such as sensors at floor level in bedrooms and low profiling beds. Dining areas were large enough to accommodate all patients and their needs, quiet areas and outside spaces were available to patients, and rooms where patients could meet with visitors in private. Patients had a secure place to store personal possessions.
- Staff provided high quality food. The Patient-Led Assessments of the Care Environment (PLACE) score for ward food at two locations scored higher than similar trusts which was 91.5%. Willow ward was 99.5%, and Laurel 98.5%, while Rose, Reed, Beach, and Sandringham scored 89.4%. The trust did not submit a score for Abbeygate.
- Patients were happy with their care. The service received five times more compliments than complaints for the period 01 June 2017 to 31 May 2018, reflecting that patients and carers appeared satisfied with their care.

However:

- Not all signage on the dementia wards was dementia friendly. Such as directional and instructional signage. Not all information was available in easy read format. Though staff advised us they could print off information in larger font and other languages as needed.

Is the service well-led?

Requires improvement

Our rating of well-led went down. We rated it as requires improvement because:

- The disconnect between local services and the senior leadership impacted on the ability of the service to offer a safe service. The trust leadership team did not involve staff in decisions about the service. Staff on wards, including ward level leaders, expressed frustration about senior leadership decisions and that they were not involved in the decision making when they had the specialist knowledge of their environments and risks. Examples of this included trust wide implementation of environmental works, such as replacement and reduction of ligature points. While reducing or replacing some ligature points in this service they had created others, like replacing handrails around toilets with anti -ligature rails they had also installed new handrails around the sinks in the same rooms with non-anti- ligature rails.
- Staff did not feel connected to the wider trust. They described visible local leadership to service manager level, but felt above that role there was a lack of visibility and understanding of the needs of their service. We heard examples where local leaders felt there was a lack of response from the trust about issues significant to their wards. Specifically, fabric covered chairs on most wards in the service, and on Sandringham ward where most areas of the ward was

carpet rather than non-porous floor coverings. This posed infection control risks. Ward mangers expressed frustration that despite having had their requests for new furniture approved the procurement process had taken a long time, some seven months, and there were still delays and uncertainty about delivery dates. We saw evidence of refused requests for replacement floor coverings thereby allowing the ward to remain an infection control risk.

- Ward staff gave examples supporting their opinion that the leadership team had unfairly blamed them for inadequacies on their wards that they had no control.

However:

- Leaders, at local level, had the right skills, knowledge, and experience to lead their teams. They had a clear understanding of the service they managed and knew how their teams worked to provide high quality care. Staff reported that they respected their local leaders and supported them to make sure that cost improvements did not compromise patients care.
- The trust gave opportunity for leaders to develop their skills and for other staff to develop leadership skills. Patients and staff knew who the ward leaders were, they were visible on the wards and staff reported they were approachable.
- The trust provided effective information governance systems. Systems included policy on confidentiality of patient records. Team managers had access to information that supported them. All governance information was accessible, usually correct and showed areas for improvement. Staff notified and shared information with external organisations when necessary, seeking patient consent when required to do so.

Wards for people with a learning disability or autism

Requires improvement 

Key facts and figures

The learning disability wards for Norfolk and Suffolk NHS Trust are located at Walker Close in Ipswich, Suffolk. The wards consist of two bungalows which are used as wards for people aged 18 or older with learning disabilities and/or autistic spectrum disorder. Bungalow three accommodated male patients and bungalow four accommodated female services users.

On the date of inspection, bungalow three had four patients and Bungalow four had three. The service usually offers six beds in total; however, this had been increased to allow the admission of an additional patient. There were no vacant beds.

The service took patients who could not be managed safely in the community. Staff worked alongside a community team which aimed to prevent inpatient admissions.

Care Quality Commission last inspected Walker Close in July 2017, when it was rated good overall. The inspection found the service had breached regulation 12 of the Health and Social Care Act by not ensuring patients received timely access to speech and language assessments. This had been resolved by the time of this inspection.

Our inspection of this service took place in September 2018 and was unannounced, (staff did not know we were coming) to enable us to observe routine activities. The inspection was comprehensive (covered all domains of safe, effective, caring, responsive and well led).

The inspection team visited bungalows three and four Walker Close on 11 September 2018 and additionally on 20 September 2018.

During the inspection visit, the team:

- Spoke to two managers, one ward manager and one service manager.
- Spoke to four other staff members including nurses, healthcare support workers, psychiatrists and occupational therapists.
- Spoke to four patients.
- Observed interactions between four patients and staff members.
- Reviewed five patients' records relating to physical health.
- Reviewed five patients' records relating to patient risk assessments and care plans, and seven prescription charts.
- Reviewed four patients' records relating to Deprivation of Liberty Safeguards.

Summary of this service

Our rating of this service went down. We rated it as requires improvement because:

- The wards did not always involve patients in the planning of their care. Care plans did not document mental capacity assessments or best interest decisions. Documentation did not show that patients with communication difficulties were being supported to make decisions about their care.

Wards for people with a learning disability or autism

- The wards reported higher rates of restraint and seclusion than in the previous reporting period. The room where the service planned to seclude patients in case of emergency did not allow good observation of the room inside. This meant that patients had to be transferred by secure ambulance to another service. The wards did not routinely create positive behavioural support plans.
- Patients who lacked capacity to give consent to treatment were being given antipsychotic medicines outside of an appropriate legal framework. Staff did not always inform patients who were detained under the Mental Health Act of their legal rights. Staff did not always ensure that Deprivation of Liberty Safeguard paperwork was completed and signed correctly.
- Staff had raised concerns about the suitability of the ward environment for patients with learning disabilities and had not had a response. Staff felt that the trust vision for the future of their service was not always communicated to them.
- Staff did not have enough computers to do their jobs.
- Managers did not measure the performance of their service against other providers.

However:

- The wards had fully equipped clinic rooms which staff could use for monitoring the physical health of patients. Emergency equipment and medicines were available and checked regularly.
- The wards had enough nursing staff to provide safe care. Staff completed mandatory training, were supervised regularly and received an annual appraisal. Staff felt respected, supported and valued by the ward manager and had protected time to improve their skills. Staff learnt from incidents by making changes to their procedures. The wards had access to a full multi-disciplinary team and had employed a speech and language therapist since the last inspection.
- Staff provided patients with a range of activities and treatments to meet their needs and monitored their physical health. Staff used a range of methods to communicate effectively with patients. Patients had their own bedrooms, could meet with relatives privately, and were supported to access activities in the community.
- Staff supported patients to prepare for their discharge and made a range of information available on the ward in different formats including other languages and easy read.

Is the service safe?

Requires improvement 

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

- The wards were experiencing higher rates of restraint and seclusion than in the previous reporting period. Staff's opinion was that this was due to there being a different mix of patients at the unit than previously.
- The room where the service planned to seclude patients in case of emergency did not allow good observation of the room inside. This meant that patients had to be transferred by secure ambulance to another service. While a protocol was in place we were concerned that patients would need to be restrained for longer than necessary.
- Staff assessed the wards for ligature anchor points and other risks and mitigated the majority of these. However, the wards had recently had new ligature proof toilets installed, but these included soap and towel dispensers that could be used as a ligature point.

Wards for people with a learning disability or autism

- Medical staff were covering additional duties in community teams which sometimes put pressure on service to the ward.
- Staff were not always debriefed following a serious incident.

However:

- The wards had fully equipped clinic rooms which staff could use for monitoring the physical health of patients. Emergency equipment and medicines were available and checked regularly.
- The wards had enough nursing staff to provide safe care. Managers could bring in additional staff to cover in case of short staffing. Managers ensured bank and agency staff were given a comprehensive induction to the ward.
- Staff mandatory training was 93%.
- Staff knew how to report incidents.

Is the service effective?

Requires improvement 

Our rating of effective went down. We rated it as requires improvement because:

- The wards did not routinely create positive behaviour support plans for patients.
- Care plans did not document mental capacity assessments or best interest decisions.
- Managers did not measure the performance of their service against other providers.
- Patients who lacked capacity to give consent to treatment were being given antipsychotic medicines outside of the appropriate legal framework.
- Staff did not always inform patients who were detained under the Mental Health Act of their legal rights.
- Staff did not always ensure that Deprivation of Liberty Safeguard paperwork was completed and signed correctly.

However:

- Staff provided patients with a range of activities and treatments to meet their needs and monitored their physical health.
- Staff used a range of methods to communicate with patients.
- The wards had access to a full multi-disciplinary team and had employed a speech and language therapist since the last inspection.
- Staff had regular supervision and appraisals.

Is the service caring?

Requires improvement 

Our rating of caring went down. We rated it as requires improvement because:

- Staff did not always involve patients in the planning of their care. Patients were not given copies of their care plans.

Wards for people with a learning disability or autism

- Staff did not make sufficient effort to enable patients with communication difficulties to make decisions about their care. We found little evidence in the documentation that staff had considered communication needs.

However:

- Staff interactions with patients were supportive and respectful. Patients and carers were positive about the staff team.
- Patients were given opportunities to improve the service through patient group meetings.

Is the service responsive?

Good ➔➔

Our rating of responsive stayed the same. We rated it as good because:

- The service had no out of area placements and they had not had to refuse admission to any potential patients. Managers opened additional beds when needed.
- Patients had their own bedrooms and accessed outside and quiet spaces when they wanted to.
- Patients could have visitors and there were private spaces where they could meet them. Patients were supported to maintain contact with relatives.
- Patients could access religious services in their own community. Patients were supported to access activities outside the ward environment.
- Staff supported patients to prepare for their discharge using booklets with goals and tasks. There was a range of information available on the ward in different formats including other languages and easy read.

However:

- The service had had 25 delayed transfers of care during a 12-month period. These discharges, however, were often due to lack of suitable placements for the patients.
- The clinic rooms in the bungalows did not have examination couches. Staff would use the patient's bedroom

Is the service well-led?

Requires improvement ➔

Our rating of well-led went down. We rated it as requires improvement because:

- Staff had raised concerns about the suitability of the ward environment and had not had a response. Staff felt that the trust vision for the future of their service was not always communicated to them.
- The wards were experiencing increased rates of restraint and seclusion but the management team had not acted to address this by adopting positive behaviour support plans.
- Managers did not make sufficient effort to ensure that patients with communication difficulties where enabled to make decisions about their care.
- Managers did not measure the performance of their service against other providers.
- Staff did not have access to enough computers to do their jobs.

Wards for people with a learning disability or autism

However:

- Staff felt respected, supported and valued by the ward manager. All staff felt they could raise concerns without retribution.
- Staff felt they understood the arrangements the trust had with internal and external teams.
- Staff had protected time to complete training and professional development.
- Patients and carers were given opportunities to feed back about the service.

Child and adolescent mental health wards

Outstanding ☆ ➔➔

Key facts and figures

Dragonfly Unit is an eleven-bed acute child and adolescent mental health inpatient unit for male and female young people aged from 12 – 18 years. At the last inspection the unit had seven beds. An additional bed will open from 25 October 2018. At the time of inspection, the unit had ten patients on the unit - one male and nine females.

The Dragonfly Unit primarily serves young people from the Norfolk and Suffolk area, but like all Tier 4 child and adolescent mental health services inpatient units, they can take young people from across England

The Dragonfly Unit opened in September 2016 and was previously inspected in July 2017 when it was rated outstanding overall.

Our inspection of this service took place on 26 September 2018 and was unannounced (staff did not know we were coming) to enable us to observe routine activities. The inspection was comprehensive (covered all domains of safe, effective, caring, responsive and well-led).

The inspection team spent one day on the unit and during the inspection:

- Spoke with one ward manager and one consultant psychiatrist
- Spoke with three other members of staff, including a charge nurse and a support worker
- Spoke with three patients
- Spoke with one carer
- Reviewed three patients care plans, risk assessments and prescription charts
- Reviewed minutes of team meetings and community meetings.
- Visited the education unit and reviewed the weekly timetable of education

Summary of this service

Our rating of this service stayed the same. We rated it as outstanding because:

- The Unit was exceptionally clean, bright, welcoming and well-maintained throughout. Patients were fully involved in designing and planning the further improvements which were being made to the outside area. Patients were protected by a strong comprehensive safety system: The unit had an up to date ligature risk assessment and staff mitigated risk on the unit by using relational security, positive behaviour plans and staff observation alongside convex mirrors and CCTV. The Unit had a positive, non-hierarchal culture where all staff were encouraged to express any concerns, and a focus on openness, transparency and learning when things go wrong.
- The Unit had enough nursing staff to provide safe care. Staff found their jobs rewarding and felt valued, respected and supported by the unit manager. One staff member talked about how lucky they felt to work on the unit. Staff were encouraged to pursue personal and professional development opportunities and seek out, and implement, innovative and best practise, for instance by visiting other services and taking advantage of external training. Staff gave up their free time for the benefit of patients, for example by helping to organise a summer fayre.

Child and adolescent mental health wards

- The service provided age-appropriate structured and individualised therapeutic programmes, group activities including wellbeing and exercise, art therapies and education. Activities were offered in the evenings and at weekends. Staff prioritised daily 1-1 sessions with the patients and they had access to psychologists, occupational therapists, a social worker and a family therapist on the ward. The psychologists and family therapist worked across the ward and community to ensure continuity of care.
- The Unit employed staff to prepare freshly cooked meals on site. Staff discussed with patients their dietary requirements and preferences, including working with them around making healthy choices. The menu was varied and interesting using fresh, locally sourced products. Baking was offered as a therapeutic activity and food tech was part of the education curriculum.
- Care records were comprehensive, person centred, recovery focused and up to date. Care records showed that patients physical health care needs were assessed and monitored. Patients were fully involved in devising their care plans and were given an updated copy every week. Services were tailored to meet the needs of individual young people and were delivered in a way to ensure flexibility, choice and continuity of care.
- Staff were knowledgeable about how both the Mental Health Act and Mental Capacity Act applied or not, to the young people they worked with. Staff sought appropriate consent from patients, for example Gillick competency for examinations and treatment. Staff had explained rights to patients detained under the Mental Health Act and repeated these at regular intervals. Patients had access to a social worker and advocacy and knew how to make a complaint if they needed to.
- The leadership, governance and culture were used to drive and improve the delivery of high-quality person-centred care.
- Feedback from patients and carers was continually positive. Both a patient and carer said that this was the best child and adolescent unit they had been to, that patients were safe and secure and staff took a collaborative approach and were genuinely caring 'without exception'. Patients felt truly respected and valued as individuals and empowered as partners in their care, practically and emotionally, by an exceptional and distinctive service.

Is the service safe?

Good  

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

- There were separate sleeping arrangements for male and female patients that complied with the Department of Health and Mental Health Act 1983 Code of Practice guidelines on eliminating mixed sex accommodation.
- The unit had an up to date ligature risk audit, safety checks were carried out daily and a safety briefing for staff took place twice a day. Staff mitigated risk by using relational security, observation, convex mirrors and CCTV.
- Following a serious incident, changes were made to anti-ligature doorstops on the ward to ensure these were safe.
- Staff were all trained in safeguarding and knew how to make a safeguarding referral. A social worker was available on the ward to offer specialist advice and support to staff, patients and families regarding safeguarding. In line with trust policy, physical intervention was only used in exceptional circumstances.
- Staff knew how to report incidents and were aware of safety issues in other parts of the trust, for example recent fire risks. Learning from serious incidents was disseminated effectively by means of noticeboards, newsletters, team meetings, supervision and e-mails.

- Staff on the unit had developed a 'central point of enquiry' staff role (CPOC). This member of staff took the lead in ensuring smooth handover between shifts to ensure no important information was lost, completing daily tasks - including safety checks and visitor checks -and being a visible first point of contact for enquiries from patients and visitors.
- There were sufficient, appropriately qualified staff to provide good care and treatment for patients. Managers had effectively reviewed staffing needs to maintain safety with the increase in bed numbers from seven to twelve by the end of October 2018.
- The ward was clean, well maintained and well equipped throughout.

Is the service effective?

Outstanding ☆ ➔➔

Our rating of effective stayed the same. We rated it as outstanding because:

- Care records were comprehensive, person centred, recovery focused and up to date. Care records showed that a physical examination had been undertaken and that there was ongoing monitoring of physical health problems.
- Staff were knowledgeable about how both Mental Health Act and Mental Capacity Act applied or not, to the young people they worked with. Staff sought appropriate consent from patients, for example Gillick competency for examinations and treatment. Staff had explained rights to patients detained under the Mental Health Act and repeated these at regular intervals. Consent practices and records were actively monitored and reviewed to improve how patients were involved in making decisions about their care and treatment.
- Staff offered a range of therapeutic interventions in line with National Institute for Health and Care Excellence guidelines such as: cognitive analytic therapy, family therapy, multifamily therapy, occupational therapy, psychology sessions and one to one sessions with staff on a range of topics. Psychology staff also worked in the community to ensure continuity of care for patients.
- Staff had introduced positive behaviour practise for patients and were monitoring the effect this had on the number of restrictive interventions used with patients.
- Staff were appraised and supervised and had access to regular team meetings, personal and professional development opportunities, group supervision and peer support. Staff were experienced and qualified and received specialist training in children and young people. The continuing development of staff skills, competence and knowledge was integral to ensuring high quality care. For example, the unit manager had recently achieved funding to buy in some specialist training from the Anna Freud Centre in London.
- Staff were encouraged to visit other units to learn from best practise, for example a visit was planned to a flagship specialist eating disorder unit the week after the inspection.
- Staff participated in regular clinical audits. This included audits such as care programme approach, Mental Health Act and antipsychotic medicines.

Is the service caring?

Outstanding ☆ ➔➔

Our rating of caring stayed the same. We rated it as outstanding because:

- Staff understood the individual needs of patients. Patients felt staff were genuinely caring and they were treated with dignity and respect. One patient said that they were treated as an individual and no assumptions were made about their needs even though they had previous admissions to the unit.
- Feedback from patients and those close to them was continually positive. One patient and one carer said this was the best child and adolescent unit they had been to. A parent described the staff as being genuinely caring 'without exception'
- Staff recognised and respected the need to empower families to look after their children. Staff reflected individual needs in the delivery of patient care. There was a strong visible person-centred culture from all staff.
- Each patient had a named nurse who offered regular 1-1 sessions. These sessions were written daily on a whiteboard on the ward and patients confirmed that these sessions were prioritised and if their named nurse was not at work, there was always another member of staff they could talk to.
- On admission, staff provided patients with a welcome pack and verbal information about the ward in a way they could understand. Patients were given some information about new arrivals, for example their first name and favourite hobby and were encouraged to make welcome cards and pictures to help them settle on the unit.
- Following feedback from patients and carers, a welcome meeting was arranged for carers and the patient a few days after admission to help them understand information given, at a time when they may feel less overwhelmed.
- Patients give feedback about the service. Patients had been involved with planning improvements to the outdoor space and were making planters to help decorate this.
- We saw examples of when staff had given up their free time to benefit patients. For example, one member of staff had spent a weekend collecting old tyres to be painted and used as planters. Many of the staff were involved in planning an annual summer fayre involving patients and carers. Patients were supported to make arts and crafts on the ward to sell at the fayre.

Is the service responsive?

Outstanding ☆ ➔➔

Our rating of responsive stayed the same. We rated it as outstanding because:

- The service provided structured and individualised therapeutic programmes, comprising of a mixture of group work, activities, individual sessions and education. Musical instruments, including a piano, were available on the unit. A kitchen was available for young people to participate in food preparation and baking.
- Patients had opportunities for regular exercise, for example, cycling, dance classes, walks on the beach, yoga, and gardening. A fitness instructor visited the ward regularly to offer a variety of fitness and wellbeing activities.
- There was a holistic approach to planning a patient's discharge, transfer or transition to services, which was done at the earliest possible stage. The unit psychologists and family therapist worked some of their time in the community to provide continuity of care.
- There was a large, bright education space attached to the unit. Patients were provided with education services and educational materials required for continuing their education. Staff liaised with local schools and colleges to ensure continuity of education, including post-discharge.
- There was a sensory room which had been designed with input from patients which offered an accessible quiet, calming space for those who needed it.

- Doors were labelled with whose office it was on unit room doors, for example, occupational therapist. This meant patients could easily contact clinicians on the unit.
- The trust employed staff to prepare freshly cooked meals on site, using locally sourced ingredients. There was a choice of food to meet dietary requirements, including for those patients on eating plans. One patient who was vegan said that the food was tasty and of good variety.
- Patients had access to a multi-faith room and regular spiritual support. The chaplain ran a weekly session.
- Patients on the unit had created the designs on the walls and decorated the space themselves with artwork and soft furnishings such as throws and cushions.
- A member of staff had given up some of their free time to paint a beautiful 'getting to know you' tree at the entrance to the ward which had pictures and short biographies of all the staff on the ward to help familiarise patients and carers with the staff.
- The unit provided for patients and staff a, "what stuck with you this week" board. This was a way for patients and staff to communicate things that had, had an impression on them that week.
- Well-attended community meetings were held daily for patients and staff to share news, their goals for the day and celebrate birthdays and other special events.

Is the service well-led?

Outstanding ☆ ↑

Our rating of well-led improved. We rated it as outstanding because:

- Staff demonstrated the trust values in their behaviour and attitude. Staff we spoke with were passionate about helping young people with mental illness. There was very high staff morale and team cohesion, with members of staff saying the work was rewarding and they felt lucky to work here.
- There were high levels of compliance with mandatory training and staff were encouraged and supported by managers to acquire new skills and share best practice. Staff participated in team meetings, reflective practice, sharing skills and supporting each other to help improve the health of the patients in their service.
- Managers ensured that there were sufficient staff to provide care and treatment to patients. Staff told us that managers allowed protected time so that they had sufficient time to meet with patients and complete administrative tasks, including updating care plans and risk assessments.
- All staff felt comfortably able to raise concerns with higher management without fear of victimisation and all believed those concerns would be acted upon. Staff felt able to suggest improvements to the service and could be innovative and shape best practise. Staff felt there was a non-hierarchical, collaborative culture within the team.
- Staff participated in regular clinical audits. This included audits such as care programme approach, Mental Health Act and antipsychotic medicines.
- The unit managers told us that they shared information on lessons learnt, complaints and feedback at team meetings, supervision and handovers. Information was also shared by way of a '5 key learning points' newsletter and a large whiteboard in the office.

Child and adolescent mental health wards

- Staff told us there was strong leadership; and managers supported staff well. There were good opportunities for professional and leadership development. One member of staff gave an example of being supported and encouraged to start a university degree, with flexibility around shifts and further support given when they needed to intermit for a year.
- The clinical team leader had visited other child and adolescent units and brought ideas back as well as sharing their successes.
- The service was working towards accreditation with the Quality Network for Inpatient CAMHS (QNIC).

Community-based mental health services for older people

Requires improvement 

Key facts and figures

Community mental health services for older people offer assessment and intervention services for older people with dementia and other mental health conditions associated with later life. The service is made up of fifteen teams across Norfolk and Suffolk.

The dementia intensive support teams (DISTs) offer assessment and intensive support to people with dementia or suspected dementia. In Norfolk and Great Yarmouth and Waveney; teams operate as crisis teams and work with older people with other mental health conditions.

The dementia and complexity in later life (DCLL) teams offer assessment, diagnosis and treatment in the community for adults experiencing memory problems, cognitive impairment, dementia and other mental health issues associated with later life.

In Norfolk and Great Yarmouth and Waveney, these are separate teams while in East and West Suffolk the CLL pathway is provided through five integrated delivery teams (IDTs) in Ipswich, Stowmarket, Bury St Edmunds and Newmarket. Memory clinics operate alongside the CLL teams or pathway.

The trust is registered for the following regulated activities:

Assessment or medical treatment for persons detained under the Mental Health Act 1993

Diagnostic and screening procedures

Treatment of disease, disorder or injury

The service was last inspected in July 2017 and requirement notices were issued in relation to:

- Regulation 9 HSCA (RA) Regulations 2014 Person-centred care
- Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment
- Regulation 18 HSCA (RA) Regulations 2014 Staffing

We found that the trust had addressed some of the issues from the previous inspection but that ligature risk assessments and emergency medications still required improvement.

Our inspection was announced (staff knew we were coming) to ensure that everyone we needed to talk to was available. We inspected the whole service and looked at all key questions.

Before the inspection visit, we reviewed information that we held about these services and information requested from the trust.

During the inspection visit, the inspection team:

- visited nine teams in seven locations
- spoke with nine managers
- spoke with nine patients and carers who were using the service
- spoke with 29 members of staff including nurses, assistant practitioners, psychologists and occupational therapists

Community-based mental health services for older people

- spoke with 6 medical staff including consultant psychiatrists
- Reviewed 49 patient care records.

Summary of this service

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

- Services were unable to offer a full range of occupational therapy and psychological therapies due to lack of staff from those disciplines.
- The trust was unable to provide numbers of patients waiting and waiting times for access to psychological treatment and told us that they did not currently have a system for monitoring this.
- The trust had not fully completed the actions from the last inspection. Ligature risk assessments had not been completed for all areas of trust premises. The ligature risk assessments did not capture the risks from all ligature points. The trust had not updated its policy to reflect changes they had made to the risk assessment process. Emergency medication and equipment was not in place at all locations. The Great Yarmouth and Waveney premises did not have an emergency bag at one location and an incomplete bag at one location.
- Staff felt disconnected from the trust and wider management. Staff felt that the senior trust management were not visible and that the number of management levels between teams and the senior management meant that information passed either way got lost or miscommunicated.

However:

- The service had sufficient numbers of nursing staff in post to provide safe care for patients. Staff caseloads were manageable and enabled nurses to see patients regularly.
- Staff completed a risk assessment, comprehensive needs assessment and care plan for all patients following referral into the service.
- Staff had good communication with GP and community health services to monitor and review patients' physical health. We also saw good communication with staff at care homes where patients lived, and Great Yarmouth and Waveney team had a dedicated nurse post to work with care homes develop de-escalation techniques and therapeutic interventions.
- Patients and carers all spoke positively about the care they had received. Patients told us that staff were kind, respectful and supportive. Carers were involved and updated on patients' care, and received copies of care plans where appropriate.
- Team leaders had a clear understanding of the service they managed. Team leaders were visible within the service and staff told us that they felt supported by their leaders.

Is the service safe?

Requires improvement 

Our rating of safe improved. We rated it as requires improvement because:

Community-based mental health services for older people

- The service had not fully completed the actions from the last inspection requiring ligature risk assessments to be completed for all areas of trust premises. The ligature risk assessments did not capture the risks from all ligature points. The trust had not updated its policy to reflect changes they had made to the risk assessment process.
- The service had not fully completed the action from the last inspection requiring emergency medication and equipment to be in place at all locations. The Great Yarmouth and Waveney premises did not have an emergency bag at one location and an incomplete bag at one location.
- Staff did not always follow trust policy on transporting medications as medicines were stored away from trust premises overnight on occasion.

However:

- The service had sufficient numbers of nursing staff in post to provide safe care for patients. Staff caseloads were manageable and enabled nurses to see patients regularly.
- Staff completed a risk assessment for all patients following referral into the service. We found that 39 of the 49 risk assessments we reviewed had been updated regularly and following any significant change.
- Staff had completed mandatory training appropriate to their role, with compliance of 95% for mandatory training courses. All staff were up to date with Safeguarding Adults, Infection Control and 98% of staff had completed Mental Health Act training.
- All locations were visibly clean with records in place to show that cleaning was completed regularly and infection control procedures were in place.

Is the service effective?

Requires improvement

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

- Services were unable to offer a full range of occupational therapy and psychological therapies. Teams lacked sufficient occupational therapy and psychology staff to provide the range of care recommended by the National institute for Health and Care Excellence guidelines. Teams did not have full time occupational therapists or psychologists in post in any of the locations we visited and accessed these disciplines via other teams.

However:

- Staff completed a comprehensive assessment of all patients following referral and all patients had a care plan completed. We reviewed 49 care plans and found that 37 of those were personalised, holistic and had been regularly updated.
- Managers completed monthly supervision and annual appraisals with staff, in line with trust policy. The community teams held weekly meetings to discuss new referrals, allocations to care co-ordinators and to review caseloads. Managers held monthly team meetings with a set agenda that included incidents, complaints and outcomes.
- Staff had good communication with GP and community health services to monitor and review patients' physical health. We also saw good communication with staff at care homes where patients lived, and Great Yarmouth and Waveney team had a dedicated nurse post to work with care homes develop de-escalation techniques and therapeutic interventions.

Community-based mental health services for older people

- Staff had a good working knowledge of the Mental Health Act and Mental Capacity Act with 98% of staff having completed Mental Health Act training and 99% of staff having completed Mental Capacity Act training. We reviewed 49 patient care records and saw that capacity assessments were completed where appropriate, and staff consulted carers when making a best interests decision for patients who lacked capacity.

Is the service caring?

Good  

Our rating of caring stayed the same. We rated it as good because:

- Patients and carers all spoke positively about the care they had received. Patients told us that staff were kind, respectful and supportive.
- Staff documented patient and carer views in care plans and clearly documented where patients were unable to give their views and why. Staff supported patients to make advance decisions about their future care and crisis plans for times when they may not have capacity to make those decisions.
- Staff kept carers informed of any changes through regular phone calls and where patients consented, provided copies of their care plan. Carers felt supported by staff and had been given information about additional support available and how to access a carer's assessment.

Is the service responsive?

Requires improvement 

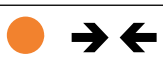
Our rating of responsive went down. We rated it as requires improvement because:

- The trust was unable to provide figures and waiting times for access to psychological treatment and told us that they did not currently have a system for monitoring this.
- The service did not meet the target times seeing patients from referral to assessment in all teams, with Coastal East Suffolk team reporting an average of 66 days against a 28-day target. None of the services reported a waiting list for patients at the time of inspection.

However:

- The Dementia and Intensive Support teams saw urgent referrals within 72 hours of referral.
- Staff supported patients when they transferred between services, or needed physical health care. The Great Yarmouth and Waveney team had two beds commissioned by the trust at a residential care home where patients who could no longer stay in their own home could temporarily stay until additional support was available. This reduced the need to admit patients to inpatient wards where it could be avoided.
- The service received a low number of complaints with 14 complaints received in the past year, and received 23 compliments.

Is the service well-led?

Requires improvement 

Community-based mental health services for older people

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

- The service had not fully addressed all actions required from the last inspection. For example, ligature risk assessments had not been completed for all areas of the service's premises.
- Senior managers did not support new managers and staff acting up into manager roles by providing them with timely access to information. Managers did not always have access to a governance dashboard and staff information including appraisals and supervision within reasonable time.
- Staff felt disconnected from the trust and wider management. Staff felt that the senior trust management were not visible and that the number of management levels between teams and the senior management meant that information passed either way got lost or miscommunicated. Whilst the feeling of division between Norfolk and Suffolk services had improved since the last inspection there was still some division between these services.

However:

- Data analysts sent managers spreadsheets to show their compliance with KPI's including assessment times, care programme reviews, Mental Health Act and Mental Capacity Act. Managers could review this by individual staff member so that non-compliance could be raised in supervision.
- The service had implemented a trust wide older people's community mental health forum where staff met monthly to discuss learning and good practice, and receive additional support and training in meeting the needs of patients.

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 the service provider was not meeting. The provider must send CQC a report that says what action it is going to take to meet these requirements.

For more information on things the provider must improve, see the Areas for improvement section above.

Please note: Regulatory action relating to primary medical services and adult social care services we inspected appears in the separate reports on individual services (available on our website www.cqc.org.uk)

This guidance (see goo.gl/Y1dLhz) describes how providers and managers can meet the regulations. These include the fundamental standards – the standards below which care must never fall.

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Treatment of disease, disorder or injury	Regulation 9 HSCA (RA) Regulations 2014 Person-centred care

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Treatment of disease, disorder or injury	Regulation 10 HSCA (RA) Regulations 2014 Dignity and respect

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

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Treatment of disease, disorder or injury	Regulation 13 HSCA (RA) Regulations 2014 Safeguarding service users from abuse and improper treatment

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Treatment of disease, disorder or injury	Regulation 16 HSCA (RA) Regulations 2014 Receiving and acting on complaints

This section is primarily information for the provider

Requirement notices

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

Regulated activity	Regulation
	Regulation 18 HSCA (RA) Regulations 2014 Staffing

Our inspection team

Chair: Paul Devlin, Chair of Lincolnshire Partnership NHS Foundation Trust

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

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

The team included CQC inspection managers, mental health inspectors, assistant inspectors, pharmacy inspectors, Mental Health Act reviewers, support staff, a variety of specialist advisors. Specialist advisers are experts in their field who we do not directly employ.