Requires Improvement

Norfolk and Suffolk NHS Foundation Trust

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

Quality Report

Hellesdon Hospital
Drayton High Road
Norwich
NR6 5BE
Tel: 01603 421421
Website: www. nsft.nhs.uk

Date of inspection visit: 20 – 24 October 2014
Date of publication: 6 February 2015

Locations inspected

Name of CQC registered location	Location ID	Name of service (e.g. ward/ unit/team)	Postcode of service (ward/ unit/ team)
Trust Headquarters Hellesdon Hospital	RMY01	Mental Health crisis services and health-based place of safety	NR6 5BE IP1 2DG IP4 5PD NR33 8AG IP33 2QZ
Woodlands	RMYX1	Health-based place of safety	IP4 5PD
Fermoy Unit	RMYXX	Health-based place of safety	PE30 4ET
Coastlands Northgate Hospital	RMY03	Health-based place of safety	NR30 1BU
Carlton Court	RMY13	Health-based place of safety	NR33 8AG
Wedgwood House	RMYX5	Health-based place of safety	IP33 2QZ

Summary of findings

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

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

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

Summary of findings

Ratings

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

Overall rating for mental health crisis services and health based places of safety	Requires Improvement 
Are mental health crisis services and health based places of safety safe?	**Requires Improvement** 
Are mental health crisis services and health based places of safety effective?	**Requires Improvement** 
Are mental health crisis services and health based places of safety caring?	**Good** 
Are mental health crisis services and health based places of safety responsive?	**Requires Improvement** 
Are mental health crisis services and health based places of safety well-led?	**Inadequate** 

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

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

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

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

Summary of findings

Contents

Summary of findings

Overall summary

We rated the mental health crisis services for adults and health based places of safety as 'requires improvement' because:

- We found that, although areas of environmental risk in Mariner House had been identified these were not adequately addressed.
- We found concerns with environmental health and safety in some health-based places of safety.
- All the teams reported staffing pressures that affected delivery of care. This was supported by duty rotas.
- Each of the home treatment teams had delayed transfers of care. These were caused by a lack of capacity within the integrated delivery teams in Suffolk and the community mental health teams in Norfolk and in-patient services.
- There was no trust wide 'standard operating procedure' for the interface between the varying community based services. We noted that there were gaps in the attendance of staff at mandatory training.
- Morale was very low and staff were increasingly disaffected
- A majority of staff felt that their views were not being listened to and reported a lack of consultation by senior trust managers about the trust's strategy and values.
- We identified concerns with the trust's consultation process regarding the reconfiguration of the community based services at Carlton Court.
- Some carers told us that it was difficult to speak to the crisis teams as the phone was sometimes not answered or was often engaged.
- We noted delays in the assessment of some people who were admitted under section 136 of the Mental Health Act and found that all of these units could only accommodate one person at a time. This could mean the need for people to be transported long distances to an alternative health-based place of safety.

However:

- Staff told us in all six units that children and adolescents and people with learning difficulties were accepted for Section 136 assessments and that specialist consultant psychiatrists were made available to assess them.
- We found robust systems for the safe management of medicines throughout this service.
- We observed staff treating people with dignity and respect and delivering support and treatment in a way that took into account people's wishes.

Summary of findings

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

Are services safe?

We rated the mental health crisis services for adults and health based places of safety as 'requires improvement' because:

- We found that, although areas of environmental risk in Mariner House had been identified, these were not adequately addressed.
- We found concerns with environmental health and safety in some health-based places of safety.
- All the teams reported staffing pressures that affected service delivery. This was supported by duty rotas.

However:

- We found robust systems in place for the safe management of medicines throughout this service.

Requires Improvement

Are services effective?

We rated the mental health crisis services for adults and health based places of safety as 'requires improvement' because:

- Home treatment teams had delayed transfers of care.
- There was no trust wide 'standard operating procedure' for the interface between these varying services.
- There were gaps in the attendance of staff at mandatory training.
- Staff appraisal and supervision rates varied between services inspected. Most staff told us that they did not receive individual clinical supervision.
- The Norfolk access and assessment service had three different data recording systems which was confusing for staff and could lead to information being lost. This could present risks to people who used this service.

However

- Staff used the Health of the Nation Outcome Scales (HoNoS) as part of each assessment. On-going individual assessments used the situation, background assessment and risk (SBAR) model..
- We found effective multi-disciplinary team working within the local service.

Requires Improvement

Are services caring?

We rated the mental health crisis services for adults and health based places of safety as 'good' because:

- We observed staff treating people with dignity and respect

Good

Summary of findings

- People were positive about the support the service provided and praised the staff. Most carers were complimentary regarding the services provided and individual staff members whom they felt were professional and caring towards their relative.
- Staff involved people with their decisions and care needs. Carers told us that they felt involved by staff in the assessment and treatment being provided to their relative.

However:

- Some carers and patients told us they had experienced an uncaring response from staff.

Are services responsive to people's needs?

Requires Improvement

We rated the mental health crisis services for adults and health based places of safety as 'requires improvement' because:

- Call handlers had not received specific mental health awareness training to assist them when taking calls from people who were often seriously ill.
- There were delays in the assessment of people who were admitted under section 136 of the Mental Health Act.
- There was no robust system to ensure that trust learning from individual concerns and complaints was disseminated throughout the services inspected.
- Carers and some patients told us that it was difficult to speak to the crisis teams as the phone was sometimes not answered or was often engaged.

However:

- Senior staff monitored delays and transfers in line with the trust's key performance indicators. Exception reporting took place when these indicators were breached.
- Staff told us in all six units that children and adolescents and people with learning difficulties were accepted for Section 136 assessments and that specialist consultant psychiatrists were made available to assess them.

Are services well-led?

Inadequate

We rated the mental health crisis services for adults and health based places of safety as 'inadequate' because:

- A majority of staff that we talked with were unaware of the trust strategy.
- Staff described a lack of consultation by senior trust managers about the trust's strategy and values.

Summary of findings

- Staff felt that the trust should make more effort to communicate directly with them.
- Morale was very low and staff were increasingly disaffected.
- We identified some concerns with the trust's consultation process regarding the reconfiguration of the community based services at Carlton Court.
- We found little evidence of changes made by the trust following concerns identified by their performance monitoring systems.

However

- We saw good examples of locally based teams working effectively together.

Summary of findings

Background to the service

- The trust provided mental health acute services. This included home treatment and crisis resolution services. These offered an alternative to admission, or support after discharge from in-patient wards when people were in need of further intensive support. They also provided psychiatric liaison services in partnership with Norfolk and Suffolk's acute physical healthcare NHS hospitals.
- The trust provided access and assessment teams to make it easier for people to get the right mental health care and social care service as quickly and efficiently as possible.
- These core services have not been inspected previously by the Care Quality Commission however; the health-based place of safety unit at Hellesdon hospital was inspected by a Mental Health Act reviewer in 2013. The recommendations made in that report were being addressed by the trust.

Our inspection team

Our inspection team was led by:

Chair: Joe Rafferty, Chief Executive Officer, Merseycare NHS Trust

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

Inspection Manager: Lyn Critchley, Inspection Manager, CQC

The team included CQC managers, inspection managers, inspectors and support staff and a variety of specialist and experts by experience that had personal experience of using or caring for someone who uses the type of services we were inspecting.

The team that inspected these services were two CQC inspectors, one consultant psychiatrist, one specialist registrar in psychiatry, three Mental Health Act reviewers, senior nurse managers, an occupational therapist and one expert by experience who had experience of using services.

Why we carried out this inspection

We inspected this trust as part of our ongoing comprehensive mental health inspection programme.

How we carried out this inspection

To get to the heart of people who use services' experience of care, we always ask the following five questions of every service and trust:

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

Before visiting, we reviewed a range of information we hold about Norfolk and Suffolk NHS Foundation Trust and asked other organisations to share what they knew. We carried out an announced visit between 21 October and 23 October 2014. Unannounced inspections were also carried out on the late evening of 06 November 2014.

We spoke in detail with nine people and three carers who used services and held informal telephone discussions with other people and their carers. We reviewed 35 assessment and treatment records and 46 medical administration records (MAR).

Summary of findings

We attended staff handovers, observed initial assessment appointments, and accompanied trust staff on community visits with the prior permission of those involved. We observed telephone based assessment procedures or triages.

We spoke with managers, front line staff, support staff and doctors. We held discussions with approved mental health practitioners (AMHP) and spoke to primary healthcare practitioners.

We also reviewed the trust's systems for obtaining feedback from other people who had contact with the service. This assisted the Care Quality Commission to obtain a view of the experiences of people who use the services.

What people who use the provider's services say

Most of the people spoken with were positive about the support the service provided and praised the staff. We observed that people were encouraged to contribute to their individual risk assessments and crisis planning. We saw good examples of effective assessment processes of risk and needs based on effective communication by staff.

Most carers were complimentary regarding the services provided and individual staff members whom they felt were professional and caring towards their relative. However, a number of people reported concerns about the trust's plans to reconfigure services at the Carlton Court and expressed their distrust of the trust's current consultation process regarding this service.

We saw the staff, friends and families survey which had recently been introduced by the trust. The early results of these had yet to be collated. Evidence was seen of thank you cards and letters from people in the services visited.

Good practice

- We found positive examples of transitional support for those people who no longer required the full support of the home treatment teams but were awaiting an allocated care co-ordinator from the integrated delivery team (IDT). This meant that people continued to receive the required community based psychiatric support.
- We found that the trust had successfully obtained funding from the Clinical Commissioning Group (CCG) to appoint a number of nurses to provide permanent staff to the 136 suites at Hellesdon Hospital and the Fermoy unit. When these units were not in use the staff concerned would provide extra support to the in-patient wards. This meant that services would benefit from extra dedicated staff resources.
- Staff told us that, in all six S136 units, children and adolescents and people with learning difficulties were accepted for Section 136 assessments and that specialist consultant psychiatrists were made available to assess them.
- We found that the trust had obtained funding to employ two nurses to accompany police officers in a triage car, again with the aim of reducing the use of Section 136 detention at the Woodlands unit in Suffolk. This meant that people would benefit from this specialised mental health diversion services.

Areas for improvement

Action the provider MUST or SHOULD take to improve

Actions the trust MUST take to improve

- The trust must address the identified environmental health and safety concerns in the health-based places of safety.

Summary of findings

- The trust must ensure that all staff receive their mandatory training in accordance with the trust's own policy.
- The trust must review the provision of in-patient beds to ensure that the needs of the local population are met.
- The trust must review their staff consultation processes to ensure that staff are aware of and actively engage with any changes proposed by the trust board.
- The trust must take steps to address the low morale of staff.
- The trust must ensure that all staff receive an annual appraisal and regular managerial supervision in accordance with their own policy and protocols.

Actions the trust SHOULD take to improve

- The trust should ensure that the care plans and physical healthcare assessments within the Carlton Court service are reviewed and updated in line with the trust's own policy and protocols.
- The trust should ensure that a 'standard operating procedure' is introduced to manage effectively the interface between the various community services provided.
- The trust should ensure that the good example of health-based place of safety monitoring information seen at one unit is used throughout this service.
- The trust should review the provision of their single bedded health based place of safety units in the light of the potential demand for this service.
- The trust should ensure that all call handlers receive specific mental health awareness training to assist them when taking calls from people who were often seriously ill.
- The trust should promote their vision and values effectively so that these are understood by frontline staff.

Norfolk and Suffolk NHS Foundation Trust

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

Detailed findings

Locations inspected

Name of service (e.g. ward/unit/team)	Name of CQC registered location
Central and West Norfolk access and assessment service	Trust Headquarters
Central Norfolk crisis resolution and home treatment (CRHT)	Trust Headquarters
Waveney crisis resolution and home treatment (CRHT)	Carlton Court
Suffolk access and assessment service Ipswich	Trust Headquarters
East Suffolk home treatment team	Woodlands
West Suffolk home treatment team	Wedgwood House
Section 136 health based place of safety	Hellesdon Hospital
Section 136 health based place of safety	Woodlands
Section 136 health based place of safety	Fermoy Unit
Section 136 health based place of safety	Coastlands Northgate Hospital
Section 136 health based place of safety	Carlton Court
Section 136 health based place of safety	Wedgwood House

Detailed findings

Mental Health Act responsibilities

We found that the relevant legal documentation was completed appropriately in those records reviewed. The access and assessment teams were clear about the procedure and processes involved if a person required assessment under the Mental Health Act.

Those health-based places of safety records seen were well completed in relation to Section 136 of the Act.

Staff appeared to be knowledgeable about the Act and the code of practice. They were aware of their responsibilities around the practical application of the Act. However, those training records seen showed us that not all staff had received refresher training.

Mental Capacity Act and Deprivation of Liberty Safeguards

Staff had training on the Mental Capacity Act 2005 and the implications this had for their clinical and professional practice. Most staff had received refresher training on this Act.

There was evidence that mental capacity assessments were being completed appropriately and were being reviewed as required.

Requires improvement

Are services safe?

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

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

Summary of findings

We rated the mental health crisis services for adults and health based places of safety as 'requires improvement' because:

- We found that, although areas of environmental risk in Mariner House had been identified, these were not adequately addressed.
- We found concerns with environmental health and safety in some health-based places of safety.
- All the teams reported staffing pressures that affected service delivery. This was supported by duty rotas.

However:

- We found robust systems in place for the safe management of medicines throughout this service.

Our findings

Trust Headquarters - Central and West Norfolk access and assessment service, Central Norfolk crisis resolution and home treatment (CRHT), Waveney crisis resolution and home treatment (CRHT), Suffolk access and assessment service, Ipswich East Suffolk home treatment team, West Suffolk home treatment team

Safe and clean environment

We found that areas of potential risk had been identified in all the services visited. These related to a lack of space in some services. This meant that there was a potential risk to staff and patients if people in crisis felt trapped or needed space. Staff were often working alone.

A significant environmental risk had been identified at the Suffolk access and assessment service in July. This had been added to the local risk register and escalated appropriately by local managers. However no action had been taken to resolve the issue.

Some staff expressed concerns about the system for summoning assistance if required at the Suffolk access and assessment service. For example, we were informed that the telephone based system for raising concerns was not answered at times. This had left staff feeling vulnerable.

Safe staffing

All the teams reported staffing pressures and this was supported by duty rotas These showed that recruitment of permanent staff was required. We were informed that incidents related to staffing levels were escalated through the trust's incident reporting system. This was supported by the records seen. However some staff remained concerned about how the trust responded to these direct concerns.

When we inspected Carlton Court CRHT there were only two health care assistants and a student on duty from 8 to 11 am due to staff sickness. This meant that they did not have the capacity to undertake assessments and people in need of assessment were not able to access the service they needed. We immediately identified this concern to the service manager who arranged for emergency assessments to be undertaken by another team within the trust, but no action was taken until we pointed this out to the trust. This was not safe practice. Rotas showed that understaffing was frequent at this service.

Senior managers confirmed that the trust was currently actively recruiting. Recruitment was particularly difficult in the service based at Carlton Court which was being affected by the trust's on-going consultation about the reconfiguration of services at this location.

The service used NHS professionals and agency staff to address staffing shortfalls. Some agency staff were on long term placements with the team.

Assessing and managing risk to patients and staff

The assessment and treatment records reviewed showed us that staff had assessed people's historical risks and behaviours. Care plans were in place to address current risks and individual needs. Most of these had been regularly reviewed and re-assessed following staff engagement with the person who used the service. However we saw gaps in those records maintained by the Carlton Court location.

Requires improvement

Are services safe?

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

Individual concerns about people who used the service were discussed at team meetings and within individual managerial supervisions.

Carers told us that staff were proactive and supportive when risks during assessment and treatment episodes were identified.

Staff had undertaken 'prevention of management and aggression' (PMA) training to help them manage challenging behaviour. In an emergency crisis situation staff told us that they would call '999' for emergency services.

We found robust systems in place for the safe management of medicines throughout this service and records had been completed appropriately by staff.

Maintenance records sampled showed that systems were in place to ensure that equipment was being serviced, repaired or replaced as required.

The trust had set a target of 90% for safeguarding mandatory training for both adults and children. The training records we saw showed that the target had been met for both safeguarding adults and children at level 2. However, we found that training at level 3 varied between 13% and 46% which is well below the target.

We found low levels of "prevent training" relating to the government's counter-terrorism strategy throughout those services visited. The percentage of staff attendance varied between 13% and 20%.

Staff were aware of the trust's lone worker policy. We saw examples of how different teams monitored staff whereabouts. For example via on line diaries and team communication boards. We saw examples of staff visiting in pairs where particular concerns had been identified.

Each service was aware of the trust's emergency contingency arrangements and staff gave us examples of how they dealt with adverse weather conditions and communication breakdown. Most people who used the service told us that staff informed them if there were delays in making specific appointments.

Reporting incidents and learning from when things go wrong

There were mechanisms in place to report and record safety incidents, concerns and near misses. The trust wide evidence provided showed us that the trust was reporting concerns appropriately through the National Reporting and Learning System (NRLS).

We noted that the trust had an on-line system to report and record incidents and near misses. We saw staff had access to the system via "password" protected computer systems.

We saw examples of root cause analysis (RCA) taking place following serious incidents within the trust. We noted that the trust had recently appointed two RCA investigators and that a third was being recruited.

Staff confirmed they were encouraged to report incidents and "near misses" and managers said incidents were also discussed at individual supervision. However there was no learning from incidents that occurred in other teams.

Section 136 health based place of safety - Hellesdon Hospital, Woodlands, Fermoy unit, Coastlands Northgate Hospital, Carlton Court, Wedgwood House

Safe and clean environment

The service at Hellesdon Hospital was being refurbished following concerns expressed by the Care Quality Commission on a previous inspection. Staff informed us that this would re-open in early 2015.

In the meantime this service was being temporarily provided on another site within the hospital. We found all of the units to be clean and well maintained. Clocks had at one time been installed in the majority of the units although most of them had since been damaged and removed. Nothing had been done to replace them so timing waits in places of safety was not robust.

During our visits to the six units we identified concerns over environmental health and safety and privacy and dignity issues. For example, furniture was light and portable and not secured to the floor and these could be used as a potential weapon. This was the case at the Fermoy, Carlton Court, Wedgwood and Northgate units.

The unit at Woodlands had good anti barricade doors but at the Hellesdon, Fermoy, Carlton Court and Northgate units the doors opened inwards and presented a potential barricade against staff.

Requires improvement

Are services safe?

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

The entrance to Fermoy Unit was secure, fenced and gated and protected people's privacy and dignity. However, at the Woodlands,Wedgwood and Northgate units the entrances were visible to members of the public; sometimes from an adjacent car park.

The Carlton Court, Northgate and Wedgwood units had some non-frosted glass that enabled people to see into the units which compromised privacy and dignity of the people who used the service

Safe staffing

Section 136 staff received the support of the individual service's bleep holder when notification was received about an admission to this unit. Clear management guidance was available for staff. This included guidance on seeking additional staff support if required.

Assessing and managing risk to patients and staff

We reviewed examples of the trust's joint operation detention record (JODR). Joint risk assessments were completed with the relevant police force. Records confirmed that a search had taken place prior to the person being admitted to the service.

Physical healthcare monitoring took place if required and physical injuries were recorded upon admission. Intoxication, when suspected, could be assessed by using an alcoholmeter and had been documented appropriately.

Staffing levels were re-assessed based on a clear risk assessment. Emergency medications could be given whilst awaiting the duty doctor to attend using the trust's patient group directive (PGD). Staff had undertaken 'prevention of management and aggression' (PMA) training to help them manage any challenging behaviour. In an emergency crisis situation staff would call local police for priority assistance.

Reporting incidents and learning from when things go wrong

There were mechanisms in place to report and record safety incidents, concerns and near misses.

We found that areas of risk within this crisis service were identified. These included the potential risk to staff who undertook assessments of people in crisis and the potential risks associated with people who were not previously known by psychiatric services.

Senior managers confirmed that incidents that took place in this service were immediately reviewed. Staff confirmed they were encouraged to report incidents and "near misses".

Are services effective?

Requires Improvement

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

Summary of findings

We rated the mental health crisis services for adults and health based places of safety as 'requires improvement' because:

- Home treatment teams had delayed transfers of care.
- There was no trust wide 'standard operating procedure' for the interface between these varying services.
- There were gaps in the attendance of staff at mandatory training.
- Staff appraisal and supervision rates varied between services inspected. Most staff told us that they did not receive individual clinical supervision.
- The Norfolk access and assessment service had three different data recording systems which was confusing for staff and could lead to information being lost. This could present risks to people who used this service.

However

- Staff used the Health of the Nation Outcome Scales (HoNoS) as part of each assessment. On-going individual assessments used the situation, background assessment and risk (SBAR) model..
- We found effective multi-disciplinary team working within the local service.

Our findings

Trust headquarters - Central and West Norfolk access and assessment service, Central Norfolk crisis resolution and home treatment (CRHT), Waveney crisis resolution and home treatment (CRHT), Suffolk access and assessment service, Ipswich East Suffolk home treatment team , West Suffolk home treatment team

Assessment of needs and planning of care

The trust's weekly newsletter highlighted new guidance as published and this was a topic of discussion at team meetings if relevant to the service.

The records seen showed that staff were using the Health of the Nation Outcome Scores (HoNOS) as part of each assessment. The mental health clustering tool was used to assess the severity of individual's mental health needs.

Most carers and people who used the service told us that they had been involved in their initial assessment and that treatment options were explained with them.

Most, but not all, services monitored physical health care needs and we found that referrals were made to the person's general practitioner when concerns were identified.

At Carlton Court, we found no evidence of regular physical health monitoring in those records reviewed. We identified a specific concern with the monitoring of one person's physical health at this location and immediately escalated our concerns to the trust. These were subsequently addressed by senior clinicians at this location.

Best practice in treatment and care

Ongoing individual assessments used the situation, background assessment and risk (SBAR) model. The trust had adopted the improving recovery through organisational change (ImROC) model. Individual teams linked with the trust's recovery college.

Staff used the Health of the Nation Outcome Scale (HoNOS) to monitor people's progress. Audits which demonstrated people's progress through the service and the flow of patients into and out of the service were in place.

All teams used electronic records which were accessible to all staff. The Suffolk teams used one system throughout the county. However, we saw that the Norfolk access and assessment service had three different data recording systems which we were told was confusing for staff and could lead to information being lost. This could present risks to people who used this service and reduce effectiveness.

As people moved between services, initial assessment information was passed electronically or by fax. An initial transfer of information was done verbally.

People's confidentiality was assured through password protected access to computers. Any faxed information was anonymised.

Are services effective?

Requires Improvement

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

Most staff had received training in obtaining and recording consent to treatment. This was supported by records seen and we observed consent being obtained during telephone triages and other assessments.

People told us that staff sought their consent before offering treatment and most carers felt involved in the assessment process.

We found positive examples of transitional support for those people who no longer required the full support of the home treatment teams but were awaiting an allocated care co-ordinator from the integrated delivery team (IDT).

Skilled staff to deliver care

We reviewed mandatory training records across all of the services inspected. There were gaps in the attendance of staff at mandatory training. The results for one service showed that 66% of staff had received clinical risk assessment, 77% had received complaints and incident investigation and 56% suicide prevention training. This represents a very low proportion especially for suicide prevention in a team working with people in crisis which affects the effectiveness of staff.

Some staff raised concerns about access to training and the location of training provision within a large trust. This made it difficult for front line staff to attend.

We saw examples of staff receiving role specific training. Staff could attend institute of leadership and management courses, nurse prescriber courses for trained nurses and band 6 study days. However staff told us it was difficult to get the protected time to attend these courses.

Appraisal rates varied from 50% to 100% within these services.

Staff management supervision rates varied from 34% to 100% dependent upon the service inspected. Most staff told us that they did not receive individual clinical supervision so the trust cannot be sure that staff are properly supervised.

Staff sickness and other absences and pressures of workloads were identified as reasons for staff not receiving regular appraisals and supervision.

Multi-disciplinary and inter-agency team work

Staff reported effective team working within their own team. This was supported by our observations of initial assessments and other staff interventions. Teams were multi-disciplinary in composition. However the East Suffolk team did not have a psychologist attached.

Staff with specialist interests were identified as 'champions' and lead advocates for different conditions For example we saw a 'champion' of adult attention deficit hyperactivity disorder (ADHD) in one of the services inspected.

The relationship between different services could be confusing for people who required crisis care. Whilst the access and assessment teams were identified as the single point of admission to services, a number of other trust services, such as liaison psychiatry, were also involved in the gatekeeping of services. There was no trust wide 'standard operating procedure' for the interface between the varying community services. This meant that people could fall between services and not receive the care and treatment they needed.

We spoke with a GP surgery that referred patients to the access and assessment service. They told us that usually the service was good but they did not appreciate or understand on occasions why a doctor's assessment was being re-done by a nurse.

Adherence to the MHA and the MHA Code of Practice

The relevant legal documentation was completed appropriately in those records reviewed. The access and assessment teams were clear about the procedure and processes involved if a person required assessment under the Act.

Staff appeared to be knowledgeable about the Act and the code of practice. They were aware of their responsibilities around the practical application of the Act. However training records showed that not all staff had received refresher training .

Good practice in applying the MCA

Staff said they knew about and had training on the Mental Capacity Act and the implications this had for their clinical and professional practice. Most staff had received refresher training on this Act.

Are services effective?

Requires Improvement

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

There was evidence in assessment and treatment records that capacity assessments were being completed appropriately and were being reviewed as required.

Section 136 health based place of safety - Hellesdon Hospital, Woodlands, Fermoy unit, Coastlands Northgate Hospital, Carlton Court, Wedgwood House

Assessment of needs and planning of care

We reviewed examples of the trust's joint operation detention record (JODR).and noted that these had been completed appropriately. Short term care plans were in place as required.

The accurate recording of all episodes of the use of Section 136 was essential to enable the trust to plan their service provision effectively; but we found that the procedures and practice varied from unit to unit.

Best practice in treatment and care

The Wedgwood unit had detailed spread sheets which included conduct/behaviour leading to detention, the time of initial detention, risk, ethnicity time of arrival of the mental health professionals, subsequent assessment, outcome, mode of transport and other relevant information. This enabled detailed and accurate analysis of the data concerned.

The other units visited all kept various degrees of data some electronically and some in a register and these were being utilised in local monitoring forms. This meant that the good practice demonstrated on one unit was not being used throughout all of these services.

Skilled staff to deliver care

Some staff raised concerns about access to training and the location of training provision within a large trust. This made it difficult for front line staff to attend suitable training opportunities.

We saw some examples of staff receiving role specific training. Staff sickness and other absences and pressures of workloads were identified as reasons for staff not receiving regular appraisals and supervision.

Multi-disciplinary and inter-agency team work

We were informed that, increasingly, the ambulance service was being used to transport people to the designated place of safety and that in some areas paramedics were now undertaking an initial assessment before onward transition to either the 136 units or accident and emergency departments if this was required. However, the evidence given to us at the Wedgwood unit showed that most transportation during the period May to August 2014 was being undertaken in police vehicles which is not best practice.

During our visit to Norfolk Police headquarters; we met with two approved mental health professionals (AMHP), a police officer and the inspector responsible for the integrated mental health team. We were told that having the AMHP situated in the control room had benefitted both services

Adherence to the MHA and the MHA Code of Practice

We found that the relevant legal documentation was completed appropriately in those records reviewed. Staff were clear about the procedure and processes involved if a person required assessment under the Act.

Staff appeared to be knowledgeable about the Mental Health Act and the code of practice. They were aware of their responsibilities around the practical application of the Act.

Good practice in applying the MCA

Staff said they were aware of the Mental Capacity Act 2005 and the implications this had for their clinical and professional practice. Most staff had received refresher training on this Act.

There was evidence in records that capacity assessments were being completed appropriately and were being reviewed as required.

Good

Are services caring?

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

Summary of findings

We rated the mental health crisis services for adults and health based places of safety as 'good' because:

- We observed staff treating people with dignity and respect
- People were positive about the support the service provided and praised the staff. Most carers were complimentary regarding the services provided and individual staff members whom they felt were professional and caring towards their relative.
- Staff involved people with their decisions and care needs. Carers told us that they felt involved by staff in the assessment and treatment being provided to their relative.

However:

- Some carers and patients told us they had experienced an uncaring response from staff.

Our findings

Trust headquarters - Central and West Norfolk access and assessment service, Central Norfolk crisis resolution and home treatment (CRHT), Waveney crisis resolution and home treatment (CRHT), Suffolk access and assessment service, Ipswich East Suffolk home treatment team , West Suffolk home treatment team

Kindness, dignity, respect and support

We observed staff treating people with dignity and respect and they delivered support and treatment in a way that took into account people's wishes. Staff were aware of the requirement to maintain person confidentiality at all times. We attended home visits and found interactions were respectful and friendly.

We observed initial reviews, assessments and phone call based assessments of people. The staff were courteous and polite. They showed empathy and made effort to ensure people understood what they were talking about.

People were positive about the support the service provided and praised the staff. Most carers were complimentary regarding the services provided and individual staff members whom they felt were professional and caring towards their relative.

We received some comments that staff did not give caring responses when people were in crisis.

The involvement of people in the care they receive

Staff involved people with their decisions and care needs. We found that assessments were detailed with individual preferences including the preferred gender of staff respected by the trust. People were asked their opinions and these were documented.

Carers told us that they felt involved by staff in the assessment and treatment being provided to their relative.

Section 136 health based place of safety - Hellesdon Hospital, Woodlands, Fermoy unit,

Coastlands Northgate Hospital, Carlton Court, Wedgwood House

Kindness, dignity, respect and support

Guidelines were in place for staff to follow. The records showed that people were treated with respect and their privacy and dignity was respected as much as possible.

The involvement of people in the care they receive

In Woodland unit we were given a copy of a questionnaire asking detainees to complete this on their experience in the suite.

Requires Improvement

Are services responsive to people's needs?

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

Summary of findings

We rated the mental health crisis services for adults and health based places of safety as 'requires improvement' because:

- Call handlers had not received specific mental health awareness training to assist them when taking calls from people who were often seriously ill.
- There were delays in the assessment of people who were admitted under section 136 of the Mental Health Act.
- There was no robust system to ensure that trust learning from individual concerns and complaints was disseminated throughout the services inspected.
- Carers and some patients told us that it was difficult to speak to the crisis teams as the phone was sometimes not answered or was often engaged.

However:

- Senior staff monitored delays and transfers in line with the trust's key performance indicators. Exception reporting took place when these indicators were breached.
- Staff told us in all six units that children and adolescents and people with learning difficulties were accepted for Section 136 assessments and that specialist consultant psychiatrists were made available to assess them.

Our findings

Trust headquarters - Central and West Norfolk access and assessment service, Central Norfolk crisis resolution and home treatment (CRHT), Waveney crisis resolution and home treatment (CRHT), Suffolk access and assessment service, Ipswich East Suffolk home treatment team , West Suffolk home treatment team

Access and discharge

Senior staff confirmed that bed management was a great concern to front line staff and provided constant pressure throughout all of the trust's services. For example, when an in-patient bed was required or services were trying to discharge people into community based services.

Senior managers within the home treatment teams reported regular meetings with in-patient ward managers and discharge co-ordinators to discuss admission avoidance where possible and early discharge support for people, but delays in admissions and discharges were frequent.

Carers and some people told us that it was often difficult to speak to the crisis teams as the phone was sometimes not answered or often engaged. We spoke with managers who acknowledged this.

Senior staff explained how delays and transfers were monitored weekly in line with the trust's key performance indicators. We saw that the access and assessment teams were currently meeting their four and 72 hour and nearly achieving their 28 day performance targets.

Senior staff in the home treatment teams reported that some people were difficult to discharge due to capacity pressures being experienced by the integrated delivery teams in Suffolk and the community mental health teams in Norfolk and in-patient services.

Each of the home treatment teams had delayed transfers of care. These were caused by a lack of capacity within the integrated delivery teams in Suffolk and the community mental health teams in Norfolk and in-patient services. We found staff encountered difficulties with obtaining suitable accommodation for those people with no fixed abode.

We were also contacted by the campaign group who told us that there were examples of people not being able to access services due to staff shortages.

Meeting the needs of all people who use the service

Call handlers within the service had received customer care training. However they had not received specific mental health awareness training to assist them when taking calls from people who were often seriously ill.

Staff had access to translation services and interpreters where required. Most staff had received their mandatory equality, diversity and human rights (EDHR) training. We found that the training figures varied between 61% and 90% according to those training records seen in different services.

Requires Improvement

Are services responsive to people's needs?

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

One team had sourced a Polish speaking psychotherapist for a patient to ensure the therapy would be of maximum benefit due to the person's level and understanding of English.

There was a trust provided interpreter and translation service. There was an independent advocacy service available and staff were aware of this. Information leaflets were available in all of the services inspected. Staff informed us that these would be given to people as required. Some people told us that they had received condition specific information leaflets from staff.

Listening to and learning from concerns and complaints

Information about raising concerns and complaints was available to people who used the service and their carers. Information was also available on the trust's website. This information could be made available in different languages.

People could raise their concerns about their care and treatment through a number of trust supported services. For example, Voice Ability (independent advocacy service), the Independent mental capacity advocacy service (IMCA) and the patient advisory and listening service (PALS).

Some people told us that when they had raised individual concerns, these had been addressed appropriately. However, it was not clear how wider trust learning from individual concerns and complaints was disseminated throughout the services inspected.

Feedback to front line staff regarding any complaints or concerns raised was variable. Some staff did not feel informed about the outcome of the complaints escalated by them. Whilst others told us that they had to seek this information from the person concerned.

Section 136 health-based place of safety - Hellesdon Hospital, Woodlands, Fermoy unit, Coastlands Northgate Hospital, Carlton Court, Wedgwood House

Access and discharge

We found that the trust target for commencing assessments in these suites was within the intra-agency protocol of three hours. However in the quarterly trust report on the use of Section 136 for the period April - June 2014 it was reported that the majority of the assessments took place only within the first six hours of detention at Hellesdon and Northgate hospitals and the Fermoy unit. At Hellesdon eight cases took between six and nine hours to resolve, two at Northgate had exceeded six hours and four of the twelve cases at Fermoy took in excess of nine hours to resolve. Reasons for the delays include, lack of available in-patient beds and delays in emergency AMHP response.

The trust were aware of the likelihood of there being more than one person requiring the facility at any given time. We were told that a second 136 detainee would be conveyed to another suite within the trust. This could be a lengthy and time consuming exercise whilst increasing risks to people, police officers and trust staff. We noted an example of this happening and found that this caused undue distress to the person concerned.

Should the person concerned not be admitted following initial assessment they may be many miles from their home or where they had first been placed on a Section 136 by the police. All units confirmed that in such circumstances the trust would pay for a taxi to return the person home if no suitable trust transport was available.

Meeting the needs of all people who use the service

Staff told us in all six units that children and adolescents and people with learning difficulties were accepted for Section 136 assessments and that specialist consultant psychiatrists were made available to assess them.

Staff confirmed that they had access to translation services and interpreters where required. We saw that most staff had received mandatory equality diversity and human rights (EDHR) training.

The 136 units visited had patient information readily available for those people placed in the suites and staff told us that everyone was given a leaflet about the powers and responsibilities of Section 136 of the Act.

Listening to and learning from concerns and complaints

Information about raising concerns and complaints was available to people who were assessed in these units.

Are services well-led?

Inadequate

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

Summary of findings

We rated the mental health crisis services for adults and health based places of safety as 'inadequate' because:

- A majority of staff that we talked with were unaware of the trust strategy.
- Staff described a lack of consultation by senior trust managers about the trust's strategy and values.
- Staff felt that the trust should make more effort to communicate directly with them.
- Morale was very low and staff were increasingly disaffected
- We identified some concerns with the trust's consultation process regarding the reconfiguration of the community based services at Carlton Court.
- We found little evidence of changes made by the trust following concerns identified by their performance monitoring systems.

However

- We saw good examples of locally based teams working effectively together.

Our findings

Trust headquarters - Central and West Norfolk access and assessment service, Central Norfolk crisis resolution and home treatment (CRHT), Waveney crisis resolution and home treatment (CRHT), Suffolk access and assessment service, Ipswich East Suffolk home treatment team , West Suffolk home treatment team

Vision and values

The trust's values for 2014/16 were aimed at delivering safe effective services which met local needs. The trust said they would keep their promises and be "accountable for what they do."

We did not see the trust's vision and values on display in the locations visited. Some staff told us they were unaware of the trust strategy and they felt that the trust should make more effort to communicate directly with them. Staff described a lack of consultation by senior trust managers about the trust's values and future direction.

Staff expressed their anxiety about the future of the access and assessment teams and the community services located at Carlton Court. They were concerned about a lack of effective consultation with regards to the trust's future plans for this service. This affected service delivery as it was hard to recruit to the vacancies. Morale was very low and staff were increasingly disaffected at this service.

Good governance

The trust measured quality against key performance indicators (KPI). Examples of these included emergency, urgent and routine assessments. Exception reporting took place when breaches of these were identified. However there was little evidence of changes made following performance monitoring.

Managers attended monthly performance meetings with the lead commissioning clinical governance groups and informed us that they passed the information to their teams via managerial supervision and team meetings. There was no evidence to show that these meetings brought about increased resources.

Auditing and governance systems in place throughout the services however they were not up to date in each service . Reasons cited were time pressure due to lack of staff, lack of motivation due to low staff morale and apathy. For example in one access and assessment service there were two deputy managers who were unable to undertake their auditing responsibilities due to pressure to fulfil assessments because of staff shortages. No recent auditing had taken place at Carlton Court except bed status reports.

Some staff confirmed they had received feedback regarding the outcome of incidents and complaints. However, other staff did not feel that this feedback was helpful to enable learning from these to be fully embedded throughout the service.

Leadership, morale and staff engagement

We found that staff morale was very low. For example staff didn't feel they were consulted on trust wide changes. They felt they were just told to do things with little explanation or warning. However, we saw some good examples of locally based teams working effectively together.

Staff felt that their views were not being listened to. We noted that staff at Carlton Court were particularly demoralised. There was no manager for this location.

Are services well-led?

Inadequate

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

Commitment to quality improvement and innovation

We saw some good examples of innovative work at a local level. For example, some services in Suffolk were working with the Suffolk continuing improvement partnership (CSIP). The actions arising from these meetings were followed up by the Suffolk West action group (SWAG).

Some home treatment teams were self-assessing themselves against the 'triangle of care' assessment tool. This was a holistic assessment and care delivery model involving the person their family and the health professional. Effective implementation of this model was being monitored by the trust's 'carers led advisory group' (CLAG).

Some services told us that they had received recent monitoring visits by senior trust managers and non –executive trust directors.

Section 136 health based place of safety - Hellesdon Hospital, Woodlands, Fermoy unit, Coastlands Northgate Hospital, Carlton Court, Wedgwood House

Vision and values

We were impressed by the commitment of staff and the police we met in providing a safe, responsive, and caring environment to people who were being assessed at these units. Staff spoken to were aware of the local vision and strategy of this service, but less aware of the trust wide strategy.

Good governance

We saw clear clinical governance arrangements were in place at a local level. The Trust measured quality against key performance indicators (KPI), but there was less evidence about actions following monitoring.

Leadership, morale and staff engagement

We found a low level of staff morale. However the specialised nature of the services and recent extra resources had improved morale recently. Evidence was seen of partnership working with other agencies and the AMHP service.

Commitment to quality improvement and innovation

We found that having AMHP mental health professionals in the main Norfolk police control room enabled police officers answering emergency calls from the public to have accessible and readily available expertise, support and advice. This brought benefits to the community as a whole.

We were informed that the trust had successfully obtained funding from the Clinical Commissioning Group (CCG) in order to appoint a number of nurses to provide permanent staff to the 136 suites at Hellesdon Hospital and the Fermoy unit. When these units were not in use the staff concerned would provide extra support to the in-patient wards.

The trust had obtained funding to employ two nurses to accompany police officers in a triage car with the aim of reducing the use of Section 136 detention at the Woodlands unit in Suffolk.