Hertfordshire Partnership University NHS Foundation Trust

Evidence appendix

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This evidence appendix provides the supporting evidence that enabled us to come to our judgements of the quality of service provided by this trust. It is based on a combination of information provided to us by the trust, nationally available data, what we found when we inspected, and information given to us from patients, the public and other organisations. For a summary of our inspection findings, see the inspection report for this trust.

Facts and data about this trust

The trust had 18 locations registered with the CQC (on 21 January 2019).

Registered location	Code	Local authority
Albany Lodge	RWR13	Hertfordshire
Astley Court, Little Plumstead Hospital	RWRX1	Norfolk
Elizabeth and Victoria Court	RWR76	Hertfordshire
Eric Shepherd Unit	RWR23	Hertfordshire
Gainsford House	RWR79	Hertfordshire
Hampden House	RWR78	Hertfordshire
HPFT North Essex	RWRG7	Essex
Kingsley Green	RWR96	Hertfordshire
Lambourne Grove	RWR31	Hertfordshire
Lister Adult Mental Health Unit	RWR34	Hertfordshire
Little Plumstead Hospital	RWRF3	Norfolk
Logandene	RWR32	Hertfordshire
Prospect House	RWR45	Hertfordshire
Seward Lodge	RWR47	Hertfordshire
Sovereign House	RWR08	Hertfordshire
The Beacon	RWRG9	Hertfordshire
The Stewarts	RWR62	Hertfordshire
Trust Head Office	RWRPU	Hertfordshire

The trust had 426 inpatient beds across 38 wards, 16 of which were children's mental health beds. The trust also had no acute outpatient clinics, 188 community mental health clinics and no

community physical health clinics per week. At the time of the inspection, bed numbers had reduced following elimination of shared rooms within the adult acute wards and the closure of The Stewarts; an inpatient unit for older people.

Total number of inpatient beds	426
Total number of inpatient wards	38
Total number of day case beds	n/a
Total number of children's beds (MH setting)	16
Total number of children's beds (CHS setting)	n/a
Total number of acute outpatient clinics per week	n/a
Total number of community mental health clinics per week	188
Total number of community physical health clinics per week	n/a

The methodology of CQC provider information requests has changed, so some data from different time periods is not always comparable. We only compare data where information has been recorded consistently.

Is this organisation well-led?

Leadership

The trust had a senior leadership team in place with the appropriate range of skills, knowledge and experience to perform its role. The trust board and senior leadership team displayed integrity on an ongoing basis. We observed a strong experienced board, developed over time, benefitting from an effective longstanding chief executive with an open and healthy relationship with the Chairman; both focused on managing the cycle of non-executive appointments to ensure smooth transitions and succession.

Executive board members were inspirational, capable, open and responsive to feedback and striving for improvement throughout the organisation. The trust's board of directors was well established and the six non-executive members of the board had a broad range of experience and qualification, including banking, consultancy services, law, commercial, finance and healthcare. The chief executive had been in post since 2009 and the chair since 2014 (second term). The executive director of finance had worked within the NHS since 1990, predominately with organisations providing mental health and learning disability services in Hertfordshire and had recently been appointed as deputy chief executive for the trust. We were particularly impressed by the clear focus and priority for providing safe and high-quality care consistently demonstrated by the finance director.

We were impressed by the compassionate, inclusive and effective leadership at all levels. Leaders demonstrated the high levels of experience, capacity, integrity and capability needed to deliver excellent and sustainable care. We were particularly impressed by the leadership demonstrated by the leaders of the three trust strategic business units and the lead for safeguarding. Staff across the trust spoke highly of the executive team and praised their ongoing support and visibility in services. Staff were particularly praising of the chief executive, medical director and chief nurse.

The trust leadership team had a comprehensive knowledge of current priorities and challenges across all sectors and acted to address them. The trust board and senior leadership team set the tone for the values of the trust on an ongoing basis. The trust's non-executive members of the board were challenging, holding the executive team to account to improve the performance of the

trust. The leadership team had worked hard to model behaviours and practices that underpinned the values of the trust.

The executive board had two (25%) black and minority ethnic (BME) members and four (57%) women. The non-executive board had no BME members and five (71%) women.

The board were seen as supportive to the wider health and social care system. The trust's chief executive had led on the Hertfordshire and West Essex sustainability and transformation plan (STP) for the region between August 2016 and January 2018 and was named in the health service journal's top 50 chief executives in 2014 and 2016. In 2017 the chief executive received the health service journal's chief executive of the year award.

The trust demonstrated openness and responsiveness in its relationship with the care quality commission and NHS Improvement, with a 'no surprises approach' and had to date kept the regulators informed appropriately. Reports from external sources, including NHS improvement and commissioners were consistently favourable. The trust has demonstrated its focus on delivering improvement throughout the organisation and has gained national and regional recognition under the current leadership, for a number of the services provided by the trust.

The trust had a lead for child and adolescent mental health, learning disability and autism.

The trust reviewed leadership capacity and capability on an ongoing basis. Succession planning was in place throughout the trust, aligned to the trust strategic objectives. The trust provided a range of leadership development programmes both internally and externally to meet the different requirements and learning styles of staff. These comprised of formalised in-house training programmes covering basic management skills and leadership development, relaunched in February 2018 as part of the trust's management fundamentals, delivered through an internal leadership academy, which is a level 7 accredited programme delivered in partnership with the University of Hertfordshire. Cohort 9 of the leadership academy had recently graduated with 20 delegates passing and gaining accreditation. The trust was also participating in the local Mary Seacole programme within the STP, with cohort 4 recently graduating and cohorts 5 and 6 near completion of the course.

The trust had also participated in the Bedfordshire and Hertfordshire accelerated directors' development scheme; which is a chief executive sponsored scheme to identify and develop leaders for Bedfordshire and Hertfordshire, who have the potential to fill key executive director roles. The current executive director of service delivery and experience, the executive director of quality and safety and the interim director of workforce and organisational development have all been through this course. Specific leadership development programmes were supported by additional support to managers through the coaching network and the creation of podcasts to provide support around key management and leadership issues. Eight members of staff have recently qualified as ILM level 5 coaches and are registered with the Beds and Herts coaching network, coaching both internal and external staff.

The trust had also recently participated in the pilot for the Midlands and East talent board with two candidates from the trust being put forward. Staff have also participated in national programmes such as Nye Bevan, Mary Seacole, aspiring directors of nursing programmes and the chief pharmacist development programme. A senior community nurse lead had been successful in her application, supported by the trust, to join the 70@70 senior nurse and midwife research leaders programme.

Internally the trust had delivered a leadership programme for service line leads using a coaching and mentoring style, and team leader development days continued to run for the second year. Development days for medical leads have also taken place during the year and more

recently for matrons. The 70 senior leaders in the organisation met regularly to hear from the chief executive about key strategic developments and to do focused thinking around strategic and operational objectives. This forum was also used for development sessions, for example a session on outward mindset by Alec Grimsley. The national leadership framework shared the same evidence base as the collective leadership model, which the trust has used to inform the organisational development strategy. Succession planning also took place within each strategic business unit, to ensure leaders of the future were identified and supported to gain the development they needed.

Senior leaders established in community teams led the monthly educational (continuing professional development programme). The programme entailed teaching on risk formulation, collaborative safety planning and role play on managing difficult clinical situations.

Fit and proper persons checks were in place. We reviewed the personnel files of senior staff and found that checks were carried out, disclosure and barring checks were completed on appointment and within the last three years. There was an annual declaration of interests and records maintained of professional qualifications and registrations with expiry dates present. Appraisals were completed, with actions identified.

In the 2017 NHS Staff Survey, 40% of staff said there was good communication between senior management and staff, which was better the national average of 36%

Senior leaders were highly visible in services. The board of directors and governors completed a programme of board visits to services, with a focus on talking to staff on the ground. Staff told us leaders were visible and approachable. Following feedback from staff about how they would like to access the executive team, the executives undertook a ‘big listen’ engagement every quarter, which was open to all staff. A full day was spent meeting the executives and discussing any issues that matter to staff. Staff were asked to put forward their comments regarding how the senior leadership team could improve both the staff and service user experience around certain themes such as workforce race equality standards (WRES), bullying and harassment, and recruitment and retention. There was a ‘question time’ panel during the day where attendees had opportunity to ask questions directly of the executive team, or anonymously should they prefer.

The trust evaluated feedback and reported actions taken via a ‘you said, we did’ approach. For example, in the October 2018 ‘big listen’ staff complained about the backlog and length of time to get IT equipment. The executive team took action that day and an additional 250 laptops were ordered. ‘Local listens’, which follow a similar format to the ‘big listen’, are also held across Norfolk, Essex, and Buckinghamshire to reach an even greater audience. Local listens had also been adopted by the strategic business units locally and were attended by senior leaders and managers. Staff working in trust sites within Essex and Norfolk reported feeling connected to the trust, despite geographical challenges.

Chief executive breakfasts also took place throughout the year, in which the chief executive met with a certain staff group to understand what was going well, and what could improve their working lives. Over the last year breakfasts have been held with 30 staff from the following staff groups Medical Consultants, Modern Matrons, Band 5 and Band 6 Nurses, Assistant Psychologists and Occupational Therapists.

Vision and strategy

The trust strategy and supporting objectives and plans were stretching, challenging and innovative, while remaining achievable.

The trust had a clear vision and set of values with quality, safety and sustainability as the top priorities. The trust's values and behaviours were developed by over 800 service users, carers and staff. All trust staff had attended a values training session.

The board used regular meetings to monitor progress against delivery of the strategy and we saw minutes of board meetings, strategy meetings, quality improvement meetings and others where staff reviewed, challenged and updated the strategy.

The trusts vision and values were:

Vision

Delivering great care, achieving great outcomes – together.

We will achieve our vision by:

- Putting the people who need our care, support and treatment at the heart of everything we do - always.
- Consistently achieving the outcomes that matter to the individuals who use our services, their families and carers, by working in partnership with them and others who support them.
- Providing the very best experience of joined-up care in line with what service users and carers have told us makes 'Great Care'.

Values

- We are welcoming so you feel valued as an individual
- We are kind so you can feel cared for
- We are positive so you can feel supported and included
- We are respectful so you can feel listened to and heard
- We are professional so you can feel safe and confident

The trust's mission statement is short, informative and clear, readily understandable to staff, patients and stakeholders.

Everything we do is aimed at providing consistently high quality, joined up care, support and treatment that:

- empowers individuals to manage their mental and physical wellbeing
- keeps people safe from avoidable harm
- is effective and ensures the very best clinical and individual recovery outcomes
- provides the best possible experience.

The trust aligned its strategy to local plans in the wider health and social care economy and had developed it with external stakeholders. The trust was working with other local health economy stakeholders with an intention to improve the sustainability of the care the system delivered to the population of Hertfordshire. This is particularly evidenced by the commitment and involvement of the trust's chief executive through leading the regional sustainability and transformation plans. The trust's strategy recognised the need to be inclusive through established networks and partnerships.

The trust strategy and vision for high quality, sustainable care is set out in the trust's 'Good to Great' strategy which spans between 2016 - 2021. This strategy aligned itself to four specific principals: great care, great outcomes, great people, great organisation, great networks and partnerships. The trust held 'good to great' roadshows, every six months, aligned to their strategy. This was an opportunity for the trust's executive team and senior leadership team to meet with staff at their work locations to discuss a certain topic. The latest good to great roadshows had taken place throughout December and January 2019 and focussed on improvements that teams had made over the last year. Sixteen roadshows were held at 15 sites with 224 members of staff attending.

The trust aligned its financial strategy to support delivery of its strategy. An example of this was the work being done by the trust to optimise its use of resources to deliver value and quality improvements throughout the trust.

The trust had a physical health care strategy, 2017-2022, aligned to the trust's strategy. The strategy was co-produced with service users and carers, staff and other local stakeholders. The trust had considered national guidance, for example the Five Year Forward View for Mental Health and 'Bringing Together Physical and Mental Health' published by The Kings Fund in 2016 to inform the strategy, together with 'patient and carer views from the 2016 'having your say' data.

We saw the trust values were embedded throughout the trust through recruitment, new initiatives, staff appraisals and staff wellbeing. The leadership team and the staff we spoke with during the inspection of services could discuss the values and what they meant to the service they provided. As part of the inspection 284 staff, from all disciplines, were spoken to in a number of focus groups across all geographical areas of the trust. Staff consistently knew and understood the vision, values and strategic goals and how their role helped in achieving them.

We were very impressed at how the trust's vision and values were embedded at board level and informed how the senior leadership team operated. At board and committee meetings discussions were consistently linked to the values. The values, vision and behaviours were visible on the trust website, intranet and notice boards across all services. The board culture was open, collaborative, positive and honest.

The trust values were introduced to candidates as part of the recruitment process. All potential candidates were screened against the trust values at the point of application by completion of a values based assessment. Upon appointment staff attended a values session at induction which was attended by staff, volunteers and students. The trust's values and behaviours framework was included as part of all staff's personal development plans.

The leadership team regularly monitored and reviewed progress on delivering the strategy and local plans. Strategic business unit business plans were developed in line with the trust strategy. These were shared at the senior leaders' forum for comments to ensure that all the leaders were aware and working towards the same priorities. Strategic business unit business plans were reviewed at core management meetings and monitored via performance review meetings.

The trust proactively worked alongside partners to provide joined up healthcare for the local population. For example, the trust worked alongside the local community NHS trust in The Marlowes Health and Wellbeing Centre in Hemel Hempstead. Opening in May 2018, The Marlowes provided community mental health services for adults and children, delivered by the trust, alongside a range of physical services provided by the local NHS community trust. Also located at The Marlowes was The Herts Valley Integrated Diabetes Service (HIDS) an integrated diabetes service commissioned to provide holistic, integrated care to the diabetes population in West Hertfordshire. HIDS was specifically designed to ensure that both the physical and mental

health needs of patients with diabetes would be met by the local acute, community and mental health trusts, along with primary care support. The centre provided an opportunity for healthcare professionals to share expertise with each other to improve the treatment patients received.

Hertfordshire University Partnership NHS Foundation trust provided the mental health component of the integrated service via two teams:

i) the wellbeing for long-term conditions team for lower risk/complexity patients and

ii) the diabetes mental health liaison team for higher risk/complexity patients.

The service was regional winner of excellence in mental health team NHS70 Parliamentary Award.

For learning disability services, the trust was leading a new service model in Essex having been asked to take the lead role across the county. The trust had begun implementation as lead provider in partnership with two other organisations. The service model was outcome based, with a collaboratively agreed set of outcome measures. The development of this work had been in partnership with integrated commissioners from the local authority and clinical commissioning groups.

The trust also co-produced a celebration of recovery-orientated practice with partners from the mental health sector across Hertfordshire, Buckinghamshire, Essex and Norfolk. In October 2018 the trust held 6 locality-based events across their service delivery area on the themes of hope and opportunity. These were all co-produced by groups of professionals, service-users and carers. In 2018, close to 500 people attended and 94% rated their experience good or excellent.

The four largest ethnic minorities within the Hertfordshire catchment population are: White other (5%), Asian Indian (2.6%), Black African (1.8%) and Asian other (1.6%).

The four largest ethnic minorities within the Essex catchment population are: White other (2.6%), Asian Indian (0.9%), Black African (0.9%) and White Irish (0.8%).

The four largest ethnic minorities within the Norfolk catchment population are: White other (3.5%), Asian Indian (0.5%), Asian other (0.5%) and Chinese (0.4%).

The four largest ethnic minorities within the Buckinghamshire catchment population are: Asian Pakistani (4.2%), White other (4.1%), Asian Indian (2.2%) and Asian other (1.4%).

Culture

We were particularly struck by the extent to which the executive team modelled the culture they wished to see in the organisation. Leaders at every level lived the vision and prioritised high quality sustainable and compassionate care.

Leaders showed an inspiring positive culture with a shared purpose towards the vision, values and strategy, and modelled and encouraged compassionate, inclusive and supportive relationships between all grades of staff. Leaders had an inspiring shared purpose and strive to deliver and motivate staff to succeed. Comprehensive and successful leadership strategies were in place to ensure delivery and to develop the desired culture.

The trust's strategy, vision and values underpinned a culture which was patient centred. We were particularly impressed with the caring and compassionate attitudes of staff across all services we visited. Staff consistently demonstrated that patients were at the heart of every interaction. This included working collaboratively with families, carers and outside agencies.

Staff felt respected, supported and valued. Across all services, staff reported exceptionally supportive relationships with colleagues and local managers. Staff showed pride and talked passionately about their roles, their personal progression opportunities, opportunities to access

specialist training and open and transparent relationships with senior colleagues. We were impressed by the culture promoted within the trust for shared learning and encouragement of staff to offer ideas to improve service delivery and patient experience. Overall, staff received appraisals and supervision. However, we were not assured that staff working within the older people's inpatient service received supervision in accordance with trust policy.

Vision and values were embedded in both recruitment and appraisal processes. We were impressed by how well the vision and values were considered in all aspects of care provided to patients, including service re-design. The trust benchmarked their 'business as usual' against the vision and values and kept the message at the heart of all aspects of the running of the organisation.

The trust worked appropriately with trade unions and managers addressed poor performance of staff where needed, regardless of seniority.

Staff in all areas had good relationships with the people they cared for, including their families and carers. In some services staff went over and above to provide the best care possible. We felt that this was due in part to staff feeling recognised for their hard work and the quality of the care they delivered.

The trust celebrated and rewarded staff for a number of achievements. The trust held an annual staff awards event. The afternoon is dedicated to the development awards where staff who had completed an academic qualification throughout the year were recognised. In 2018, 164 members of staff were invited to the staff development awards with 98 members of staff attending to collect their certificates. The last staff awards ceremony was held November 2018 and was attended by over 300 staff. Over 300 nominations for achievement awards were received with 25 members of staff either winning an award or gaining highly commended. The trust also held monthly inspire awards to recognise and reward those staff who consistently demonstrated trust values. Nominations were received, with a supporting statement, from staff, service users and carers. Between April and November 2018 there were 99 inspire award nominations with 49 winners.

Staff development was a focus of board reports, with the trust board pack for November 2018 showing 90% compliance with personal development plans for the business units and mandatory training compliance of 88%.

Commissioners and other stakeholders confirmed that the trust was responsive to challenge and worked collaboratively with stakeholders, other local NHS trusts and the third sector to deliver services to patients.

The trust promoted a culture of openness, transparency, support and learning in a blame free environment, with safety as a top priority. We saw a number of examples. One example was the use of a process known as 'SWARM' (a multidisciplinary forum which provides open support, guidance and feedback following serious incidents to learn and improve services). Staff held a 'SWARM' as soon as possible following a patient safety incident, allowing for immediate actions to be taken, where applicable. The trust also used information from 'SWARMS' to form the terms of reference for serious incident investigations. Staff we spoke to confirmed that they felt supported by peers and senior colleagues during this process.

A further example was the process of 'safety huddles'. Since our last inspection, safety huddles have been introduced in inpatient service areas and take place up to three times a day. All members of the huddle stand to enable the process to be fast and effective and ask the same three questions:

- Do you feel safe or do you have a concern?

- Which service user is unhappy with their care?
- What is the plan (and who is going to implement this and when)?

Staff consistently reported the benefit of safety huddles during our interviews and focus groups.

The trust had also implemented a process of undertaking 'Schwartz rounds'. Schwartz rounds are an evidence-based forum for hospital staff from all backgrounds to come together to talk about the emotional and social challenges of caring for patients. During 2018, 16 Schwartz rounds were held throughout the Trust with 243 participants. An evaluation of Schwartz rounds found that 92% of participants would attend again, 95% of staff would recommend Schwartz rounds to a colleague, 90% of staff said it would help them to work with colleagues, and 98% have a better understanding of how colleagues feel about their work. Additional staff support also consisted of workplace mediation, mindfulness courses, resilience training, stress management tutorials, and the trust health and wellbeing magazine known as 'working together as one'

Since our last inspection, the trust had reviewed its appointment of the freedom to speak up guardian. At the time of the last inspection, this post was filled with a deputy director. The trust was asked to consider the appropriateness of a senior leader in this role. The trust appointed a new freedom to speak up guardian in August 2018, through an open recruitment drive and competitive interview process. The current post holder worked across the trust, attended staff induction, engaged with staff and attended events, raising awareness of his role. Staff we spoke with were aware of the role and how to make contact if needed. The trust ensured contact details were widely publicised. The trust was recruiting freedom to speak up champions in Norfolk and Essex and a member of staff in pharmacy had also volunteered to support the speak up programme. Data showed that the guardian had received 17 referrals since appointment. Staff confidence in the role was demonstrated by increasing numbers of referrals no longer anonymised. There was a robust system to report to the trust board and the guardian was also supported to present his ideas for development of the role to the trust board in February 2019. We observed this was well received.

Staff consistently told us they could raise concerns without fear of retribution and gave examples where this had occurred.

The trust applied the duty of candour appropriately. We reviewed serious incident investigation reports and saw that the trust contacted families and carers for their views and kept them informed. We also saw robust evidence of application of duty of candour within trust responses to complaints.

Staff morale across all teams was consistently high. This was evidenced during the core service inspections and via focus groups.

We reviewed data from the 2017 NHS staff survey.

In the 2017 NHS Staff Survey, 76.3% of staff said they had worked extra hours, which was worse than the national average of 71.1%.

In the 2017 NHS Staff Survey, 54.2% of staff said they had had attended work despite feeling unwell because they felt pressure from their manager, colleagues or themselves, which was worse than the national average of 52.8%.

At September 2018, there were 7.9 occupied beds to each full-time equivalent member of the nursing staff, which was worse than the national average of 4.7.

The trusts engagement score shows how it compares with other mental health trusts on an overall indicator of staff engagement. Possible scores range from one to five, with one indicating that staff

are poorly engaged (with their work, their team and their trust) and five indicating that staff are highly engaged.

In the 2017 NHS Staff Survey, the trust's score of 3.87 was above (better than) trusts of a similar type.

In the 2017 NHS Staff Survey, the trust had better results than other similar trusts in 14 key areas:

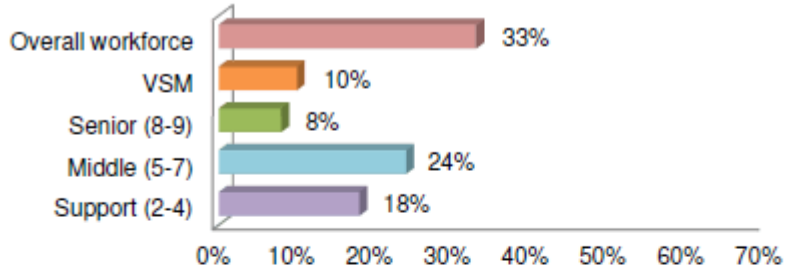
Key finding	Trust score	Previous trust average	Comparison to last year
KF1. Staff recommendation of the organisation as a place to work or receive treatment	3.85	3.84	→
KF2. Staff satisfaction with the quality of work and care they are able to deliver	3.89	3.98	→
KF4. Staff motivation at work	3.97	4.05	→
KF6. Percentage of staff reporting good communication between senior management and staff	40%	42%	→
KF12. Quality of appraisals	3.29	3.43	→
KF13. Quality of non-mandatory training, learning or development	4.14	4.18	→
KF15. Percentage of staff satisfied with the opportunities for flexible working patterns	64%	64%	→
KF19. Organisation and management interest in and action on health and wellbeing	3.83	3.76	→
KF24. Percentage of staff/colleagues reporting most recent experience of violence	95%	94%	→
KF27. Percentage of staff/colleagues reporting most recent experience of harassment, bullying or abuse	61%	60%	→
KF29. Percentage of staff reporting errors, near misses or incidents witnessed in the last month	94%	91%	→
KF30. Fairness and effectiveness of procedures for reporting errors, near misses and incidents	3.82	3.77	→
KF31. Staff confidence and security in reporting unsafe clinical practice	3.80	3.80	→
KF32. Effective use of patient / service user feedback	3.88	3.78	→

In the 2017 NHS Staff Survey, the trust had worse results than other similar trusts in seven key areas:

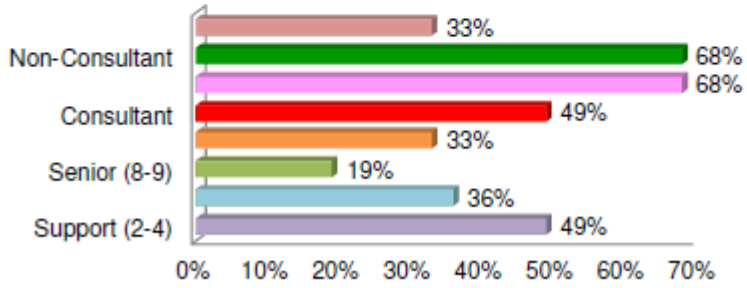
Key finding	Trust score	Previous trust average	Comparison to last year
KF11. Percentage of staff appraised in last 12 months	88%	88%	→
KF16. Percentage of staff working extra hours	76%	79%	→
KF20. Percentage of staff experiencing discrimination at work in the last 12 months	17%	16%	→
KF22. Percentage of staff experiencing physical violence from patients, relatives or the public in last 12 months	22%	24%	→
KF23. Percentage of staff experiencing physical violence from staff in last 12 months	3%	2%	→
KF26. Percentage of staff experiencing harassment, bullying or abuse from staff in last 12 months	24%	23%	→
KF28. Percentage of staff witnessing potentially harmful errors, near misses or incidents in last month	27%	32%	→

The trust also operated its own quarterly staff pulse survey; which showed a 30% improvement in responses over the last four years.

The Workforce Race Equality Standard (WRES) became compulsory for all NHS trusts in April 2015. Trusts have to show progress against nine measures of equality in the workforce. The percentages of White and BME staff in each of the Agenda for Change (AfC) pay bands 1 to 9, and at Very Senior Manager (VSM) level (including executive board members), compared with the percentage of staff in the overall workforce: This indicator changed in 2017, clarifying the definition of Senior Medical Manager and Very Senior Manager. The following graphs provide a representation of 2018 data against the overall workforce.



Graph1 – Representation of BME staff, non-clinical



Graph 2 – Representation of BME staff, clinical

The cluster of band 2-4 continues to see the most significant proportion of BME staff across clinical staff. Nationally and locally, BME representation at Board and Very Senior Manager level remain significantly lower than BME representation in the overall NHS workforce and in the local communities served. Over the past year, there has been an increase in Band 7 and Band 8 nursing roles, which is in line with national trends. There has been no increase in Band 6 nursing staff, which is also what is seen at a national level.

1. In 2018, White candidates were 1.44 times more likely than BME candidates to get jobs for which they had been shortlisted. The trust performance against this measure has worsened from 1.42 times more likely in 2017.
2. In 2018, BME staff were more likely to enter the formal disciplinary process, when compared with White staff. This has increased from 1.92 times more/less likely in 2017.
3. In 2018, White staff were 1.19 times more likely to take part in voluntary training than BME staff.
4. Thirty-five percent of BME staff experienced harassment, bullying or abuse from patients, relatives and the public in the past year (2017 NHS staff survey). This decreased from 43% in 2016 and was better than the national average for similar trusts (36%). The figure for White staff decreased from 31% in 2016 to 28% in 2017. This was better than the national average for similar trusts (32%). The difference between White and BME Staff was similar to expected in 2017 and was significant in 2016.

5. 28% of BME staff experienced harassment, bullying or abuse from staff in the past year (2017 NHS staff survey). This decreased from 29% in 2016 and was worse the national average for similar trusts (26%). The figure for White staff increased from 21% in 2016 to 22% in 2017. This was worse than the national average for similar trusts (21%). The difference between White and BME Staff was similar to expected in 2017 and was not significant in 2016.
6. 77% of BME staff believed that the trust provided equal opportunities for career progression and promotion (2017 NHS staff survey). This decreased from 79% in 2016 and was the same as the national average for similar trusts (77%). The figure for White staff decreased from 91% in 2016 to 87% in 2017. This was the same as the national average for similar trusts (87%). The difference between White and BME Staff was similar to expected in 2017 and was significant in 2016.
7. 6% of White staff experienced discrimination from a colleague or manager in the past year (2017 NHS staff survey). This decreased from 7% in 2016 and was the same as the national average for similar trusts (6%). Figures for BME staff in 2017 (17%) were the same as 2016 (17%). This was worse than the national average for similar trusts (14%). The difference between White and BME Staff was similar to expected in 2017 and was significant in 2016.
8. The percentage of BME staff on the board was 14.3% compared with 33.1% BME staff in the overall workforce. The percentage difference between the board voting membership and overall workforce was 18.8%.
9. The percentage of BME staff on the board was 14.3% compared with 33.1% BME staff in the overall workforce. The percentage difference between the board voting membership and overall workforce was 18.8%.

The trust's information governance committee responded by recommending that the WRES action plan was more focused, concentrating on recruitment, the disciplinary process, bullying and harassment as well as the culture of the organisation. The trust was undergoing a programme of all staff training in unconscious bias. Over the past few months the trust had begun to hold drop in 'surgeries' for BME staff within their business units to provide opportunity for BME staff to meet both management and equality & diversity staff to share their experience.

The trust inclusion & engagement team oversaw the day to day work around equality and diversity. The team included two dedicated roles (equality & diversity lead and inclusion & engagement manager). The trust equality plan was co-produced in 2018 to guide much of this work up to 2022 and included focus on both staffing and provision of high quality services. Additionally, to support inclusion at work, the trust had developed a role models programme. These were staff members from certain protected groups who were available to support and signpost other staff should they need this.

The trust had an impressive number of staff networks, including black Asian and minority ethnic (BAME), staff carers, disabled, mental health, lesbian gay bisexual and transgender (LGBT) and women's. The trust had plans to introduce a faith/spirituality staff network in the future. Staff networks were involved in a number of events both within the trust and externally, for example the LGBT network also engaged in the Hertfordshire LGBT partnership, networking with the University of Hertfordshire staff network and supporting Hertfordshire Pride. These initiatives have all contributed to increasing LGBT awareness in the trust.

The trust held an annual event for staff focused on supporting race equality across the workforce and how changes to culture can be implemented to ensure no differential, negative, experience for black, Asian and minority ethnic (BAME) staff.

The black Asian and minority ethnic (BME) network has included focused work around the workforce race equality standard. The network was also instrumental in the planning of the trust annual race equality at work event in October each year. There had also been focus in the past year on how the network can get more engaged with reviewing outcomes of recruitment processes as a critical friend to the process. During focus groups some BME staff reported concerns related to access to information for job opportunities. We raised this with the trust who took immediate action.

The workforce disability equality standard (WDES) comes into force from 1st April 2019 with first reporting due from 1st August 2019. There are 10 metrics across both workforce data and staff survey data with the requirement to look more closely at engagement of people with disabilities. The disability network contributed to the development (WDES) within the trust. The trust had an action plan in place to ensure readiness for implementation by April 2019 and reporting by August 2019.

The Patient Friends and Family Test asks patients whether they would recommend the services they have used based on their experiences of care and treatment.

The trust scored between 82.2% and 90.4%, lower than the England average for patients recommending it as a place to receive care for five of the six months in the period (June 2018 to November 2018).

The trust was higher than the England average in terms of the percentage of patients who would not recommend the trust as a place to receive care in five of the six months.

	Trust wide responses				**England averages**	
	Total eligible	**Total responses**	**% that would recommend**	**% that would not recommend**	**England average recommend**	**England average not recommend**
Jun 2018	37093	449	82.2%	8.5%	88.8%	3.8%
Jul 2018	36998	580	82.8%	5.7%	88.9%	3.9%
Aug 2018	12032	511	87.7%	3.7%	90.0%	3.5%
Sep 2018	12088	535	87.1%	5.4%	89.6%	3.7%
Oct 2018	12121	574	86.9%	5.1%	90.1%	3.3%
Nov 2018	12676	481	90.4%	2.7%	89.5%	3.6%

The trust ensured staffing levels and skill mix were planned, implemented and reviewed to keep people safe at all times. Any staff shortages were responded to quickly and adequately. The trust managed vacancies and staffing shortfalls with bank and agency staff. However, where possible services ensured these staff were regular and knew the wards and patients well. The trust measured staff demand through the use of the e-roster ‘safecare systems.’ Twelve-week rotas had been introduced across the trust and weekly roster scrutiny meetings allowed ward managers and matrons to understand the level of demand through measuring care hour per patient data. This had resulted in the flexible transfer of staff across the system to make best use of staffing resources and reduce need for agency staffing. Seasonal variance in the use of agency staffing was not observed in August 2018 and January 2019, as had been noted in previous years. Staff reported staffing levels were good across all services inspected.

The trust continued to work proactively to recruit and retain staff. This included recruitment campaigns, recruitment days, attendance at recruitment fairs, working with agencies, and offering students substantive roles with the trust upon qualifying. The trust had reduced its time to hire to 8.5 weeks, following a series of initiatives to streamline processes for recruitment. We saw many staff retention initiatives including the retire and return process, internal transfer process, a piloted buddy system for new starters and 'grow don't go' workshops.

The Trust was the lead for the Hertfordshire and West Essex STP nursing associate programme. The trust used the apprenticeship levy in partnership with the University of Hertfordshire to train 34 Nursing Associates. The first cohort are due to register with the Nursing and Midwifery Council in May 2019.

This provider has reported a vacancy rate for all staff of 13% as of 30 September 2018.

This provider reported an overall vacancy rate of 21% for registered nurses at 30 September 2018.

This provider reported an overall vacancy rate of 12% for nursing assistants at 30 September 2018.

	Registered nurses			Health care assistants			Overall staff figures		
Core service	**Vacancies**	**Establishment**	**Vacancy rate (%)**	**Vacancies**	**Establishment**	**Vacancy rate (%)**	**Vacancies**	**Establishment**	**Vacancy rate (%)**
MH - Child and adolescent mental health wards	7.0	13.0	54%	5.0	16.7	30%	13.2	39.0	34%
MH - Long stay/rehabilitation mental health wards for working age adults	12.6	38.7	33%	4.3	25.1	17%	17.4	74.3	23%
MH - Specialist community mental health services for children and young people	17.0	47.1	36%	1.5	31.6	5%	37.4	187.9	20%
MH - Wards for older people with mental health problems	14.3	73.0	20%	28.7	178.6	16%	54.4	310.1	18%
MH - Community mental health services for people with a learning disability or autism	19.5	92.1	21%	5.5	60.7	9%	38.4	263.4	15%
MH - Community-based mental health services for adults of working age	26.5	114.4	23%	20.9	169.7	12%	78.9	541.9	15%

	Registered nurses			Health care assistants			Overall staff figures		
Core service	**Vacancies**	**Establishment**	**Vacancy rate (%)**	**Vacancies**	**Establishment**	**Vacancy rate (%)**	**Vacancies**	**Establishment**	**Vacancy rate (%)**
MH - Secure wards/Forensic inpatient	24.5	80.6	30%	11.2	113.8	10%	35.0	227.1	15%
MH - Community-based mental health services for older people	13.2	97.4	14%	5.8	71.4	8%	33.9	266.9	13%
MH - Acute wards for adults of working age and psychiatric intensive care units	19.6	91.1	22%	6.1	118.8	5%	29.6	252.3	12%
MH - Wards for people with learning disabilities or autism	10.0	58.4	17%	15.2	115.8	13%	28.0	233.5	12%
Other	2.0	15.6	13%	5.4	51.2	10%	49.3	418.3	12%
MH - Mental health crisis services and health-based places of safety	6.6	90.7	7%	6.8	43.7	16%	17.3	159.6	11%
MH - Other specialist services	5.3	41.7	13%	7.8	66.1	12%	7.5	401.6	2%
Trust total	**178.1**	**853.7**	**21%**	**124.2**	**1063.0**	**12%**	**440.3**	**3375.9**	**13%**

NB: All figures displayed are whole-time equivalents

Between 1 November 2017 and 31 October 2018, 225857 hours were filled by bank staff to cover sickness, absence or vacancy for qualified nurses.

The main reason for bank and agency usage for the wards/teams was vacancies.

In the same period, agency staff covered 99260 available hours for qualified nurses and 12096 hours were unable to be filled by either bank or agency staff.

Caveat: the total hours available data provided by the trust was inconclusive and therefore this, along with the percentages of bank, agency and not filled hours has not been included.

Core service	**Total hours available**	**Bank Usage**		**Agency Usage**		**NOT filled by bank or agency**	
		Hrs	**%**	**Hrs**	**%**	**Hrs**	**%**
MH - Secure wards/Forensic inpatient	n/a	25191	n/a	3468	n/a	2311	n/a
MH - Acute wards for adults of working age and psychiatric intensive care units	n/a	33612	n/a	20278	n/a	1762	n/a

Core service	Total hours available	Bank Usage		Agency Usage		NOT filled by bank or agency	
		Hrs	%	Hrs	%	Hrs	%
MH - Specialist community mental health services for children and young people	n/a	3894	n/a	13530	n/a	0	n/a
MH - Community-based mental health services for adults of working age	n/a	14730	n/a	37183	n/a	179	n/a
MH - Wards for people with learning disabilities or autism	n/a	20821	n/a	2586	n/a	2708	n/a
MH - Mental health crisis services and health-based places of safety	n/a	32020	n/a	2563	n/a	1059	n/a
MH - Other Specialist Services	n/a	8634	n/a	3882	n/a	337	n/a
MH - Community-based mental health services for older people	n/a	9214	n/a	2035	n/a	65	n/a
MH - Wards for older people with mental health problems	n/a	42522	n/a	7444	n/a	2486	n/a
MH - Child and adolescent mental health wards	n/a	5565	n/a	3907	n/a	769	n/a
MH - Long stay/rehabilitation mental health wards for working age adults	n/a	22904	n/a	143	n/a	421	n/a
Other	n/a	6153	n/a	814	n/a	0	n/a
MH - Community mental health services for people with a learning disability or autism	n/a	599	n/a	1428	n/a	0	n/a
Trust Total	**n/a**	**225857**	**n/a**	**99260**	**n/a**	**12096**	**n/a**

Between 1 November 2017 and 31 October 2018, 386308 hours were filled by bank staff to cover sickness, absence or vacancy for nursing assistants.

The main reason for bank and agency usage for the wards/teams was vacancies.

In the same period, agency staff covered 439 available hours for nursing assistants and 15 hours were unable to be filled by either bank or agency staff.

Caveat: the total hours available data provided by the trust was inconclusive and therefore this, along with the percentages of bank, agency and not filled hours has not been included.

Core service	Total hours available	Bank Usage		Agency Usage		NOT filled by bank or agency	
		Hrs	%	Hrs	%	Hrs	%
MH - Secure wards/Forensic inpatient	n/a	52887	n/a	3113	n/a	4299	n/a
MH - Acute wards for adults of working age and psychiatric intensive care units	n/a	99580	n/a	20380	n/a	5467	n/a
MH - Specialist community mental health services for children and young people	n/a	897	n/a	3003	n/a	0	n/a
MH - Community-based mental health services for adults of working age	n/a	9323	n/a	2579	n/a	876	n/a
MH - Wards for people with learning disabilities or autism	n/a	59110	n/a	7509	n/a	5200	n/a
MH - Mental health crisis services and health-based places of safety	n/a	16204	n/a	1808	n/a	2635	n/a
MH - Other Specialist Services	n/a	4277	n/a	834	n/a	180	n/a
MH - Community-based mental health services for older people	n/a	3928	n/a	0	n/a	0	n/a
MH - Wards for older people with mental health problems	n/a	97969	n/a	7666	n/a	9658	n/a
MH - Child and adolescent mental health wards	n/a	26970	n/a	5604	n/a	3933	n/a
MH - Long stay/rehabilitation mental health wards for working age adults	n/a	14301	n/a	36	n/a	314	n/a
Other	n/a	389	n/a	0	n/a	0	n/a
MH - Community mental health services for people with a learning disability or autism	n/a	473	n/a	439	n/a	15	n/a
Trust Total	**n/a**	**386308**	**n/a**	**52970**	**n/a**	**32577**	**n/a**

This provider had 461.5 (16%) staff leavers between 1 October 2017 and 30 September 2018.

Core service	Substantive staff (latest month)	Substantive staff Leavers (over the past 12 months)	Average % staff leavers (over the past 12 months)
MH - Secure wards/Forensic inpatient	191.2	46.1	24%

Core service	Substantive staff (latest month)	Substantive staff Leavers (over the past 12 months)	Average % staff leavers (over the past 12 months)
MH - Specialist community mental health services for children and young people	147.9	32.8	24%
MH - Child and adolescent mental health wards	25.8	5.9	21%
MH - Other Specialist Services	388.1	78.5	21%
Other	361.3	64.1	17%
MH - Community-based mental health services for adults of working age	459.0	68.7	15%
MH - Long stay/rehabilitation mental health wards for working age adults	56.9	8.6	15%
MH - Wards for people with learning disabilities or autism	206.1	28.1	14%
MH - Community-based mental health services for older people	228.9	26.6	13%
MH - Wards for older people with mental health problems	254.1	34.2	13%
MH - Acute wards for adults of working age and psychiatric intensive care units	220.3	26.1	12%
MH - Community mental health services for people with a learning disability or autism	221.6	26.0	12%
MH - Mental health crisis services and health-based places of safety	142.3	16.0	12%
Trust Total	**2903.4**	**461.5**	**16%**

The sickness rate for this provider was 4.5% between 1 October 2017 and 30 September 2018. The most recent month's data (September 2018) showed a sickness rate of 3.7%.

Core service	Total % staff sickness (at latest month)	Ave % permanent staff sickness (over the past year)
MH - Long stay/rehabilitation mental health wards for working age adults	4.9%	6.5%
MH - Wards for older people with mental health problems	5.6%	6.4%
MH - Secure wards/Forensic inpatient	4.6%	6.2%
MH - Mental health crisis services and health-based places of safety	4.0%	6.0%
MH - Community-based mental health services for older people	4.2%	5.3%
MH - Wards for people with learning disabilities or autism	3.7%	4.6%

Core service	Total % staff sickness (at latest month)	Ave % permanent staff sickness (over the past year)
MH - Other Specialist Services	3.1%	3.1%
Other	2.7%	3.0%
MH - Specialist community mental health services for children and young people	2.3%	2.7%
Trust Total	**3.7%**	**4.5%**

The compliance for mandatory and statutory training courses at 30 September 2018 was 83%. Of the training courses listed, twenty-six failed to achieve the trust target and of those, six failed to score above 75%.

The trust set a target of 92% for completion of mandatory and statutory training.

Trust completion is reported as a final figure at year end.

The training compliance reported for this provider during this inspection was lower than the 85% reported in the previous year.

Key:

Below CQC 75%	Met trust target ✓	Not met trust target ✖	Higher ↑	No change →	Lower ↓

Training Module	Number of eligible staff	Number of staff trained	YTD Compliance (%)	Trust Target Met	Compliance change when compared to previous year
Safeguarding Adults Level 2 [3 Years]	2196	2015	92%	✓	↑
Care Records and Confidentiality Awareness [3 Years]	1388	1257	91%	✖	↓
Equality, Diversity & Human Rights [3 Years]	3281	3000	91%	✖	↓
Ligature Awareness [3 years]	791	715	90%	✖	↓
Mental Capacity Act and Deprivation of Liberty Safeguards [3 Years]	2055	1828	89%	✖	↓
Safeguarding Children Level 2 [3 Years]	1836	1626	89%	✖	↑
Clinical Risk Assessment and Management [3 Years]	2160	1896	88%	✖	↑
Mental Health Act [3 Years]	2024	1751	87%	✖	↓
Infection, Prevention & Control Level 2 [2 Years]	2196	1899	86%	✖	↑
Data Security Awareness [1 Year]	3282	2746	84%	✖	↓

Training Module	Number of eligible staff	Number of staff trained	YTD Compliance (%)	Trust Target Met	Compliance change when compared to previous year
Health, Safety & Welfare [3 Years]	3282	2747	84%	✗	↓
Safeguarding Children Level 3 [3 Years]	484	408	84%	✗	↑
Preventing Radicalisation (WRAP) [Once]	2015	1642	81%	✗	↑
Safeguarding Adults Level 1 [3 Years]	1086	872	80%	✗	↑
Moving and Handling L2 [2 Years]	1564	1233	79%	✗	↓
Fire Safety [2 Years]	2347	1836	78%	✗	↓
Infection, Prevention & Control Level 1 [2 Years]	1086	837	77%	✗	↓
Intermediate Life Support (includes BLS) [1 Year]	441	339	77%	✗	↓
Relating to People Mod 4 [1 Year]	675	520	77%	✗	↓
Relating to People Mod 5 [1 Year]	215	166	77%	✗	↓
Moving and Handling L1 [3 Years]	1737	1319	76%	✗	↓
Basic Life Support [1 Year]	1843	1328	72%	✗	↓
Fire Safety [1 Year]	809	582	72%	✗	↓
Paediatric Basic Life Support [1 Year]	18	13	72%	✗	↓
Relating to People Mod 3a [3 Years]	411	281	68%	✗	↓
Relating to People Mod 3b [1 Year]	1259	811	64%	✗	↑
Safeguarding Children Level 1 [3 Years]	1001	631	63%	✗	↓
Total	**41482**	**34298**	**83%**	✗	↓

The trust's target rate for appraisal compliance is 95%. At the end of last year (31 March 2018), the overall appraisal rate for non-medical staff was 88%. This year so far, the overall appraisal rate was 92% (as at 30 September 2018). Seven of the 13 core services (54%) achieved the trust's appraisal target. The core services with the lowest compliance were 'Other' with 83%, 'MH - Specialist community mental health services for children and young people' with 84% and 'MH - Child and adolescent mental health wards' with 88%.

Core Service	Total number of permanent non-medical staff requiring an appraisal	Total number of permanent non-medical staff who have had an appraisal	% appraisals (as at 30 September 2018)	% appraisals (previous year 1 April 2017 – 31 March 2018)
MH - Long stay/rehabilitation mental health wards for working age adults	27	27	100%	93%
MH - Wards for older people with mental health problems	69	68	99%	88%
MH - Mental health crisis services and health-based places of safety	94	91	97%	93%
MH - Acute wards for adults of working age and psychiatric intensive care units	85	81	95%	83%
MH - Community-based mental health services for older people	134	127	95%	97%
MH - Wards for people with learning disabilities or autism	55	52	95%	91%
MH - Community-based mental health services for adults of working age	389	371	95%	92%
MH - Secure wards/Forensic inpatient	125	116	93%	90%
MH - Community mental health services for people with a learning disability or autism	81	73	90%	85%
MH - Other Specialist Services	31	28	90%	90%
MH - Child and adolescent mental health wards	25	22	88%	81%
MH - Specialist community mental health services for children and young people	135	114	84%	84%
Other	217	180	83%	74%
Total	**1467**	**1350**	**92%**	**88%**

The trust has not provided appraisal data for medical staff.

Prior to the inspection, the trust was asked to provide their clinical supervision data. The trust advised they were unable to provide this data from a central point at the time of the request.

During the inspection, the trust provided data to support compliance with supervision to March 2019. This showed an average compliance across all three strategic business units of 94%. However, some teams across the trust were unable to demonstrate supervision compliance locally and some paper records of supervision were of poor quality. The trust action plan from the last CQC inspection included a target of spring 2019 for the system to be fully embedded. We considered that the trust's new data management system, 'discovery' had not fully embedded at the time of the inspection but remained concerned that some local managers did not have easy

access to this information to ensure compliance with mandatory training or supervision for staff in their teams.

The trust provided data that showed overall compliance with supervision for medical staff, as at March 2019, was 98%.

Governance

The trust's governance arrangements were proactively reviewed and reflected best practice. A systematic approach was taken to working with other organisations to improve care outcomes. Executives and non-executive directors were impressive in their understanding of their roles and responsibilities. The trust used a systematic approach to continually improve the quality of its services and safeguarding high standards of care by creating an environment in which excellence in clinical care would flourish.

The trust's annual plan identified outcomes and specific targets against strategic objectives. The trust board reviewed progress on a quarterly basis.

The trust's annual governance statement demonstrated the roles and relationships of the council of governors, the board of directors and the statutory and assurance committees. The trust's board of directors had a clear division of responsibilities between the chairing of the board of directors and the council of governors and the executive responsibility for the running of the trust's business.

The trust had effective structures, systems and processes in place to support the delivery of its strategy and oversight of performance, quality and risk. The trust had an overarching integrated governance committee to which all other governance meetings reported. There was robust scrutiny at board level and non-executive directors challenged decisions where necessary. We attended an integrated governance committee meeting in February 2019, chaired by a non-executive director. We observed that all parties had received robust reports for discussion, and engaged in discussion and challenge around the contents.

There were four committees which reported to the trust board:

- Audit Committee
- Finance and Investment Committee
- Integrated Governance Committee
- Nomination and Remuneration Committee

A review of a sample of trust board papers evidenced that the trust board was provided with updates from all board sub-committees.

The audit committee's role was to review and report upon the adequacy and effective operation of the organisation's overall system of governance and internal control, encompassing risk management, both clinical and non-clinical. The board and the audit committee were assisted with specific risk management oversight by the integrated governance committee and the finance and investment committee.

The trust's physical health committee oversaw implementation of the physical health strategy, reporting via the quality and risk committee to the integrated governance committee. Objectives were incorporated into each strategic business unit's business plan and a physical health champion nominated from each service area to take forward these actions. We reviewed the trust's delivery plan against the strategy and saw this was broken down into two-yearly cycles, with clear priorities, objectives, activity/outcomes and timeframes. A physical health policy supported the implementation of the strategy and was available to staff via the trust intranet.

The trust discharged its duties under the Mental Health Act efficiently. Mental Health Act administration and compliance teams had effective governance arrangements in place. A non-executive director was in post to oversee governance in this area. Regular governance meetings reviewed compliance with the Mental Health Act and the Mental Capacity Act, including deprivation of liberty safeguards monitoring. The team delivered training to local police on mental health issues and application of the Mental Health Act and Mental Capacity Act. There was collaboration with local and national networks to ensure practice was inline or exceeding guidance.

The trust reported an increase in patients detained by police, under Section 136 since implementation of the Police and Crime Act, without recourse to the street triage team. For a small number of detentions, the trust reported delays in their ability to locate a bed within the 24-hour period, resulting in unlawful detentions. The trust completed an audit covering October – December 2018. This audit showed that 8% (19 out of 231) of Section 136 detentions exceeded the 24 hours. An extension form is required to be completed by a registered medical practitioner to extend the detention from 24 hours up to 36 hours, in exceptional circumstances. Out of the 19 cases exceeding 24 hours, staff completed extension forms for 7 detentions. The trust had recorded this as a risk within their risk register, with escalation protocols in place. In instances where this had occurred, the trust wrote directly to the patient to inform that of their detention outside of the parameters of the Mental Health Act and offered support should they wish to take the matter further.

The trust demonstrated robust arrangements to ensure hospital managers and non-executive directors discharged their specific powers and duties, according the provisions of the Mental Health Act 1983.

The trust had systems in place to conduct clinical audits in areas of practice. Staff audited adherence to the MHA Code of Practice best practice, Mental Health Act and Mental Capacity Act. Findings were discussed at quality meetings attended by service leads and good practice was routinely shared. Actions from audits were fed back to teams and addressed through team meetings. Managers checked to make sure staff followed guidance through practice and re-audit cycles.

At November 2018, the trust was not categorised as ‘receiving mandated support for significant concerns’ by the NHS Improvement Single Oversight Framework.

Staff throughout the trust felt able to report issues and successes through local meetings, knowing the board had oversight of local challenges, developments and successes. We saw minutes from a variety of meetings from board level, middle management to local ward level. This included safety, risk, workforce, board meetings and service development meetings. Interaction between all levels of governance in the trust worked well.

The trust provided psychiatric liaison teams working within the two local acute hospitals. Staff worked in partnership with staff in each organisation. Performance was monitored through the trust’s involvement in the strategic commissioning group and operational delivery groups for both commissioners involved, and focused on the stability and functioning of the health system locally. Protocols and escalation pathways were in place. Psychiatric liaison staff participated in the daily acute teleconference for each hospital site and contributed to the monitoring and facilitation of flow through the A&E department. Psychiatric liaison staff participated in the frequent attender meetings and worked with the acute trusts to improve coding in relation to people with mental health conditions.

The trust had a robust and effective complaints process led by qualified and experienced staff. Staff across the trust knew how to support patients and carers to complain, and were not afraid to

raise complaints themselves. Staff who investigated complaints received training and had access to a toolkit to help them investigate. Managers shared learning and action plans from complaints to teams via team meetings, learning summaries, and trust news and governance forums. We sampled complaints during our inspection and found the trust were robust in their investigations. Duty of candour principals were applied, where required.

The board positively shared with staff the importance of reporting things that were not right and were open to apologising when things went wrong. The chief executive saw every complaint and in all cases, wrote to the complainant either to acknowledge and/or to apologise where appropriate.

The trust was asked to comment on their targets for responding to complaints and current performance against these targets for the last 12 months. Data showed the trust did not consistently meet its target of 90% for completing a complaint within 25 days. However, met its target for initial contact.

	In Days	**Current Performance**
What is your internal target for responding to* complaints?	3 working days	97%
What is your target for completing** a complaint?	Target is 90% in 25 Working Days	82%
If you have a slightly longer target for complex complaints, please indicate what that is here	no defined target	not applicable

* Responding to defined as initial contact made, not necessarily resolving issue but more than a confirmation of receipt

**Completing defined as closing the complaint, having been resolved or decided no further action can be taken

	Total	**Date range**
Number of complaints resolved without formal process*** in the last 12 months	375	1 November 2017 – 31 October 2018
Number of complaints referred to the ombudsmen (PHSO) in the last 12 months	1	1 November 2017 – 31 October 2018

**Without formal process defined as a complaint that has been resolved without a formal complaint being made. For example, PALS resolved or via mediation/meetings/other actions

Between May 2016 and April 2017, there were 29.6 Mental Health Act complaints received by CQC for every 1,000 detentions and community treatment orders (CTO's).

This trust received 1645 compliments during the last 12 months from 1 November 2017 to 31 October 2018. 'MH - Other Specialist Services' had the highest number of compliments with 47%, followed by 'Specialist community mental health services for children and young people' with 14% and 'Community based mental health services for people of working age' with 12%.

We analysed data about safety incidents from three sources: incidents reported by the trust to the National Reporting and Learning System (NRLS) and to the Strategic Executive Information System (STEIS) and serious incidents reported by staff to the trust's own incident reporting

system. These three sources are not directly comparable because they use different definitions of severity and type and not all incidents are reported to all sources. For example, the NRLS does not collect information about staff incidents, health and safety incidents or security incidents.

Between 1 November 2017 and 31 October 2018, the trust reported 131 serious incidents. The most common type of incident was 'Unexpected Death' with 59. Twenty-seven of these incidents occurred in MH - Community-based mental health services for adults of working age.

We reviewed the serious incidents reported by the trust to the Strategic Executive Information System (STEIS) over the same reporting period. The number of the most severe incidents recorded by the trust incident reporting system was comparable with STEIS with 131 reported.

Never events are serious incidents that are entirely preventable as guidance, or safety recommendations providing strong systematic protective barriers, are available at a national level, and should have been implemented by all healthcare providers. The trust reported no never events during this reporting period.

Type of incident reported	MH - Acute PICU	MH - CAMHS	MH - Community LD Or Autism	MH – Community Adults Of Working Age	MH – Community Older People	MH – MH Crisis Services and HBPOS	MH - Other Specialist Services	MH - Secure wards/Forensic inpatient	MH - Specialist Community C&YP	MH - Wards For Older People	MH - Wards For People With LD or Autism	Total
Unexpected Death	3	0	1	27	4	11	12	0	1	0	0	59
Apparent/actual/suspected self-inflicted harm meeting SI criteria	1	5	0	9	1	4	1	0	3	0	0	24
Slips/trips/falls meeting SI criteria	2	0	0	0	0	0	0	0	0	6	0	8
Disruptive/ aggressive/ violent behaviour meeting SI criteria	1	0	0	0	0	1	0	3	1	0	1	7
Abuse/alleged abuse of adult patient by third party	1	0	1	2	0	0	0	1	0	0	0	5
Confidential information leak/information governance breach meeting SI	1	0	1	0	0	1	2	0	0	0	0	5
Unauthorised absence meeting SI criteria	1	1	0	0	0	0	0	2	0	0	0	4
Violence & aggression meeting SI criteria	0	1	0	3	0	0	0	0	0	0	0	4
Adverse media coverage or public concern about the organisation or the wider NHS	0	0	1	2	0	0	0	0	0	0	0	3

Type of incident reported	MH - Acute PICU	MH - CAMHS	MH - Community LD Or Autism	MH – Community Adults Of Working Age	MH – Community Older People	MH – MH Crisis Services and HBPOS	MH - Other Specialist Services	MH - Secure wards/Forensic inpatient	MH - Specialist Community C&YP	MH - Wards For Older People	MH - Wards For People With LD or Autism	Total
Medication incident meeting SI criteria	0	0	0	0	0	0	0	3	0	0	0	3
Apparent/actual/suspected homicide meeting SI criteria	0	0	0	1	0	0	0	0	1	0	0	2
Homicide	0	0	0	1	0	0	0	0	0	0	0	1
Major incident/ emergency preparedness. resilience and response/ suspension of services	0	0	0	0	0	0	1	0	0	0	0	1
Adult Safeguarding	0	0	0	0	0	0	0	1	0	0	0	1
Mental Health Act Paperwork	0	0	0	0	0	0	0	1	0	0	0	1
Incident threatening organisations ability to continue to deliver an acceptable quality of healthcare services	0	0	0	0	0	0	0	0	1	0	0	1
Pressure ulcer meeting SI criteria	0	0	0	0	0	0	0	0	0	1	0	1
Sub optimal care	0	0	0	0	0	0	0	0	0	0	1	1
Total	**10**	**7**	**4**	**45**	**5**	**17**	**16**	**11**	**7**	**7**	**2**	**131**

Between October 2017 and September 2018, the trust notified CQC of the suicides of no patients detained under the Mental Health Act.

Between October 2017 and September 2018, the number of deaths due to natural causes of patients detained under the Mental Health Act (aged under 75) was better than the expected number based on the number of detained patients.

Hertfordshire Partnership University NHS Foundation Trust has submitted details of five external reviews commenced or published in the last 12 months (1 November 2017 – 31 October 2018).

We were impressed with the trust oversight and management of restrictive practices (restraint). The trust commissioned a review of RESPECT training, by an external consultant, finalised January 2018. Feedback suggested training for low to moderate violent physical incidents was fit for practice; however, staff felt they required further skills to manage extreme violence. RESPECT training programme has been reviewed and updated to meet the needs of staff and service users

with an ongoing system for internal monitoring and review as well as the trust joining other trusts in a collaborative group to peer review developments that respond to new and emerging challenges as they become evident.

The trust commissioned a review of seclusion practice by Mersey Care NHS Foundation Trust following the CQC's visit and recommendations in 2018. Although there are some factual inaccuracies in the report the recommendations have been taken forward. Good practice was highlighted and a number of recommendations were made that the trust has addressed, including strengthening practice around privacy and dignity, improvements to RESPECT training as above, strengthening the governance to review of seclusion and regular audits of seclusion.

An external review in September 2017 by 'Mental health Strategies' (a bespoke mental and social care consultancy), 'Modelling of Improving Access to Psychological Therapy (IAPT) services in Essex', considered demand and capacity modelling in order to improve the IAPT services in mid Essex, specifically in relation to waiting to access treatment. The project's objectives were to answer the following questions:

- Can the Trust improve performance to meet all local and national performance standards within existing resources?
- If this is possible, what will the Trust need to do?
- If this is not possible, what additional resources would be needed to meet performance standards at the levels of 15%, 16.8% (target for 2017/18) and 25% access levels?

The key outcomes from the review found that all performance targets could be achieved, but it was dependant on full recruitment. It was suggested that a further review on recruitment, training and retention takes place. The trust has worked hard to address these issues across all its services. The report also suggested there was opportunity to increase demand.

An external review by Niche (health and social care consultation) of 'Secure and Forensic Services provided by HPFT', was commissioned to review of the strategic options. The report was published in September 2018. The strategic options identified:

- Develop a new care model partnership to provide the secure and forensic pathway across all or part of East of England for mental health and/or learning disabilities.
- Cease providing learning disabilities services at The Broadland Clinic, Norfolk.
- Develop further forensic community mental health services in Hertfordshire.
- Invest in a new (replacement) learning disabilities and mental health medium and low secure unit in Hertfordshire or Essex.
- Gradually decrease number of patients in all units as demand from commissioners recedes due to repatriation.

An external review of corporate services is underway, looking at productivity and efficiency. The first outcomes are expected in early 2019.

Management of risk, issues and performance

The trust had addressed all concerns raised at the previous CQC inspection, with some issues ongoing; including further updates to the environments within seclusion rooms.

The trust demonstrated a commitment to best practice performance and risk management systems and processes. We had high levels of confidence that the senior leadership had the focus, ability and drive to address issues of poor performance quickly and effectively. For

example, improvements at the Broadlands Clinic in Norfolk, subsequently rated outstanding in 2018, and re-provision of beds due to eliminating dormitory style accommodation. However, we found some concerns related to privacy and dignity and the management of mixed sex accommodation within older peoples' inpatient wards. The trust began a review immediately after the inspection.

The trust utilised a board assurance framework. The board assurance framework provided a structure and process which enabled an organisation to focus on those risks which might compromise achieving the strategic objectives. The board assurance framework identified the key controls which were in place to manage and mitigate those risks and enabled the board to gain assurance about the effectiveness of those controls. At the time of the inspection, seven risks to strategic objectives were identified.

We will provide safe services, so that people feel safe and are protected from avoidable harm.

We will deliver a great experience of our services, so that those who need to receive our support feel positively about their experience.

We will improve the health of our service users through the delivery of effective evidence based practice.

We will attract, retain and develop people with the right skills and values to deliver consistently great care, support and treatment.

We will improve, innovate and transform our services to provide the most effective productive and high-quality cate.

We will deliver joined up care to meet the needs of our service users across mental, physical and social care services in conjunction with our partners

We will shape and influence the future development and delivery of health and social care to achieve better outcomes for our population(s).

The trust had made improvements to the board assurance framework following advice from the internal audit and later discussion at their integrated governance committee. Further detail had been added to the document to demonstrate lines of assurance more clearly. However, we considered further improvements could be made to the document. For example, we saw dates of assurance were often over six or 12 months old. We also identified that not all risks had identified actions and time limits recorded. This was of note particularly in risks with medium levels of assurance identified. The trust identified inability to recruit to vacancies within the document; however, no controls, assurance or actions were recorded. We therefore considered that the trust might consider a review the board assurance framework, paying attention to these arrears. However, we were satisfied that the document was sufficiently focused and robust to provide assurance to the board. The document provided clear evidence of the executive lead for each risk.

The trust had a robust and regularly reviewed risk register. We reviewed the risk register dated January 2019 and saw the trust had identified 15 risks, which reduced to 14 by March 2019. The risk register was discussed monthly with each senior responsible officer and risk owner, who was an executive director. Following this the executive team undertook a monthly peer review of the register, acting as a critical friend to each other. The register was then discussed at the executive business meeting and integrated governance committee meeting prior to going to the audit committee and the trust board.

The trust risk register was reviewed at strategic business unit meetings, service line and team level and each risk was regularly reviewed with an effective alert system via the electronic incident

reporting system. All staff could add a risk to the register and this was then reviewed, along with mitigations, at local meetings and escalated through the governance system.

The trust's director of delivery and service user experience was responsible for the day-to-day management of risk and performance within operational services and there were designated roles of deputy director, safer care and standards, and deputy director of nursing and quality, providing leadership and support in their respective areas.

The trust had effective systems for identifying risks, planning to eliminate or reduce them, and coping with both the expected and unexpected. For example, the trust supported senior service line leaders to undertake demand and capacity training, run by NHS England and completed a review of teams, including memory clinics, CAMHS, ADHD service and adult community initial assessment. The trust used technology to forecast demand peaks based on previous year's activity across the health system.

The trust's audit committee worked with internal auditors to develop an annual audit programme which focused on quality, financial risks and safety, linked to the strategic objectives. Examples of this work include the strengthening of controls in relation to medical devices, responding to medical emergencies and improvements to processes supporting safeguarding responsibilities.

	Historical data		**Projections**	
Financial Metrics	Previous financial year (2 years ago) (2016/2017)	Last financial year (2017/2018)	This financial year (2018/2019)	Next financial year (2019/2020)
Actual income	£224,797	£230,309	£235,000	£240,000
Actual surplus (deficit)	£9,068	£8,873	£2,135	£360
Actual costs/expenditure - full	£215,729	£221,436	£232,865	£239,640
Planned budget or (deficit)	£600	£2,048	£2,135	£360

The trust had accreditation with future-focused finance and a number of chartered accountancy bodies. Future focused finance is a national initiative for all NHS finance departments which the trust's finance department had participated in for some years. In 2018, the trust became the first trust in East of England to be accredited with future focused finance at Level 1. This is essentially a mark of quality and best practise in a number of areas. In order to obtain accreditation, the trust also had to gain accredited employer status with the main accounting bodies i.e. CIMA, ACCA and CiPFA. This exempts members and students from certain compliance processes in recognition of the fact that the trust and the finance department's processes are sufficient to meet the accounting bodies' requirements.

The trust had a strong financial position. In 2017/18 the trust obtained additional sustainability transformation fund payment for delivering a higher surplus than planned. Going forward into 2018/19 achievement of the financial position will be more challenging. However, the trust had identified mitigations and had a track record of delivering its financial plan. In 2018, The trust received a use of resource risk rating of 1 (the highest rating) from NHSI and met the agreed

spend (agency cap level) set by NHSI of £8.5m. The trust board reported in March 2019 that agency spend remained below cap.

A review of the trust's risk register of November 2018 confirmed that financial risks had been identified to delivery of trust objectives and mitigating actions identified.

The delivery of the financial efficiency programme (CIPs) was monitored constantly and the trust had a designated efficiencies manager to oversee this. The performance is presented monthly to the board for review.

The trust had also demonstrated a measured and balanced approach to the assessment of the risks and benefits from potential new business opportunities and developments, conducting its own due diligence as required.

The trust had shown awareness of fraud prevention, an example of this is the planned implementation of measures to help identify fraudulent medications.

The trust has submitted details of two serious case reviews commenced or published in the last 12 months.

Reference Number	Team/Ward/Unit	Recommendations	Actions Taken	Outstanding Actions
SCR Child J	Community Peri-natal team	1. To ensure all clinical staff receive safeguarding children supervision 2. To ensure all clinical staff are familiar with the Herts Safeguarding Children Board policy for physical abuse in children and attend the associated training session	1. Corporate safeguarding team to facilitate safeguarding children supervision 2. The HSCB policy on physical abuse has been cascaded to all staff. For staff to attend physical abuse in children training by March 2019	Currently all physical abuse in children training sessions are fully booked, up until the end of March 2019. It was agreed at the last safeguarding strategy committee that additional training would be commissioned if the CCG safeguarding team or the HSCB could not provide any additional dates.

SAR	Adult Community Mental Health Team – East and South East	1. Assurance to be sought that there is evidence across the Trust of use of Wellbeing Plans to support full consideration of Wellbeing outcomes in keeping with the principles of the Care Act 2014. 2. Seek assurance that Psychiatric Liaison teams are inviting the care co-ordinator and/or other involved professional/agencies to Frequent Attender meetings. This will ensure a holistic approach to dealing with crises when they occur in situations where a person is resistant to support 3. In complex cases, when more than one agency is involved, ensure HPFT are working to Delivery of Care Policy incorporating principles of the Care Programme Approach. 4. In line with work undertaken in the East & South East Improvement Project ensure that learning from this case is shared and considered with the project lead. 5. Review risk assessment documentation and systems on PARIS to ensure that the risk assessment is personalised and integrates the person's perspective and their wishes throughout in keeping with the principles of the Wellbeing Plan	1. Wellbeing Plan Audit 2. Psychiatric Liaison Services provided minutes and case examples as evidence 3. Audit of adult mental health service users who are on CPA to ensure that the policy is being adhered to. 4. Learning note circulated across Herts. Rolling programme of self neglect workshops for staff in investigating teams 5. Audit of risk assessment and crisis planning.	No outstanding actions

Reference Number	Team/Ward/Unit	Recommendations	Actions Taken	Outstanding Actions
		and the Emergency Care Plan.		

Providers are encouraged to report patient safety incidents to the National Reporting and Learning System (NRLS) at least once a month. The highest reporting categories of incidents reported to the NRLS for this trust for the period 1 November 2017 to 31 October 2018 were Self-harming behaviour, Patient accident and Infrastructure (including staffing, facilities, environment). These three categories accounted for 2536 of the 5330 incidents reported. Self-harming behaviour accounted for 54 of the 56 deaths reported.

Ninety-three percent of the total incidents reported were classed as no harm (73%) or low harm (20%).

Incident type	Death	Internal Comprehensive	Internal Concise	Low	Moderate	No Harm	Severe	To Be Confirmed	Total
Self-harming behaviour	54	0	0	367	61	462	7	0	**951**
Patient accident	0	0	0	383	30	435	0	0	**848**
Infrastructure (including staffing, facilities, environment)	0	0	0	10	2	725	0	0	**737**
Disruptive, aggressive behaviour (includes patient-to-patient)	1	0	0	136	7	544	1	0	**689**
Access, admission, transfer, discharge (including missing patient)	0	0	0	85	12	540	1	0	**638**
Documentation (including electronic & paper records, identification and drug charts)	0	0	0	4	0	371	0	0	**375**
Medication	0	0	0	5	8	331	0	0	**344**
Implementation of care and ongoing monitoring / review	0	0	0	17	18	189	0	0	**224**
Patient abuse (by staff / third party)	0	0	0	61	5	83	0	0	**149**
Treatment, procedure	0	0	0	5	1	111	0	0	**117**

Incident type	Death	Internal Comprehensive	Internal Concise	Low	Moderate	No Harm	Severe	To Be Confirmed	Total
Apparent/actual/suspected self-inflicted harm meeting SI criteria	0	57	24	0	0	0	0	0	**81**
Other	0	0	0	0	0	49	0	0	**49**
Consent, communication, confidentiality	0	0	0	0	0	47	0	0	**47**
Medical device / equipment	0	0	0	1	0	13	0	0	**14**
Disruptive/ aggressive/ violent behaviour meeting SI criteria	0	8	3	0	0	0	0	0	**11**
Infection Control Incident	0	0	0	3	0	7	0	0	**10**
Slips/trips/falls meeting SI criteria	0	1	7	0	0	0	0	0	**8**
Clinical assessment (including diagnosis, scans, tests, assessments)	1	0	0	0	0	6	0	0	**7**
Abuse/alleged abuse of adult patient by third party	0	2	3	0	0	0	0	1	**6**
Confidential information leak/information governance breach meeting SI criteria	0	0	6	0	0	0	0	0	**6**
Unauthorised absence meeting SI criteria	0	2	2	0	0	0	0	0	**4**
Adverse media coverage or public concern about the organisation or the wider NHS	0	1	2	0	0	0	0	0	**3**
Apparent/actual/suspected homicide meeting SI criteria	0	3	0	0	0	0	0	0	**3**

Incident type	Death	Internal Comprehensive	Internal Concise	Low	Moderate	No Harm	Severe	To Be Confirmed	Total
Medication incident meeting SI criteria	0	3	0	0	0	0	0	0	**3**
Abuse/alleged abuse of adult patient by staff	0	0	0	0	0	0	0	1	**1**
Commissioning incident meeting SI criteria	0	1	0	0	0	0	0	0	**1**
Failure to obtain appropriate bed for child who needed it	0	0	1	0	0	0	0	0	**1**
Major incident/ emergency preparedness, resilience and response/ suspension of services	0	0	0	0	0	0	0	1	**1**
Pressure ulcer meeting SI criteria	0	0	1	0	0	0	0	0	**1**
Sub-optimal care of the deteriorating patient meeting SI criteria	0	0	1	0	0	0	0	0	**1**
Total	**56**	**78**	**50**	**1077**	**144**	**3913**	**9**	**3**	**5330**

Organisations that report more incidents usually have a better and more effective safety culture than trusts that report fewer incidents. A trust performing well would report a greater number of incidents over time but fewer of them would be higher severity incidents (those involving moderate or severe harm or death).

Hertfordshire Partnership University NHS Foundation Trust reported fewer incidents from 1 November 2017 to 31 October 2018 compared with the previous 12 months.

Level of harm	1 November 2016 – 31 October 2017	1 November 2017 – 31 October 2018 (most recent)
No Harm	3733	3913
Low	1406	1077
Moderate	147	144
Internal Comprehensive	35	78
Death	46	56
Internal Concise	21	50

Level of harm	1 November 2016 – 31 October 2017	1 November 2017 – 31 October 2018 (most recent)
Severe	6	9
To Be Confirmed	9	3
Total incidents	**5403**	**5330**

Between October 2017 and March 2018, the trust reported incidents to the National Reporting and Learning System in all six months.

The Chief Coroner's Office publishes the local Coroners Reports to Prevent Future Deaths which all contain a summary of Schedule 5 recommendations, which had been made, by the local coroners with the intention of learning lessons from the cause of death and preventing deaths. In the last two years, there have been no 'prevention of future death' reports sent to Hertfordshire Partnership NHS Trust.

The trust had a major incident and continuity plan in place for emergencies. For example, to deal with adverse weather, a flu outbreak or a disruption to business continuity. The trust was not affected by a national cyber-attack, in May 2018, which affected some NHS trusts nationally, as it had taken appropriate, proactive actions to mitigate and protect itself. The trust was taking further proactive steps to ensure future protection with a national scheme to guard against future attacks.

Information Management

We were particularly impressed with innovations in information management we observed and the trust focus on ensuring staff had access to innovative and best practice information systems and processes to support delivery of high quality care to patients. For example, the trust took a proactive and visionary approach to improving staff access to essential information with the development of a new information and clinical support system, SPIKE v2. The system allowed key information from electronic patient record systems to be in one place, reducing staff time searching for information. The system enabled teams and individuals to prioritise work, review caseloads and guide conversations around supervision. We reviewed this system during our inspection and found it intuitive and easy to navigate. Staff across all services reported time saved in searching for information, improvement in caseload management and better oversight of compliance with the principals of care programme approach.

The trust had made further improvements to their data management systems. Since the last inspection and in response to feedback received from staff, the trust had procured and implemented a new learning management system, known as 'Discovery'. The system monitored compliance with supervision and staff could access and book training directly. The trust reported initial feedback from staff as positive. However, during the core service inspections we found some managers had not yet accessed training in the use of the system and were not yet able to utilise its full functionality. The trust confirmed further developments to the system were planned and roll out of staff training was ongoing at the time of inspection.

Staff had access to the equipment and information technology needed to do their work. The information technology infrastructure, including the telephone system, worked well and helped to improve the quality of care. Staff had laptops, broadband dongles, Wi-Fi access and a 'safecare' system was used by staff to monitor staffing levels and considered observation levels. The trust invested in electronic tablets for surveys and to access the clinical note system, lone working trackers to maintain staff safety, and a 'big hand' system for digital dictation. The trust had

introduced virtual meetings via the intranet to save staff travel time. Staff in Norfolk were particularly praising of this initiative. However, staff across the trust reported some delays in telephone response for IT support.

The trust provided financial information to NHS Improvement regularly and timely to meet with imposed deadlines. The trust communicated with NHS Improvement in an open and prompt manner. There were meetings with NHS Improvement through scheduled progress review meetings (PRMs) or by exception.

The trust was continuously identifying efficiency opportunities highlighted by benchmarking against similar organisations. The trust had begun to use the model hospital database to compare performance and identify opportunities. Cost improvement plans (CIPs) for 2018/19 build on the analysis of model hospital data to deliver financial efficiency savings.

The Trust has a capital improvement programme which was subject to a prioritisation process.

The trust's information rights and compliance team led on implementing the principles of the Data Protection Act. The team led in ensuring that the organisation was compliant to all 12 steps of the General Data Protection Regulations (GDPR). The team regularly attended local team meetings across all strategic business units to share good practices and lessons learnt from data breaches. In 2018/19, the team introduced a new case management system for freedom of information and subject access requests. The trust reported a measurable improvement in compliance since implementation. In addition, the system gives Information at individual, function and trust level for performance management.

The information rights and compliance team had oversight of information risk and rights and had processes in place to identify and respond to risk in this area. There was an information governance toolkit in place to help staff. We saw a consistent flow of information escalated to board and shared with all staff via the intranet. Systems were in place including confidentiality of patient records. The trust learned from data security breaches and followed a robust process for investigating such incidents and sharing learning across the strategic business units.

Leaders used key performance indicators to monitor performance. This data fed into a board assurance framework and the integrated governance committee. Team managers had access to a range of information to support them with their management role.

Staff had access to a range of policies and procedures via their intranet. We reviewed all policies and found that whilst they gave clear direction to staff, were accessible and reflected best practice, not all policies had been reviewed in accordance with approved timescales. We reviewed all trust policies. Overall, twenty-one had not been reviewed in accordance with review dates. Of these, five were service operational policies and one was the consent to examination, care and treatment MHA policy. Other examples included pressure ulcer management, speak up policy and clinical risk assessment and management for service users. Three key strategies, the risk management strategy 2014-2017, infection control programme 2017-2018 and clinical risk strategy 2015-2018 had not been updated clearly within documents. We were concerned that staff did not always have the latest information and guidance for their roles.

The annual Community Mental Health Survey is the only national survey in the UK focusing on people's experience of using these services that enables direct comparison between providers. The trust did submit data to the Community Mental Health Survey, which means that it was possible to compare the experience of people who use community mental health services with other providers.

When a patient is detained under the Mental Health Act (MHA) in hospital, the provider is required to submit a record to the Mental Health Services Data Set each month until the detention ends. Between March 2017 and February 2018, the trust only provided end dates for 88.8% of Mental Health Act episodes for detentions, which had ended. This gives an incomplete picture about the provider's use of the MHA and indicates there may be problems with recording or sharing data externally.

Staff ensured notifications to external bodies were submitted as needed.

Engagement

The trust demonstrated high levels of constructive engagement with staff, external stakeholders and people who use services, including equality groups.

The trust had a systematic approach to working with other organisations, patients, staff and the public to improve care outcomes, tackle health inequalities and obtain best value for money. There was strong collaboration and support across all functions and a common focus on improving quality of care and people's experiences. For example, the trust took an active role in the wider health economy relating to system resilience. A series of contacts were in place which included a daily teleconference to discuss patient flow from general hospital care, a weekly "system resilience" meeting to discuss shared issues across the system and a monthly meeting to develop shared strategies for system resilience.

The trust worked with partners in delivering the new leaf wellbeing college. The college offered educational support across mental and physical health domains adult community of Hertfordshire. The college was co-produced by organisations and individuals across the spectrum of mental and physical health in Hertfordshire. In February 2019, there were almost 2000 registered students taking part in 18 courses. Students rated their experience at the college highly with over 90% reporting good or excellent experience. The service was provided in partnership with MIND.

The trust implemented primary care mental health pilot projects, running in three areas of Hertfordshire and had had evaluations supporting their continuation and extension. Staff provided quick assessments, signposting or referral to secondary services as appropriate. This had resulted in a significant reduction in demand for trust services and patients receiving quicker assessments and appropriate triage. For example, minutes of the service user council in December 2018 showed out of 17 referrals in one week, only 2 patients required onward referral to trust services. GPs also used the drop-in clinics as a resource of minor mental health medication changes, rather than referring back to secondary care. This model was being reviewed to see how it could be replicated elsewhere.

There was evidence of good joint working with other stakeholders in relation to the application of the Mental Health Act. This included several meetings and forums to address day to day issues. All professionals that met with us, spoke highly about their experience of working in partnership with the trust. There was a service level agreement memorandum of understanding in place with the neighbouring acute hospital NHS trust, to support legislation that applied to patients admitted to those sites requiring MHA assessments. The SLA included providing a MHA administrative function to the acute NHS trust. The trust provided MHA training to the acute NHS trust and the police.

The trust had section 75 (arrangements between NHS bodies and local authorities) agreement in place for the delivery of local authority functions. The section 75 agreement was monitored through the partnership oversight group and Hertfordshire county council and the trust had a joint AMHP service operations and practice group.

The trust worked proactively and effectively with the police. The police had a named contact for the trust. The police liaison told us the trust have fantastic facilities and they have a very good partnership relationship with the trust. However, we were told, on occasions, when police were called to one of the trust wards to support during an incident involving a patient, the police were not always provided with enough information to press criminal charges against a patient who committed a crime or offence.

The trust ensured at every board meeting a service user, carer and professional from a specific service were invited to share their experiences and suggest board actions for positive change. Examples of changes made following the board acknowledging the patient voice included adjustments made to the physical access of a building following a service user identifying access difficulties. It was pleasing to see that the board had an exclusive approach, valued their patient and staff voices and worked alongside them.

The trust had an equality, diversity and inclusion strategy, approved in May 2018. A formal launch was planned in February 2019 as part of the development of a new governance group for oversight. The trust encouraged staff inclusion, including staff with protected characteristics, via a number of network groups; including BAME, disabled, staff carers, mental health, women's and LGBT. Meetings were held regularly and advertised across the trust.

We were particularly impressed by the priority the trust gave to involving patients, families and carers in care, demonstrating real involvement. This was evident throughout the inspection across all core services and modelled by the senior leadership team. Examples included the emphasis on involvement in planning services and recruitment of senior staff. We saw many examples of co-production, for example, the Making our Services Safer (MOSS) strategy involved patients working with staff to improve the impact of restrictive practice.

The trust actively supported a number of carers' groups and councils, for example, the service user council, the youth council and the carers council. The service user council was formed of a group of service users (primarily with lived experience of using mental health services) who met monthly to discuss trust business and provided feedback on quality and areas of concern or good practice. The carer's council had a chair and deputy (both carers) and agreed an annual work-plan of issues important for carers.

The youth council was the primary source of feedback for CAMHS services when approaching service changes and provided a consultative and advisory role to senior managers looking to develop quality of services.

The carers council comprised up to 15 members. Their aim was to support the trust to improve its services by hearing what works well from the perspective of those who are caring for people using trust services. Feedback provided to CQC prior to the inspection showed that several members of the carers council had gone on to become experts by experience, were involved in task and finish groups, and worked alongside the trusts' involvement and engagement team.

The trust encouraged and supported its peer experience listening programme. Peer experience listeners have lived experience of mental health, as a service user or carer and gather feedback from people currently using services. The trust reviewed the programme in December 2018 ahead of relaunching with strengthened quality improvement methodology to enhance the effectiveness of the information collated.

The trust had implemented a community chaplains project, a core part of the spiritual care strategy. To extend the care it offered beyond inpatient units, suitable spiritual care providers (chaplains and others) were placed within some trust community hubs. A further 12-month pilot started in 2018, at community hubs in Watford & Borehamwood.

The trust publishes its annual report and accounts on its public website, alongside a number of other trust reports and papers.

Learning, continuous improvement and innovation

The leadership drove continuous improvement and staff were accountable for delivering change. There was a clear proactive approach to seeking out and embedding new and more sustainable models of care. We were particularly impressed with new pathways of care implemented in the inpatient ward for children and young people. The service had introduced a new care pathways model which had reduced the average length of stay for patients from 80 days to 15. These pathways included 72-hour urgent admission, and four-week, six week, and eight-week admissions for patients with more complex needs. Staff worked closely with community teams and crisis teams to ensure that patients were supported throughout the process of admission. The service also had access to a home treatment team on site. The team supported ward staff to arrange discharge for patients so they did not spend any more time in hospital than was necessary.

The trust held patient safety and the identification and management of risk as a top priority.

The trust ensured effective systems were in place to identify and learn from incidents, including unanticipated deaths. Learning from risk related issues, incidents, complaints and claims was shared through clinical management teams and trust wide forums such as the quality and risk management committee and health and safety committee.

We observed how the trust responded positively and proactively to concerns raised during our last inspection in February 2018. During this inspection, we identified and reported on concerns in relation to whether moderate harm incidents were appropriately reported as serious incidents within the trust, in accordance with the NHS framework. The trust was asked to review their process. The trust undertook a retrospective review of moderate harm incidents, involving three deputy directors, which resulted in 3 incidents being upgraded and reported as serious incidents.

During this inspection, we considered the medical director's leadership of the mortality oversight by the trust was exemplary in the use of urgent critical reviews and modelling reflection and learning within the leadership team and in clinical services.

The trust introduced a moderate harm panel which met weekly and had representation across all strategic business units, including, safeguarding, clinical directors, managing directors and deputy directors of nursing, safer care and the deputy medical director. The panel met to ensure that incidents reported on the electronic incident reporting system as moderate harm, severe harm or death were discussed, immediate learning shared and themes identified. Other staff were encouraged to attend the panel, either as investigator, for personal development, for learning or due to having been part of an incident. We saw evidence where this had occurred.

The moderate harm panel shared learning across teams which informed work in suicide prevention, restrictive practice, health & safety and safeguarding work streams and practice. Themes were discussed in the safety committee. The panel liaised with the mortality governance team, and referred cases where appropriate for structured judgment review. The panel also set terms of reference for any serious incident investigations and instigated SWARMs to support staff through reflective practice. A moderate harm section had been added to the electronic incident reporting system to support the panel process and decisions and actions are recorded in the incident module. The moderate harm panel reported weekly to the executive team and a monthly report was sent via the information governance committee to the trust board. We considered the trust had rectified their shortfalls and had significantly improved practice in this area.

The trust subsequently reported a significant increase in serious incidents investigations and a backlog of those being completed within the required timeframe developing. A discussion was held with the clinical commissioning groups and agreement reached to set a recovery trajectory for those prior to October 2018. A continuous quality improvement project was started which considered the whole serious incident process and, for any serious incidents from October 2018, this new system aimed to ensure that serious incidents were delivered within the agreed timeframes. As at March 2019, the trust reported being ahead of target to meet the agreed May 2019 deadline for all reports to be completed. The trusts had recruited to a second serious incident investigator post, also focussing on embedding human factors and support to the ongoing safety culture work.

The mortality governance team undertook a comprehensive audit on unexpected deaths and self-harm audit, for first 6 months January to June 2018. It addressed a number of demographics, diagnosis and explored risk factors (such as isolation/ employment/alcohol/drug use), protective factors, community, crisis plans, risk assessments and formulation. The trust identified learning from this audit and set up an education task and finish group to look at risk assessment and risk formulation and education required.

The trust had a robust and planned approach to take part in national audits. The trust's practice audit and clinical effectiveness team led on clinical audit work for the trust, including nationally mandated audits, alongside a variety of audit topics requested internally. Completed reports were discussed at the practice audit implementation group whose members included the deputy medical director, clinical director and chief pharmacist. Reports were disseminated throughout the trust for learning, for example, the annual trust wide antibiotics audit in February 2018 highlighted areas for improvement including increasing the knowledge around antibiotic stewardship. The trust antimicrobial stewardship policy was updated. Specific training on the prudent use of antibiotics was placed on the trusts learning directory and highlighted across the trust. The audit was awarded audit of the month in July 2018.

We were particularly impressed by the extent to which innovation was encouraged throughout the trust to improve outcomes for patients. Staff and patients were encouraged to make suggestions for improvement and we saw examples of ideas which had been implemented. However, we were not always clear on the outcome measures used or timeframes for evaluation. We were concerned the trust would not always have clear evidence to monitor success, or otherwise, of some of the projects and pilots it implemented.

The trust had a fully embedded and systematic approach to quality improvement. The trust had a continuous quality Improvement agenda which focused on six themes: safety, clinical effectiveness, service user experience, access, workforce and productivity. The trust had an 'innovation hub' in which they held a number of regularly scheduled sessions and bespoke workshops. Within the hub, staff were supported in numerous ways, including how to understand and use improvement techniques and concepts, collaborate with colleagues, research positive practices, generate solutions and plan rapid tests of their ideas, try out available technologies, learn from the success and failures of others and find creative inspiration to innovate and improve. Staff identified that the hub was a useful resource.

The trust had an innovation fund, launched in October 2016 with 17 panels held to date which included 38 staff and 6 service users and carer panel members assessing 56 applications with 28 awards made totalling £213,407 invested in ideas. Areas that had been tested have ranged from working in partnership with the Prince's Trust in the provision of employment opportunities for the first episode psychosis service to the trailing of body scanners in the acute, CAMHS and forensic services. The trust identified no upper limit to innovation fund awards.

We saw examples of staff at all levels taking personal responsibility for innovation and implementing better ways of doing things, fully supported by their leaders. For example, a physiotherapist on secondment from a neighbouring trust identified a way to reduce falls in older peoples' inpatient services by introducing 'non-slip' (gummy) socks. The trust ran a pilot on Logandene Ward and measured outcomes. Evidence showed that unsafe footwear on wards halved following physiotherapist input from 40% to 20%. The gummy socks were then discussed at the east and north strategic business unit falls group and adopted across all the older people inpatient units in the summer. Following the pilot, the trust funded a full-time band 7 physiotherapist post in older people's services.

We were impressed by the trust's involvement in the 'pimp my zimmer' (PMZ) project in Watford, through the Watford locality group. PMZ has been adopted across the country and has been proven to reduce falls as people can recognise their own, correctly adjusted walking frames. A GP from the GP Federation, a mental health OT and support worker, care home staff and a local school joined forces to run 3 intergenerational, interagency sessions to 'pimp' 9 care home residents' zimmer frames. The team pulled in the concepts of reminiscence and life story work and measured the residents' wellbeing before and after the sessions. Outcomes showed a 50% reduction in referrals for depression, 86% improvement in resident wellbeing validated scores, 66% increase in zimmer frame usage, 50% improved mobility, 33% mobility remained constant despite deteriorating health (due to frame usage), 17% stable.

Innovations were taking place in services to promote the privacy and dignity of patients. For example, the trust eliminated all its dormitory style accommodation prior to the inspection and all inpatient beds were now located in single rooms. This supported the Department of Health's guidance on eliminating mixed sex accommodation.

The trust obtained an innovation award to carry out a service user project using photovoice with Dr Wendy Fitzgibbon, reader in criminology at the University of Leicester. This project invited offenders on the OPD Pathway to use photography to share their experience of being on probation and the challenges they faced in the community.

The trust was engaged with peers in providing support to the local system (STP) across a variety of areas where improvement was required: financial, operational and quality.

The trust participated in a number of research projects, monitored via the research and development team. The trust benefited from a formal partnership with The University of Hertfordshire and was jointly successful in securing approximately £2 million worth of research grant funding over the last seven years. The trust was also part of the NIHR Eastern Clinical Research Network. Details of research projects were published on the trust website.

The trust had an impressive library located at its headquarters. The library operated an outreach librarian model and teams were trained locally on study skills, how to conduct a literature search and critical appraisals.

The trust had recently undertaken a joint exercise with a neighbouring trust, whereby there is now a multi entity shared service for back office finance and procurement.

The trust attended regional network improvement events such as the NHS improvement director of finance meetings.

The trust was focused on improving pathways and has adopted a continuous improvement approach to the delivery of services.

NHS trusts can take part in accreditation schemes that recognise services' compliance with standards of best practice. Accreditation usually lasts for a fixed time, after which the service must be reviewed.

The table below shows services across the trust awarded an accreditation (trust-wide only) and the relevant dates.

Accreditation scheme	**Core service**	**Service accredited**	**Comments and Date of accreditation / review**
AIMS - PICU (Psychiatric Intensive Care Units)	Adult PICU	Oak	Going through 3rd Evaluation. First accredited 29/02/2016. Next Peer Review expected Spring 2019.
Quality Network for Inpatient Learning Disability Services (QNLD)	-	Astley Court	End date 30.05.2020
Quality Network for Inpatient Learning Disability Services (QNLD)	-	Dove Ward	End date July 2020
Quality Network for Inpatient Learning Disability Services (QNLD)	-	Lexden ATU	End date 22.11.2019
ECT Accreditation Scheme (ECTAS)	-	ECT Suite (Kingfisher Court)	End date 12.12.2019. First accredited 13.12.2016.
Psychiatric Liaison Accreditation Network (PLAN)	-	CORE 24 Psychiatric Liaison Team based at Lister General Hospital and Watford General Hospital. Psychiatric Liaison Team renewal in Spring 2019.	Accreditation started October 2015. Psychiatric Liaison Team are currently in the process of submitting further evidence for ongoing accreditation to PLAN for accreditation
Memory Services National Accreditation Programme (MSNAP)	-	EMDASS North	Next review due October 2019
Memory Services National Accreditation Programme (MSNAP)	-	EMDASS North West	Review due in April 2020
Memory Services National Accreditation Programme (MSNAP)	-	EMDASS South West	Review due in April 2020
Memory Services National Accreditation Programme (MSNAP)	-	EMDASS East	Re-accreditation in January 2019.
Accreditation for Psychological Therapies Services (APPTS)	-	The Wellbeing service received its accreditation	End date April 2019

Accreditation scheme	Core service	Service accredited	Comments and Date of accreditation / review
		in April 2016 (assessed by Royal College in Jan 2016). The accreditation is not just for the Herts Wellbeing service as a whole, so all quadrants are covered.	
Forensic MH inpatient wards - Royal College of Psychiatrists Centre for Quality Improvement - Peer Review. Aim to raise the standard of care that people with emotional or mental health needs receive by helping providers, users and commissioners of services to assess and increase the quality of care they provide.	Forensic Inpatients	Beech Unit	Full review on the 10th of April 2018 (scored 78%). Next full review is due in April 2020.
Forensic MH inpatient wards - Royal College of Psychiatrists Centre for Quality Improvement - Peer Review. Aim to raise the standard of care that people with emotional or mental health needs receive by helping providers, users and commissioners of services to assess and increase the quality of care they provide.	Forensic Inpatients	Broadland Clinic	Full review on the 25 September 2018. The score has not been finalised as yet. However, the draft provisional score is 87%, compared to 73% at the previous review. Next review September 2020.
Forensic MH inpatient wards - Royal College of Psychiatrists Centre for Quality Improvement - Peer Review. Aim to raise the standard of care that people with emotional or mental health needs receive by helping providers, users and commissioners of services to assess and increase the quality of care they provide.	Forensic Inpatients	Warren Court	On 19 October 2018, the service had a quality improvement day. Full review due in October 2019. Last full review on 9th October 2017 scored 91%.

Accreditation scheme	Core service	Service accredited	Comments and Date of accreditation / review
Forensic MH inpatient wards - Royal College of Psychiatrists Centre for Quality Improvement - Peer Review. Aim to raise the standard of care that people with emotional or mental health needs receive by helping providers, users and commissioners of services to assess and increase the quality of care they provide.	Forensic Inpatients	4 Bowlers Green	On 19th October 2018, the service had a quality improvement day. Full review due in October 2019. Last full review on the 9th October 2017 scored 95%
Prison In- Reach team	Community-based mental health services for adults of working age.	MHP The Mount Peer	Review took place June 2017
Perinatal Community Service	Other Specialist MH Service	Perinatal Community Service	Peer review took place November 2017 and summer 2018. Working towards accreditation in 2019 cycle.

Mental health services

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

Facts and data about this service

Location site name	Ward name	Number of beds	Patient group (male, female, mixed)
Lister Hospital (RWR34)	Aston Ward	20	Mixed
Kingsley Green (RWR96)	Oak Ward	12	Male
Kingsley Green (RWR96)	Swift Ward	18	Mixed
Kingsley Green (RWR96)	Robin Ward	18	Female
Kingsley Green (RWR96)	Owl Ward	18	Male
Albany Lodge (RWR13)	Albany Lodge	24	Mixed

The methodology of CQC provider information requests has changed, so some data from different time periods is not always comparable. We only compare data where information has been recorded consistently.

Is the service safe?

Safe and clean care environments

Safety of the ward layout

Over the 12-month period from 1 November 2017 to 31 October 2018 there were no mixed sex accommodation breaches within this service.

The trust was compliant with Department of Health guidance on eliminating mixed sex accommodation, Swift ward, Aston ward and Albany Lodge were mixed-gender wards. On Swift and Aston wards female and male patients were sometimes accommodated in the same bedroom corridor, however all the bedrooms had ensuite shower rooms. The lounge attached to the designated female corridor had no signage up to identify that it was female only. The trust took action during our inspection to address this. Not all the bedrooms on Albany Lodge were ensuite. However, staff made use of the four 'swing' bedrooms that could be designated male or female depending on gender/need.

All four wards at the Kingsley Green site had nurse call buttons installed in patient bedrooms. Aston and Albany Lodge wards did not have this in place. However, staff carried personal alarms on all the wards. Staff were designated to manage the entry and exit of the ward at busy times, such as visiting times and when patients left the ward. Staff had access to wands or portable scanners to detect contraband items entering the ward.

There were ligature risks on six wards within this service. All wards had a ligature risk assessment in the last 12 months.

Ward / unit name	Briefly describe risk - one sentence preferred	High level of risk? Yes/ No	Summary of actions taken
Albany Lodge	Described as P1 - acute, potential self - harm, detained under the Mental Health. Standalone unit: poor lines of sight on corridors towards the edge of the building. 3: gardens - 2x managed, 1 open	Yes	Unit refurbished with: New anti-ligature door sets, internal door and full anti-ligature specification. Capital bid agreed to replace: All windows, with modern anti-ligature windows, radiator covers, curtain rails. This will include replacing false ceiling as part of an extension of the ward. This has included fitting of mirrors for line of sight / CCTV and a proposed extension of the CCTV. Windows by corridors have all curtains removed, to improve the line of sight. Additional works will propose proximity swipe cards for gender specific areas and an extension of this to bedroom doors.
Aston	High profile risk - described as P1 - acute, potential self - harm, detained under the Mental Health. Standalone unit: poor	Yes	Unit refurbished with: New anti-ligature door sets, internal door and full anti-ligature specification. Ceilings are being replaced,

	lines of sight in central dormitory style accommodation corridors. 1: garden		with additional air conditioning and new collapsible shower rails and curtains as part of a Capital bid.
Swift	High profile risk - described as P1 - acute, potential self - harm, detained under the Mental Health. Bedroom doors facing corridors, bathroom doors	Yes	As part of Kingfisher rebuild and anti - ligature specification / new bathroom doors - specific advice on bedroom doors facing corridors as a managed risk.
Robin	High profile risk - described as P1 - acute, potential self - harm, detained under the Mental Health. Bedroom doors facing corridors, bathroom doors	Yes	As part of Kingfisher rebuild and anti - ligature specification / new bathroom doors - specific advice on bedroom doors facing corridors as a managed risk.
Owl	High profile risk - described as P1 - acute, potential self - harm, detained under the Mental Health. Bedroom doors facing corridors, bathroom doors	Yes	As part of Kingfisher rebuild and anti - ligature specification / new bathroom doors - specific advice on bedroom doors facing corridors as a managed risk.
Oak (including S136)	PICU unit. Line of sight for isolated areas - bedroom	Yes	Bathroom doors cut down (ligature specification as part of build). Cut down door added to the 136 suite, with additional redundancy: CCTV and mirrors.

Ward managers were aware of the ligature risks on their ward and staff managed these with the use of observations and individual risk assessments. High risk areas like disabled bathrooms and laundry rooms were kept locked and patients could not gain access to these rooms without a staff member being present. Ligature cutters were accessible and kept in the main staff offices. All staff knew how to access ligature cutters in an emergency.

The trust had reduced ligature risks with appropriate anti-ligature fixtures and fittings across all wards and had installed convex or dome mirrors to manage areas with poor lines of sight. At Kingsley Green there were two gardens per ward; one was designated as a ‘active’ garden that was locked with supervised access only due to poor lines of sight. The other was designated as ‘passive’ which had open access for patients throughout the day. On Aston ward the garden was situated downstairs from the ward. Staff and patients said more garden access was needed as all garden access was escorted.

Staff carried out regular environmental walk arounds and separate security walk arounds. Hourly room checks took place during general observations.

Maintenance, cleanliness and infection control

For the most recent Patient-Led Assessments of the Care Environment (PLACE) (2018), the locations scored about the same as similar trusts for cleanliness and scored lower than similar trusts for condition, appearance and maintenance.

Site name	Core service(s)	Cleanliness	Condition appearance and maintenance
Albany Lodge	MH - Acute wards for adults of working age and psychiatric intensive care units	97.6%	85.5%
Oak	MH - Acute wards for adults of working age and psychiatric intensive care units	98.0%	87.5%
Lister Hospital (RWR34)	MH - Acute wards for adults of working age and psychiatric intensive care units	98.0%	90.3%
Trust overall		**98.6%**	**93.5%**
England average (Mental health and learning disabilities)		**98.0%**	**95.2%**

All six wards we visited appeared clean and well-maintained. Cleaners were present and patients told us the wards were cleaned regularly. Infection control was adhered to with clear handwashing guidance placed above sinks. We saw maintenance staff on the wards addressing work required, such as damaged doors and baths.

Seclusion room (if present)

The trust had one seclusion room, situated on Oak Ward.

We completed a seclusion review in February 2019, prior to our onsite inspection. Our review identified a number of environmental concerns and risks. For example, the knob to open and close the blinds was broken and a screw was protruding. This posed a risk to patients and staff. The general cleanliness and hygiene of the seclusion room was poor. The window and windowsill were soiled and staff were not always able to operate the intercom system. Senior staff told is the system was to be replaced. A blind spot existed within the en-suite facilities, which was not covered by CCTV, meaning that staff could not observe this area of the room.

During the inspection, we completed a further review of seclusion. We saw that there had been improvements made to the lines of sight. Recent changes included an extra dome mirror and three additional cameras, to eliminate blind spots. Senior staff showed us plans to renovate Oak ward seclusion facilities, including creating two purpose built seclusion rooms. During planning process, senior management had sought expert advice from leading authorities with robust seclusion facilities that complied with Mental Health Act Code of Practice guidance.

Evidence showed a significant improvement from our earlier findings. We were, therefore, satisfied that the trust had made some immediate changes for safety within the environment and had plans to rebuild the seclusion facilities completely.

Clinic room and equipment

Staff had access to a clinic room and separate treatment room with a couch for examination, fridges, blood pressure machines, electrocardiogram and weighing scales. All medical equipment had been tested and was within date. Controlled drugs and controlled stationary were managed effectively.

Medicines and equipment for use in emergencies were readily accessible to staff and were checked regularly, with tamper evident seals in place to ensure medicines were secured in accordance with trust guidance. However, on Aston ward, some equipment was out of date; including two airways, eight syringes and 11 vacutainer tubes.

Safe staffing

Nursing staff

This core service has reported a vacancy rate for all staff of 12% as of 30 September 2018.

This core service reported an overall vacancy rate of 22% for registered nurses at 30 September 2018.

This core service reported an overall vacancy rate of 5% for nursing assistants at 30 September 2018.

		REGISTERED NURSES			HEALTH CARE ASSISTANTS			OVERALL STAFF FIGURES		
LOCATION	**WARD/TEAM**	**VACANCIES**	**ESTABLISHMENT**	**VACANCY RATE (%)**	**VACANCIES**	**ESTABLISHMENT**	**VACANCY RATE (%)**	**VACANCIES**	**ESTABLISHMENT**	**VACANCY RATE (%)**
LISTER HOSPITAL	AMH Medical North	0.0	0.0	0%	0.0	0.0	0%	0.5	1.5	33%
KINGFISHER COURT	MH Adult OT East Herts	0.0	0.0	0%	0.0	0.4	0%	4.3	13.2	33%
ROBIN WARD	Robin Ward	4.6	11.6	40%	3.6	16.2	22%	8.2	27.8	29%
OAK WARD	Oak Ward	7.0	13.0	54%	1.5	17.0	9%	8.4	30.7	27%
KINGFISHER COURT	OT Recreational Workers	0.0	0.0	0%	0.0	0.0	0%	1.0	5.8	17%
SWIFT WARD	Swift Ward	2.0	18.0	11%	2.6	15.1	17%	4.6	33.1	14%
KINGFISHER COURT	Psychology - Acute	0.0	0.0	0%	0.0	0.0	0%	0.3	2.4	13%
OWL WARD	Owl Ward	2.0	11.0	18%	0.0	14.5	0%	2.0	25.5	8%

		REGISTERED NURSES			HEALTH CARE ASSISTANTS			OVERALL STAFF FIGURES		
LOCATION	**WARD/TEAM**	**VACANCIES**	**ESTABLISHMENT**	**VACANCY RATE (%)**	**VACANCIES**	**ESTABLISHMENT**	**VACANCY RATE (%)**	**VACANCIES**	**ESTABLISHMENT**	**VACANCY RATE (%)**
ALBANY LODGE	Albany Lodge	3.0	13.5	22%	0.0	22.0	0%	2.4	35.5	7%
LISTER HOSPITAL	Aston Ward	3.0	14.7	20%	-1.6	16.2	-10%	1.4	30.9	5%
KINGFISHER COURT	Kingfisher Court	0.0	0.0	0%	0.0	0.0	0%	0.2	4.9	3%
KINGSLEY GREEN	Pathway	0.0	3.6	0%	0.0	0.0	0%	0.0	3.6	0%
ALBANY LODGE	Albany Lodge Medical	0.0	0.0	0%	0.0	0.0	0%	0.0	2.0	0%
KINGFISHER COURT	ECT Suite Kingfisher Court	0.0	2.7	0%	0.0	0.0	0%	0.0	2.7	0%
WAVERLEY ROAD	Host Families Scheme	0.0	0.0	0%	0.0	1.0	0%	0.0	1.0	0%
KINGFISHER COURT	Kingfisher Court Medical AMH	0.0	0.0	0%	0.0	0.0	0%	0.0	6.5	0%
WAVERLEY ROAD	MH Administration East & North Herts	0.0	0.0	0%	0.0	2.8	0%	0.0	2.8	0%
KINGFISHER COURT	MH Medical Secretaries	0.0	0.0	0%	0.0	4.1	0%	0.0	4.1	0%
GAINSFORD HOUSE	MH OT Adult Services North Herts	0.0	0.0	0%	0.0	0.0	0%	-1.4	0.0	0%
OAK & BEECH UNITS	Oak & Beech Administration	0.0	0.0	0%	0.0	4.5	0%	0.0	4.5	0%
OAK & BEECH UNITS	Oak PICU Medical	0.0	0.0	0%	0.0	0.0	0%	0.0	1.0	0%
KINGSLEY GREEN	Bed Manager	0.0	0.0	0%	0.0	4.0	0%	-0.3	8.8	-3%
SWIFT WARD	AMH West Modern Matrons	-2.0	3.0	-67%	0.0	1.0	0%	-2.0	4.0	-50%

		REGISTERED NURSES			HEALTH CARE ASSISTANTS			OVERALL STAFF FIGURES		
LOCATION	**WARD/TEAM**	**VACANCIES**	**ESTABLISHMENT**	**VACANCY RATE (%)**	**VACANCIES**	**ESTABLISHMENT**	**VACANCY RATE (%)**	**VACANCIES**	**ESTABLISHMENT**	**VACANCY RATE (%)**
KINGFISHER COURT										
CORE SERVICE TOTAL		**19.6**	**91.1**	**22%**	**6.1**	**118.8**	**5%**	**29.6**	**252.3**	**12%**
TRUST TOTAL		**178.1**	**853.7**	**21%**	**124.2**	**1063.0**	**12%**	**440.3**	**3375.9**	**13%**

NB: All figures displayed are whole-time equivalents

During our inspection, registered nurse vacancies were low, with the exception of Aston and Oak wards, each with four registered nurse vacancies. (Swift:1, Robin: 0.6, Owl: 0.3, Albany: 1.4.). Retention of staff on Albany Lodge had improved during the 12 months prior to our inspection.

Despite some wards occasionally being short-staffed, staff made efforts to ensure they escorted patients on leave. Managers moved staff from other wards, adjusted shift patterns and staff negotiated with patients timing of escorted leave. If a patient's 1:1 time with staff had to be cancelled, staff tried to have more targeted conversations with patients instead.

There were safecare bed conference calls once or twice daily to review staffing and manage cover as well as weekly roster scrutiny group meetings.

Staff ratios were increased based on the complexity and needs of patients. Staff ratios for each ward varied. Robin and Owl wards had the fewest number of registered nurses per shift compared to the other wards.

Between 1 November 2017 and 31 October 2018, of the 32020 total working hours available, 19% were filled by bank staff to cover sickness, absence or vacancy for qualified nurses.

The main reasons for bank and agency usage for the wards/teams were vacancies and sickness absence.

In the same period, agency staff covered 11% of available hours for qualified nurses and 1% of available hours were unable to be filled by either bank or agency staff.

Wards	**Total hours available**	**Bank Usage**		**Agency Usage**		**NOT filled by bank or agency**	
		Hrs	**%**	**Hrs**	**%**	**Hrs**	**%**
Pathway	7020	215	3%	0	0%	0	0%
Albany Lodge	26455	6299	24%	6973	26%	206	1%
Aston Ward	28626	5851	20%	1533	5%	189	1%
Bed Management	5850	1370	23%	0	0%	0	0%
ECT	5304	831	16%	0	0%	125	2%
Oak Ward	25838	5026	19%	3038	12%	395	2%
Owl Ward	21450	4930	23%	2444	11%	285	1%
Robin Ward	22620	4094	18%	5273	23%	281	1%

Wards	Total hours available	Bank Usage		Agency Usage		NOT filled by bank or agency	
		Hrs	%	Hrs	%	Hrs	%
Swift Ward	34613	4998	14%	1016	3%	279	1%
Core service total	**177775**	**33612**	**19%**	**20278**	**11%**	**1762**	**1%**
Trust Total	**1668150**	**225857**	**14%**	**99260**	**6%**	**12096**	**1%**

Between 1 November 2017 and 31 October 2018, 99580 were filled by bank staff to cover sickness, absence or vacancy for nursing assistants.

The main reasons for bank and agency usage for the wards/teams were vacancies and sickness absence.

In the same period, agency staff covered 20380 available hours and 5467 hours were unable to be filled by either bank or agency staff.

Caveat: the total hours available data provided by the trust was inconclusive and therefore this, along with the percentages of bank, agency and not filled hours has not been included.

Wards	Total hours available	Bank Usage		Agency Usage		NOT filled by bank or agency	
		Hrs	%	Hrs	%	Hrs	%
Pathway	n/a	87	n/a	0	n/a	0	n/a
Albany Lodge	n/a	19348	n/a	2674	n/a	338	n/a
Aston Ward	n/a	17341	n/a	3732	n/a	1169	n/a
Bed Management	n/a	0	n/a	0	n/a	0	n/a
ECT	n/a	297	n/a	0	n/a	55	n/a
Oak Ward	n/a	20224	n/a	6040	n/a	1032	n/a
Owl Ward	n/a	13164	n/a	1799	n/a	805	n/a
Robin Ward	n/a	15210	n/a	3773	n/a	1239	n/a
Swift Ward	n/a	13910	n/a	2362	n/a	827	n/a
Core service total	**n/a**	**99580**	**n/a**	**20380**	**n/a**	**5467**	**n/a**
Trust Total	**n/a**	**386308**	**n/a**	**52970**	**n/a**	**32577**	**n/a**

This core service had 26.1 (12%) staff leavers between 1 October 2017 and 30 September 2018.

Location	Ward/Team	Substantive staff (at latest month)	Substantive staff Leavers over the last 12 months	Average % staff leavers over the last 12 months
Kingfisher Court	MH Adult OT East Herts	8.9	4.4	50%
Oak Ward	Oak Ward	22.3	7.6	31%
Swift Ward Kingfisher Court	AMH West Modern Matrons	6.0	1.0	21%
Gainsford House	MH OT Adult Services North Herts	1.0	0.9	19%

Location	Ward/Team	Substantive staff (at latest month)	Substantive staff Leavers over the last 12 months	Average % staff leavers over the last 12 months
Kingfisher Court	OT Recreational Workers	4.8	1.0	19%
Kingfisher Court	Psychology - Acute	2.1	0.3	14%
Albany Lodge	Albany Lodge	33.1	3.6	13%
Robin Ward	Robin Ward	19.6	2.0	11%
Swift Ward	Swift Ward	28.5	3.0	10%
Lister Hospital	Aston Ward	27.5	1.0	4%
Owl Ward	Owl Ward	23.5	1.0	4%
Kingfisher Court	Kingfisher Court Medical AMH	6.5	0.2	3%
Kingsley Green	Pathway	3.6	0.0	0%
Lister Hospital	AMH Medical North	1.0	0.0	0%
Albany Lodge	Albany Lodge Medical	2.0	0.0	0%
Kingsley Green	Bed Manage	9.0	0.0	0%
Kingfisher Court	ECT Suite Kingfisher Court	2.7	0.0	0%
Waverley Road	Host Families Scheme	1.0	0.0	0%
Kingfisher Court	Kingfisher Court	4.7	0.0	0%
Waverley Road	MH Administration East & North Herts	2.8	0.0	0%
Kingfisher Court	MH Medical Secretaries	4.1	0.0	0%
Oak & Beech Units	Oak & Beech Administration	4.5	0.0	0%
Oak & Beech Units	Oak PICU Medical	1.0	0.0	0%
Core service total		**220.3**	**26.1**	**12%**
Trust Total		**2903.4**	**461.5**	**16%**

The sickness rate for this core service was 5.2% between 1 October 2017 and 30 September 2018. The most recent month's data (September 2018) showed a sickness rate of 5.3%.

Swift ward had the highest rate of sickness of all the wards during this period, however, during our inspection there were no staff members off sick on Swift ward. The modern matron on Albany lodge reported the higher level of sickness on their ward was largely related to patient assaults on staff members.

Location	Ward/Team	Total % staff sickness (at latest month)	Ave % permanent staff sickness (over the past year)
Swift Ward Kingfisher Court	AMH West Modern Matrons	16.7%	15.3%
Kingfisher Court	ECT Suite Kingfisher Court	0.0%	13.2%
Oak Ward	Oak Ward	8.3%	9.7%
Kingfisher Court	OT Recreational Workers	3.4%	9.2%
Albany Lodge	Albany Lodge	7.4%	7.4%
Lister Hospital	Aston Ward	7.8%	7.1%
Waverley Road	MH Administration East & North Herts	0.0%	6.6%
Lister Hospital	AMH Medical North	0.0%	6.0%
Kingfisher Court	Psychology - Acute	2.4%	5.6%
Owl Ward	Owl Ward	5.2%	4.4%
Kingfisher Court	Kingfisher Court	1.9%	4.2%
Gainsford House	MH OT Adult Services North Herts	6.7%	3.0%
Albany Lodge	Albany Lodge Medical	46.7%	2.9%
Kingsley Green	Bed Manager	7.8%	2.8%
Robin Ward	Robin Ward	1.9%	2.5%
Swift Ward	Swift Ward	2.7%	2.4%
Oak & Beech Units	Oak PICU Medical	0.0%	1.9%
Kingfisher Court	MH Adult OT East Herts	0.9%	1.5%
Oak & Beech Units	Oak & Beech Administration	0.0%	1.2%
Kingfisher Court	Kingfisher Court Medical AMH	0.0%	1.1%

Location	Ward/Team	Total % staff sickness (at latest month)	Ave % permanent staff sickness (over the past year)
Waverley Road	Host Families Scheme	0.0%	0.8%
Kingfisher Court	MH Medical Secretaries	0.0%	0.7%
Waverley Road	AMH Acute Medical Trainees	0.0%	0.5%
Kingsley Green	Pathway	0.0%	0.4%
Core service total		**5.3%**	**5.2%**
Trust Total		**3.7%**	**4.5%**

The below table covers staff fill rates for registered nurses and care staff during January, February and March 2018.

All wards had above 125% of the planned care staff for night shifts in January 2018.

Oak ward, Robin ward and Aston ward had above 125% of planned care staff for day and night shifts in January and February 2018.

Key:

> 125%	< 90%

	Day		Night		Day		Night		Day		Night	
	Nurses (%)	Care staff (%)	Nurses (%)	Care staff (%)	Nurses (%)	Care staff (%)	Nurses (%)	Care staff (%)	Nurses (%)	Care staff (%)	Nurses (%)	Care staff (%)
	January 2018				**February 2018**				**March 2018**			
Oak	96	147	100	191	97	183	100	163	103	99	100	100
Swift	107	124	101	210	108	121	100	202	99	90	98	98
Robin	101	170	100	287	100	130	100	243	92	87	98	96
Owl	99	123	102	142	96	139	100	102	100	96	100	98
Albany Lodge	100	134	100	164	101	94	100	112	101	100	100	100
Aston	94	200	103	200	117	153	120	192	105	91	114	90

Medical staff

There was adequate medical cover day and night with an on-call doctor system that meant medical staff could attend the ward quickly in an emergency. Consultant psychiatrists attended their allocated ward each morning for multi-disciplinary meetings and regularly throughout the week for ward reviews of patients.

Between 1 November 2017 and 31 October 2018, of the 1920 total working hours available, none were filled by bank staff to cover sickness, absence or vacancy for medical locums.

The main reasons for bank and agency usage for the wards/teams were sickness and vacancies.

In the same period, agency staff covered 27% of available hours and no shifts were unable to be filled by either bank or agency staff.

The trust used regular agency and bank staff when needed. Agency staff told us they received an induction, felt included and attended team meetings and some relevant training.

Ward/Team	Total hours available	Bank Usage		Agency Usage		NOT filled by bank or agency	
		Hrs	%	Hrs	%	Hrs	%
Swift Ward	1920	0	0%	517	27%	0	0%
Core service total	**1920**	**0**	**0%**	**517**	**27%**	**0**	**0%**
Trust Total	**146022**	**418**	**<1%**	**21401**	**15%**	**1**	**<1%**

Mandatory training

The compliance for mandatory and statutory training courses at 30 September 2018 was 82%. Of the training courses listed 23 failed to achieve the trust target and of those, seven failed to score above 75%.

We saw training matrixes that demonstrated that some staff were waiting to do their training and low compliance figures were often connected to long-term leave or sickness. Most staff told us they were compliant with mandatory training targets overall and that the new monitoring system – discovery – would improve oversight of this.

The trust set a target of 92% for completion of mandatory and statutory training.

Trust completion is reported as a final figure at year end.

The training compliance reported for this core service during this inspection was the same as the 82% reported in the previous year.

Key:

Below CQC 75%	Met trust target ✓	Not met trust target ✘	Higher ↑	No change →	Lower ↓

Training Module	Number of eligible staff	Number of staff trained	YTD Compliance (%)	Trust Target Met	Compliance change when compared to previous year
Fire Safety [2 Years]	57	55	96%	✓	↑
Care Records and Confidentiality Awareness [3 Years]	113	107	95%	✓	↑

Training Module	Number of eligible staff	Number of staff trained	YTD Compliance (%)	Trust Target Met	Compliance change when compared to previous year
Mental Capacity Act and Deprivation of Liberty Safeguards [3 Years]	197	178	90%	✘	↑
Safeguarding Children Level 1 [3 Years]	29	26	90%	✘	↑
Equality, Diversity & Human Rights [3 Years]	248	220	89%	✘	↓
Mental Health Act [3 Years]	197	176	89%	✘	↑
Relating to People Mod 3a [3 Years]	32	28	88%	✘	↑
Safeguarding Adults Level 2 [3 Years]	215	188	87%	✘	↑
Safeguarding Children Level 2 [3 Years]	197	169	86%	✘	↑
Ligature Awareness [3 years]	167	143	86%	✘	↓
Clinical Risk Assessment and Management [3 Years]	197	168	85%	✘	↑
Infection, Prevention & Control Level 1 [2 Years]	33	28	85%	✘	↑
Data Security Awareness [1 Year]	248	205	83%	✘	↓
Health, Safety & Welfare [3 Years]	248	206	83%	✘	↓
Relating to People Mod 4 [1 Year]	171	142	83%	✘	↑
Safeguarding Adults Level 1 [3 Years]	33	27	82%	✘	↑
Infection, Prevention & Control Level 2 [2 Years]	215	173	80%	✘	↑
Moving and Handling L1 [3 Years]	74	56	76%	✘	↓
Moving and Handling L2 [2 Years]	174	130	75%	✘	↓
Intermediate Life Support (includes BLS) [1 Year]	86	62	72%	✘	↓
Preventing Radicalisation (WRAP) [Once]	201	144	72%	✘	↑
Fire Safety [1 Year]	160	109	68%	✘	↓
Basic Life Support [1 Year]	108	72	67%	✘	↓
Relating to People Mod 5 [1 Year]	24	16	67%	✘	↓
Relating to People Mod 3b [1 Year]	16	6	38%	✘	↓
Total	**3440**	**2834**	**82%**	✘	→

Assessing and managing risk to patients and staff

Assessment of patient risk

We looked at 33 risk assessments in patient care records. Staff completed risk assessments of patients on admission and these were regularly updated and whenever a risk changed. Staff used the risk assessment template embedded in the electronic patient record system. Swift ward staff

(acute assessment ward) commented that they would prefer more risk information about patients at the admission stage.

Management of patient risk

Daily multi-disciplinary meetings identified initial risks and explored changing risks. These were followed by staff safety huddles that occurred several times a day as a way of sharing key risk information regarding patients and the environment. The wards recently introduced the colour coded safety cross which was updated daily (green: safe, amber: verbal aggression, red: physical aggression). Patients told us they felt safe.

Swift and Oak wards were exploring the option of piloting a system for staff to wear body cameras and were seeking patient feedback.

Informal patients could leave the ward on request, however, Swift ward, the acute assessment unit, staff ensured that doctors assessed patients prior to their leaving the ward.

The trust made use of the 'safewards' interventions such as clear mutual expectations, calm boxes and discharge messages.

The trust had provided equipment for staff to search patients coming on to the wards. However, staff on Aston commented on the lack of scanning equipment on their ward. Patients were searched only if staff believed they were in possession of contraband items.

Staff felt that management of the trust's smoke-free policy was a continual challenge. Staff told us that patients sometimes smoked on the ward or in the grounds. We reviewed an incident of a patient that smoked on the ward which had been recorded appropriately on the incident reporting system, including that searches had taken place and contraband items had been removed. Senior managers maintained oversight of all smoking related incidents. Staff made efforts to vary the amount and frequency of leave from wards to enable patients who smoked, to do so, off site. Doctors prescribed nicotine replacement therapy for patients, including vapes which were allowed in the garden areas.

The trust provided family visiting rooms that were external to the wards.

Use of restrictive interventions

This service had 388 incidences of restraint (187 different service users) and 50 incidences of seclusion between 1 November 2017 and 31 October 2018.
The below table focuses on the last 12 months' worth of data: 1 November 2017 to 31 October 2018.

Ward name	Seclusions	Restraints	Patients restrained	Of restraints, incidents of prone restraint	Of restraints, incidences of rapid tranquilisation
Albany Lodge	1	47	31	0 (0%)	25 (53%)
Aston Ward	0	70	25	0 (0%)	26 (37%)
Robin	0	80	34	0 (0%)	24 (30%)
Swift	0	63	49	1 (2%)	26 (41%)
Oak	48	93	31	1 (1%)	42 (45%)
Owl	1	35	17	0 (0%)	21 (60%)

Ward name	Seclusions	Restraints	Patients restrained	Of restraints, incidents of prone restraint	Of restraints, incidences of rapid tranquilisation
Core service total	**50**	**388**	**187**	**2 (1%)**	**164 (42%)**

There were two incidences of prone restraint, which accounted for 1% of the restraint incidents. The number of incidences (two) had decreased from the previous 12-month period (10).

There were 164 incidences of rapid tranquilisation over the reporting period. Incidences resulting in rapid tranquilisation for this service ranged from six to 23 per month. The number of incidences (164) was the same as the previous 12-month period.

Where medicines were being used for patient rapid tranquilisation they were prescribed in line with guidance from the National Institute for Health and Clinical Excellence (NICE) and trust policy. However, on Oak ward, staff did not always record patients' physical observations consistently, or attempt to take clinical observations, after rapid tranquilisation had been administered. This did not follow trust policy or national guidance. For example, staff on Oak ward recorded patient refusals to have physical observations but did not record revisiting the patient and trying to complete these observations a second time and on the last four occasions when rapid tranquilisation was administered to people, the post administration monitoring was not carried out every 15mins when people were asleep or sedated. Staff were not always clear when to carry out hourly monitoring and when to carry out 15min monitoring. The trust had identified these issues via internal audit and an action plan was in place to ensure compliance.

There have been zero instances of mechanical restraint over the reporting period. The number of incidences (zero) was the same as the number of incidences from the previous 12-month period.

The number of restraint incidences reported during this inspection was lower than the 460 reported for the previous 12-month period.

Staff used de-escalation techniques to good effect and we saw evidence of this during our inspection. Staff undertook 'Respect' training for managing violence and aggression and considered physical restraint to be a last resort. The wards took part in monthly safewards meetings called MOSS (Making our services Safer).

There have been 50 instances of seclusion over the reporting period. Over the 12 months, incidences of seclusion ranged from one to 16 per month. The number of incidences (50) had increased from the previous 12-month period (49).

Prior to our inspection, the trust identified gaps in seclusion monitoring documentation and completed an internal review to understand where improvements were required. Following this review, the trust completed an action plan. This included the provision of a seclusion checklist for staff, training sessions on the seclusion practice and process and weekly safety meetings to review all seclusions that have taken place during the week, attended by the practice development & patient safety team.

Mental Health Act Reviewers completed a historical paperwork review of seclusion practice in February 2019 and identified a number of gaps in seclusion recording. We found these were similar to those identified by the trust during their internal review. During the inspection, we completed a further review of seclusion. We saw that there had been improvements made to the recording of seclusion. We viewed four seclusion records which were adequately completed with

minor omissions, such as the nurse signature for two records and one where fluids had not been recorded as offered. We were, therefore, satisfied the trust had implemented their action plan and a significant improvement was noted.

There have been three instances of long-term segregation over the 12-month reporting period. The number of incidences (three) was the same as the previous 12-month period (three).
During our inspection, there were no patients being cared for under long-term segregation.

Safeguarding

A safeguarding referral is a request from a member of the public or a professional to the local authority or the police to intervene to support or protect a child or vulnerable adult from abuse. Commonly recognised forms of abuse include: physical, emotional, financial, sexual, neglect and institutional.

Each authority has their own guidelines as to how to investigate and progress a safeguarding referral. Generally, if a concern is raised regarding a child or vulnerable adult, the organisation will work to ensure the safety of the person and an assessment of the concerns will also be conducted to determine whether an external referral to Children's Services, Adult Services or the police should take place.

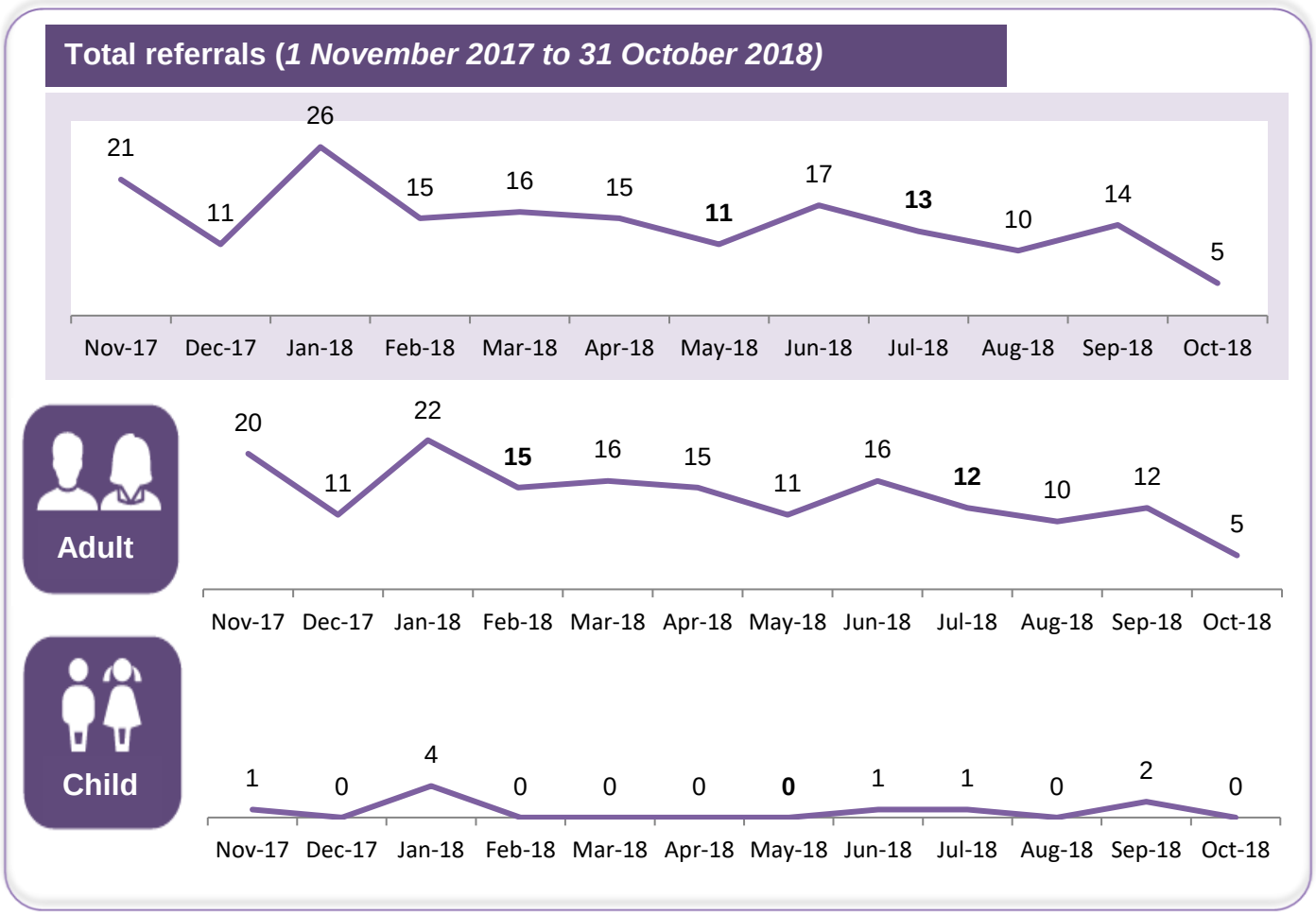
This core service made 174 safeguarding referrals between 1 November 2017 and 31 October 2018, of which 165 concerned adults and nine children.

We saw examples of safeguarding incidents reported by the trust to the local authority safeguarding team and these were appropriate. Staff were trained in safeguarding and demonstrated confidence and knowledge around safeguarding procedures and risks.

	Number of referrals		
Core service	**Adults**	**Children**	**Total referrals**
MH - Acute wards for adults of working age and psychiatric intensive care units	165	9	174

The number of adult safeguarding referrals ranged from five to 22 per month (as shown below).

The number of child safeguarding referrals ranged from zero to four per month (as shown below).



The trust has submitted details of no serious case reviews commenced or published in the last 12 months (20 November 2017 and 20 November 2018) that relate to this service.

Staff access to essential information

All information needed to deliver patient care was available to all relevant staff (including agency staff) when they needed it and was in an accessible form. Staff recorded information electronically and on paper, but this did not cause them any difficulty in entering or accessing information.

Medicines management

Medicines were stored securely and disposed of appropriately. Medicines were stored in line with trust policy and when temperatures went out of range, staff took remedial action.

We viewed medicine charts on every ward. For those patients prescribed high dose anti-psychotics there was appropriate documentation of physical health monitoring including BMI, appropriate blood tests, efficacy of dose and patient led monitoring of side effects.

Pharmacists attended multi-disciplinary team meetings and ward reviews to provide advice, strategic direction and governance to optimise the use of medicines. Pharmacy technicians support the management of medicines across the organisation and ran medication groups for staff.

Blood glucose machines had calibration solutions and tests trips. On Oak ward, the testing solutions had expired and therefore staff could not ensure that the peoples blood glucose monitoring results were accurate.

Track record on safety

Between 1 November 2017 and 31 October 2018 there were 10 serious incidents reported by this service. Of the total number of incidents reported, the most common type of incident was 'Unexpected Death' with three.

We reviewed the serious incidents reported by the trust to the Strategic Executive Information System (STEIS) over the same reporting period. The number of the most severe incidents recorded by the trust incident reporting system was comparable with STEIS with 10 reported.

A 'never event' is classified as a wholly preventable serious incident that should not happen if the available preventative measures are in place. This service reported zero never events during this reporting period.

	Number of incidents reported							
Type of incident reported (SIRI)	Abuse/alleged abuse of adult patient by third party	Apparent/actual/suspected self-inflicted harm meeting SI criteria	Confidential information leak/information governance breach meeting SI	Disruptive/ aggressive/ violent behaviour meeting SI criteria	Slips/trips/falls meeting SI criteria	Unauthorised absence meeting SI criteria	Unexpected Death	**Total**
Albany Lodge	0	0	0	0	1	0	2	**3**
Aston Ward	0	0	1	0	0	1	0	**2**
Owl Ward	1	1	0	0	0	0	1	**3**
Oak Ward (PICU)	0	0	0	1	0	0	0	**1**
Robin Ward (Kingfisher Court)	0	0	0	0	1	0	0	**1**
Total	**1**	**1**	**1**	**1**	**2**	**1**	**3**	**10**

Reporting incidents and learning from when things go wrong

The Chief Coroner's Office publishes the local coroners Reports to Prevent Future Deaths which all contain a summary of Schedule 5 recommendations, which had been made, by the local coroners with the intention of learning lessons from the cause of death and preventing deaths.

In the last two years, there have been no ‘prevention of future death’ reports sent to Hertfordshire Partnership NHS Trust.

Senior staff, such as ward managers, received information and learning around incidents via monthly patient safety meetings and practice governance meetings and fed back key learning elements to staff via team meetings, safety huddles and in email alerts. Senior management and medical staff discussed incidents during the weekly moderate harm group attended by leaders from all services and members of the executive team.

On Albany lodge, we saw evidence of learning in place in response to a patient death on the ward. The process for safe and supportive observations was reviewed with the introduction of competency checklists for observations and training for staff. High risk times were researched and identified and observations were signed off by two staff members during these times. We also saw work to encourage meaningful activities and evidence of healthcare assistant development. We saw evidence of competency checklists for completing enhanced observations in staff supervision records.

Is the service effective?

Assessment of needs and planning of care

We looked at 33 care plans across the wards; these were current and in date and overall holistic and person centred.

Most of the wards had good physical health care plans in place with a good oversight of physical health needs by medical staff. Medical staff included rotational junior doctors and trainee GPs and medical management of physical health needs was thorough.

However, on Owl ward, there was a lack of physical health care plans for two patients with physical health needs. One patient required fluid restriction and another had a respiratory illness, but there was no care plan in place for these needs. The care plan for a patient with diabetes was brief and did not contain a management plan to instruct staff what to do in the event of change. On the same ward we reviewed the notes regarding a patient who had a seizure but nothing had been further documented about this and there was no management plan recorded should it happen again.

Best practice in treatment and care

There was a lack of psychological therapies recommended by the National Institute for Health and Care excellence provided on some wards. There was no psychological input available on Aston, Owl or Robin wards during this inspection. Where possible, staff accompanied patients to see the community psychologist. However, patients had support to access mindfulness sessions and to music and drama therapists. The trust was actively recruiting into psychology vacancies.

Patients had access to specialist practitioners like dieticians, dietetics nurses, speech and language therapists and physiotherapists. Chiropody was only available privately. The wards used MEWS (modified early warning system) for regular monitoring of physical health and the results were reviewed in the ward reviews and multi-disciplinary meetings.

Staff used recognised rating scales to assess and record severity and outcomes like the health of the nation outcome scale (HONOS). Occupational therapy staff used the model of human occupation (MOHO).

The pharmacy team and occupational health team jointly carried out wellbeing sessions with patients. Three sessions were ongoing: weight management caused by medication, cardiovascular disease and exercise. There was a page on the trust's intranet page linked to 'choice for medication' and pharmacists has shown patients on the wards how to access the website to obtain information about medicines, conditions and managing side effects. Information was presented in a more visual way with more pictures and less words. This was available in different languages, including Polish and Hindi.

Activities were offered seven days a week and were supported by nurses and healthcare assistants. Some healthcare assistants on Swift ward had received training on supporting service users to engage in meaningful activity, with plans for one staff member per shift trained to run groups. Wards also employed a recreational worker to assist with occupational therapy activities.

Occupational therapy activities were individually risk assessed with group protocols in place. There were planned changes for a new occupational therapy pathway to enable standardisation and time framing. Occupational therapists at Albany lodge carried out community visits to help prepare patients for discharge and updated activity schedules based on feedback from mutual help meetings with patients.

We observed a horticulture group take place in the dining room area of Albany Lodge. The session took place in a communal area and more patients became involved or showed interest as the group progressed. The atmosphere was calm and staff demonstrated skill, flexibility and encouragement. Patients liked that staff worked with them individually and were pleased with the end results of their work. On Albany Lodge patients were sowing seeds with a plan to sell the produce to reinvest the money into items for the horticultural service.

We observed a cooking group on Aston ward; patients made pizza and there was a positive conversation taking place between staff and patients. There was not an activities of daily living kitchen on Albany lodge so patients needed to go to Kingsley Green for this. Owl ward facilitated dog walks, cinema and shopping visits for patients. Patients also had opportunities to access drama therapists and music therapists on the wards.

Some patients on Aston wished there was more to do and as the ward was situated on the first floor, staff were required to escort them to access the garden.

This service participated in 26 clinical audits as part of their clinical audit programme 2017 – 2018.

Audit name	Audit scope	Core service	Audit type	Date completed	Key actions following the audit
Timeliness of Discharge Summaries being sent to the GP (Quarter 3)	Adult and Older Peoples Inpatient Wards	MH - Acute wards for adults of working age and psychiatric intensive care units, MH - Wards for older people with mental health problems, MH - Long stay/rehabilitation mental health wards for working age adults, MH - Wards for people with	Clinical	01/02/2018	To share the findings of this report with teams. Ensure staff are aware of process. To review the acute inpatient operational policy.

		learning disabilities or autism			
Timeliness of Discharge Summaries being sent to the GP (Quarter 4)	Adult and Older Peoples Inpatient Wards	MH - Acute wards for adults of working age and psychiatric intensive care units, MH - Wards for older people with mental health problems, MH - Long stay/rehabilitation mental health wards for working age adults, MH - Wards for people with learning disabilities or autism	Clinical	10/05/2018	Share findings with teams. Remind staff of requirements for discharge summaries. To set up quality improvement group to focus on improving quality. To present the audit at Medical staffing committee (MSC).
POMH-UK Topic 15bPrescribing valproate for bipolar disorder	Adult Inpatient/ Community/CATT/ADTU	MH - Acute wards for adults of working age and psychiatric intensive care units, MH - Community-based mental health services for adults of working age, MH - Mental health crisis services and health-based places of safety	Clinical	19/07/2018	Medicines management to re issue email reminder regarding use of sodium valproate for women of child bearing age. To promote the use of HPFT choice and medication websites. Also, a presentation at the medical staff committee.
Hand Hygiene within HPFT- Q3 Report	Inpatient Wards	MH - Acute wards for adults of working age and psychiatric intensive care units, MH - Wards for older people with mental health problems, MH - Long stay/rehabilitation mental health wards for working age adults, MH - Wards for people with learning disabilities or autism, MH - Forensic inpatient, MH - Child and adolescent mental health wards	Environmental	25/01/2018	Actions for these audits are held locally
Hand Hygiene within HPFT- Q4 Report	Inpatient Wards	MH - Acute wards for adults of working age and psychiatric intensive care units, MH - Wards for older	Environmental	10/05/2018	Actions for these audits are held locally

		people with mental health problems, MH - Long stay/rehabilitation mental health wards for working age adults, MH - Wards for people with learning disabilities or autism, MH - Forensic inpatient, MH - Child and adolescent mental health wards			
CQUIN Risky Behaviours	Inpatient Wards	MH - Acute wards for adults of working age and psychiatric intensive care units, MH - Wards for older people with mental health problems, MH - Long stay/rehabilitation mental health wards for working age adults, MH - Wards for people with learning disabilities or autism	Clinical	09/08/2018	Forms part of a national CQUIN goal (Year 2)
Audit of Wellbeing Plans in acute & rehab services	Acute/Rehab Services	MH - Long stay/rehabilitation mental health wards for working age adults, MH - Acute wards for adults of working age and psychiatric intensive care units	Clinical	10/05/2018	Correspondence to staff to ensure staff are discussing self-rating tool with service users. Request 6 monthly audits from team leaders. Amendment to operational policy. Communication to teams highlighting importance of care planning. Work to be carried out on wellbeing as part of the quality service delivery strategy.
To Review the Effectiveness of Crisis Plans	Acute/ Crisis Services	MH - Mental health crisis services and health-based places of safety, MH - Acute wards for adults of working age and psychiatric intensive care units	Clinical	10/05/2018	Work to continue on mental health crises in Hertfordshire with Service Line Lead from HPFT and the Police in the Herts Crisis Care Concordat.

MEEP Independent Check	Inpatient Wards	MH - Acute wards for adults of working age and psychiatric intensive care units	Clinical	22/03/2018	Share findings with teams at acute patient safety meetings. Communication with team leaders in regard to prohibited items poster. Revaluate MEEP policy.
7 Day Capacity to Consent (MHA)	Inpatient Wards	MH - Acute wards for adults of working age and psychiatric intensive care units, MH - Wards for older people with mental health problems, MH - Long stay/rehabilitation mental health wards for working age adults, MH - Wards for people with learning disabilities or autism, MH - Forensic inpatient, MH - Child and adolescent mental health wards	Clinical	18/01/2018	MHA team to meet with PG leads to develop local action plan. To discuss findings with Exec Director for Quality and Medical Leadership. To conduct a re-audit 6 monthly.
The Management of Diabetes within Inpatient wards in Hertfordshire	Inpatient Wards	MH - Acute wards for adults of working age and psychiatric intensive care units, MH - Wards for older people with mental health problems, MH - Long stay/rehabilitation mental health wards for working age adults, MH - Wards for people with learning disabilities or autism, MH - Forensic inpatient, MH - Child and adolescent mental health wards	Clinical	22/03/2018	To share the findings at the physical health committee. Design learning note, highlighting importance of recording glucose screening, care plan, risk assessment.
S136 to Health Based PoS within HPFT - Oct-Dec2017	Inpatient Wards	MH - Acute wards for adults of working age and psychiatric intensive care units, MH - Child and adolescent mental health wards	Clinical	08/03/2018	S136 monitoring form to be put as a UDF on Paris. Present findings at Interagency Group. Training for staff regarding Section136 in Oak Ward, Section 136 Suite and Kingfisher court.

Information Governance - Clinical Record Keeping	CAMHS, Older Peoples Inpatient, EMDASS, Older People Community, LD Inpatient, LD Community, CATT, psychiatric liaison teams, Acute Inpatient, Wellbeing	MH - Acute wards for adults of working age and psychiatric intensive care units, MH - Wards for older people with mental health problems, MH - Wards for people with learning disabilities or autism, MH - Forensic inpatient, MH - Child and adolescent mental health wards	Clinical	14/06/2018	Annual Information Governance Training to be merged with Care Records & Confidentiality Training to make both courses mandatory. Compliance drive to meet the 95% requirement. To review the use of the SPIKE contingency and monitor feedback. To raise awareness of the naming structure throughout the Trust and ensure it is used through action plans and learning notes publicised throughout the Trust. Data Quality Checklist needs to be publicised and communicated effectively throughout the Trust to ensure its use at Clinical Supervision.
Treatment for Mental Disorder Authorised by a Second Opinion Appointed Doctor (SOAD) Excluding ECT January – December 2017	Adult Inpatient	MH - Acute wards for adults of working age and psychiatric intensive care units	Clinical	15/032018	Send reminder to all responsible clinicians. To disseminate requirements to deputy director of nursing. Correspondence to be sent to staff in MHA team, providing guidance on process to follow.
Nutrition & Dysphagia	Inpatient Wards	MH - Acute wards for adults of working age and psychiatric intensive care units, MH - Wards for older people with mental health problems, MH - Long stay/rehabilitation mental health wards for working age adults, MH - Wards for people with learning disabilities or	Clinical	26/04/2018	Audit to be shared at the inpatient patient safety meeting and QRM. To develop a how to guide to completing the new Paris form. To promote nutrition & dysphagia e-learning video.

		autism, MH - Forensic inpatient, MH - Child and adolescent mental health wards			
The PLACE (Patient Led Audit of the Care Environment) Annual Programme	Inpatient Wards	MH - Acute wards for adults of working age and psychiatric intensive care units, MH - Wards for older people with mental health problems, MH - Long stay/rehabilitation mental health wards for working age adults, MH - Wards for people with learning disabilities or autism, MH - Forensic inpatient, MH - Child and adolescent mental health wards	Environmental	14/11/2018	Carry out regular audits by Trust and Interserve, service user feedback forms to be collated in regard to food and hydration services.
Communication to GP	Inpatient & Adult Community	MH - Acute wards for adults of working age and psychiatric intensive care units, MH - Wards for older people with mental health problems, MH - Community-based mental health services for adults of working age.	Clinical	17/5/2018	To present findings at medical staffing committee. To be discussed at Physical health committee and agree dissemination route. Communicate findings to services. Communicate to CPA admin of the requirement to include date letter was sent to the GP.
S136 to Health Based PoS within HPFT - Jan-Mar 2018	Inpatient Wards	MH - Acute wards for adults of working age and psychiatric intensive care units, MH - Child and adolescent mental health wards	Clinical	17/05/2018	Review request of Paris form. To raise issues from audit at section 136 interagency group. Training for staff to be provided for those working in section 136 suites.
Timeliness of Discharge Summaries being sent to the GP	Inpatient	MH - Acute wards for adults of working age and psychiatric intensive care units, MH - Wards for older people with mental health problems	Clinical	20/09/2018	As below
Timeliness of Discharge Summaries	Inpatient	MH - Acute wards for adults of working age and psychiatric intensive care units,	Clinical	20/09/2018	Reminder to be sent out to admin staff regarding attaching notifications on Paris. Monthly spot check

being sent to the GP		MH - Wards for older people with mental health problems			to be conducted. To share audit requirements with Jr Doctors on the wards. Consultants to check every discharge notification prior to being sent to the GP for the first 2 weeks following Junior doctor starting on ward.
Post ECT Checklist Audit	ECT	MH - Acute wards for adults of working age and psychiatric intensive care units	Clinical	12/07/2018	The ECT nurse to spot check those files given to admin for upload to ensure these are not missed and are uploaded accurately before paper records being safely destroyed.
Section 132/133 (Rights for inpatients detained under the MHA 1983)	Inpatient	MH - Acute wards for adults of working age and psychiatric intensive care units, MH - Wards for older people with mental health problems, MH - Long stay/rehabilitation mental health wards for working age adults, MH - Wards for people with learning disabilities or autism, MH - Forensic inpatient, MH - Child and adolescent mental health wards	Clinical	12/07/2018	Service Line lead to disseminate information including Trust policy to staff.
Inpatient Falls Audit	Trust wide Inpatient	MH - Acute wards for adults of working age and psychiatric intensive care units, MH - Wards for older people with mental health problems, MH - Long stay/rehabilitation mental health wards for working age adults, MH - Wards for people with learning disabilities or autism, MH - Forensic inpatient, MH - Child	Clinical	30/08/2018	Policy to be amended to reflect all services. Head of Nursing to hold discussions for FRA form to be built onto the EPR within care documents.

		and adolescent mental health wards			
Self-Harm Audit	Inpatients/ Community	MH - Acute wards for adults of working age and psychiatric intensive care units, MH - Wards for older people with mental health problems, MH - Wards for people with learning disabilities or autism, MH - Forensic inpatient, MH - Child and adolescent mental health wards	Clinical	07/11/2018	To complete a NICE compliance audit for EUPD trust-wide as this was the most common co-morbidity in the self -harm audit Training in risk formulation to ensure a better understanding of protective factors and its use in managing risk Provide good understanding of EUPD and risks to HPFT Staff and countywide GPs
Mental Health Act 136	Inpatient	MH - Acute wards for adults of working age and psychiatric intensive care units	Clinical	20/09/2018	Review request of Paris form. To raise issues from audit at section 136 interagency group. Training for staff to be provided for those working in section 136 suites.
MHA Act - Assessment of Capacity within the First Seven Days of Admission to a Ward/Unit	Inpatient Wards	MH - Acute wards for adults of working age and psychiatric intensive care units, MH - Wards for older people with mental health problems, MH - Long stay/rehabilitation mental health wards for working age adults, MH - Wards for people with learning disabilities or autism, MH - Forensic inpatient	Clinical	07/11/2018	Clinical Leads to discuss requirements of completion of capacity assessments in relation to MHA and MCA within their SBU's. To re-audit in 6 months.

A medicines safety audit for all wards was at 100% (the audits looked at: accurate completion of service user details on charts, completion of medicines reconciliation, number of omitted medicines, drug allergy recordings.) Other ward audits included risk assessments and care plans, infection control and the fundamentals of care audit.

Skilled staff to deliver care

The trust's target rate for appraisal compliance is 95%. At the end of last year (31 March 2018), the overall appraisal rate for non-medical staff within this service was 83%. This year so far, the overall appraisal rates was 95% (as at 30 September 2018). The wards with the lowest appraisal

rate at 30 September 2018 were Host Families Scheme with an appraisal rate of 0%, Bed Manager with an appraisal rate of 88% and Aston ward at 93%.

Ward name	Total number of permanent non-medical staff requiring an appraisal	Total number of permanent non-medical staff who have had an appraisal	% appraisals (as at 30 September 2018)	% appraisals (previous year 1 April 2017 – 31 March 2018)
Pathway	4	4	100%	75%
Kingfisher Court	6	6	100%	100%
ECT Suite Kingfisher Court	5	5	100%	100%
Albany Lodge	28	28	100%	83%
AMH West Modern Matrons	4	4	100%	67%
Aston Ward	29	27	93%	83%
Bed Manager	8	7	88%	75%
Host Families Scheme	1	0	0%	100%
Core service total	**85**	**81**	**95%**	**83%**
Trust wide	**1467**	**1350**	**92%**	**88%**

The trust has not provided appraisal data for medical staff.

During the inspection, we found staff were in receipt of regular supervision. We reviewed supervision compliance on the wards. The average across wards was 94%. Compliance was highest on Owl Ward at 100% and lowest on Swift ward at 84%. We viewed a sample of supervision records and saw that the majority of staff received supervision regularly.

Staff had away days and development days with access to the trainee nurse associate apprenticeship scheme. Nurse Associates were a new support role introduced to the health care workforce. Healthcare assistants were encouraged to undertake nurse training. Staff completed vocational qualifications, physical health care training, electrocardiogram training and mindfulness. Staff commented that there was less access to specialist training than there used to be, such as cognitive behavioural therapy, although there had been in-house training provided for staff on the awareness of emotionally unstable personality disorder.

Multi-disciplinary and interagency team work

Managers held monthly team meetings which were minuted and emailed to staff. Each ward had daily multi-disciplinary meetings; we observed one on Oak ward and saw each patient was reviewed in detail; observation levels and activities were discussed. Ward reviews occurred once to three times per week across the wards and included input from a wide-range of disciplines, including pharmacists and occupational therapists.

The wards had developed good links with local authority safeguarding teams. Crisis team attended some multi-disciplinary meeting and ward reviews and facilitated discharge. External organisations invited onto the wards to work with patients, included alcohol and narcotics support services, eating disorder services and MIND. A police liaison officer had an office base within the trust and

had good links with the wards. A housing officer facilitated accommodation and worked across the wards alongside discharge coordinators.

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

As of 30 September 2018, 89% of the workforce in this service had received training in the Mental Health Act. The trust stated that this training is mandatory for all services for inpatient and all community staff and renewed three years.

The training compliance reported during this inspection was higher than the 87% reported for the previous year.

Staff ensured consent to treatment documentation (form T2 and T3) was kept with the medication charts. This ensured staff administered medication under the appropriate legal authority. Pharmacists kept a spread sheet with dates of when T2/T3s needed to be reviewed and when to contact second opinion approved doctors.

Staff ensured patients were aware of their rights under the Act. We saw evidence that patients were frequently read their Section132 rights in the patient care records.

Patients accessed the support of independent mental health advocates while on the wards and information regarding this service was clearly evident on the ward notice boards.

Mental Health Act detention papers and leave forms were kept as hard copy in the MHA office. MHA administrators scanned them on to the electronic notes system for staff reference.

Good practice in applying the Mental Capacity Act

As of 30 September 2018, 90% of the workforce in this service had received training in the Mental Capacity Act. The trust stated that this training is mandatory for all services for inpatient and all community staff and renewed three years.

The training compliance reported during this inspection was higher than the 89% reported for the previous year.

Staff assessed capacity for patients in patient ward reviews and documented in care records and staff acted in patients' best interest when needed. Information about general advocacy was displayed on notice boards and staff supported patients to access independent mental capacity advocates, when needed.

The trust told us that no Deprivation of Liberty Safeguard (DoLS) applications were made to the Local Authority for this service between 1 November 2017 to 31 October 2018. There were no patients on Deprivation of Liberty safeguards during our inspection

Is the service caring?

Kindness, privacy, dignity, respect, compassion and support

Patients could use their mobile phones and there was a hand-held phone kept in the office they could use to make calls in private. Patients had use of a computer and WIFI access.

Patients felt safe, cared for and treated with respect and dignity.

Patients who did not have night lights in their bedrooms felt disturbed by observation checks at night. Senior managers at Albany Lodge had requested funding for night lights (and call bells) for patient bedrooms.

The 2018 Patient-Led Assessments of the Care Environment (PLACE) score for privacy, dignity and wellbeing at all service locations scored lower than similar organisations.

Site name	Core service(s) provided	Privacy, dignity and wellbeing
Albany Lodge	MH - Acute wards for adults of working age and psychiatric intensive care units	80.6%
Oak	MH - Acute wards for adults of working age and psychiatric intensive care units	86.1%
Lister Hospital (RWR34)	MH - Acute wards for adults of working age and psychiatric intensive care units	88.7%
Trust overall		**90.9%**
England average (mental health and learning disabilities)		**90.6%**

Involvement in care

Involvement of patients

Patients told us that they felt able have a say in their ward reviews. Two patients told us they did not have a copy of their care plan and two had received a copy just prior to our inspection, although they had been there for several weeks. We reviewed 33 care plans and 20 of these did not demonstrate that patients had been offered or had received a copy of their care plan. Most patients told us they felt involved in their care planning and they felt able to discuss their treatment options.

Patients received welcome packs on arrival that included key information such as accessing nicotine replacement therapy and how to complain. Patients had access to interpreters and could requests leaflets in different languages if their preferred language was not English. Four patients said they were not orientated or shown around the wards and felt they had to ask other patients.

The wards held regularly scheduled patient community meetings known as ‘mutual help meetings’ that were minuted with actions. Patients told us they found these meetings beneficial and they felt that staff attempted to meet their individual requests when appropriate. However, on Swift ward and Aston ward held these meetings occurred less frequently. Ward managers told us they were working to improve the frequency of the meetings.

We saw minutes from some of these meetings displayed on ward notice boards. We observed one mutual help meeting on Albany Lodge where most of the patients on the ward were present. The session followed the agreed format and started with thanks to staff and patients. Information was shared and patients gave feedback and made requests. Progress on previous requests was shared and if requests took longer to respond to, this was explained to patients with reasons why.

Staff distributed ‘have your say’ forms to patients on discharge. Patient feedback included that they would have liked more meaningful activities.

Involvement of families and carers

The trust provided 'having your say' carers forms that were kept on the wards and given to carers. Carers were invited to ward reviews across the wards. Two well-furnished bedrooms on Kingsley Green site were designated for relatives to use while family members were in hospital.

Albany lodge had secured resources from the innovation fund for psychological input for a family project; weekly sessions with patients and their family/carers. This followed the reflective model and was well-received by patients and carers.

Is the service responsive?

Access and discharge

Bed management

The trust provided information regarding average bed occupancies for six wards in this service between 1 November 2017 to 31 October 2018.

Four wards within this service reported average bed occupancies ranging above the minimum benchmark of 85% over this period.

Ward name	Average bed occupancy range (1 November 2017 – 31 October 2018) (current inspection)
Albany Lodge	97 – 114%
Aston Ward	96 – 102%
Oak Unit	82 – 98%
Owl Ward	99 – 106%
Robin Ward	104 – 126%
Swift Ward	84 – 98%

The trust provided information for average length of stay for the period 1 November 2017 to 31 October 2018.

The trust's bed management and the crisis teams made decisions about which patients to admit to Swift ward (acute assessment unit). Swift ward had the shortest average length of stay but also the highest rate of readmissions to the same ward.

Swift ward followed National Institute for Health and Care Excellence guidelines regarding the benefits of shorter admissions for patients with emotionally unstable personality disorder. Staff on the ward worked closely with community staff to manage the shorter admission times for patients with this diagnosis. Staff on Swift ward told us that that there was now more flexibility around length of stay and this was individually assessed. However, some patients felt they were being discharged too soon and had complained about this, individually and via the mutual help meetings.

The trust minimised the impact on patients and spot purchased private beds with consultant and crisis team input to support them. This was due to capacity and the requirement for specialist beds. The majority of out of area placements from Swift ward were due to the need for specialist beds, such as access to a female psychiatric intensive care unit. During our inspection three private beds were being used externally. Swift ward used beds for patients on leave but this was planned with the assistance of the bed management team. If a patient returned early from leave, they would have a bed on Swift ward by the end of the day.

Ward name	Average length of stay in days range (1 November 2017 – 31 October 2018) (current inspection)
Albany Lodge	21 – 55
Aston Ward	30 – 79
Oak Unit	1 – 93
Owl Ward	23 – 70
Robin Ward	34 – 90
Swift Ward	5 - 10

Discharge and transfers of care

Between 1 November 2017 to 31 October 2018 there were 1328 discharges within this service. This amounts to 68% of the total discharges from the trust overall (1950).

Delayed discharges across the 12-month period ranged from two to 13 per month. There was a total of 94 delayed discharges which amounts to 7% of the total discharges for this core service.

Delayed discharges were predominately due to accommodation and/or the complex needs of patients, as well as awaiting specialist assessment, such as neuropsychiatry, via external organisations.

Discharges were planned from admission with dates given to patients at the first ward review. The discharge coordinator liaised with the housing co-ordinator and ward managers to assist discharge and were possible, onward accommodation and sometimes accompanied patients to the local authority to facilitate housing options.

Facilities that promote comfort, dignity and privacy

The trust provided adequate activity rooms for patients, including gyms, quiet rooms, multi-faith rooms, creative spaces and occupational therapy kitchens. Kingsley Green had a good range of activity rooms on and off ward that were shared between the wards. Patients could leave the wards to use these rooms without leave as they were considered part of ward area. The trust provided patient access to pastoral/spiritual support visits from the trust's spiritual team. Patients had access to pool tables, table tennis, games consoles, headphones for music and in the summer, there were outdoor gardening, sports and social groups.

Before our inspection, the trust reconfigured each dormitory to create single bedrooms, which reduced the number of beds on Aston ward from 20 to 15 beds. Because of the reduction in bed numbers, the trust moved five patients to private beds externally. Therefore, at the time of our inspection, the wards did not have any dormitories or shared bedrooms. The service was compliant with the Department of Health guidance on eliminating mixed sex accommodation.

Patients had fob access to their own bedroom corridors so had access to their bedrooms during the day. Patients told us they had the option to personalise their rooms.

Patients told us that the food was of good quality and variety. Once a month, on Albany Lodge, as a change to the continental breakfast offered, staff facilitated a hot breakfast for patients which was very well received.

The 2018 Patient-Led Assessments of the Care Environment (PLACE) score for ward food at the locations scored lower than similar trusts.

Site name	Core service(s) provided	Ward food
Albany Lodge	MH - Acute wards for adults of working age and psychiatric intensive care units	48.9%
Oak	MH - Acute wards for adults of working age and psychiatric intensive care units	88.5%
Lister Hospital (RWR34)	MH - Acute wards for adults of working age and psychiatric intensive care units	90.6%
Trust overall		**84.8%**
England average (mental health and learning disabilities)		**91.5%**

Patients' engagement with the wider community

Following horticultural sessions on one of the wards, a patient returned to gardening work after their discharge.

Meeting the needs of all people who use the service

For the most recent Patient-Led Assessments of the Care Environment (PLACE) (2018) the locations scored lower than similar trusts for the environment supporting those with disabilities.

The wards at Kingsley Green had good access for people with physical disabilities as the wards were purpose built and situated on the ground floor. Aston ward had the least access for people with physical disabilities as it was situated on the first floor. Each ward had two bedrooms that were large enough to accommodate wheelchairs and specialist beds could be ordered via the occupational therapy department. Each ward had an assisted communal bathroom.

Site name	Core service(s) provided	Dementia friendly	Disability
Albany Lodge	MH - Acute wards for adults of working age and psychiatric intensive care units	n/a	70.7%
Oak	MH - Acute wards for adults of working age and psychiatric intensive care units	n/a	70.6%
Lister Hospital (RWR34)	MH - Acute wards for adults of working age and psychiatric intensive care units	n/a	66.7%
Trust overall		**88.7%**	**81.9%**
England average (Mental health and learning disabilities)		**84.8%**	**86.3%**

Listening to and learning from concerns and complaints

This service received 48 complaints between 1 November 2017 to 31 October 2018. Five of these were upheld, 16 were partially upheld and 13 were not upheld. None were referred to the Ombudsman.

Most of the complaints on Swift ward were related to patients not feeling ready for discharge. All wards had complaint leaflets accessible to patients and we saw examples of patient advice and

liaison service (PALS) involvement in ongoing complaints made by patients. Not all wards recorded informal complaints. Albany Lodge sent informal complaints to PALs as well as formal complaints. Following a complaint by a relative of noise disturbance experienced by a patient during refurbishment at Albany Lodge, the relative was invited in to talk about the experience.

Ward name	Total Complaints	Fully upheld	Partially upheld	Not upheld	Other	Under Investigation	Withdrawn	Referred to Ombudsman
Swift Ward	**17**	3	6	4	0	3	1	0
Albany Lodge	**11**	0	4	2	0	4	1	0
Robin Ward	**8**	1	2	2	0	3	0	0
Aston Ward	**5**	1	2	2	0	0	0	0
Owl Ward	**3**	0	1	1	0	1	0	0
Kingsley Green – Adult Acute	**2**	0	0	1	0	1	0	0
Oak Ward	**2**	0	1	1	0	0	0	0

This service received 44 compliments during the last 12 months from 1 November 2017 and 31 October 2018 which accounted for 3% of all compliments received by the trust as a whole.

Is the service well led?

Leadership

Leaders demonstrated that they had the skills, knowledge and experience to perform their role. Leadership development opportunities were available for staff. Some staff commented that higher level management was out of touch with the frontline and that they were not often seen on the wards.

Vision and strategy

Staff were conversant with the trust's vision and goals.

Culture

There was strong evidence of a good staff support culture. Staff had good morale and felt supported by and able to approach their immediate managers. Staff enjoyed working on the wards, they felt valued and found the experience rewarding.

There was registered nurse within this core service, who was also the trust chairperson for workforce race equality standards (WRES) and staff had access to a number of staff networks, including black Asian and minority ethnic and lesbian, gay, bisexual and transgender.

Governance

The trust had a robust governance framework and structure. Service managers attended local monthly clinical governance meetings, which fed into the trust wider governance meetings. Local governance meetings discussed ward issues, such as incidents, safeguarding, staffing concerns, and identified and shared learning from incidents.

Management of risk, issues and performance

Staff maintained and had access to the risk register at ward or directorate level. Staff at ward level could escalate concerns when required.

Information management

Information technology systems and use of technology applications enabled staff to deliver care more safely and efficiently. Quality improvement initiatives were in place. 'Discovery' was a new system recently introduced to improve management oversight of staff compliance with supervision and mandatory training. Mandatory training reminders were sent to ward manager and staff.

Ward managers had oversight of staff performance and attended monthly unit reviews to look at staff performance. We saw some staff members were undergoing performance management. The trust had introduced a new information and clinical support system, SPIKE 2. This allowed staff and managers to view and monitor clinical performance and assisted with caseload management.

Engagement

Staff, patients and carers had access to up-to-date information about the work of the provider and the services they used, through the intranet, bulletins, newsletters etc.

Patients and carers had opportunities to give feedback on the service they received in a manner that reflected their individual needs. Staff gave carers and patients 'having your say' forms to obtain feedback, and carers were invited to the wards to discuss any concerns or to give feedback. Patients had an opportunity to give feedback during their 1:1 sessions with their named nurse, or within the patient community meeting. The trust's 'inclusion and engagement team' booked patients to participate in staff interviews and were exploring more ways to engage carers.

Learning, continuous improvement and innovation

NHS trusts are able to participate in a number of accreditation schemes whereby the services they provide are reviewed and a decision is made whether or not to award the service with an accreditation. A service will be accredited if they are able to demonstrate that they meet a certain standard of best practice in the given area. An accreditation usually carries an end date (or review date) whereby the service will need to be re-assessed in order to continue to be accredited.

The table below shows which services within this service have been awarded an accreditation together with the relevant dates of accreditation.

At the time of our inspection PICU was the only AIMS accredited service, however, the other wards were at different stages of applying for accreditation with AIMS-acute.

We saw the improvement plan 2018-2019 for Albany Lodge that was detailed with clear time frames. This included an annual plan for continuous recruitment, mandatory training, a plan of works to improve the environment for staff and service users, commencement of a carers group and engagement with patients about the improvement plan.

Swift and Oak wards were exploring the option of piloting a system for staff to wear body cameras and were seeking patient feedback.

Accreditation scheme	Core service	Service accredited	Comments
AIMS - PICU (Psychiatric Intensive Care Units)	Acute wards for adults of working age and psychiatric intensive care units	Oak	Going through 3rd Evaluation. First accredited 29/02/2016. Next Peer Review expected Spring 2019.

Since our previous inspection, staff and patients spoke highly of the changes brought in by the modern matron for Albany Lodge. The matron had requested funding for a carers group, a therapy garden, call bells and night lights. The matron had endorsed rigorous development opportunities for healthcare assistants and put in place clear changes as the result of a serious incident on the ward. The matron had also set up a social media messaging group to quickly contact a small number of trusted agency staff that could be engaged when required.

Using a quality improvement framework, the trust had implemented the 'red2green' approach across adult wards. 'Red and green bed days' was a visual management system to assist in the identification of wasted time in a patient's journey, with the purpose of taking action to reduce this waste – both for the individual service user and for any systemic issues. The approach was used effectively to reduce internal and external delays and achieve clinically appropriate flow through the acute care pathway. The multi-disciplinary team used this tool daily as part of their meetings and reviews.

MH – Child and adolescent mental health wards

Facts and data about this service

Location site name	Ward name	Number of beds	Patient group (male, female, mixed)
Kingsley Green	Forest House Adolescent Unit	16	Mixed

The methodology of CQC provider information requests has changed, so some data from different time periods is not always comparable. We only compare data where information has been recorded consistently.

Is the service safe?

Safe and clean care environments

Safety of the ward layout

Over the 12-month period from 1 November 2017 to 31 October 2018 there were no mixed sex accommodation breaches within this service.

Staff completed regular risk assessments of the environment. Staff completed weekly environment audits to identify any health and safety risks. We reviewed the audits for the past three months and saw that these were up-to-date and completed appropriately.

The ward layout did not allow staff to observe all parts of the ward. However, staff used convex mirrors and closed-circuit television in the bedroom corridors to reduce the risk of blind spots.

Staff had access to alarms should they need to summon assistance quickly. There were panels throughout the ward which would display the information of where the alarm had been activated so staff could respond quickly.

There were ligature risks on one ward within this service. All wards had a ligature risk assessment in the last 12 months.

Ward / unit name	Briefly describe risk - one sentence preferred	High level of risk? Yes/ No	Summary of actions taken
Forest House Adolescent Unit	Described as P1 - acute, potential self - harm, detained under the Mental Health. Lines of sight within the building	Yes	Managed environment via active observation and anti-ligature specification. CCTV, mirrored domes, along corridors. This includes removal of curtains in more public area to improve line of sight.

Staff had mitigated the risks of ligature anchor points. The service had a ligature risk assessment which covered all possible ligature risks. This included photos of the ligature anchor points and how they could be used to ligate. Bedrooms and bathrooms had anti-ligature fittings in place. If a patient was considered a of risk of harm to themselves, staff increased their level of observations to manage the risk.

Maintenance, cleanliness and infection control

For the most recent Patient-Led Assessments of the Care Environment (PLACE) (2018), the locations scored lower than similar trusts for cleanliness and scored comparable to similar trusts for condition, appearance and maintenance.

Site name	Core service(s)	Cleanliness	Condition appearance and maintenance
Forest House Adolescent Unit	MH - Child and adolescent mental health wards	96.2%	95.1%
Trust overall		**98.6%**	**93.5%**

Site name	Core service(s)	Cleanliness	Condition appearance and maintenance
England average (Mental health and learning disabilities)		**98.0%**	**95.2%**

All areas of the ward were clean and furnishings were in good condition and well maintained. However, some areas of the ward were in need of redecoration. This included the area around the public telephone where the hood above the phone had been removed following an incident. This was included within the services maintenance plan.

Cleaning records were up-to-date and demonstrated that the ward areas were cleaned regularly. Staff used `I am clean` stickers to show when an area of the ward or equipment had been cleaned.

Staff adhered to infection control principles. There were hand washing facilities available as well as disinfectant hand gel. Staff carried small bottles of disinfectant hand gel on them at all times.

Seclusion room

The service did not have a seclusion room. However, the service used a seclusion room on another ward in the hospital if required. Staff had identified part of the ward to manage a patient in long-term segregation. We reviewed staff records for this and found that they had been completed appropriately and all necessary checks and safeguards had been completed.

Clinic room and equipment

Clinic rooms were equipped with all necessary equipment including resuscitation equipment and emergency medication. Emergency equipment was checked daily and the staff audit for this was up-to-date and completed appropriately.

Safe staffing

Nursing staff

This core service has reported a vacancy rate for all staff of 34% as of 30 September 2018.

This core service reported an overall vacancy rate of 54% for registered nurses at 30 September 2018.

This core service reported an overall vacancy rate of 30% for nursing assistants at 30 September 2018.

		Registered nurses			Health care assistants			Overall staff figures		
Location	**Ward/Team**	**Vacancies**	**Establishment**	**Vacancy rate (%)**	**Vacancies**	**Establishment**	**Vacancy rate (%)**	**Vacancies**	**Establishment**	**Vacancy rate (%)**
Kingsley Green	Forest House Adolescent Unit	7.0	13.0	54%	5.0	16.7	30%	14.2	38.0	37%
Kingsley Green	Forest House Medical	0.0	0.0	0%	0.0	0.0	0%	-1.0	1.0	-100%
Core service total		**7.0**	**13.0**	**54%**	**5.0**	**16.7**	**30%**	**13.2**	**39.0**	**34%**
Trust total		**178.1**	**853.7**	**21%**	**124.2**	**1063.0**	**12%**	**440.3**	**3375.9**	**13%**

NB: All figures displayed are whole-time equivalents

Between 1 November 2017 and 31 October 2018, 5565 hours were filled by bank staff to cover sickness, absence or vacancy for qualified nurses.

The main reason for bank and agency usage for the wards/teams was vacancies.

In the same period, agency staff covered 3907 available hours for qualified nurses and 769 hours were unable to be filled by either bank or agency staff.

Caveat: The case mix and needs of service users on CAMHS inpatient wards are assessed on an individual basis and often require greater staffing ratios. Bank and agency staff are used where additional staff are required to meet these requirements. Therefore, the total hours available is unable to be determined.

Wards	**Total hours available**	**Bank Usage**		**Agency Usage**		**NOT filled by bank or agency**	
		Hrs	**%**	**Hrs**	**%**	**Hrs**	**%**
Forest House	n/a	5565	n/a	3907	n/a	769	n/a
Core service total	**n/a**	**5565**	**n/a**	**3907**	**n/a**	**769**	**n/a**
Trust Total	**n/a***	**n/a***	**n/a***	**n/a***	**n/a***	**n/a***	**n/a***

*Unable to provide trust total hours and percentages due to inconclusive data provided by the trust.

Between 1 November 2017 and 31 October 2018, 26970 hours were filled by bank staff to cover sickness, absence or vacancy for nursing assistants.

The main reason for bank and agency usage for the wards/teams was vacancies.

In the same period, agency staff covered 5604 hours and 3933 hours were unable to be filled by either bank or agency staff.

Caveat: The case mix and needs of service users on CAMHS inpatient wards are assessed on an individual basis and often require greater staffing ratios. Bank and agency staff are used where additional staff are required to meet these requirements. Therefore, the total hours available is unable to be determined.

Wards	Total hours available	Bank Usage		Agency Usage		NOT filled by bank or agency	
		Hrs	%	Hrs	%	Hrs	%
Forest House	n/a	26970	n/a	5604	n/a	3933	n/a
Core service total	**n/a**	**26970**	**n/a**	**5604**	**n/a**	**3933**	**n/a**
Trust Total	**n/a***	**n/a***	**n/a***	**n/a***	**n/a***	**n/a***	**n/a***

*Unable to provide trust total hours and percentages due to inconclusive data provided by the trust.

This core service had 5.9 (21%) staff leavers between 1 October 2017 and 30 September 2018.

Location	Ward/Team	Substantive staff (at latest month)	Substantive staff Leavers over the last 12 months	Average % staff leavers over the last 12 months
Kingsley Green	Forest House Adolescent Unit	23.8	5.9	22%
Kingsley Green	Forest House Medical	2.0	0.0	0%
Core service total		**25.8**	**5.9**	**21%**
Trust Total		**2903.4**	**461.5**	**16%**

The sickness rate for this core service was 4.8% between 1 October 2017 and 30 September 2018. The most recent month's data (September 2018) showed a sickness rate of 5.9%.

Location	Ward/Team	Total % staff sickness (at latest month)	Ave % permanent staff sickness (over the past year)
Kingsley Green	Forest House Adolescent Unit	6.2%	5.0%
Kingsley Green	Forest House Medical	0.0%	0.0%
Core service total		**5.9%**	**4.8%**
Trust Total		**3.7%**	**4.5%**

The below table covers staff fill rates for registered nurses and care staff during January, February and March 2018.

Forest House had above 125% of the planned care staff for day shifts in January 2018 and night shifts in January and February 2018.

Forest House also had below 90% planned care staff for day shifts in March 2018.

Key:

> 125%	< 90%

	Day		Night		Day		Night		Day		Night	
	Nurses (%)	Care staff (%)	Nurses (%)	Care staff (%)	Nurses (%)	Care staff (%)	Nurses (%)	Care staff (%)	Nurses (%)	Care staff (%)	Nurses (%)	Care staff (%)
	Jan-18				Feb-18				Mar-18			
Forest House	98	202	100	203	95	123	100	152	96	85	95	96

The service had sufficient staff with the appropriate experience and skills for the safe care and treatment of patients. The ward staffing levels were nine whole time equivalent nurses and 13 whole time equivalent healthcare assistants. The ward had two vacancies for band six nurses and four vacancies for healthcare assistants. The service had an ongoing recruitment programme and were continuing to recruit into vacant posts.

Managers used the Keith Hurst safe staffing model recommended by the National Institute for Health and Care Excellence to determine staffing levels (this is a tool used to calculate staffing numbers based on the number and needs of patients). Due to an increase in patients' needs managers had used this tool to make a business case to increase staffing numbers.

Each shift was required to have two nurses and six healthcare assistants on duty. We checked the duty rotas for the past three months and saw that shifts were filled with the appropriate number of staff. The manager could adjust staffing levels to manage any increase in need for the patients such as increased observation levels.

Managers used bank and agency staff to fill gaps in the rota. The bank staff were regular staff, or staff from other wards, working extra hours. The staff were familiar with ward and the patients.

There were qualified nurses present on the wards at all times. Duty rotas showed there was at least two qualified nurses on shift.

Staffing levels allowed patients to have regular one-to-one time with their named nurse. Patients told us there were always staff available should they need someone to talk too or if they needed support.

Patients' leave was occasionally postponed and activities rearranged due to shortage of staff when activity levels on the ward had increased significantly. Patients told us that leave and activities would be rearranged (but not cancelled) if there was not enough staff available at the particular time. However, patients told us that this had improved over recent weeks, due to recruitment of new staff.

There was enough staff to carry out physical interventions safely, for example restraint and seclusion. If there were significant activity levels on the ward such as patient aggression, managers increased staffing numbers to manage this.

Medical staff

The trust advised there was no use of medical locums for this core service.

There was adequate medical cover day and night. There was a consultant psychiatrist on site Monday to Friday. Staff were able to access a doctor on call outside of office hours who could attend quickly if there was an emergency.

Mandatory training

The compliance for mandatory and statutory training courses at 30 September 2018 was 78%. Of the training courses listed 21 failed to achieve the trust target and of those, nine failed to score above 75%.

The trust set a target of 92% for completion of mandatory and statutory training.

Trust completion is reported as a final figure at year end.

The training compliance reported for this core service during this inspection was lower than the 80% reported in the previous year.

Key:

Below CQC 75%	Met trust target ✓	Not met trust target ✘	Higher ↑	No change →	Lower ↓

Training Module	Number of eligible staff	Number of staff trained	YTD Compliance (%)	Trust Target Met	Compliance change when compared to previous year
Clinical Risk Assessment and Management [3 Years]	20	19	95%	✓	↑
Mental Capacity Act and Deprivation of Liberty Safeguards [3 Years]	18	17	94%	✓	↑
Ligature Awareness [3 years]	14	13	93%	✓	↑
Care Records and Confidentiality Awareness [3 Years]	11	10	91%	✘	↓
Equality, Diversity & Human Rights [3 Years]	32	28	88%	✘	↓
Safeguarding Children Level 3 [3 Years]	24	21	88%	✘	↑
Mental Health Act [3 Years]	18	15	83%	✘	↓
Infection, Prevention & Control Level 2 [2 Years]	28	23	82%	✘	↑
Safeguarding Adults Level 2 [3 Years]	28	23	82%	✘	↑
Fire Safety [2 Years]	10	8	80%	✘	↓
Data Security Awareness [1 Year]	32	25	78%	✘	↓
Health, Safety & Welfare [3 Years]	32	24	75%	✘	↓
Infection, Prevention & Control Level 1 [2 Years]	4	3	75%	✘	↓
Safeguarding Adults Level 1 [3 Years]	4	3	75%	✘	↓
Safeguarding Children Level 1 [3 Years]	4	3	75%	✘	↓
Preventing Radicalisation (WRAP) [Once]	27	20	74%	✘	↓
Relating to People Mod 4 [1 Year]	15	11	73%	✘	↑
Basic Life Support [1 Year]	18	13	72%	✘	↑
Intermediate Life Support (includes BLS) [1 Year]	6	4	67%	✘	↓
Relating to People Mod 3a [3 Years]	3	2	67%	✘	↓

Training Module	Number of eligible staff	Number of staff trained	YTD Compliance (%)	Trust Target Met	Compliance change when compared to previous year
Moving and Handling L1 [3 Years]	15	9	60%	✘	↓
Fire Safety [1 Year]	15	8	53%	✘	↑
Relating to People Mod 3b [1 Year]	6	3	50%	✘	↑
Moving and Handling L2 [2 Years]	17	7	41%	✘	↑
Total	**401**	**312**	**78%**	✘	↓

During the inspection we found staff had received and were up-to-date with mandatory training. The trust had arranged extra safeguarding and fire training at weekends to help increase compliance as staff found it difficult to attend during the week.

Assessing and managing risk to patients and staff

Assessment of patient risk

Staff had completed a risk assessment of every patient upon admission. We reviewed six care records. This showed that risk assessments were completed upon admission and updated regularly during weekly ward rounds; following an incident or if there was a change in the level of risk presented.

Staff used the trust's risk assessment tool which was part of their electronic recording system. This covered all identified risks.

Management of patient risk

Staff responded to risks posed by patients appropriately and reported these using the trust's incident reporting system. Staff updated patients' risk assessments following any changes in the level of risk.

Staff followed the trust's policies and procedures for the use of observations, searching patients or their bedrooms. Staff used different levels of observations such as intermittent checks, one-to-one within eyesight, or one-to-one within arm's reach. These were used appropriately for patients who were considered high-risk of harm to themselves or others. Staff only searched patients if they were considered to be at risk of bringing contraband items onto the ward such as items that could be used to self-harm.

Staff did not use blanket restrictions except for when this was justified on clinical grounds such as, patients not being able to use mobile phones during the day when they attended school or therapeutic groups.

Informal patients were aware of the right to leave. Patients were made aware of their rights at the start of their admission.

Use of restrictive interventions

The service had one incident of seclusion in the past 12 months. We reviewed the paperwork and found that staff had completed this appropriately in line with the Mental Health Act code of practice.

The service had one incident of long-term segregation in the past 12 months. This was in place at the time of inspection. We reviewed the documentation and found that staff were managing this in line with the Mental Health Act code of practice and all necessary checks and safeguards had been completed.

Staff only used restraint if de-escalation was unsuccessful. All staff had received training in the use of restraint and de-escalation. We reviewed incidents where staff used restraint and these showed that staff had managed these appropriately.

Staff followed the National Institute for Health and Care Excellence guidance when using rapid tranquillisation. We reviewed medication charts for all patients and reviewed the clinical records of patient who had been restrained and where rapid tranquillisation was used. These showed that staff had followed the guidance and had completed necessary physical health observations.

This service had 116 incidences of restraint (21 different service users) and one incidence of seclusion between 1 November 2017 and 31 October 2018.
The below table focuses on the last 12 months' worth of data: 1 November 2017 to 31 October 2018.

Ward name	Seclusions	Restraints	Patients restrained	Of restraints, incidents of prone restraint	Of restraints, incidences of rapid tranquilisation
Forest House Adolescent Unit	1	116	21	0 (0%)	25 (22%)
Core service total	**1**	**116**	**21**	**0 (0%)**	**25 (22%)**

There were no incidences of prone restraint.

Over the 12 months, incidences of restraint ranged from zero to 45 per month. The number of incidences (116) had increased from the previous 12-month period (86).

There were 25 incidences of rapid tranquilisation over the reporting period. Incidences resulting in rapid tranquilisation for this service ranged from zero to six per month. The number of incidences (25) had increased from the previous 12-month period (10).

There have been zero instances of mechanical restraint over the reporting period. The number of incidences (zero) was the same as the number of incidences from the previous 12-month period.

There has been one instance of seclusion over the reporting period. The number of incidences (one) had decreased from the previous 12-month period (five).

There have been two instances of long-term segregation over the 12-month reporting period. The number of incidences (two) had increased from the previous 12-month period (zero).

Safeguarding

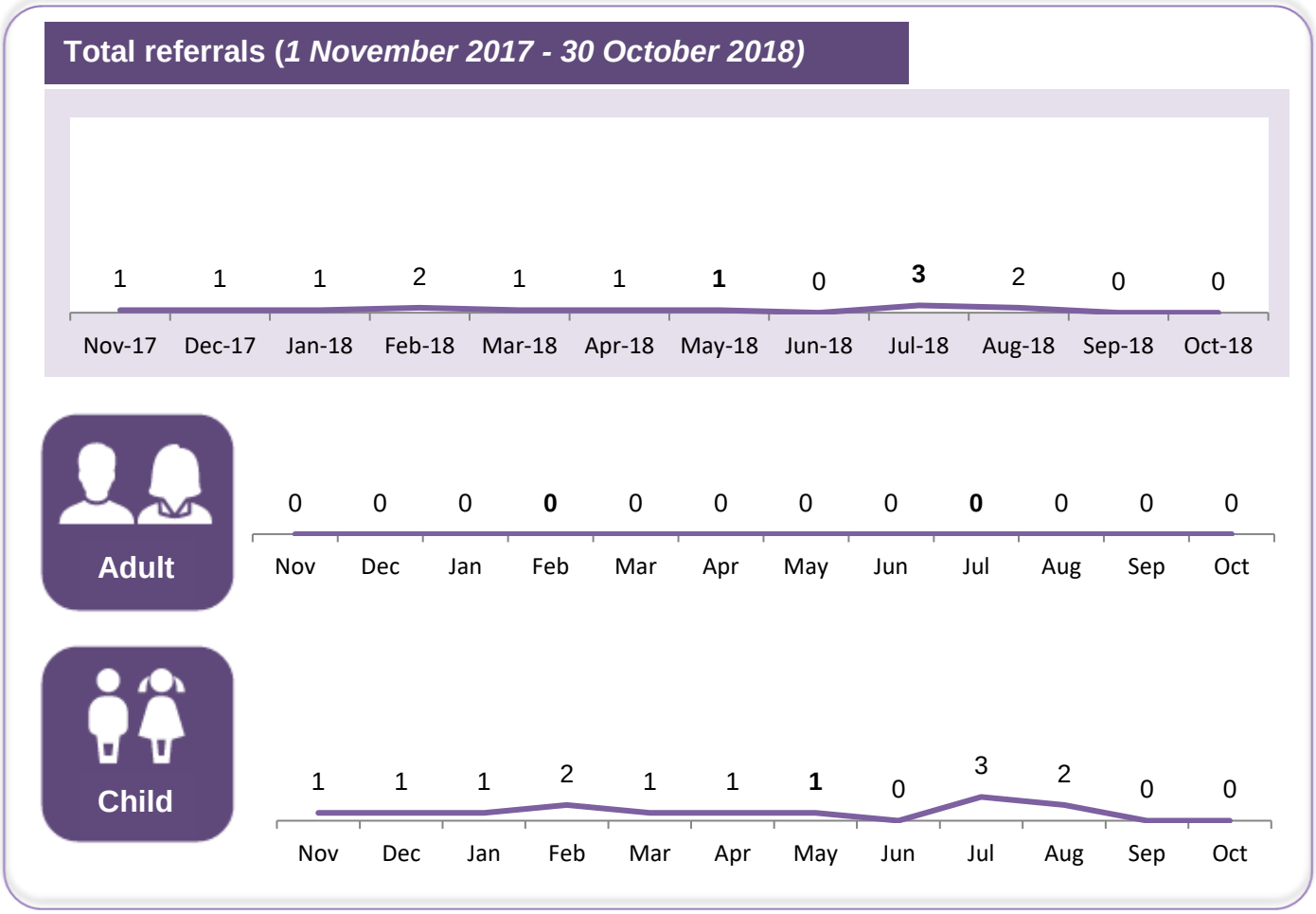
A safeguarding referral is a request from a member of the public or a professional to the local authority or the police to intervene to support or protect a child or vulnerable adult from abuse. Commonly recognised forms of abuse include: physical, emotional, financial, sexual, neglect and institutional.

Each authority has their own guidelines as to how to investigate and progress a safeguarding referral. Generally, if a concern is raised regarding a child or vulnerable adult, the organisation will work to ensure the safety of the person and an assessment of the concerns will also be conducted to determine whether an external referral to Children's Services, Adult Services or the police should take place.

This core service made 13 safeguarding referrals between 1 November 2017 and 31 October 2018, of which all concerned children.

	Number of referrals		
Core service	**Adults**	**Children**	**Total referrals**
MH - Child and adolescent mental health wards	0	13	13

The number of child safeguarding referrals ranged from zero to three per month (as shown below).



Staff received safeguarding vulnerable children training and knew how to make a safeguarding alert when appropriate. Overall 88% of staff were up to date with training This equated to three

staff being out of date. However, the service had recently had three new staff start who would complete the training as part of their induction programme.

Staff knew how to identify if someone was risk of suffering significant harm. Staff could explain potential signs and symptoms of potential abuse. The trust employed two social workers who dealt with safeguarding concerns raised by the ward and liaised with partnership organisations and other agencies to ensure safeguarding processes were implemented.

The trust has submitted details of no serious case reviews commenced or published in the last 12 months (20 November 2017 and 20 November 2018) that relate to this service.

Staff access to essential information

Staff used an electronic recording system for documenting patients care records. Staff also kept paper backup records of important information such as patient personal information, care plans, and risk assessments in case of electronic system failure.

All staff had access to the electronic record system. This included bank and agency staff who worked on the ward.

Medicines management

Staff followed good medication management practices. Medication was stored appropriately in locked cabinets and within the clinic room which was always kept locked. We checked the medication administration records for all patients. These demonstrated good administration practices and all medications were accounted for. The service had good disposal of medication procedures in place. We reviewed the disposal of medication records and saw that these were completed appropriately. The trust's pharmacy team completed medication reconciliation. We spoke to the pharmacist on site who told us that they monitored stock medication and dispensed medication to the ward for individual patients. A monthly audit was completed to ensure medication was being used appropriately.

We did not find evidence that staff were monitoring the effects of medication on patient's physical health regularly and in line with the National Institute for Health and Care Excellence guidance. Care records did not show that there was regular ongoing monitoring of patients' physical health.

Track record on safety

Between 1 November 2017 and 31 October 2018 there were seven serious incidents reported by this service. Of the total number of incidents reported, the most common type of incident was 'Apparent/actual/suspected self-inflicted harm meeting SI criteria' with five.

We reviewed the serious incidents reported by the trust to the Strategic Executive Information System (STEIS) over the same reporting period. The number of the most severe incidents recorded by the trust incident reporting system was comparable with STEIS with seven reported.

A 'never event' is classified as a wholly preventable serious incident that should not happen if the available preventative measures are in place. This service reported zero never events during this reporting period.

	Number of incidents reported			
Type of incident reported (SIRI)	**Apparent/actual/suspected self-inflicted harm meeting SI criteria**	**Unauthorised absence meeting SI criteria**	**Violence & aggression meeting SI criteria**	**Total**
Forest House Adolescent Inpatient Unit	5	1	1	**7**
Total	**5**	**1**	**1**	**7**

Reporting incidents and learning from when things go wrong

The Chief Coroner's Office publishes the local coroners Reports to Prevent Future Deaths which all contain a summary of Schedule 5 recommendations, which had been made, by the local coroners with the intention of learning lessons from the cause of death and preventing deaths.

In the last two years, there have been no 'prevention of future death' reports sent to Hertfordshire Partnership NHS Trust.

Staff knew what incidents to report on how to report them. The trust used an online incident reporting system and this was accessible to all staff.

Staff reported incidents appropriately and in line with trust policy. We reviewed incidents on the incident reporting system. This showed that staff were reporting incidents appropriately.

Staff understood their responsibilities under duty of candour. Staff we spoke to were able to explain the process to inform patients if something had gone wrong and were aware of the importance of being open and transparent. Staff explained if there had been an incident involving a patient, they would discuss this with the patient and their next-of-kin if appropriate.

Staff received feedback from investigations into incidents. Lessons learned from incidents were shared during team meetings, staff handover meetings, or via internal emails. Staff gave an example of learning from an incident where following a patient tying a ligature through anti-ligature door hinges, they had reviewed the ward's ligature risk assessment. They had taken photographs of the potential risk and shared this with other teams in the trust.

Staff were offered a debrief following incidents. Staff met after an incident to discuss what had gone well and what they could do better next time. Staff told us they would make themselves available if the patient wish to have a debrief.

Is the service effective?

Assessment of needs and planning of care

Staff completed a comprehensive mental health assessment of the patient on admission to the ward. We reviewed six care records and found all patients had a detailed and comprehensive

assessment covering the history, current presentation, historical and current risks and any current medication. Staff used the information gathered in the assessment to complete initial care plans.

Staff assessed patients' physical health needs as part of the admission process and a doctor completed a physical examination of the patient.

Care plans were personalised holistic and recovery orientated. Care plans were individualised to the patient's needs and covered a full range of aspects to their care.

Staff updated care plans on a weekly basis as part of the patient's care review. This was completed in real time during the review, using a display screen. Staff updated the plan during the review. This allowed all those involved in the patients' care to have input into the care plan ensuring that all the patients' views and needs were covered.

Best practice in treatment and care

This service participated in twelve clinical audits as part of their clinical audit programme 2017 – 2018.

Audit name	Audit scope	Core service	Audit type	Date completed	Key actions following the audit
Hand Hygiene within HPFT-Q3 Report	Inpatient Wards	MH - Acute wards for adults of working age and psychiatric intensive care units, MH - Wards for older people with mental health problems, MH - Long stay/rehabilitation mental health wards for working age adults, MH - Wards for people with learning disabilities or autism, MH - Forensic inpatient, MH - Child and adolescent mental health wards	Environ mental	25/01/2018	Actions for these audits are held locally
Hand Hygiene within HPFT-Q4 Report	Inpatient Wards	MH - Acute wards for adults of working age and psychiatric intensive care units, MH - Wards for older people with mental health problems, MH - Long stay/rehabilitation mental health wards for working age adults, MH - Wards for people with learning disabilities or autism, MH - Forensic inpatient, MH - Child and adolescent mental health wards	Environ mental	10/05/2018	Actions for these audits are held locally
7 Day Capacity to Consent (MHA)	Inpatient Wards	MH - Acute wards for adults of working age and psychiatric intensive care units, MH - Wards for older people with mental health problems,	Clinical	18/01/2018	MHA team to meet with PG leads to develop local action plan. To discuss findings with Exec Director for Quality

Audit name	Audit scope	Core service	Audit type	Date completed	Key actions following the audit
		MH - Long stay/rehabilitation mental health wards for working age adults, MH - Wards for people with learning disabilities or autism, MH - Forensic inpatient, MH - Child and adolescent mental health wards			and Medical Leadership. To conduct a re-audit 6 monthly.
The Management of Diabetes within Inpatient wards in Hertfordshire	Inpatient Wards	MH - Acute wards for adults of working age and psychiatric intensive care units, MH - Wards for older people with mental health problems, MH - Long stay/rehabilitation mental health wards for working age adults, MH - Wards for people with learning disabilities or autism, MH - Forensic inpatient, MH - Child and adolescent mental health wards	Clinical	22/03/2018	To share the findings at the physical health committee. Design learning note, highlighting importance of recording glucose screening, care plan, risk assessment.
S136 to Health Based PoS within HPFT - Oct-Dec2017	Inpatient Wards	MH - Acute wards for adults of working age and psychiatric intensive care units, MH - Child and adolescent mental health wards	Clinical	08/03/2018	S136 monitoring form to be put as a UDF on Paris. Present findings at Interagency Group. Training for staff regarding Section136 in Oak Ward, Section 136 Suite and Kingfisher court.
Information Governance - Clinical Record Keeping	CAMHS, Older Peoples Inpatient, EMDASS, Older People Community, LD Inpatient, LD Community, CATT, Psychiatric Liaison Teams, Acute Inpatient, Wellbeing	MH - Acute wards for adults of working age and psychiatric intensive care units, MH - Wards for older people with mental health problems, MH - Wards for people with learning disabilities or autism, MH - Forensic inpatient, MH - Child and adolescent mental health wards	Clinical	14/06/2018	Annual Information Governance Training to be merged with Care Records & Confidentiality Training to make both courses mandatory. Compliance drive to meet the 95% requirement. To review the use of the SPIKE contingency and monitor feedback. To raise awareness of the naming structure throughout the Trust and ensure it is used through action plans and learning notes publicised throughout the Trust. Data Quality Checklist needs to be publicised and communicated effectively

Audit name	Audit scope	Core service	Audit type	Date completed	Key actions following the audit
					throughout the Trust to ensure its use at Clinical Supervision.
Nutrition & Dysphagia	Inpatient Wards	MH - Acute wards for adults of working age and psychiatric intensive care units, MH - Wards for older people with mental health problems, MH - Long stay/rehabilitation mental health wards for working age adults, MH - Wards for people with learning disabilities or autism, MH - Forensic inpatient, MH - Child and adolescent mental health wards	Clinical	26/04/2018	Audit to be shared at the inpatient patient safety meeting and QRM. To develop a how to guide to completing the new Paris form. To promote nutrition & dysphagia e-learning video.
The PLACE (Patient Led Audit of the Care Environment) Annual Programme	Inpatient Wards	MH - Acute wards for adults of working age and psychiatric intensive care units, MH - Wards for older people with mental health problems, MH - Long stay/rehabilitation mental health wards for working age adults, MH - Wards for people with learning disabilities or autism, MH - Forensic inpatient, MH - Child and adolescent mental health wards	Environ mental	14/11/2018	Carry out regular audits by Trust and Interserve, service user feedback forms to be collated in regard to food and hydration services.
S136 to Health Based PoS within HPFT - Jan-Mar 2018	Inpatient Wards	MH - Acute wards for adults of working age and psychiatric intensive care units, MH - Child and adolescent mental health wards	Clinical	17/05/2018	Review request of Paris form. To raise issues from audit at section 136 interagency group. Training for staff to be provided for those working in section 136 suites.
Section 132/133 (Rights for inpatients detained under the MHA 1983)	Inpatient	MH - Acute wards for adults of working age and psychiatric intensive care units, MH - Wards for older people with mental health problems, MH - Long stay/rehabilitation mental health wards for working age adults, MH - Wards for people with learning disabilities or	Clinical	12/07/2018	Service Line lead to disseminate information including Trust policy to staff.

Audit name	Audit scope	Core service	Audit type	Date completed	Key actions following the audit
		autism, MH - Forensic inpatient, MH - Child and adolescent mental health wards			
Inpatient Falls Audit	Trust wide Inpatient	MH - Acute wards for adults of working age and psychiatric intensive care units, MH - Wards for older people with mental health problems, MH - Long stay/rehabilitation mental health wards for working age adults, MH - Wards for people with learning disabilities or autism, MH - Forensic inpatient, MH - Child and adolescent mental health wards	Clinical	30/08/2018	Policy to be amended to reflect all services. Head of Nursing to hold discussions for FRA form to be built onto the EPR within care documents.
Self-Harm Audit	Inpatients/ Community	MH - Acute wards for adults of working age and psychiatric intensive care units, MH - Wards for older people with mental health problems, MH - Wards for people with learning disabilities or autism, MH - Forensic inpatient, MH - Child and adolescent mental health wards	Clinical	07/11/2018	To complete a NICE compliance audit for EUPD trust-wide as this was the most common co-morbidity in the self -harm audit Training in risk formulation to ensure a better understanding of protective factors and its use in managing risk Provide good understanding of EUPD and risks to HPFT Staff and countywide GPs

Staff provided a range of care and treatment interventions appropriate for the patient group. These included education and therapeutic activities as well as offering psychological therapies recommended by the National Institute for Health and Care Excellence. Staff also offered patients a choice of medication where appropriate.

Staff could access physical healthcare specialists when required. For example, staff accessed specialist support to help a patient with diabetes.

Staff completed nutrition and hydration assessments as part of the admission process and met the needs of patients. Staff appropriately assessed and treated patients with an eating disorder.

Staff used recognised rating scales to assess and record severity and outcomes for patients, such as the health of the nation outcome scales for children and adolescents (HoNOSCA). Staff also completed recognised side effect monitoring rating scales. We saw evidence in the care records that staff were regularly completing the Liverpool university neuroleptic side effect rating scale as well as the Glasgow antipsychotic scale.

Staff participated in clinical audits and quality improvement initiatives including medication management, record keeping, cleaning records, and clinical equipment calibration audits. Staff had completed these appropriately within the timeframe stated in the trust's policy.

Skilled staff to deliver care

The trust's target rate for appraisal compliance is 95%. At the end of last year (31 March 2018), the overall appraisal rate for non-medical staff within this service was 81%. This year so far, the overall appraisal rates was 88% (as at 30 September 2018).

Ward name	Total number of permanent non-medical staff requiring an appraisal	Total number of permanent non-medical staff who have had an appraisal	% appraisals (as at 30 September 2018)	% appraisals (previous year 1 April 2017 – 31 March 2018)
Forest House Adolescent Unit	25	22	88%	81%
Core service total	25	22	88%	81%
Trust wide	**1467**	**1350**	**92%**	**88%**

We reviewed staff compliance with appraisal during the inspection. All eligible staff had received an appraisal. We reviewed staff records and saw that staff had been appraised annually. The compliance rate for appraisals was 100%.

The staff team included a full range of specialisms to meet the needs of patients. These included doctors, nurses, health care assistants, occupational therapists, social workers, clinical psychologists, and family therapists. All staff were experienced and qualified and had the right skills and knowledge to meet the needs of the patient group.

Managers provided new staff with an appropriate induction. We checked staff records and saw staff had completed this and mandatory training.

Managers had identified the learning needs of staff and provided them with opportunities to develop their skills. This included providing staff with dialectical behavioural therapy training to enhance their skills to work with their patient group.

Managers told us that they dealt with poor performance promptly and effectively. However, there had been no cases of poor performance in the past 12 months.

The trust has not provided appraisal data for medical staff.

During the inspection we found managers provided staff with supervision. The trust had introduced a new management database known as discovery to record staff compliance. The overall compliance rate for supervision was 82%. Staff used their time in supervision to discuss case management and reflect on practice. Staff told us that supervision happened regularly every four to six weeks.

Multi-disciplinary and interagency team work

Staff held weekly multidisciplinary meetings. These included all relevant staff, care coordinators, the patient and their families or carers. We observed three meetings. All staff were given the

opportunity to share their views. The patient was given the opportunity to share their views and have input into their care plan.

We observed that staff shared information about patients through an effective handover meeting between shifts. This included information about the patients' current presentation and any change in risk. This meant that the staff coming on duty were informed of any changes in patient need.

The ward team had effective working relationships with other teams in the organisation. Staff told us they had good relationships with patients' community care coordinators and they regularly visited the ward. We also received feedback from the community team that ward staff were always friendly and welcoming. There was a good working relationship between the two teams.

Ward teams had effective working relationships with teams outside the organisation. for example, a social worker regularly liaised with the local authority and social services and stated there were good lines of communication between the organisations.

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

As of 30 September 2018, 83% of the workforce in this service had received training in the Mental Health Act. The trust stated that this training is mandatory for all services for inpatient and all community staff and renewed every three years.

The training compliance reported during this inspection was lower than the 88% reported for the previous year.

Staff had access to administrative support and legal advice on the implementation of the Mental Health Act and its Code of Practice. The trust had a team of Mental Health Act administrators who were available should staff required any advice or support.

Patients had access to an independent mental health advocate. Staff displayed information on how to access the advocacy service on ward noticeboards.

Staff explained to patients their legal rights under the Mental Health Act. Patients care records demonstrated that staff explained patients' rights monthly or more regularly if they had concerns that the patient's capacity fluctuated.

Staff ensured that patients were able to take their Section 17 leave once granted. However, patients told us that sometimes this could be postponed or rearranged if activity levels on the ward were high and there was a shortage of available staff. However, patients told us that this had improved over recent weeks, due to recruitment of new staff.

Staff stored copies of patients' detention papers appropriately so they were available to staff should they need them. The copy was also sent to the Mental Health Act administrators.

Mental Health Act administrators completed regular audits to ensure that the Act was applied correctly. We saw evidence that these audits were completed regularly.

Good practice in applying the Mental Capacity Act

As of 30 September 2018, 94% of the workforce in this service had received training in the Mental Capacity Act. The trust stated that this training is mandatory for all services for inpatient and all community staff and renewed three years.

The training compliance reported during this inspection was higher than the 83% reported for the previous year.

The service had a policy on the Mental Capacity Act, including deprivation of liberty safeguards. Staff were aware of the policy and were able to access it via the trust's intranet site.

Staff knew where to get advice regarding the Mental Capacity Act. Staff told us if they needed support they would speak to their manager, the social workers for the Mental Health Act administrators.

Staff took all practicable steps to enable patients to make their own decisions where appropriate. We saw evidence in the care records that staff supported patients and provided them with information to enable them to make informed decisions.

Staff made best interest decisions for patients who lacked capacity and recorded this in care records. Staff held best interest decision meetings and invited all relevant people involved in the patients' care, including their families and carers. Records showed decisions taken in the best interest of the patients and the discussions to support the decisions.

Staff completed audits of Mental Capacity Act documentation. These were completed on a monthly basis.

The trust told us that no Deprivation of Liberty Safeguard (DoLS) applications were made to the Local Authority for this service between 1 November 2017 to 31 October 2017.

Is the service caring?

Kindness, privacy, dignity, respect, compassion and support

Staff treated patients with kindness respect and compassion. We observed staff's attitude and behaviours when interacting with patients. We saw staff were respectful and responsive to patients and provided them with emotional support when they needed it. Staff encouraged and supported patients to be involved in all aspects of their care and treatment. We were impressed with the person-centred culture evident throughout the ward.

Staff supported patients to understand and manage their care and treatment. Staff provided patients with information to help them understand their care and treatment and allowed patients to make informed choices. Staff used their skills in dialectic behaviour therapy to support patients in a respectful manner. Staff were highly motivated and inspired to provide care that promoted patients' dignity.

Staff supported patients to access other services when appropriate. We were impressed to find that staff supported patients to maintain attendance at their regular school where appropriate. This helped promote continuity in the patients' education. However, if the patient presented as too high risk attended the school within the service. Patients were also supported to attend other services such as hospital appointments or appointments with social workers.

Patients told us staff treated them well, behaved in a way that promoted their dignity and showed respect at all times. We spoke to seven patients who all felt that the staff were excellent and were always willing to go the extra mile to support them. Patients told us staff always made the time to offer emotional support and this was done in a respectful and compassionate manner. Patients told us that they highly valued their relationship with staff.

Staff recognised and respected the totality of patient's individual needs. We were impressed that all staff we spoke to demonstrated good understanding of individual patients and how they supported them to meet their needs. Staff always took patients' personal, cultural, social, and

religious needs into account and found ways to meet them such as identifying potential activities or groups to promote recovery.

Staff told us they would be able to raise concerns about disrespectful, discriminatory or abusive behaviour towards patients without fear of consequences. However, all staff told us that they did not feel they would ever have to do this as they considered all staff were extremely caring and respectful and everyone worked well together to support patients.

Staff respected patients' privacy and confidentiality and patients told us staff always took them to a private room to discuss any issues or concerns.

The 2018 Patient-Led Assessments of the Care Environment (PLACE) score for privacy, dignity and wellbeing at this service location scored lower than similar organisations.

Site name	Core service(s) provided	Privacy, dignity and wellbeing
Forest House Adolescent Unit	MH - Child and adolescent mental health wards	87.4%
Trust overall		**90.9%**
England average (mental health and learning disabilities)		**90.6%**

Involvement in care

Involvement of patients

Staff used the admission process to inform and orientate patients to the ward. When the patient was admitted, staff initially assessed them and then showed them around the ward, introducing them to staff and other patients. If a patient was admitted at night they were taken to their room to rest before staff went through information such as developing a care plan and risk assessment. Staff placed patients initially on one to one observations in order to support them to settle into the ward environment and to feel safe. Staff also provided patients with a welcome pack containing information on the ward, available activities, treatment, and information on how to complain.

We were very impressed to find that staff involved patients in all aspect of their care. We reviewed six care records. We saw that patients were active partners in their care and continuously involved in completing and reviewing care plans and risk assessments. We observed three multidisciplinary team meetings. During these meetings we observed staff commitment to ensuring patients were involved in discussing and updating their care plans and were encouraged to give their views on their care and treatment. Staff updated care plans using patients views and comment. Staff ensured patients had an opportunity to sign their care plan and were given a copy.

Staff communicated with patients in a way that ensured they understood their care and treatment. Staff found effective ways to communicate with patients who had communication difficulties or whose first language was not English. Staff had arranged for an interpreter to attend care reviews for one patient to ensure they were able to understand the care and treatment as well as supporting involvement in the reviewing and completion of care plans.

Staff involved patients where appropriate in decisions about the service. The trust recently set up a new youth council for the child and adolescent mental health inpatient services which met monthly and enabled young people to fully participate in discussions about services and how to improve quality. We were impressed by how they supported patients and families to be involved in

decisions about the service such as supporting them to be involved in the recruitment of staff and meeting with managers to discuss improvements to the service. The young person's council was involved in the development of the service welcome pack and the child and adolescent mental health services website on the trusts intranet page.

Staff enabled patients to give feedback on the service they received. Staff held a community meeting each weekday. We observed one of these meetings. Patients were given the chance to talk about any incidents and how they felt. Patients discussed the support they had received following incidents. Patients were involved in planning the day and the activities. Staff discussed future planning with patients around school and holidays. Staff also encouraged patients to provide feedback on the service through compliments and complaints, friends and family test, and by completing 'have your say' forms. These were then reviewed and the outcome displayed on "you said, we did" boards on the ward.

Staff ensured that patients could access an advocacy service. Information was displayed on noticeboards throughout the ward and staff encouraged the patients to seek support where appropriate.

Involvement of families and carers

Staff informed and involved families and carers where appropriate and provided them with support when needed. We were impressed to see how staff actively encouraged families and carers to attend multidisciplinary meetings and to be involved in patients' care. We spoke to two parents who attended multidisciplinary meetings. They told us staff always involved them in decisions about the patient's care and treatment and kept them informed at all times. They also told us that they were given a copy of patient's care plan and risk assessment. Parents told us staff actively encouraged them to visit and make contact with staff at any time. Parents told us staff were highly motivated, caring and compassionate and were always available should they need to discuss the patient's care and treatment.

Staff enabled families and carers to give feedback on the service they received. Staff provided family therapy groups to support patients and their families to identify how they could work together to promote the patient's recovery. Families were encouraged during meetings to provide feedback and encouraged to use the compliments and complaints service to share their views on the service. Staff also gave families and carers a 'friends and family form' to complete. Families and carers were encouraged to attend a weekly parents and carers group. Additionally, there were monthly groups in the community where they could share their views on the service.

Staff provided carers with information on how to access a carer's assessments. Staff told us they referred carers to the appropriate service if required. Staff also displayed information on noticeboards around the ward on how to access an assessment.

Is the service responsive?

Access and discharge

The service provided personalised care that was responsive to patients' needs. The service had introduced a new care pathways model which had reduced the average length of stay for patients from 80 days to 15. These pathways included 72-hour urgent admission, and four-week, six-week, and eight-week admissions for patients with more complex needs. Staff initially assessed patients prior to admission and this information was used to determine which care pathway was most suitable. For example, if a patient was in crisis they would be admitted for 72 hour high intensity work. If staff's assessment highlighted that the patient's needs were more complex and required a

longer admission then staff admitted them onto the four, six, or eight week pathways. Staff worked closely with community teams and crisis teams to ensure that patients were supported throughout the process of admission. The trust had developed a children's home treatment team as part of their transformation plan for child and adolescent mental health services. The service was based within the hospital and worked to prevent admission and to facilitate early discharge.

Bed management

The trust provided information regarding average bed occupancies for one ward in this service between 1 November 2017 to 31 October 2018.

Forest House Inpatients ward reported average bed occupancies ranging above the minimum benchmark of 85% for six of the 12 months.

Ward name	Average bed occupancy range (1 November 2017 – 31 October 2018) (current inspection)
Forest House Inpatients	75 - 97

The trust provided information for average length of stay for the period 1 November 2017 to 31 October 2018.

Ward name	Average length of stay range (1 November 2017 – 31 October 2018) (current inspection)
Forest House Inpatients	13 - 88

This service reported no out area placements between 1 November 2017 to 31 October 2018.

Beds were available on the ward when needed for patients living in the catchment area. Managers told us that the new care pathways system which had reduced the average length of stay, ensured that beds were more easily available for patients within the catchment area. We were impressed that patients would not have to wait any more than three days to access a local bed.

Staff kept patients' bedrooms available for when they returned from leave and did not admit other patients into them. This ensured that if patient became unwell whilst on leave they did not have to wait for a bed to become available and continuity of care was maintained.

Staff did not move patients between wards during an admission unless it was justified on clinical grounds or in the best interests of the patient. A bed was always available in a psychiatric intensive care unit if a patient required more intensive care. The trust did not have a child and adolescent mental health psychiatric intensive care unit, however staff liaised with NHS England and commissioners to source a psychiatric intensive care bed within the independent sector when needed. For example, we saw one patient being cared for in long-term segregation. Staff had arranged for the patient to move to a psychiatric intensive care unit where their needs and risks could be managed more safely.

Staff planned discharges during multidisciplinary team meetings. All those involved in the patient's care including their family and community care coordinators participated in discussions and planning. Staff discharged patients at an appropriate time of day, at a time convenient for families, and when appropriate support in the community could be accessed.

This service reported one readmission within 28 days between 1 November 2017 to 31 October 2018. The one readmission (100%) was to the same ward as discharge. The average number of days between discharge and readmission was 28 days. There were no instances whereby patients were readmitted on the same day as being discharged but there were no where patients were readmitted the day after being discharged.

Ward name	Number of readmissions (to any ward) within 28 days	Number of readmissions (to the same ward) within 28 days	% readmissions to the same ward	Range of days between discharge and readmission	Average days between discharge and readmission
Forest House Inpatients	1	1	100%	28	28

Discharge and transfers of care

Between 1 November 2017 to 31 October 2018 there were 123 discharges within this service. This amounts to 6% of the total discharges from the trust overall (1950).

There were no delayed discharges across the 12-month period.

Staff supported patients during referral and transfers between services. For example, if patient had to be transferred to an acute hospital for treatment of physical illness, staff would go with them and support them during their stay. Staff supported patients to attend appointments with social workers and the probation service to enable them to maintain their support networks whilst in hospital. Staff supported patients to transition from child to adult services. The trust had a pathway for patients turning 18 years which supported transition between services, with support from both teams. Staff supported patients during the discharge process and involved patients in all discussions. Staff referred patients to the home treatment team in order to provide more support on discharge or to make the process safer.

Facilities that promote comfort, dignity and privacy

The 2018 Patient-Led Assessments of the Care Environment (PLACE) score for ward food at the location scored lower than similar trusts.

Site name	Core service(s) provided	Ward food
Forest House Adolescent Unit	MH - Child and adolescent mental health wards	83.2
Trust overall		**84.8%**
England average (mental health and learning disabilities)		**91.5%**

Patients had their own bedrooms with an ensuite bathroom. This met the Department of Health guidelines and promoted privacy, dignity and safety.

Patients could personalise their bedroom, for example, they could bring their own bed linen and other personal items to make their room more homely.

Staff and patients had access to full range of rooms and equipment to support treatment and care. These included a clinic room, activity room and therapy rooms including an occupational therapy kitchen. The service had plans to implement a sensory room within the ward. An area of the ward had been identified for this and work was due to start later in the year. Patients could access quiet areas on ward. There were three quiet lounges where patients could go, should they not wish to be around lots of people. Patients could also use these rooms to meet family and other visitors.

Patient could make private telephone calls in their bedrooms and had access to their mobile phones when they were not in school or in therapeutic groups. There was also a pay phone in the corridor that patients could use. However, this was not private. Staff told us that the phone used to be located in a private room but due to an incident elsewhere in the trust they moved it out into a communal area for staff to be able to monitor it more easily.

Patients had access to outside space. The ward had a garden area for patients to use with staff supervision at all times. This was required to reduce the risks as there were numerous ligature points.

Patients could make hot drinks and snacks at any time. Staff provided cold drinks and snacks in the dining room and patients could use the occupational therapy kitchen to make hot drinks under supervision.

Patients' engagement with the wider community

Staff ensured that patients had access to education and work opportunities where appropriate. The trust had a school on site. However, we were impressed that staff supported patients to continue to attend their usual mainstream schools where this was appropriate. This enabled patients to have continuity with their education needs and to maintain their relationships with people that matter to them within the wider community. We were very impressed to find that staff had supported a patient to continue with their part-time weekend job. This proactive approach enabled the patient to maintain their relationships within the community and ensured they would be able to continue working once discharged. The trust recently trialled a drama therapy group for young people which was held at a local community theatre. This helped young people with social anxiety to engage with the community once a week. The trust is currently evaluating the outcomes of the group and is planning another group later this year.

Staff supported patients to maintain contact with their families and carers. Staff actively encouraged families and carers to visit regularly. Families told us that they could telephone the ward any time if the patient was not in school or therapeutic activities. Patients were actively encouraged to go on leave at weekends if it was safe for them to do so. Staff discussed potential risks with families and carers as well as the patient in order to minimise the risk of leave being unsuccessful.

Meeting the needs of all people who use the service

For the most recent Patient-Led Assessments of the Care Environment (PLACE) (2018) the location scored lower than similar trusts for the environment supporting those with disabilities.

Site name	Core service(s) provided	Dementia friendly	Disability
Forest House Adolescent Unit	MH - Child and adolescent mental health wards	n/a	85.0%
Trust overall		**88.7%**	**81.9%**

England average (Mental health and learning disabilities)		**84.8%**	**86.3%**

The service had made adjustments for patients with disabilities. For example, the ward was located on the ground floor and there were ramps to give easy access. Doors were wide enough for wheelchair access. The ward had an accessible bathroom with equipment to assist people with mobility disabilities.

Staff told us how they supported patients with other protected characteristics under the Equalities Act 2010 such as children who were transgender or identified as gender neutral. Staff told us that they would ensure that children were allocated a bedroom in the area of the patient's preference depending on what gender they related to.

Staff ensured that patients obtained information on treatments, local services, their rights, and how to complain. Staff ensured patients had a welcome pack upon admission which contained various information. Two staff told us that they could also print off information on patients' treatments such as medication.

Staff provided information in an accessible form for the patient group. This included easy read information as well as information that was written in a non-jargon style that was easy for patients to understand. Staff told us that they could access information in different languages patients whose first language was not English.

Managers ensured that staff and patients had easy access to interpreters and signers. On the day of inspection, staff had arranged for an interpreter to attend the ward for a multidisciplinary meeting to enable the patient and their family to communicate effectively. We were impressed to find that staff had accessed signers to support a patient whose parents were deaf so that the parents were able to participate in care reviews and talk to staff about their child's care.

Staff provided a choice of food for patients to meet differing dietary requirements including religious, ethnic or cultural such as vegetarian, and vegan food. Food was prepared in a central kitchen brought over to the ward.

Listening to and learning from concerns and complaints

This service received one complaint, which was withdrawn, between 1 November 2017 to 31 October 2018.

Ward name	Total Complaints	Fully upheld	Partially upheld	Not upheld	Other	Under Investigation	Withdrawn	Referred to Ombudsman
Adolescent Unit	**1**	0	0	0	0	0	1	0

This service received 14 compliments during the last 12 months from 1 November 2017 to 31 October 2018 which accounted for 1% of all compliments received by the trust as a whole.

Patients knew how to complain or raise concerns. Seven patients told us that they had been given information regarding the complaint process as part of their welcome pack. Patients also said they could raise concerns during community meetings or patient forums. Patients could use the 'have your say' forms to raise concerns. When patients complained or raised concerns we saw they had received feedback. Patients told us they received feedback from concerns raised by the 'you said, we did' board displayed on the ward or during community meetings and patient forums.

Staff knew how to handle complaints appropriately. Staff told us that they provided the patient with information to support them such as accessing the advocacy service. Staff told us they escalated concerns to their line manager for investigation.

Staff told us they would receive feedback on the outcome of investigations into complaints during team meetings. However, the only complaint made in the past 12 months was withdrawn so we were unable to find any evidence of feedback.

Is the service well led?

Leadership

Leaders had the skills, knowledge, and experience to perform their roles. Leaders were visible in the service and approachable for patients and staff. Staff told us that ward managers and senior managers were kind and compassionate, very approachable and were regularly on the ward to support staff. We were impressed that the staff felt that leaders consistently reflected the trust's values. Patients told us that they knew who the managers were and they were always available to talk to should they have any concerns. Leaders demonstrated they had a good knowledge of the patients on the ward and that they understood patient's needs.

Leadership development opportunities were available for managers and non-management staff below management level. Staff told us they had attended in-house training which covered basic management and leadership skills development. Managers told us that they attend bimonthly team leader development days. The aim of these events is to support and develop team leaders to enable them to consistently deliver high quality safe services.

Vision and strategy

Staff knew and understood the trust's visions and values and how they applied to the work of their team. We saw evidence that the staff were always welcoming and kind to patients, always acted in a positive and respectful manner and were professional.

Staff had the opportunity to contribute to discussions about the strategy for the service. For example, staff were involved in the discussions and plans around changing the model of care on the ward and introducing the new care pathways. Staff could also attend chief executive breakfasts. This is where staff could go and meet the chief executive and discuss quality improvement ideas. The trust had also introduced the listening events. These are days where staff can go along meet the executive team and discuss matters that are important to them.

Culture

Staff felt respected, supported, and valued. Staff told us that managers were always available to support them they felt happy talking to them. Staff told us that following a difficult week due to high activity levels on the ward. managers had been very supportive and helped make staff feel valued and respected.

Staff felt positive and proud about working for the trust and their team. We were impressed how staff were extremely positive about working on the ward and felt that they worked in an excellent team who all supported each other and worked well together. Staff felt that the culture on the ward encouraged person centred care and centred on the needs and experiences of people who used the service.

Staff felt able to raise concerns without fear of retribution. Staff were aware of how to use the 'speaking up' process and about the role of the speak up guardian. Staff told us they were confident that managers would support them, listen to their concerns and take action when needed.

Managers dealt with poor staff performance when needed and explained the process they followed, such as discussion during supervision and implementing performance management plans. However, managers confirmed there had not had any issues around poor staff performance in the past year.

Teams worked well together. Staff told us that if there were any difficulties they felt that managers would listen to them and deal with these appropriately. Staff reported that the trust promoted equality and diversity in its day-to-day work and in providing opportunities for career progression. Staff told us they would be given equal opportunities to progress in their career regardless of their ethnicity or gender.

Services staff sickness as absence rate was similar to the trust target and below the NHS average at 4.1%.

Staff had access to trust support for their physical and emotional health needs through an occupational health service and a variety of wellbeing schemes. Staff also had access a counselling service should they need any extra support.

The trust recognised staff success within the service through staff awards. We were impressed to hear that staff at the service had recently won 12 awards at the annual staff awards ceremony, including the unsung hero for a member of staff who regularly went above and beyond the call of duty to support patients to meet their needs.

Governance

There was a clear agenda for meetings held at ward, team, or directorate level to ensure that essential information such as learning from incidents and complaints were shared and discussed. We reviewed the minutes from team and governance meetings. We saw that there was a set agenda for these meetings which included learning from incidents and complaints. Staff undertook local clinical audits. We reviewed various audits which were sufficient to provide managers assurance and staff acted on the results when needed.

Staff understood the arrangements for working with other teams in the trust and externally. Staff could tell us how they worked with community teams, the home treatment team, and local authority to support and meet the needs of patients.

Management of risk, issues and performance

Staff could escalate concerns when required and submit issues for the trust's risk register.

The service had plans for emergencies. Manager kept an emergency plan folder which contained information for staff to use situations such as adverse weather, flu outbreak, diarrhoea and vomiting outbreak, or major incidents.

Information management

The service had systems in place to collect data from the wards. The trust had recently introduced a new learning management system 'discovery' to help staff monitor training, supervision, and appraisals. However, on the day of inspection managers found it difficult to get information from these systems to provide inspectors with data on supervision compliance. The trust had also introduced a new information and clinical support system 'SPIKE 2'. This system provided an overview of care records and allowed all clinical information to be easily monitored and accessible to both staff and managers.

Staff had access to the equipment and information technology needed to do their work. Staff told us that the information technology infrastructure worked well and helped improve the quality of care. Staff told us that having access to an electronic smart board during multidisciplinary meetings had allowed them to show patients their care and treatment plans and improved patient and carer involvement.

Team managers had access to information to support them with their management role. This included information on the performance of the service, staffing, and patient care. Team managers dialled into telephone conferences on a daily basis to discuss staffing levels on the various wards on site. Managers could access information on the performance of the service through clinical audits.

Information was in an accessible format, was timely, accurate, and identified areas for improvement. We reviewed various audits which showed that where issues had been identified staff had taken action.

Engagement

Staff, patients, and carers had access to up-to-date information about the of work the trust and the services they used. Staff told us that they received regular email updates about any changes or updates from senior managers. Patients and carers told us that staff on the ward provided them with updates on changes to the service.

Patients and carers had the opportunity to give feedback on the service they received. Carers told us that they were encouraged to complete "have your say" forms where they could give their views on the service. Parents and carers also completed 'friends and family test' questionnaires. The trust held regular patient and carer forums where patients and carers could give feedback and make suggestions on improvements to services.

Managers and staff had access to the feedback from patients and carers. Results from "have your say" were displayed on "you said we did" boards. Staff also received the results of friends and family test questionnaires as well as patient surveys. The trust acted on the comments and suggestions made, for example, the trust refurbished the waiting area following comments that it was not comfortable or welcoming.

Patients and carers were involved in decision-making about changes to the service. The youth council supported patients to attend meetings where they could discuss potential changes to the service with senior managers such as implementing a sensory room.

Directorate leaders engaged with external stakeholders such as commissioners and NHS England. Managers told us that they liaised with commissioners and NHS England should they need to refer a patient to a psychiatric intensive care unit.

Learning, continuous improvement and innovation

NHS trusts are able to participate in a number of accreditation schemes whereby the services they provide are reviewed and a decision is made whether or not to award the service with an

accreditation. A service will be accredited if they are able to demonstrate that they meet a certain standard of best practice in the given area. An accreditation usually carries an end date (or review date) whereby the service will need to be re-assessed in order to continue to be accredited.

There have been no accreditations awarded to this core service.

Staff were given the time and support to consider opportunities for improvement and innovation which led to changes. Staff told us that they were involved in the changes to the care pathways, especially around the high dependency 72-hour admissions. Staff had been involved in the discussions to implement a sensory room which is planned to be built later in the year. Staff were working towards developing a service for patients with an eating disorder.

Innovations were taking place in the service. These included the development of the care pathways which had reduced the average length of stay from 80 days to 15.

The ward participated in accreditation schemes relevant to the service. Managers told us that they were working towards accreditation from the Quality Network for Inpatient Child and Adolescent Mental Health Services. Quality networks provide services with an accreditation by using a review and accreditation process to promote the highest level of care.

MH – Wards for older people with mental health problems

Facts and data about this service

Location site name	Ward name	Number of beds	Patient group (male, female, mixed)
Lambourn Grove (RWR31)	Lambourn Grove	24	Mixed
Kingsley Green (RWR96)	Frail Functional Service / Wren Ward	16	Mixed
The Stewarts (RWR62)	The Stewarts - Older People Inpatient	16	Mixed
Logandene (RWR32)	Logandene	16	Mixed
Elizabeth and Victoria Court (RWR76)	Victoria Court	27	Mixed
Seward Lodge (RWR47)	Seward Lodge	16	Mixed

The methodology of CQC provider information requests has changed, so some data from different time periods is not always comparable. We only compare data where information has been recorded consistently.

The Stewarts had closed the week before our inspection. Victoria Court had combined with Elizabeth Court in May 2018, the service was known Victoria Court.

Is the service safe?

Safe and clean care environments

Annual ligature audits had been completed for each service. Not all managers and staff were familiar with these risk assessments. At Lambourne Grove, Seward Lodge and Logandene, the documents contained inaccuracies and were not sufficiently detailed. The risk assessments were dated 2018-2019, and some text had been copied into the wrong risk assessment template. However, managers and staff were aware of risks in their environments and acted to reduce any risks they found. Weekly ligature assessments took place using a system known as advanced new technologies (ANT) which promoted staff to do weekly environmental walk rounds to identify any changes in their environment which might represent a risk.

Staff members were allocated to zonal areas with the role of, monitoring patients' whereabouts (in addition to regular observations), looking for potential risks, trip, slip and falls hazards protecting patients from potential risk, helping patients and visitors where possible, and reporting any damage or maintenance issues. Staff told us zonal observations had reduced the number of unwitnessed falls on these wards, and improved risk management.

Staff could see patients in all parts of the wards when using the zonal observations. Staff completed general observation to monitor patient interaction, risk and respond to patient needs. There were blind spots within some areas of the wards however, staff mitigated the risks with mirrors, zonal observations, and the use of floor walkers allowing clear lines of sight. Floor walkers were staff members who were allocated the role of walking the wards looking for potential risks.

Safety of the ward layout

Over the 12-month period from 1 November 2017 to 31 October 2018 there were no mixed sex accommodation breaches within this service.

At Logandene the female only lounge was used by both male and female patients. Staff on Logandene told us at night, other lounges were closed off and the female only lounge was the only lounge open to all patients.

At Victoria Court one female patient was on the male ward in a small self-contained area. This was a bedroom that could be used as a male or female bedroom, depending on the needs of the service. The bathroom arrangements meant the patient did not have to pass male bedrooms to get to a bathroom. We saw appropriate risk assessments and care plans in place.

Managers and staff were not confident around the trust policy on same sex accommodation. During the inspection we asked to see the trusts eliminating mixed sex accommodation policy. Managers could not find this on the electronic system. The trust provided the guidance and policy after the inspection.

There were ligature risks on six wards within this service. All wards had a ligature risk assessment in the last 12 months.

Mitigation included the use of individual risk management plans, weekly audits, zonal observations and floor walkers protecting patients from potential risks.

The trust had environmental assessments for each service, although not fully accurate or completed. The trust had taken steps to ensure reduction works on ligature and anchor points.

Staff at Lambourne Grove, Seward Lodge and Logandene told us zonal observations had improved risk management. Kingsley Green, Wren ward and Victoria Court where just introducing zonal observations.

Ward / unit name	Briefly describe risk - one sentence preferred	High level of risk? Yes/ No	Summary of actions taken
Wren	Frail Functional Assessment ward - though graded as P1. Bedroom doors facing corridors, bathroom doors	Yes	As part of Kingfisher rebuild and anti - ligature specification / new bathroom doors - specific advice on bedroom doors facing corridors as a managed risk
Logandene	P3: Relative risk of falls / low anchor point risk. Taps, flush windows	No	Organic Unit: complies to Dementia standards - low level taps are managed because of the relative risks
Victoria Court	P3: Relative risk of falls / low anchor point risk. Taps, flush windows	No	Organic Unit/ continuing care: Managed for this low risk group with observation
Lambourne Grove	P3: Relative risk of falls / low anchor point risk. Taps, flush windows	No	Organic Unit: complies to Dementia standards - low level taps are managed because of the relative risks
Seward Lodge	P3: Relative risk of falls / low anchor point risk. Taps, flush windows	No	Organic Unit: complies to Dementia standards - low level taps are managed because of the relative risks
The Stewarts	P3: Relative risk of falls / low anchor point risk. Taps, flush windows	No	Decant ward for wider refurbishment programme - due to close 2018

At the time of inspection, the trust had closed The Stewarts.

Staff had easy access to alarms and patients had easy access to nurse call systems. The exception was at Lambourne Grove. Not all nurse call systems were accessible to patients. The manager agreed to undertake a review of nurse call systems during the inspection.

Maintenance, cleanliness and infection control

For the most recent Patient-Led Assessments of the Care Environment (PLACE) (2018), the locations scored higher than similar trusts for cleanliness. All locations except Victoria Court scored higher than similar trusts for condition, appearance and maintenance.

All wards were clean and tidy, staff cleaned ward areas regularly and kept cleaning records up to date. Staff adhered to infection control principles including handwashing, with accessible gels and displayed handwashing signs around wards. Six out of 15 comment cards specifically commented on the cleanliness of the wards.

Site name	Core service(s)	Cleanliness	Condition appearance and maintenance
Lambourn Grove	MH - Wards for older people with mental health problems	100.0%	99.2%

Site name	Core service(s)	Cleanliness	Condition appearance and maintenance
Logandene	MH - Wards for older people with mental health problems	100.0%	97.2%
Seward Lodge	MH - Wards for older people with mental health problems	98.6%	96.1%
Victoria Court	MH - Wards for older people with mental health problems	99.6%	89.3%
Elizabeth Court	MH - Wards for older people with mental health problems	98.6%	96.0%
Trust overall		**98.6%**	**93.5%**
England average (Mental health and learning disabilities)		**98.0%**	**95.2%**

At the time of inspection, the trust had closed The Stewarts. Victoria Court had combined with Elizabeth Court.

Seclusion room (if present)

There were no seclusion rooms in this service.

Clinic room and equipment

Clinic rooms were fully equipped, with accessible resuscitation equipment and emergency drugs. There were processes in place to check that drugs were in date and that staff maintained equipment.

Safe staffing

Nursing staff

This core service has reported a vacancy rate for all staff of 18% as of 30 September 2018.

This core service reported an overall vacancy rate of 20% for registered nurses at 30 September 2018.

This core service reported an overall vacancy rate of 16% for nursing assistants as of 30 September 2018.

		Registered nurses			Health care assistants			Overall staff figures		
Location	**Ward/Team**	**Vacancies**	**Establishment**	**Vacancy rate (%)**	**Vacancies**	**Establishment**	**Vacancy rate (%)**	**Vacancies**	**Establishment**	**Vacancy rate (%)**
Waverley Road	MHSOP Admin & Modern Matrons	1.0	5.0	20%	1.5	1.5	100%	3.5	8.5	41%
Logandene	Logandene Inpatient MHSOP	4.6	12.4	37%	5.6	26.7	21%	10.2	39.1	26%
Lambourn Grove	Lambourn Grove Inpatient MHSOP	2.9	11.2	26%	7.5	39.3	19%	10.4	50.5	21%
Kingsley Green	Wren Ward	2.9	9.1	32%	3.9	23.7	17%	6.9	32.8	21%
The Stewarts	Prospect House Inpatient MHSOP @ The Stewarts	1.3	11.1	12%	5.3	24.2	22%	6.6	35.4	19%
Seward Lodge	Seward Lodge	1.2	12.0	10%	3.7	23.1	16%	7.0	37.3	19%
Rosanne House	MHSOP Occupational Therapy	0.0	0.0	0%	-1.0	1.0	-100%	7.3	55.5	13%
Victoria Court	Victoria Court	0.4	12.1	3%	4.2	39.1	11%	4.6	51.2	9%
The Stewarts	The Stewarts Inpatient MHSOP	0.0	0.0	0%	-2.0	0.0	0%	-2.0	0.0	0%
Core service total		**14.3**	**73.0**	**20%**	**28.7**	**178.6**	**16%**	**54.4**	**310.0**	**18%**
Trust total		**178.1**	**853.7**	**21%**	**124.2**	**1063.0**	**12%**	**440.3**	**3375.9**	**13%**

NB: All figures displayed are whole-time equivalents

Between 1 November 2017 and 31 October 2018, of the 176667 total working hours available, 24% were filled by bank staff to cover sickness, absence or vacancy for qualified nurses.

The main reason for bank and agency usage for the wards/teams was vacancies.

In the same period, agency staff covered 4% of available hours for qualified nurses and 1% of available hours were unable to be filled by either bank or agency staff.

There was low use of agency staff. Managers told us they contacted regular bank staff to ensure safe staffing levels and to cover periods of staff absence. Bank staff were usually experienced staff known to the patients and wards. Between 1 November 2017 to the time of inspection

Lambourne Grove had not used agency staff. Logandene had the highest use of agency staff at 11%. Managers at Lambourne Grove told us in late 2018 they had four staff off on maternity leave, or with health-related reasons. At the time of inspection, they had no staff vacancies.

Wards	Total hours available	Bank Usage		Agency Usage		NOT filled by bank or agency	
		Hrs	%	Hrs	%	Hrs	%
Elizabeth Court	19728	2819	14%	907	5%	632	3%
Lambourn Grove	21840	8513	39%	0	0%	104	1%
Logandene	24531	5155	21%	2600	11%	362	1%
Seward Lodge	23400	8364	36%	1865	8%	409	2%
The Stewarts	21704	6201	29%	593	3%	490	2%
Victoria Court	23673	4963	21%	833	4%	319	1%
Wren Ward	21561	6456	30%	646	3%	170	1%
MHSOP Admin & Modern Matrons	20231	51	<1%	0	0%	0	0%
Core service total	**176667**	**42522**	**24%**	**7444**	**4%**	**2486**	**1%**
Trust Total	**n/a***	**n/a***	**n/a***	**n/a***	**n/a***	**n/a***	**n/a***

*Unable to provide trust total hours and percentages due to inconclusive data provided by the trust.

Between 1 November 2017 and 31 October 2018, of the 377351 total working hours available, 26% were filled by bank staff to cover sickness, absence or vacancy for nursing assistants.

The main reason for bank and agency usage for the wards/teams was vacancies.

In the same period, agency staff covered 2% of available hours and 3% of available hours were unable to be filled by either bank or agency staff.

Wards	Total hours available	Bank Usage		Agency Usage		NOT filled by bank or agency	
		Hrs	%	Hrs	%	Hrs	%
Elizabeth Court	57395	8439	15%	281	0%	1134	2%
Lambourn Grove	71877	19737	27%	0	0%	1200	2%
Logandene	49530	13277	27%	2968	6%	2205	4%
Seward Lodge	41691	12832	31%	259	1%	1101	3%
The Stewarts	44246	13787	31%	361	1%	1112	3%
Victoria Court	73242	15510	21%	1123	2%	1447	2%
Wren Ward	38396	14386	37%	2675	7%	1459	4%
MHSOP Admin & Modern Matrons	975	0	0%	0	0%	0	0%
Core service total	**377351**	**97969**	**26%**	**7666**	**2%**	**9658**	**3%**
Trust Total	**n/a***	**n/a***	**n/a***	**n/a***	**n/a***	**n/a***	**n/a***

*Unable to provide trust total hours and percentages due to inconclusive data provided by the trust.

Managers made sure all bank and agency staff had a full induction and understood the service before starting their shift.

This core service had 34.2 (13%) staff leavers between 1 October 2017 and 30 September 2018.

Location	Ward/Team	Substantive staff (at latest month)	Substantive staff Leavers over the last 12 months	Average % staff leavers over the last 12 months
Logandene	Logandene Inpatient MHSOP	28.9	5.5	19%
Waverley Road	MHSOP Admin & Modern Matrons	5.0	2.0	19%
Kingsley Green	Wren Ward	26.0	5.0	19%
Rosanne House	MHSOP Occupational Therapy	48.0	6.5	16%
Lambourn Grove	Lambourn Grove Inpatient MHSOP	38.6	4.0	11%
Seward Lodge	Seward Lodge	29.3	3.0	11%
Victoria Court	Victoria Court	47.6	4.0	11%
Elizabeth Court	Elizabeth Court	0.0	2.1	10%
The Stewarts	Prospect House Inpatient MHSOP @ The Stewarts	28.7	2.0	8%
The Stewarts	The Stewarts Inpatient MHSOP	2.0	0.0	0%
Core service total		**254.1**	**34.2**	**13%**
Trust Total		**2903.4**	**461.5**	**16%**

The service had enough nursing and medical staff who knew the patients and received training to keep people safe from avoidable harm. Managers had been successful in nurse recruitment for this service. A 16-bedded ward for older people The Stewarts, closed the week before our inspection and many staff transferred to the other five wards. Elizabeth Court closed in May 2018 and the staff group combined with Victoria Court. Overall, the wards had few to no vacancies.

The sickness rate for this core service was 6.4% between 1 October 2017 and 30 September 2018. The most recent month's data (September 2018) showed a sickness rate of 5.6%.

Location	Ward/Team	Total % staff sickness (at latest month)	Ave % permanent staff sickness (over the past year)
The Stewarts	Prospect House Inpatient MHSOP @ The Stewarts	6.5%	10.3%
Elizabeth Court	Elizabeth Court	0.0%	8.9%

Location	Ward/Team	Total % staff sickness (at latest month)	Ave % permanent staff sickness (over the past year)
Lambourn Grove	Lambourn Grove Inpatient MHSOP	6.7%	9.1%
Kingsley Green	Wren Ward	8.4%	7.2%
Logandene	Logandene Inpatient MHSOP	10.1%	6.3%
Rosanne House	MHSOP Occupational Therapy	5.0%	5.1%
Victoria Court	Victoria Court	3.0%	5.1%
Waverley Road	MHSOP Admin & Modern Matrons	2.0%	2.0%
Seward Lodge	Seward Lodge	2.7%	1.8%
The Stewarts	The Stewarts Inpatient MHSOP	0.0%	0.0%
Core service total		**5.6%**	**6.4%**
Trust Total		**3.7%**	**4.5%**

The below table covers staff fill rates for registered nurses and care staff during January, February and March 2018.

Victoria Court, Wren Ward, Seward Lodge and The Stewarts had above 125% of the planned care staff for day and night shifts in January 2018.

Seward Lodge had above 125% of the planned care staff for day and night shifts in January and February 2018.

Elizabeth Court, Logandene Ward and Seward Lodge had under 90% of the planned care staff for day shifts in March 2018.

Managers calculated the number and grade of nurses and healthcare assistants they needed for each shift based on the needs of the patients. This matched the actual number on each shift. Mangers had undertaken a review of the staffing establishment for wards using a recognised management tool.

Key:

> 125%	< 90%

	Day		Night		Day		Night		Day		Night	
	Nurses (%)	Care staff (%)	Nurses (%)	Care staff (%)	Nurses (%)	Care staff (%)	Nurses (%)	Care staff (%)	Nurses (%)	Care staff (%)	Nurses (%)	Care staff (%)
	January 2018				February 2018				March 2018			
Elizabeth Court	95	98	98	130	100	96	91	99	97	87	92	94
Victoria Court	96	130	100	208	94	182	100	104	95	94	98	99
Wren	101	218	102	202	102	122	107	104	99	90	100	94
Lambourn Grove	116	94	100	248	111	96	100	125	106	94	94	99
Logandene	102	95	103	113	106	104	100	127	104	86	98	95
Seward Lodge	98	129	100	176	99	156	102	216	98	89	97	97
The Stewarts	99	255	100	364	98	124	100	111	90	97	98	99

Medical staff

The service had enough daytime and night time medical cover and a doctor available to come to the ward quickly in an emergency. Managers could call locums when they needed more medical cover.

Between 1 November 2017 and 30 October 2018, of the 11520 total working hours available, none were filled by bank staff to cover sickness, absence or vacancy for medical locums.

In the same period, agency staff covered 14% of available hours and all available hours were able to be filled by either bank or agency staff.

Ward/Team	Total hours available	Bank Usage		Agency Usage		NOT filled by bank or agency	
		Hrs	%	Hrs	%	Hrs	%
Seward Lodge	11520	0	0%	1614	14%	0	0%
Core service total	**11520**	**0**	**0%**	**1614**	**14%**	**0**	**0%**
Trust Total	**146022**	**418**	**<1%**	**21401**	**15%**	**1**	**<1%**

Mandatory training

Calculated on a rolling basis.

Staff had completed and were up to date with their mandatory training. Managers showed us records held locally.

Where the mandatory training programme was not specifically targeted at staff working with older people, managers gave additional and bespoke training for their staff as needed. For example, recent training included zonal observations, ligature awareness, dementia training, oral hygiene, falls, end of life care, and resilience training. At Logandene junior doctors had started delivering a programme of physical health care training for ward staff.

The compliance for mandatory and statutory training courses at 30 September 2018 was 87%. Of the training courses listed 17 failed to achieve the trust target and of those, five failed to score above 75%.

The trust set a target of 92% for completion of mandatory and statutory training.

Trust completion is reported as a final figure at year end.

The training compliance reported for this core service during this inspection was higher than the 85% reported in the previous year.

Key:

Below CQC 75%	Met trust target ✓	Not met trust target ✘	Higher ↑	No change →	Lower ↓

Training Module	Number of eligible staff	Number of staff trained	YTD Compliance (%)	Trust Target Met	Compliance change when compared to previous year
Fire Safety [2 Years]	13	13	100%	✓	↑
Equality, Diversity & Human Rights [3 Years]	217	212	98%	✓	↑
Safeguarding Adults Level 2 [3 Years]	207	200	97%	✓	↑
Care Records and Confidentiality Awareness [3 Years]	56	54	96%	✓	↑
Mental Capacity Act and Deprivation of Liberty Safeguards [3 Years]	202	190	94%	✓	↑
Ligature Awareness [3 years]	200	187	94%	✓	↑
Moving and Handling L1 [3 Years]	13	12	92%	✓	↑
Clinical Risk Assessment and Management [3 Years]	202	183	91%	✘	↑
Infection, Prevention & Control Level 2 [2 Years]	207	188	91%	✘	↑
Mental Health Act [3 Years]	202	184	91%	✘	↑
Infection, Prevention & Control Level 1 [2 Years]	10	9	90%	✘	↑
Safeguarding Children Level 2 [3 Years]	208	187	90%	✘	↑
Moving and Handling L2 [2 Years]	205	176	86%	✘	↓
Health, Safety & Welfare [3 Years]	217	185	85%	✘	↓
Data Security Awareness [1 Year]	217	183	84%	✘	↓
Safeguarding Adults Level 1 [3 Years]	10	8	80%	✘	↑
Relating to People Mod 3a [3 Years]	5	4	80%	✘	↑
Intermediate Life Support (includes BLS) [1 Year]	63	49	78%	✘	↓
Preventing Radicalisation (WRAP) [Once]	203	157	77%	✘	↑
Fire Safety [1 Year]	200	147	74%	✘	↓
Basic Life Support [1 Year]	141	101	72%	✘	↓
Relating to People Mod 4 [1 Year]	198	142	72%	✘	↓
Safeguarding Children Level 1 [3 Years]	7	4	57%	✘	↑

Training Module	Number of eligible staff	Number of staff trained	YTD Compliance (%)	Trust Target Met	Compliance change when compared to previous year
Relating to People Mod 3b [1 Year]	4	2	50%	✘	↑
Total	**3207**	**2777**	**87%**	✘	↑

Assessing and managing risk to patients and staff

Assessment of patient risk

We reviewed 31 patient risk assessments. All risk assessments showed that staff completed a risk assessment for each patient on admission, and in consultation with family and carers. However, we found two patients' risk assessments were not robust. On Seward Lodge one risk assessment was not completed, or updated when the patient moved to another part of the ward. Staff on Logandene had not completed a risk assessment to identify or manage sexual disinhibition for one patient, although the care plan frequently referred to these risks.

Staff reviewed patient risk assessments regularly, including after any incident. Risk assessments were through and holistic and included falls, and physical health. Managers investigated fractures resulting from falls, and reported all grade two or above pressure ulcers, following the trust's 'incident and serious incidents requiring investigation' policy.

Staff used a recognised risk assessment tool, and sought the views of other healthcare providers, such as general practitioners, community nurses, and community mental health teams as appropriate.

Management of patient risk

Overall staff knew about the risks for each patient and acted to prevent or reduce these. Managers had set up zonal observations across wards, which allowed staff to observe most parts of the ward. Staff told us zonal observations had reduced the number of unwitnessed falls, improved engagement with patients, whilst allowing patients to move freely, and improved risk management. On wards any patient experiencing three or more slips, trips, or falls automatically triggered a multidisciplinary meeting. Staff completed additional falls assessments, to see how staff could manage the risk.

Staff identified and responded to any changes in risk to, or posed by, patients promptly. Daily morning safe calls and red to green meetings for patients ensured all staff knew of any current patient risks.

Staff could see patients in areas of the wards. Some wards had curved mirrors to aid observation. Managers had introduced the role of floor walkers on shifts. This was a way monitoring the patient, identify new risks, environmental risks, and removing or reducing the risk as far as possible.

Staff followed trust policies and procedures when they needed to search patients or patients' bedrooms to keep them safe from harm.

Use of restrictive interventions

Staff and managers worked to keep the use of restrictive interventions to a minimum. There was a policy relating to the use of restrictive practices.

This service had 45 incidences of restraint (30 different service users) and two incidences of seclusion between 1 November 2017 and 31 October 2018.

The below table focuses on the last 12 months' worth of data: 1 November 2017 and 31 October 2018.

Staff took part in the provider's restrictive interventions reduction programme, which met best practice standards. Staff used effective de-escalation strategies and techniques.

Staff made every attempt to avoid using restraint by using de-escalation techniques. Staff only restrained patients when these had failed, and were necessary to keep the patient or others safe. Restraints were low for this service. During the inspection daily care notes confirmed that staff rarely used restraint. Restraint was used for the shortest time possible. Staff recorded the reasons for its use. Staff understood the Mental Capacity Act definition of restraint and, where appropriate, worked within it.

Ward name	Seclusions	Restraints	Patients restrained	Of restraints, incidents of prone restraint	Of restraints, incidences of rapid tranquilisation
Seward Lodge	1	6	5	0 (0%)	3 (50%)
Elizabeth Court	0	1	1	0 (0%)	0 (0%)
Lambourn Grove	0	15	6	0 (0%)	0 (0%)
Logandene	0	7	5	0 (0%)	0 (0%)
Prospect House	0	0	0	0 (0%)	0 (NA%)
The Stewarts	0	1	1	0 (0%)	0 (0%)
Victoria Court	0	4	4	0 (0%)	0 (0%)
Wren Ward	1	11	8	0 (0%)	8 (73%)
Core service total	**2**	**45**	**30**	**0 (0%)**	**11 (24%)**

There were 11 incidences of rapid tranquilisation over the reporting period. Incidences resulting in rapid tranquilisation for this service ranged from zero to three per month. The number of incidences (11) had increased from the previous 12-month period (four).

There have been zero instances of mechanical restraint over the reporting period. The number of incidences (zero) was the same as the number of incidences from the previous 12-month period.

There have been zero instances of mechanical restraint over the reporting period. The number of incidences (zero) was the same as the number of incidences from the previous 12-month period.

Wren ward had the highest use of rapid tranquilisation of eight incidents between 1 November 2017 and 31 October 2018. This ward had a higher risk patient group. Staff followed National Institute for Health and Care Excellence guidance when using rapid tranquilisation.

There have been two instances of seclusion over the reporting period. Over the 12 months, incidences of seclusion ranged from zero to two per month. The number of incidences (two) had increased from the previous 12-month period (zero).

There were no seclusion rooms in this service. When patients had needed seclusion, staff had used quiet rooms on the ward and very occasionally a patient's bedroom. Staff identified this as seclusion and reported it appropriately.

There have been zero instances of long-term segregation over the 12-month reporting period. The number of incidences (zero) was the same as the previous 12-month period (zero).

Safeguarding

All staff received training in safeguarding appropriate for their role.

Staff could give clear examples of how to protect patients from harassment and discrimination.

Staff knew how to recognise adults and children at risk of, or suffering harm and worked with other agencies to protect them.

Staff followed clear procedures to keep children visiting the wards safe.

Staff knew how to make a safeguarding referral and who to inform if they had concerns.

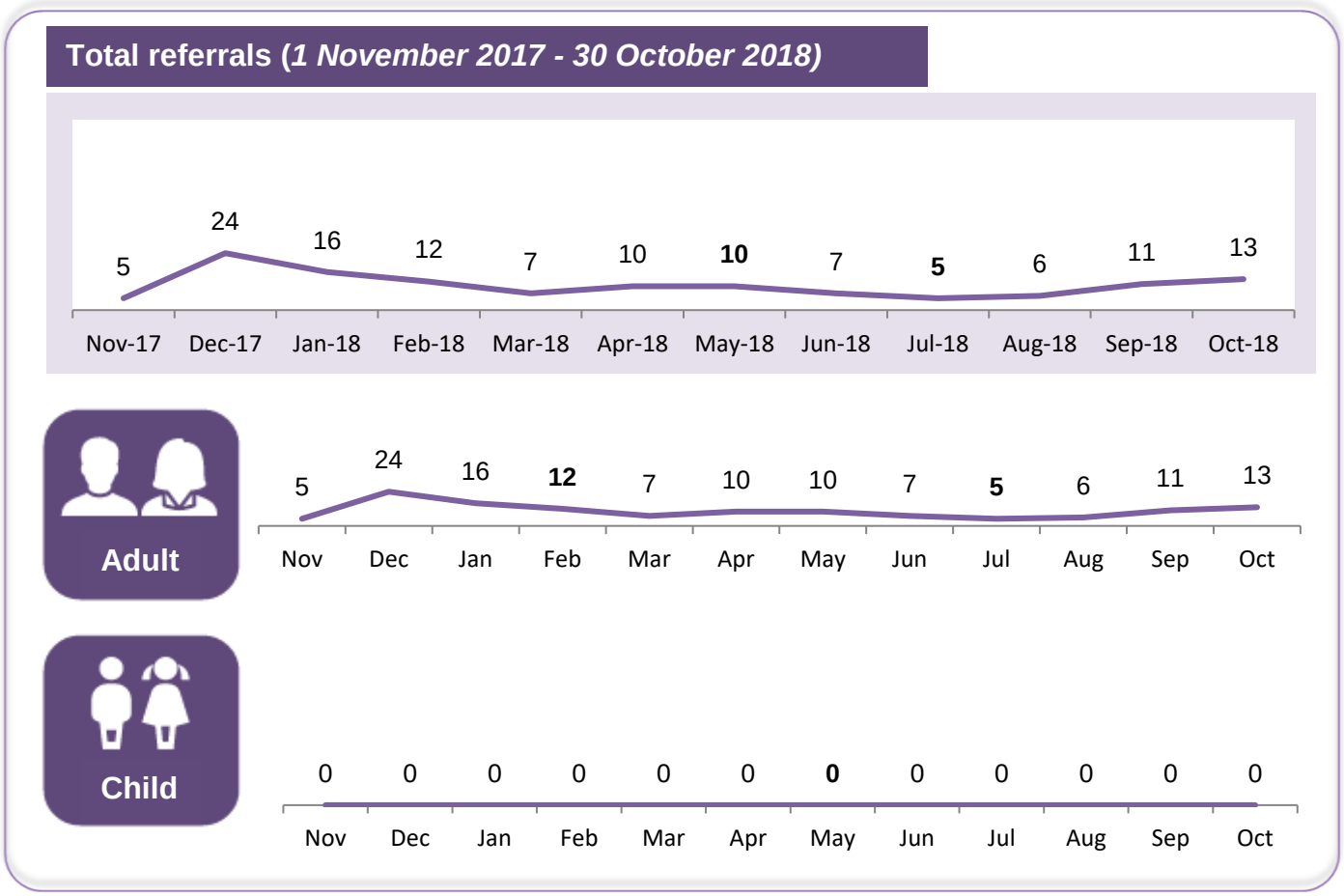
A safeguarding referral is a request from a member of the public or a professional to the local authority or the police to intervene to support or protect a child or vulnerable adult from abuse. Commonly recognised forms of abuse include: physical, emotional, financial, sexual, neglect and institutional.

Each authority has their own guidelines as to how to investigate and progress a safeguarding referral. Generally, if a concern is raised regarding a child or vulnerable adult, the organisation will work to ensure the safety of the person and an assessment of the concerns will also be conducted to determine whether an external referral to Children's Services, Adult Services or the police should take place.

This core service made 126 safeguarding referrals between 1 November 2017 and 31 October 2018, all of which concerned adults.

	Number of referrals		
Core service	**Adults**	**Children**	**Total referrals**
MH - Wards for older people with mental health problems	126	0	126

The number of adult safeguarding referrals in a month ranged from five to 24 (as shown below).



The trust has submitted details of no serious case reviews commenced or published in the last 12 months (20 November 2017 and 20 November 2018) that relate to this service.

Staff access to essential information

Staff completed patient records within an electronic patient record system. Patient notes were comprehensive and up to date.

When patients transferred to a new team, staff ensured that all key information was available to the receiving team.

Medicines management

We visited the clinics and observed medicines management on five wards, and reviewed 36 medication charts. Staff followed best practice when storing, dispensing and recording. There were effective systems in place for safe management and administration of medication. Staff had easy access to clinical information and maintained high quality clinical records. Pharmacist support was based on each ward across the week.

Staff followed national guidance and best practice in all aspects of medicines management.

Staff reviewed the effects of each patient's medication on their physical health according to National Institute for Health and Care Excellence guidance.

Track record on safety

Between 1 November 2017 and 31 October 2018 there were seven serious incidents reported by this service. Of the total number of incidents reported, the most common type of incident was 'Slips/trips/falls' with six.

We reviewed the serious incidents reported by the trust to the Strategic Executive Information System (STEIS) over the same reporting period. The number of the most severe incidents recorded by the trust incident reporting system was comparable with STEIS with seven reported.

A 'never event' is classified as a wholly preventable serious incident target should not happen if the available preventative measures are in place. This service reported zero never events during this reporting period.

All staff knew what incidents to report and how to report them. Staff reported all the incidents they should have.

Staff understood duty of candour. They were open, transparent and gave patients a full explanation when things went wrong.

Managers investigated incidents, gave feedback to staff and shared feedback from incidents outside the service.

Managers and staff made changes to practice because of incidents and feedback. Managers told us about a breach in information and action was taken across the wards.

Staff met regularly to discuss feedback and look at improvements to patient care.

Managers debriefed and supported staff after any serious incident.

	Number of incidents reported		
Type of incident reported (SIRI)	Slips/trips/falls meeting SI criteria	Pressure ulcer meeting SI criteria	**Total**
Assessment and Treatment - Logandene	1	0	**1**
Flower Wing - Victoria Court	1	0	**1**
Logandene	1	0	**1**
Seward Lodge - Female Wing	2	0	**2**
Tiger Wing - Victoria Court	0	1	**1**
Victoria Court	1	0	**1**
Total	**6**	**1**	**7**

Reporting incidents and learning from when things go wrong

The Chief Coroner's Office publishes the local coroners Reports to Prevent Future Deaths which all contain a summary of Schedule 5 recommendations, which had been made, by the local coroners with the intention of learning lessons from the cause of death and preventing deaths.

In the last two years, there have been no 'prevention of future death' reports sent to Hertfordshire Partnership NHS Trust.

Is the service effective?

Assessment of needs and planning of care

We reviewed 31 patient care records. There was a holistic approach to assessing, planning, and delivering care and treatment to people who used services. Staff assessed the physical and mental health needs of all patients on admission. They developed individual care plans and updated them when needed. Care records showed that a physical examination had been undertaken. There was ongoing monitoring of physical health problems.

Twenty-five care plans out of 31 were personalised, holistic and recovery-orientated. However, at Victoria Court six patients care records did not reflect holistic treatment goals or the patients voice. Overall staff had completed records to a high standard and records were up to date. Some patients had end of life care plans. All information needed to deliver care was stored securely and available to staff when they needed it.

Staff provided a range of treatment and care for patients based on national guidance and best practice. Patients had access to referral services, visual and hearing reviews, podiatry, wound care, specialist continence advisor and a tissue viability nurse. Each ward had a dedicated lead consultant clinician. A GP local doctor and community nurses attended wards regularly. We saw staff monitor patient's nutritional needs.

Best practice in treatment and care

Staff provided a range of care and treatment suitable for the patients in the service. Staff delivered care in line with best practice and national guidance including National Institute for Health and Care Excellence guidelines for the treatment of older people. These included involving patients and carers in care planning, physical healthcare support, use of as required medication, offering a range of meaningful activities to promote independence wherever possible, falls management, and protection of dignity.

Staff identified the physical health needs of patients and recorded them in patient care plans. Staff made sure patients had access to physical health care, including specialists as needed. Staff met patient's dietary needs, and assessed those needing specialist care for nutrition and hydration. Staff weighed patients throughout their stay.

We saw on Wren ward and Logandene, patients wearing non-slip socks as part of a pilot scheme. The scheme had been introduced by a physiotherapist, with the aim to reduce the risk of falls. On Lambourne Grove some patients were assessed as being at risk of falls and were provided with hip protectors.

Staff supported patients to live healthier lives by supporting them to take part in healthy eating, gentle exercise programmes, or giving advice.

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 reviewed ‘do not attempt resuscitation’ statements regularly with families and patients.

Staff had awareness of how to support people with hearing and visual impairment.

Staff took part in clinical audits, benchmarking and quality improvement initiatives, as detailed below.

This service participated in 20 clinical audits as part of their clinical audit programme 2017 – 2018.

Audit name	Audit scope	Core service	Audit type	Date completed	Key actions following the audit
Timeliness of Discharge Summaries being sent to the GP (Quarter 3)	Adult and Older Peoples Inpatient Wards	MH - Acute wards for adults of working age and psychiatric intensive care units, MH - Wards for older people with mental health problems, MH - Long stay/rehabilitation mental health wards for working age adults, MH - Wards for people with learning disabilities or autism	Clinical	01/02/2018	To share the findings of this report with teams. Ensure staff are aware of process. To review the acute inpatient operational policy.
Timeliness of Discharge Summaries being sent to the GP (Quarter 4)	Adult and Older Peoples Inpatient Wards	MH - Acute wards for adults of working age and psychiatric intensive care units, MH - Wards for older people with mental health problems, MH - Long stay/rehabilitation mental health wards for working age adults, MH - Wards for people with learning	Clinical	10/05/2018	Share findings with teams. Remind staff of requirements for discharge summaries. To set up quality improvement group to focus on improving quality. To present the audit at Medical staffing committee (MSC).

Audit name	Audit scope	Core service	Audit type	Date completed	Key actions following the audit
		disabilities or autism			
Hand Hygiene within HPFT-Q3 Report	Inpatient Wards	MH - Acute wards for adults of working age and psychiatric intensive care units, MH - Wards for older people with mental health problems, MH - Long stay/rehabilitation mental health wards for working age adults, MH - Wards for people with learning disabilities or autism, MH - Forensic inpatient, MH - Child and adolescent mental health wards	Environmental	25/01/2018	Actions for these audits are held locally
Hand Hygiene within HPFT-Q4 Report	Inpatient Wards	MH - Acute wards for adults of working age and psychiatric intensive care units, MH - Wards for older people with mental health problems, MH - Long stay/rehabilitation mental health wards for working age adults, MH - Wards for people with learning disabilities or	Environmental	10/05/2018	Actions for these audits are held locally

Audit name	Audit scope	Core service	Audit type	Date completed	Key actions following the audit
		autism, MH - Forensic inpatient, MH - Child and adolescent mental health wards			
CQUIN Risky Behaviours	Inpatient Wards	MH - Acute wards for adults of working age and psychiatric intensive care units, MH - Wards for older people with mental health problems, MH - Long stay/rehabilitation mental health wards for working age adults, MH - Wards for people with learning disabilities or autism	Clinical	09/08/2018	Forms part of a national CQUIN goal (Year 2)
Re-Audit of Falls in Older People Inpatient Units	Older People Inpatient Services	MH - Wards for older people with mental health problems	Clinical	18/01/2018	To share the report with relevant teams and the falls steering Group. To create a learning note of themes from serious incidents. Reminder to be sent to staff in regard to adherence to falls policy.
Audit of Capacity to Consent and Best Interest Assessments	Older People Inpatient Services	MH - Wards for older people with mental health problems	Clinical	15/03/2018	Communication to be sent to teams to remind them to complete the

Audit name	Audit scope	Core service	Audit type	Date completed	Key actions following the audit
					documentation on Paris using the appropriate Paris form so compliance can be picked up automatically via SPIKE. to discuss findings at the Patient Safety Meeting
7 Day Capacity to Consent (MHA)	Inpatient Wards	MH - Acute wards for adults of working age and psychiatric intensive care units, MH - Wards for older people with mental health problems, MH - Long stay/rehabilitation mental health wards for working age adults, MH - Wards for people with learning disabilities or autism, MH - Forensic inpatient, MH - Child and adolescent mental health wards	Clinical	18/01/2018	MHA team to meet with PG leads to develop local action plan. To discuss findings with Exec Director for Quality and Medical Leadership. To conduct a re-audit 6 monthly.
The Management of Diabetes within Inpatient wards in Hertfordshire	Inpatient Wards	MH - Acute wards for adults of working age and psychiatric intensive care units, MH - Wards for older people with mental health problems, MH - Long	Clinical	22/03/2018	To share the findings at the physical health committee. Design learning note, highlighting importance of recording glucose screening, care

Audit name	Audit scope	Core service	Audit type	Date completed	Key actions following the audit
		stay/rehabilitation mental health wards for working age adults, MH - Wards for people with learning disabilities or autism, MH - Forensic inpatient, MH - Child and adolescent mental health wards			plan, risk assessment.
Safe Use of High Risk medication In Elderly Organic Inpatient Assessment and Treatment Unit.	Inpatients	MH - Wards for older people with mental health problems	Clinical	29/03/2018	A standardised form has been created which will be used at initiation of antipsychotics in people with Dementia in HPFT and at 6 months if the patients are still under our care.
Information Governance - Clinical Record Keeping	CAMHS, Older Peoples Inpatient, EMDASS, Older People Community, LD Inpatient, LD Community, CATT, Psychiatric Liaison Teams, Acute Inpatient, Wellbeing	MH - Acute wards for adults of working age and psychiatric intensive care units, MH - Wards for older people with mental health problems, MH - Wards for people with learning disabilities or autism, MH - Forensic inpatient, MH - Child and adolescent	Clinical	14/06/2018	Annual Information Governance Training to be merged with Care Records & Confidentiality Training to make both courses mandatory. Compliance drive to meet the 95% requirement. To review the use of the SPIKE contingency and monitor feedback. To raise

Audit name	Audit scope	Core service	Audit type	Date completed	Key actions following the audit
		mental health wards			awareness of the naming structure throughout the Trust and ensure it is used through action plans and learning notes publicised throughout the Trust. Data Quality Checklist needs to be publicised and communicated effectively throughout the Trust to ensure its use at Clinical Supervision.
Nutrition & Dysphagia	Inpatient Wards	MH - Acute wards for adults of working age and psychiatric intensive care units, MH - Wards for older people with mental health problems, MH - Long stay/rehabilitation mental health wards for working age adults, MH - Wards for people with learning disabilities or autism, MH - Forensic inpatient, MH - Child and adolescent	Clinical	26/04/2018	Audit to be shared at the inpatient patient safety meeting and QRM. To develop a how to guide to completing the new Paris form. To promote nutrition & dysphagia e-learning video.

Audit name	Audit scope	Core service	Audit type	Date completed	Key actions following the audit
		mental health wards			
The PLACE (Patient Led Audit of the Care Environment) Annual Programme	Inpatient Wards	MH - Acute wards for adults of working age and psychiatric intensive care units, MH - Wards for older people with mental health problems, MH - Long stay/rehabilitation mental health wards for working age adults, MH - Wards for people with learning disabilities or autism, MH - Forensic inpatient, MH - Child and adolescent mental health wards	Environmental	14/11/2018	Carry out regular audits by Trust and Interserve, service user feedback forms to be collated in regard to food and hydration services.
Communication to GP	Inpatient & Adult Community	MH - Acute wards for adults of working age and psychiatric intensive care units, MH - Wards for older people with mental health problems, MH - Community-based mental health services for adults of working age.	Clinical	17/5/2018	To present findings at medical staffing committee. To be discussed at Physical health committee and agree dissemination route. Communicate findings to services. Communicate to CPA admin of the requirement to include date

Audit name	Audit scope	Core service	Audit type	Date completed	Key actions following the audit
					letter was sent to the GP.
Timeliness of Discharge Summaries being sent to the GP	Inpatient	MH - Acute wards for adults of working age and psychiatric intensive care units, MH - Wards for older people with mental health problems	Clinical	20/09/2018	As below
Timeliness of Discharge Summaries being sent to the GP	Inpatient	MH - Acute wards for adults of working age and psychiatric intensive care units, MH - Wards for older people with mental health problems	Clinical	20/09/2018	Reminder to be sent out to admin staff regarding attaching notifications on Paris. Monthly spot check to be conducted. To share audit requirements with Jr Doctors on the wards. Consultants to check every discharge notification prior to being sent to the GP for the first 2 weeks following Junior doctor starting on ward.
Section 132/133 (Rights for inpatients detained under the MHA 1983)	Inpatient	MH - Acute wards for adults of working age and psychiatric intensive care units, MH - Wards for older people with mental health problems, MH - Long stay/rehabilitation mental health	Clinical	12/07/2018	Service Line lead to disseminate information including Trust policy to staff.

Audit name	Audit scope	Core service	Audit type	Date completed	Key actions following the audit
		wards for working age adults, MH - Wards for people with learning disabilities or autism, MH - Forensic inpatient, MH - Child and adolescent mental health wards			
Inpatient Falls Audit	Trust wide Inpatient	MH - Acute wards for adults of working age and psychiatric intensive care units, MH - Wards for older people with mental health problems, MH - Long stay/rehabilitation mental health wards for working age adults, MH - Wards for people with learning disabilities or autism, MH - Forensic inpatient, MH - Child and adolescent mental health wards	Clinical	30/08/2018	Policy to be amended to reflect all services. Head of Nursing to hold discussions for FRA form to be built onto the EPR within care documents.
Self-Harm Audit	Inpatients/Community	MH - Acute wards for adults of working age and psychiatric intensive care units, MH - Wards for older people with	Clinical	07/11/2018	To complete a NICE compliance audit for EUPD trust-wide as this was the most common co-morbidity in

Audit name	Audit scope	Core service	Audit type	Date completed	Key actions following the audit
		mental health problems, MH - Wards for people with learning disabilities or autism, MH - Forensic inpatient, MH - Child and adolescent mental health wards			the self -harm audit Training in risk formulation to ensure a better understanding of protective factors and its use in managing risk Provide good understanding of EUPD and risks to HPFT Staff and countywide GPs
MHA Act - Assessment of Capacity within the First Seven Days of Admission to a Ward/Unit	Inpatient Wards	MH - Acute wards for adults of working age and psychiatric intensive care units, MH - Wards for older people with mental health problems, MH - Long stay/rehabilitation mental health wards for working age adults, MH - Wards for people with learning disabilities or autism, MH - Forensic inpatient	Clinical	07/11/2018	Clinical Leads to discuss requirements of completion of capacity assessments in relation to MHA and MCA within their SBU's. To re-audit in 6 months.

Skilled staff to deliver care

The service had access a range of specialists to meet the needs of the patients on the ward. Ward teams consisted of team leaders, nurses, healthcare assistants, consultant psychiatrists, junior doctors, occupational therapists, pharmacist, and volunteers. Matrons had individual responsibilities on wards. Wards had access to speech and language therapists and dietitians.

Staff knew how to access referral services such as dentistry, opticians, podiatry, wound care, phlebotomy, specialist infection control, tissue viability nurses, and community nurses.

Staff had the right skills, qualifications, and experience to meet the needs of the patients in their care. Managers ensured that new and newly qualified staff had opportunities to develop specialist skills and knowledge for their roles.

Staff on each ward had received the necessary specialist training for their role. Staff had received training in falls, end of life care, ligature awareness, dementia awareness, and innovative virtual dementia tour training, which included visual aids to give staff greater understanding of the experiences of patients with dementia. The training was requested by a staff member who had seen this elsewhere. Most staff found this training beneficial and aided their greater understanding of the patient experience. Some staff were dementia champions.

Staff had access to regular team meetings. Managers supported staff with coaching and opportunities to update and further develop their skills.

There was a clear approach for supporting and managing staff when their performance was poor or variable.

Managers supported staff through regular, constructive appraisals of their work.

The trust's target rate for appraisal compliance is 95%. At the end of last year (31 March 2018), the overall appraisal rate for non-medical staff within this service was 88%. This year so far, the overall appraisal rates was 99% (as at 30 September 2018). The team with the lowest appraisal rate at 30 September 2018 was MHSOP Admin & Modern Matrons with an appraisal rate of 75%.

Ward name	**Total number of permanent non-medical staff requiring an appraisal**	**Total number of permanent non-medical staff who have had an appraisal**	**% appraisals (as at September 2018)**	**% appraisals (previous year 1 April 2017 – 31 March 2018)**
Lambourn Grove Inpatient MHSOP	39	39	100%	89%
Logandene Inpatient MHSOP	26	26	100%	92%
MHSOP Admin & Modern Matrons	4	3	75%	75%
Core service total	**69**	**68**	**99%**	**88%**
Trust wide	**1467**	**1350**	**92%**	**88%**

Managers held records held locally, that confirmed staff had received their yearly appraisal.

We reviewed nine staff supervision records and found staff supervision was not consistent. Some staff told us they received supervision once a year, or every six to eight weeks. Staff knew the trust target was once every six weeks but not all staff had received this regularly. Supervision records were paper based and varied in quality. Some records were held locally, other records were incomplete or could not be located. Two managers were unable to show us any records, other records were chaotic. One manager told us they held supervisions but didn't always record them. Managers told us they did not know how to access the systems for recording staff supervision, and were awaiting training. Managers at Lambourne Grove and Logandene took immediate steps to update paper supervision records during the inspection.

Following the inspection, the trust provided supervision compliance rates for the end of February 2019:

- Seward Lodge 100%
- Logandene 100%
- Lambourne Grove 100%
- Kingsley Green Wren ward 81%
- Victoria Court 75%

Compliance for supervision rates could not be corroborated at a local level at the time of inspection.

Multi-disciplinary and interagency team work

Staff held regular multidisciplinary meetings to discuss patients and improve their care. Staff had daily safe calls with staff representatives from the five wards, the community mental health and bed management teams. Calls discussed patient acuity, staff deployment and risks. There was daily red to green meetings which included the matron and clinicians. Staff discussed each patient, and shared information about patient health conditions, presenting behaviours, medicine and care.

Staff made sure they shared clear information about patients and any changes in their care during handover meetings. Staff had access to a handover sheet that included key information about each patient, their status and observation levels.

Staff had effective working relationships with other teams in the organisation including safeguarding, and infection control.

Staff had effective working relationships with external teams and organisations, social care and community nursing teams.

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

Staff received training on the Mental Health Act and the Mental Health Act Code of Practice. Staff could describe how the Code of Practice and guiding principles affected their work roles.

As of 30 September 2018, 91% of the workforce in this service had received training in the Mental Health Act. The trust stated that this training is mandatory for all services for inpatient and all community staff and renewed every three years.

The training compliance reported during this inspection was higher than the 88% reported for the previous year.

Staff had access to support and advice on implementing the Mental Health Act and its Code of Practice. Staff knew who their Mental Health Act administrators were and when to ask them for support.

The service had clear, accessible, relevant, and up to date policies and procedures that reflected all relevant legislation and the Mental Health Act Code of Practice. We saw information for patients, visitors, and carers on the notice boards about how patients could access information on independent mental health advocacy.

Staff explained to each patient their rights under the Mental Health Act in a way that they could understand, repeated as necessary and recorded this in the patient's notes each time. Staff made sure patients could take section 17 leave (permission to leave the hospital) when the Responsible

Clinician. Staff requested an opinion from a second opinion appointed doctor when they needed to. Staff stored copies of patient's detention papers and associated records correctly. Staff could access them when they needed to.

Care records showed when staff had advised informal patients they could leave the ward if they wished. There were signs on exit doors telling informal patients of their rights and how to leave the ward.

Care plans included information about after care services available for those patients who qualified for section 117 aftercare under the Mental Health Act.

Managers and staff made sure the service applied the Mental Health Act correctly by completing audits and acting upon findings.

Good practice in applying the Mental Capacity Act

Staff received training in the Mental Capacity Act, and had a good understanding of the five key principles.

As of 30 September 2018, 94% of the workforce in this service had received training in the Mental Capacity Act. The trust stated that this training is mandatory for all services for inpatient and all community staff and renewed three years.

The training compliance reported during this inspection was higher than the 90% reported for the previous year.

The trust told us that 145 Deprivation of Liberty Safeguard (DoLS) applications were made to the Local Authority for this service between 1 November 2017 to 31 October 2018.

The greatest number of DoLS applications were made in July 2018 with 21.

CQC received 107 direct notifications from the trust between 1 November 2017 to 31 October 2018[1]. This is not comparable to the number of DoLS submitted in the Provider Information Request (145).

	Number of 'Standard' DoLS applications made by month												
	Nov 17	**Dec 17**	**Jan 18**	**Feb 18**	**Mar 18**	**Apr 18**	**May 18**	**Jun 18**	**Jul 18**	**Aug 18**	**Sep 18**	**Oct 18**	**Total**
Standard applications made	13	15	18	11	13	13	13	9	21	3	11	5	**145**
Standard applications approved	2	0	5	1	2	1	0	0	1	0	0	0	**12**

The trust told us that 144 urgent Deprivation of Liberty Safeguard (DoLS) applications were made to the Local Authority for this service between 1 November 2017 to 31 October 2018.

The greatest number of urgent DoLS applications were made in July 2018 with 21.

[1] DoLS CRM Analysis

	Number of 'Urgent' DoLS applications made by month												
	Nov 17	**Dec 17**	**Jan 18**	**Feb 18**	**Mar 18**	**Apr 18**	**May 18**	**Jun 18**	**Jul 18**	**Aug 18**	**Sep 18**	**Oct 18**	**Total**
Urgent applications made	13	15	18	11	13	13	12	9	21	3	11	5	**144**
Urgent applications approved	2	0	5	1	2	1	0	0	0	1	0	0	**17**

There was a clear policy on Mental Capacity Act and Deprivation of Liberty Safeguards, which staff could describe and knew how to access. Staff knew where to get accurate advice on Mental Capacity Act and Deprivation of Liberty Safeguards.

Staff gave patients support to make specific decisions for themselves before deciding a patient did not have the capacity to do so. Staff assessed and recorded capacity to consent each time a patient needed to make an important decision. There were also consent to treatment forms attached to all medical charts.

When staff assessed patients as not having capacity, they made decisions in the best interest of patients and considered the patient's wishes, feelings, culture and history.

Staff only made applications for a Deprivation of Liberty Safeguards authorisation when necessary, and monitored the progress of these applications.

Managers carried out audits on how well it adhered to the Mental Capacity Act and made changes to practice when necessary.

Staff audited how they applied the Mental Capacity Act and acted when they needed to make changes to improve.

Is the service caring?

Kindness, privacy, dignity, respect, compassion and support

We observed positive and caring interactions between staff and patients on the wards. Feedback from patients and those who were close to the patients was positive about the way staff treated people. Fourteen out of the fifteen comment cards commented upon how staff were always helpful. "Staff are caring and treat patients with respect." "Staff provide a calm and reassuring atmosphere."

Staff ensured patients personal preferences in relation to food and drink choices, bed time and clothing were respected. Staff at Lambourne Grove and Logandene provided material aprons to ensured patients dignity when eating and drinking.

Staff at Lambourne Grove were compassionate and responsive and met the wishes of a dying patient for a large bed to be provided, so their partner could join them in bed at the end of life.

Staff anticipated patients' needs and could give help, emotional support and advice when they needed it. Staff supported patients to understand and manage their own care, treatment and condition.

At Kingsley Green Wren ward one patient's dignity was not protected. A patient was observed semi dressed by a member of the CQC inspection team in a multi-use room. The multi-use room is used by different wards for visiting families and carers. This was reported to staff on duty who agreed to act, and ensure the window is reviewed for privacy.

The 2018 Patient-Led Assessments of the Care Environment (PLACE) score for privacy, dignity and wellbeing at four service location(s) scored higher than similar organisations.

Victoria Court (86.6%) scored lower when compared to other similar trusts for privacy, dignity and wellbeing.

Site name	Core service(s)	Privacy, dignity and wellbeing
Lambourn Grove	MH - Wards for older people with mental health problems	100.0%
Logandene	MH - Wards for older people with mental health problems	97.5%
Seward Lodge	MH - Wards for older people with mental health problems	97.2%
Victoria Court	MH - Wards for older people with mental health problems	86.6%
Elizabeth Court	MH - Wards for older people with mental health problems	93.8%
Trust overall		**90.9%**
England average (mental health and learning disabilities)		**90.6%**

Involvement in care

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 consulted patients about advanced decisions when they or their family members wanted to do this. Where patients did not have capacity to understand this process, staff involved family members in any discussions or decision making.

Staff contacted family members to attend any multidisciplinary meetings, ward rounds, or care programme approach meetings.

Involvement of patients

Staff supported patients to maintain and develop their relationships with those close to them, and their social networks in the community. At Lambourne Grove, staff held regular community meetings for patients. On Seward Lodge, Logandene and Lambourn Grove, the occupational therapy team ran community meetings when they had service users able to follow group conversation and cognitively were able to engage in the meeting.

At Victoria Court six patients care records sampled lacked evidence of patient's involvement and the patients voice.

Involvement of families and carers

Staff gave family and carers a welcome pack about the ward. This included how the ward worked, what updates they could expect and how they could contact ward staff if needed.

At Lambourne Grove we saw staff had made with patients and their families and carers, a memory parcel which was held in the lounge. Patients, staff, families and carers could talk with the patient about the memorable objects in the parcel.

Is the service responsive?

Access and discharge

Bed management

The trust provided information regarding average bed occupancies for seven wards in this service between 1 November 2017 to 31 October 2018.

Three of the wards within this service reported average bed occupancies ranging above the minimum benchmark of 85% for all months during this period.

At the time of inspection, the trust had closed The Stewarts and combined Elizabeth Court and Victoria Court.

Ward name	**Average bed occupancy range ((1 November 2017 – 31 October 2018) (current inspection)**
Elizabeth Court	10 – 82%
Lambourn Grove	97 – 100%
Logandene	89 – 100%
Seward Lodge	73 – 101%
The Stewarts	61 – 100%
Victoria Court	95 – 100%
Kingsley Green	80 – 99%

The trust provided information for average length of stay for the period 1 November 2017 to 31 October 2018.

Ward name	**Average length of stay in days range (1 November 2017 – 31 October 2018) (current inspection)**
Elizabeth Court	196 – 3110
Lambourn Grove	210 – 1532
Logandene	15 – 132
Seward Lodge	47 – 272
The Stewarts	46 – 149
Victoria Court	541 – 3424
Kingsley Green	28 - 51

This service reported no out area placements between 1 November 2017 to 31 October 2018.

There were no out of area placements across wards at the time of inspection.

This service reported two readmissions within 28 days between 1 November 2017 to 31 October 2018. None of the readmissions were readmissions to the same ward as discharge. The average of days between discharge and readmission was nine days. There were no instances whereby patients were readmitted on the same day as being discharged and there were no instances where patients were readmitted the day after being discharged.

Ward name	Number of readmissions (to any ward) within 28 days	Number of readmissions (to the same ward) within 28 days	% readmissions to the same ward	Range of days between discharge and readmission	Average days between discharge and readmission
Wren ward	1	0	0%	6	6
Logandene ward	1	0	0%	12	12

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.

The psychiatric intensive care unit always had a bed available if a patient needed more intensive care. This was sufficiently close for the person to maintain contact with family and friends.

Discharge and transfers of care

Between 1 November 2017 to 31 October 2018 there were 334 discharges within this service. This amounts to 17% of the total discharges from the trust overall (1950).

Delayed discharges across the 12-month period ranged from five to 13 per month. There was a total of 116 delayed discharges which amounts to 35% of the total discharges for this core service.

The service had some delayed discharges. Staff told us the delays were due to lack of local authority funding or availability of placements. The service was trying to address this issue by closer liaison with discharge teams, community mental health, adult social care and early supported discharge planning.

Managers and staff ensured they did not discharge patients before they were ready. We saw clear discharge plans in care records. Managers and staff used a red to green tracking system to monitor patients progress towards discharge.

Staff ensured that patients and carers had copies of all discharge paperwork including any aftercare plans.

Staff supported patients and their families when transferring between services. The service followed national standards for transfer.

Facilities that promote comfort, dignity and privacy

Services had a full range of rooms and equipment to support treatment and care. Managers told us wards had been refurbished to meet dementia standards. There were quiet areas on the wards where patients could meet visitors. Patients could make and receive phone calls in private, or on the hands-free phone or ward phone.

Patients had their own bedroom, which they could personalise. We saw in bedrooms brief information displayed- Knowing me- Knowing you, that provided a short narrative about the person and their life history. Some bedrooms had ensuite facilities with sufficient disabled toilets and bathroom facilities on wards. There were activity and therapy rooms including sensory rooms, large dining areas, adapted baths and shower facilities. Some wards had extra-large bedrooms with full facilities to accommodate extra-care. Seward lodge and Victoria Court had bedrooms with bedrooms doors that would swing and convert to a male or female bedroom with ensuite facilities. The trust provided falls sensor mats, standardised hoists and ultra-lowering beds.

Patients had areas to secure their possessions.

All wards had access to outside space. This included safety surface path, handrails, benches, bird table, and trees shrubs and plants. In 2017, Logandene won the Building better healthcare awards 2017 for 'Best External Environment'. Since the service was last inspected (2015) all units had undergone a refurbishment programme. Refurbishment plans considered every aspect of daily life for someone with dementia. The exception was at Victoria Court where the environment did not promote recovery. The ward was drab in some places and not pleasant or welcoming. There were some works planned for the kitchen and replacement of furniture. The garden area was fenced in with thick wire panels.

Patients had access to a range of food and drink choices including healthy snacks. Staff provided specialist feeding aids, food choices including vegetarian, specialist food consistencies, and supplements to meet assessed need.

At Victoria Court, the team recently changed the location of the dining rooms and the lounges to give service users more freedom of movement and reduce the risk of service users falling over objects in their paths. However, staff had not updated the signage following these changes, which was confusing for patients.

There was access to activities, including at weekends. We observed patients in the sensory room, at breakfast club, reading newspapers, and participating in a sing along led by a volunteer on keyboard. On Seward ward the occupational therapist had obtained an adapted table tennis table with raised sides. Only two people out of 15 fifteen comment cards, had stated there were not enough activities and stimulation for patients.

The 2018 Patient-Led Assessments of the Care Environment (PLACE) score for ward food at Lambourn Grove and Logandene scored higher than similar trusts.

There were three locations including Seward Lodge (75.1%), Victoria Court (83.5%) and Elizabeth Court (87.4%) that scored lower than other similar trusts for ward food.

Site name	Core service(s)	Ward food
Lambourn Grove	MH - Wards for older people with mental health problems	94.2%
Logandene	MH - Wards for older people with mental health problems	92.2%
Seward Lodge	MH - Wards for older people with mental health problems	75.1%

Site name	Core service(s)	Ward food
Victoria Court	MH - Wards for older people with mental health problems	83.5%
Elizabeth Court	MH - Wards for older people with mental health problems	87.4%
Trust overall		**84.8%**
England average (mental health and learning disabilities)		**91.5%**

At the time of inspection, the trust had combined Elizabeth Court and Victoria Court.

Patients' engagement with the wider community

Staff made sure patients had access to opportunities to engage in meaningful activity, including gardening and involvement in ward activities such as cooking and card making. Where necessary staff supported patients to access these activities.

Staff helped patients to stay in contact with families and carers.

Staff encouraged patients to develop and maintain relationships both in the service and the wider community.

Meeting the needs of all people who use the service

For the most recent Patient-Led Assessments of the Care Environment (PLACE) (2018) the locations scored higher than similar trusts for the environment being dementia friendly and scored higher than similar trusts for the environment supporting those with disabilities.
The service could support and make adjustments for people with disabilities, communication needs or other specific needs.

Information leaflets for patients in different language were not routinely available. Managers and staff were not confident with how this would be provided. Managers made sure staff and patients could arrange interpreters or signers when needed.

On all wards staff gave patients and their families and carers welcome packs that gave key information, including information on treatment, local services, how to contact CQC, their rights and how to complain.

The service offered good quality and a variety of food. Patients could choose their meal from a menu of food each day. The menus catered for special dietary requirements, including kosher and vegetarian options. Patients could access snacks and drinks throughout the day and night.

Patients had access to spiritual, religious, and cultural support. The chaplain visited wards regularly.

Site name	Core service(s)	Dementia friendly	Disability
Lambourn Grove	MH - Wards for older people with mental health problems	94.9%	92.3%
Logandene	MH - Wards for older people with mental health problems	93.5%	89.8%

Seward Lodge	MH - Wards for older people with mental health problems	93.7%	89.8%
Victoria Court	MH - Wards for older people with mental health problems	87.8%	86.6%
Elizabeth Court	MH - Wards for older people with mental health problems	87.6%	93.4%
Trust overall		**88.7%**	**81.9%**
England average (Mental health and learning disabilities)		**84.8%**	**86.3%**

At the time of inspection, the trust had combined Elizabeth Court and Victoria Court.

Listening to and learning from concerns and complaints

This service received nine complaints between 1 November 2017 to 31 October 2018. One of these was upheld, four were partially upheld and one was not upheld. None were referred to the Ombudsman.

One manager told us about a complaint around a breach of information. Lessons were learnt, and improvements were put in place across wards. Seward Lodge received one complaint in February 2019 around patient care, which were still under investigation. Patients and their carers and families knew how to complain or raise concerns. Staff understood the policy on complaints and knew how to handle them. We saw information displayed on wards around Patient Advice and Liaison Service (PALS).

Staff received feedback from managers after investigations, we saw evidence of this in team meeting minutes.

Ward name	Total Complaints	Fully upheld		Partially upheld	Not upheld	Other	Under Investigation	Withdrawn	Referred to Ombudsman
Seward Lodge	**3**	0		0	1	0	2	0	0
The Stewarts	**2**	0		2	0	0	0	0	0
Elizabeth and Victoria Court	**1**	0		1	0	0	0	0	0

Ward name	Total Complaints	Fully upheld		Partially upheld	Not upheld	Other	Under Investigation	Withdrawn	Referred to Ombudsman
Lambourn Grove	**1**	1		0	0	0	0	0	0
Logandene	**1**	0		1	0	0	0	0	0
Wren Ward	**1**	0		0	0	0	1	0	0

At the time of inspection, the trust had combined Elizabeth Court and Victoria Court.

This service received 79 compliments during the last 12 months from 1 November 2017 and 31 October 2018 which accounted for 5% of all compliments received by the trust as a whole.

Is the service well led?

Leadership

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. The trust gave opportunity for leaders to develop their skills and for other staff to develop leadership skills. Staff reported they respected their local leaders and supported them. Patients and staff knew who the ward leaders were, they were visible on the wards and staff reported they were approachable. However, Victoria Court leaders needed more support.

Vision and strategy

Staff knew and understood the trusts vision, values and strategic goals. However, some staff at Victoria Court were unsure about service plans. Staff included the trusts values in the ward welcome packs for patients, families and carers.

Culture

Staff felt respected, supported and valued by their team, and local and senior managers. Staff felt proud to work for their team and the trust. Staff told us about being valued and received “A birthday day” time off in recognition of hard work for a CQC inspection in 2018.

Staff felt they could raise concerns without fear. Staff understood the ‘speaking up’ policy and knew about the speak up guardian.

Managers supported staff who needed it to perform their jobs. We saw effective team working on all wards, and good staff morale. Managers dealt with any difficulties when they happened.

Staff were open and transparent and explained to patients when something went wrong.

Managers supported staff during their appraisals and discussed career progression and development. One staff member had just returned from a year secondment and told us there were opportunities for leadership development.

The trust promoted equality and diversity.

The service sickness levels were 6% higher than the trust average of 4.5 %, but lower than the previous 12 months.

The trust supported their staff with access to occupational health services.

Staff made us aware of examples where the trust had recognised staff success and innovation in this core service. Staff had suggested and introduced non- slip socks and ensured standardised hoists.

Governance

Managers received mandatory training and yearly appraisals. Shifts were covered by sufficient numbers of staff at the right grade and experience. Staff took part in local clinical audits and acted on the results. Staff learned from incidents, complaints and patient feedback. Safeguarding and Mental Health Act and Mental Capacity Act procedures were followed. Staff implemented recommended changes following reviews of the service. Managers had sufficient authority and administrative support.

Management of risk, issues and performance

The service had a designated officer in the organisation with lead responsibility for the protection of vulnerable adults.

Effective daily safe care calls and red to green multidisciplinary meetings on all wards helped to reduce patient risks and keep patients and staff safe.

Managers kept the risk register up to date and knew how to escalate any concerns.

The service had clear plans for dealing with emergencies and staff understood these.

Managers made sure that cost improvements did not compromise patient care.

Information management

The systems to collect ward and directorate data did not create extra work for frontline staff. The system in place for recording staff supervision were not fully implemented and did not provide assurance that staff were receiving regular supervision.

Information governance systems included policy on confidentiality of patient records.

Team managers had access to information that supported them.

All information was accessible, usually accurate and identified areas for improvement.

Staff notified and shared information with external organisations when necessary, seeking patient consent when required to do so. However, managers and staff were not familiar with the trusts guidance and policies around eliminating mixed sex accommodation.

Engagement

Staff, patients, and their carers could access up to date information about the services they used, and the trust, through the trust web site.

Most patients and carers could give feedback about their care and in ways that reflected their individual needs. Managers used the feedback from patients and carers to make improvements to the service.

Most managers and staff involved patients, families and carers in decisions about changes to the service at ward level.

Directorate leaders engaged with external stakeholders.

Learning, continuous improvement and innovation

Staff were involved in service improvements and some staff had made suggestions which had been put into practice for example risk reduction from falls, anti-slip socks, virtual dementia tour training.

Managers supported staff to take part in research, when appropriate.

Staff knew about quality improvement methods and could apply them.

Accreditation of services[2] (Exception reporting only) (Internal use only - Remove before publication)

NHS trusts are able to participate in a number of accreditation schemes whereby the services they provide are reviewed and a decision is made whether or not to award the service with an accreditation. A service will be accredited if they are able to demonstrate that they meet a certain standard of best practice in the given area. An accreditation usually carries an end date (or review date) whereby the service will need to be re-assessed in order to continue to be accredited.

There have been no accreditations awarded to this core service.

Some wards were working towards the accreditation scheme quality network of older adult's mental health service (QNOAMHS).

MH - Community-based mental health services for adults of working age

Facts and data about this service

Location site name	Team name	Number of clinics	Patient group (male, female, mixed)
Saffron Ground	PATH (East & North)- First Episode Psychosis Team	n/a	Mixed
Saffron Ground	Adult Community MH Team - North	North Team (Letchworth and Hitchin) - O/P, 72 per month Stevenage Team-O/P, 48 per month. Clozapine Clinic- 8 days a month-across all sites Physical health clinics-8 days a month-across all sites Depot Clinics-8 days a month across all sites Initial Assessments' 126 slots provided a month overall	Mixed
Oxford House	Adult Community MH Team - East and South-East Oxford House	E&SE adult community: Daily Initial Assessment 'clinics' and outpatient 'clinics' in each team against each Consultant Psychiatrist, plus 1 -2x depot, 1x Clozaril and 1x physical health clinics in Rosanne and Cygnet, and 2 clinics at Holly Lodge each week. Oxford House is too small to justify depot/Clozaril/physical health clinics.	Mixed

Cygnet House	Adult Community MH Team E&SE	E&SE adult community: Daily Initial Assessment 'clinics' and outpatient 'clinics' in each team against each Consultant Psychiatrist, plus 1 -2x depot, 1x Clozaril and 1x physical health clinics in Rosanne and Cygnet, and 2 clinics at Holly Lodge each week. Oxford House is too small to justify depot/Clozaril/physical health clinics.	Mixed
Rosanne House	Adult Community MH Team - East and South-East Rosanne House	E&SE adult community: Daily Initial Assessment 'clinics' and outpatient 'clinics' in each team against each Consultant Psychiatrist, plus 1 -2x depot, 1x Clozaril and 1x physical health clinics in Rosanne and Cygnet, and 2 clinics at Holly Lodge each week. Oxford House is too small to justify depot/Clozaril/physical health clinics.	Mixed
Borehamwood Civic Centre	Adult Community MH Team - South West Borehamwood	52 clinics per month	Mixed
Colne House	Adult Community MH Team - South West Colne House	56 clinics per month	Mixed
The Marlowes Health and Wellbeing Centre	Adult Community MH Team - North West	40 per month	Mixed

Centenary House	Adult Community MH Team - North	North Team (Letchworth and Hitchin) - O/P, 72 per month Stevenage Team-O/P, 48 per month. Clozapine Clinic- 8 days a month-across all sites Physical health clinics-8 days a month-across all sites Depot Clinics-8 days a month across all sites Initial Assessments' 126 slots provided a month overall	Mixed
The Orchards	Acute Day Treatment Unit - The Orchards		Mixed
Holly Lodge	Adult Community MH Team - East and South-East Holly Lodge	E&SE adult community: Daily Initial Assessment 'clinics' and outpatient 'clinics' in each team against each Consultant Psychiatrist, plus 1 -2x depot, 1x Clozaril and 1x physical health clinics in Rosanne and Cygnet, and 2 clinics at Holly Lodge each week. Oxford House is too small to justify depot/Clozaril/physical health clinics.	Mixed
Lister Hospital	Acute Day Treatment Unit - Glaxo Unit	n/a	Mixed
Kingsley Green	PATH - First Episode Psychosis Team (West)	n/a	Mixed

HMP The Mount Kingsley Green	Community Criminal Justice and Forensic Mental Health	n/a	Male
Waverley Road	Adult Community Team - North West	64 per month	Mixed

The methodology of CQC provider information requests has changed, so some data from different time periods is not always comparable. We only compare data where information has been recorded consistently.

Is the service safe?

Safe and clean environment

Managers conducted regular risk environmental assessments of the care environment. However, staff were not able to share these with us.

There was no ligature audit assessment in place for any of the community locations inspected in line with the trust's current policy. However, staff were aware of the potential risks and mitigated these. Patients were accompanied at all times whilst accessing clinics or outpatient appointments. The trust told us that the undertaking of ligature risk assessments for community services was under review. In future assessment of both the environment and ligature risks will be undertaken. The Trust had completed an action plan by the time of reporting. This was submitted to the trust's safety committee on 21st March 2019.

Staff had access to personal alarms when meeting with patients in interview rooms. Staff were aware of the local procedure, and staff were available on site to respond to alarms.

All team bases had well-equipped clinic rooms, which had the necessary equipment to carry out physical examinations. Staff checked and calibrated all equipment.

All areas were clean, well kempt, had good furnishings and were well maintained. We saw cleaning records which were up to date. Staff regularly cleaned the environment.

Infection control and handwashing posters were visible within clinical areas. Staff adhered to infection control principles including hand washing and use of alcohol gel, both in clinical areas and when working out in the community. Equipment was well-maintained and clean, however not all equipment had clean stickers which were visible and in date.

Safe staffing

Nursing staff

This core service has reported a vacancy rate for all staff of 15% as of 30 September 2018. This was not comparable to the data used at the last inspection (between September 2015).

This core service reported an overall vacancy rate of 23% for registered nurses at 30 September 2018.

This core service reported an overall vacancy rate of 12% for nursing assistants.

		Registered nurses			Health care assistants			Overall staff figures		
Location	**Ward/Team**	**Vacancies**	**Establishment**	**Vacancy rate (%)**	**Vacancies**	**Establishment**	**Vacancy rate (%)**	**Vacancies**	**Establishment**	**Vacancy rate (%)**
Centenary House	Centenary House Site Costs	0.0	0.0	0%	1.0	1.0	100%	1.0	1.0	100%
Borehamwood Civic Offices	Civic Centre	0.0	0.0	0%	0.0	0.0	0%	1.0	1.0	100%

		Registered nurses			Health care assistants			Overall staff figures		
Location	**Ward/Team**	**Vacancies**	**Establishment**	**Vacancy rate (%)**	**Vacancies**	**Establishment**	**Vacancy rate (%)**	**Vacancies**	**Establishment**	**Vacancy rate (%)**
Cygnet House	CLOSED Support & Treatment E & SE Herts	2.0	2.0	100%	0.0	0.0	0%	3.0	3.0	100%
Centenary House	Targeted Treatment N Herts	1.0	1.0	100%	0.0	0.0	0%	1.0	1.0	100%
Rosanne House	Targeted Treatment E & SE Herts	0.0	0.0	0%	0.0	0.0	0%	1.0	1.0	100%
Colne House	Carers Development Team	1.6	2.2	72%	3.5	3.5	100%	5.9	6.5	91%
Centenary House	Community Services N Herts	0.0	0.0	0%	0.0	0.0	0%	4.8	6.8	70%
Colne House	Colne House Reception	0.0	0.0	0%	0.0	0.0	0%	1.0	2.0	50%
Kingsley Green	Criminal Justice & Forensic	1.0	1.0	100%	0.0	0.0	0%	2.0	5.3	38%
Cygnet House	AMH Comm Services Cygnet House	5.0	9.6	52%	1.1	12.2	9%	9.1	27.8	33%
Rosanne House	PATH East & North Herts	4.0	9.2	43%	5.0	19.6	26%	10.6	35.4	30%
Waverley Road	Community Services NW Herts	0.0	0.0	0%	1.5	3.5	43%	1.5	5.9	26%
Borehamwood Civic Offices	AMH Comm Services SW Herts Borehamwood	2.0	5.0	40%	0.5	6.0	8%	5.1	23.4	22%
Saffron Ground	AMH Community Medical North	0.0	0.0	0%	0.0	0.0	0%	1.5	8.1	18%

		Registered nurses			Health care assistants			Overall staff figures		
Location	**Ward/Team**	**Vacancies**	**Establishment**	**Vacancy rate (%)**	**Vacancies**	**Establishment**	**Vacancy rate (%)**	**Vacancies**	**Establishment**	**Vacancy rate (%)**
New Leaf College	Wellbeing Recovery College	0.0	0.0	0%	-0.4	1.0	-40%	0.6	3.6	16%
Colne House	AMH Comm Services SW Herts Watford	4.1	11.4	36%	-0.3	11.8	-3%	6.9	43.5	16%
Marlowes Health Centre	AMH Comm Services NW Herts Dacorum	1.4	7.8	18%	0.4	14.1	3%	5.7	36.3	16%
Rosanne House	Community Services E & SE Herts	1.0	2.0	50%	1.0	3.0	33%	3.0	23.1	13%
Rosanne House	Family Safeguarding Team	0.9	1.5	64%	0.0	1.0	0%	1.0	7.5	13%
Oxford House	AMH Community Services Oxford House	2.0	2.0	100%	-0.4	2.6	-16%	0.9	7.9	12%
Colne House	AMH Comm Services SW Herts	0.0	1.0	0%	1.3	5.7	23%	2.4	21.1	11%
Rosanne House	AMH Community Services Rosanne	0.6	9.5	6%	0.0	11.8	0%	3.6	32.2	11%
The Orchards	PATH West Herts	1.0	11.0	9%	1.9	17.8	11%	4.2	37.8	11%
Rosanne House	AMH Community Medical East	0.0	0.0	0%	0.0	0.0	0%	1.3	12.4	11%
Centenary House	AMH Comm Services Centenary & Jubilee	0.0	12.6	0%	3.2	17.1	19%	3.6	38.9	9%
The Orchards	ADTU Orchards	0.0	4.6	0%	1.0	4.5	22%	1.0	14.0	7%

		Registered nurses			Health care assistants			Overall staff figures		
Location	**Ward/Team**	**Vacancies**	**Establishment**	**Vacancy rate (%)**	**Vacancies**	**Establishment**	**Vacancy rate (%)**	**Vacancies**	**Establishment**	**Vacancy rate (%)**
Waverley Road	ADTU CATT Medical	0.0	0.0	0%	0.0	0.0	0%	0.8	10.8	7%
Lister Hospital	ADTU East & North	0.0	4.0	0%	-1.0	3.0	-33%	0.9	13.1	7%
Waverley Road	AMH Comm Services NW Herts St Albans	0.4	6.2	6%	-1.0	9.0	-11%	1.4	31.5	5%
Saffron Ground	Saffron Ground Site Costs	0.0	0.0	0%	0.6	2.6	23%	0.1	3.1	3%
Waverley Road	AMH Community Medical NW	0.0	0.0	0%	0.0	0.0	0%	0.0	9.6	0%
Bowlers Green	Criminal Justice Mental Health	0.0	2.0	0%	0.0	0.0	0%	0.0	3.0	0%
Cygnet House	Cygnet House Site Costs	0.0	0.0	0%	0.0	1.0	0%	0.0	1.0	0%
Holly Lodge	Holly Lodge Site Costs	0.0	0.0	0%	0.0	1.0	0%	0.0	1.0	0%
Oxford House	Oxford House Site Costs	0.0	0.0	0%	1.0	1.5	69%	0.0	2.5	0%
HMP The Mount	Prison In-Reach HMP The Mount	0.0	3.0	0%	0.0	1.0	0%	0.0	4.6	0%
Waverley Road	Reception 99 Waverly Road	0.0	0.0	0%	0.0	0.0	0%	0.0	2.0	0%
Rosanne House	Rosanne House Site Costs	0.0	0.0	0%	0.0	0.0	0%	0.0	2.8	0%

		Registered nurses			Health care assistants			Overall staff figures		
Location	**Ward/Team**	**Vacancies**	**Establishment**	**Vacancy rate (%)**	**Vacancies**	**Establishment**	**Vacancy rate (%)**	**Vacancies**	**Establishment**	**Vacancy rate (%)**
Saffron Ground	AMH Comm Services Saffron Ground	-0.6	3.8	-16%	1.0	10.0	10%	-0.8	29.0	-3%
Holly Lodge	AMH Comm Services Holly Lodge	-1.0	2.0	-47%	0.0	4.5	0%	-0.6	11.5	-5%
Waverley Road	AMH Community Medical SW	0.0	0.0	0%	0.0	0.0	0%	-0.8	9.2	-9%
Marlowes Health Centre	Marlowes Health Centre HPFT	0.0	0.0	0%	0.0	0.0	0%	-3.1	1.0	-311%
	Core service total	**26.5**	**114.4**	**23%**	**20.9**	**169.7**	**12%**	**78.9**	**541.9**	**15%**
	Trust total	**178.1**	**853.7**	**21%**	**124.2**	**1063.0**	**12%**	**440.3**	**3375.9**	**13%**

NB: All figures displayed are whole-time equivalents

Between 1 November 2017 and 31 October 2018, 14,730 working hours were filled by bank staff to cover sickness, absence or vacancy for qualified nurses.

The main reason for bank and agency usage for the wards/teams was vacancies.

In the same period, agency staff covered 37,183 working hours for qualified nurses and 179 hours were unable to be filled by either bank or agency staff.

Caveat: the total hours available data provided by the trust was inconclusive and therefore this, along with the percentages of bank, agency and not filled hours has not been included.

Wards	**Total hours available**	**Bank Usage**		**Agency Usage**		**NOT filled by bank or agency**	
		Hrs	**%**	**Hrs**	**%**	**Hrs**	**%**
ADTU E&N	n/a	741	n/a	0	n/a	153	n/a
ADTU Shrodells	n/a	1635	n/a	0	n/a	4	n/a

Wards	Total hours available	Bank Usage		Agency Usage		NOT filled by bank or agency	
		Hrs	%	Hrs	%	Hrs	%
AMH Community Services (Borehamwood)	n/a	621	n/a	3317	n/a	0	n/a
AMH Community Services (Watford)	n/a	568	n/a	9424	n/a	0	n/a
Community Services E &SE Herts	n/a	0	n/a	820	n/a	0	n/a
Community Services N Herts	n/a	0	n/a	543	n/a	0	n/a
Community Services NW Herts Dacorum	n/a	759	n/a	4414	n/a	0	n/a
Community Services NW Herts St Albans	n/a	1702	n/a	4154	n/a	0	n/a
Criminal Justice & Forensic	n/a	447	n/a	0	n/a	0	n/a
Path West HERTS	n/a	271	n/a	3515	n/a	22	n/a
Support & Treatment E &SE (Adult Community)	n/a	51	n/a	5847	n/a	0	n/a
Support & Treatment N Herts (Adult Community)	n/a	2082	n/a	1205	n/a	0	n/a
Targeted Treatment E&SE (Adult Community)	n/a	4774	n/a	2939	n/a	0	n/a
Targeted Treatment N Herts (Adult Community)	n/a	1079	n/a	1004	n/a	0	n/a
Carers Development Team	n/a	0	n/a	0	n/a	0	n/a

Wards	Total hours available	Bank Usage		Agency Usage		NOT filled by bank or agency	
		Hrs	%	Hrs	%	Hrs	%
Core service total	**n/a**	**14730**	**n/a**	**37183**	**n/a**	**179**	**n/a**
Trust Total	**n/a**	**225857**	**n/a**	**99260**	**n/a**	**12096**	**n/a**

Between 1 November 2017 and 31 October 2018, 9,323 working hours were filled by bank staff to cover sickness, absence or vacancy for nursing assistants.

The main reason for bank and agency usage for the wards/teams was vacancies.

In the same period, agency staff covered 2,579 hours and 876 hours were unable to be filled by either bank or agency staff.

Caveat: the total hours available data provided by the trust was inconclusive and therefore this, along with the percentages of bank, agency and not filled hours has not been included.

Wards	Total hours available	Bank Usage		Agency Usage		NOT filled by bank or agency	
		Hrs	%	Hrs	%	Hrs	%
ADTU E&N	n/a	1562	n/a	0	n/a	204	n/a
ADTU Shrodells	n/a	1068	n/a	0	n/a	0	n/a
AMH Community Services (Borehamwood)	n/a	685	n/a	0	n/a	0	n/a
AMH Community Services (Watford)	n/a	724	n/a	0	n/a	0	n/a
Community Services E &SE Herts	n/a	102	n/a	672	n/a	204	n/a
Community Services N Herts	n/a	7	n/a	0	n/a	0	n/a

Wards	Total hours available	Bank Usage		Agency Usage		NOT filled by bank or agency	
		Hrs	%	Hrs	%	Hrs	%
Community Services NW Herts Dacorum	n/a	29	n/a	0	n/a	0	n/a
Community Services NW Herts St Albans	n/a	204	n/a	0	n/a	0	n/a
Criminal Justice & Forensic	n/a	267	n/a	0	n/a	0	n/a
Path West HERTS	n/a	1831	n/a	354	n/a	0	n/a
Support & Treatment E &SE (Adult Community)	n/a	356	n/a	1232	n/a	161	n/a
Support & Treatment N Herts (Adult Community)	n/a	827	n/a	0	n/a	0	n/a
Targeted Treatment E&SE (Adult Community)	n/a	796	n/a	321	n/a	307	n/a
Targeted Treatment N Herts (Adult Community)	n/a	703	n/a	0	n/a	0	n/a
Carers Development Team	n/a	161	n/a	0	n/a	0	n/a
Core service total	**n/a**	**9323**	**n/a**	**2579**	**n/a**	**876**	**n/a**
Trust Total	**n/a**	**386308**	**n/a**	**52970**	**n/a**	**32577**	**n/a**

This core service had 68.7 (15%) staff leavers between 1 October 2017 and 30 September 2018. This was not comparable to the data used at the last inspection (between September 2015).

Location	Ward/Team	Substantive staff (at latest month)	Substantive staff Leavers over the last 12 months	Average % staff leavers over the last 12 months
Oxford House	AMH Community Services Oxford House	7.0	7.1	107%
Centenary House	Community Services N Herts	2.0	2.0	77%
Colne House	Carers Development Team	0.6	1.6	57%
Rosanne House	Rosanne House Site Costs	2.8	1.0	49%
Cygnet House	AMH Comm Services Cygnet House	18.7	7.4	36%
The Orchards	ADTU Orchards	13.0	5.0	36%
Waverley Road	Community Services NW Herts	4.4	2.0	35%
Lister Hospital	ADTU East & North	12.2	4.1	34%
Oxford House	Oxford House Site Costs	2.5	1.0	34%
Colne House	AMH Comm Services SW Herts	17.6	4.2	27%
Rosanne House	PATH East & North Herts	23.8	3.0	26%
Holly Lodge	AMH Comm Services Holly Lodge	12.1	2.8	26%
Saffron Ground	Saffron Ground Site Costs	3.0	0.5	21%
The Orchards	First Episode Psychosis FEP	2.0	7.1	21%
Marlowes Health Centre	AMH Comm Services NW Herts Dacorum	30.6	4.9	17%
HMP The Mount	Prison In-Reach HMP The Mount	4.6	0.7	14%
Colne House	AMH Comm Services SW Herts Watford	36.6	4.4	13%
Waverley Road	AMH Community Medical SW	10.0	1.0	12%
The Orchards	PATH West Herts	33.6	1.0	11%
Borehamwood Civic Offices	AMH Comm Services SW Herts Borehamwood	18.3	2.0	10%
Rosanne House	Community Services E & SE Herts	20.0	2.0	10%
Waverley Road	AMH Comm Services NW Herts St Albans	30.1	2.0	7%
Rosanne House	AMH Community Services Rosanne House	28.6	1.0	4%

Location	Ward/Team	Substantive staff (at latest month)	Substantive staff Leavers over the last 12 months	Average % staff leavers over the last 12 months
Saffron Ground	AMH Comm Services Saffron Ground	29.8	0.8	3%
Centenary House	AMH Comm Services Centenary & Jubilee	33.7	0.2	1%
Waverley Road	ADTU CATT Medical	9.7	0.0	0%
Rosanne House	AMH Community Medical East	10.7	0.0	0%
Waverley Road	AMH Community Medical NW	9.1	0.0	0%
Saffron Ground	AMH Community Medical North	6.6	0.0	0%
Waverley Road	AMH Community Medical Trainees	1.6	0.0	0%
Colne House	Colne House Reception	1.0	0.0	0%
Kingsley Green	Criminal Justice & Forensic	3.3	0.0	0%
Bowlers Green	Criminal Justice Mental Health	3.0	0.0	0%
Cygnet House	Cygnet House Site Costs	1.0	0.0	0%
Rosanne House	Family Safeguarding Team	5.5	0.0	0%
Holly Lodge	Holly Lodge Site Costs	1.0	0.0	0%
Marlowes Health Centre	Marlowes Health Centre HPFT	4.1	0.0	0%
Waverley Road	Reception 99 Waverly Road	2.0	0.0	0%
Centenary House	Support & Treatment N Herts	0.0	0.0	0%
Centenary House	Targeted Treatment N Herts	0.0	0.0	0%
Rosanne House	Targeted Treatment E & SE Herts	0.0	0.0	0%
New Leaf College	Wellbeing Recovery College	3.0	0.0	0%
Core service total		**459.0**	**68.7**	**15%**
Trust Total		**2903.4**	**461.5**	**16%**

The sickness rate for this core service was 4.3% between 1 October 2017 and 30 September 2018. The most recent month's data (September 2018) showed a sickness rate of 2.9%. This was not comparable to the data used at the last inspection (between September 2015).

Location	Ward/Team	Total % staff sickness (at latest month)	Ave % permanent staff sickness (over the past year)
Colne House	Carers Development Team	0.0%	18.6%
Oxford House	Oxford House Site Costs	18.5%	14.1%
Colne House	Colne House Reception	0.0%	13.5%
Centenary House	Targeted Treatment N Herts	n/a	10.3%
The Orchards	ADTU Orchards	4.0%	7.8%
Oxford House	AMH Community Services Oxford House	12.5%	7.7%
Waverley Road	Single Point of Access	8.3%	7.6%
Rosanne House	PATH East & North Herts	0.1%	7.4%
Holly Lodge	AMH Comm Services Holly Lodge	10.3%	7.3%
Borehamwood Civic Offices	AMH Comm Services SW Herts Borehamwood	4.8%	7.1%
The Orchards	First Episode Psychosis FEP	0.0%	6.1%
Rosanne House	AMH Community Services Rosanne House	5.8%	6.0%
Marlowes Health Centre	AMH Comm Services NW Herts Dacorum	0.2%	5.5%
Rosanne House	Rosanne House Site Costs	0.0%	5.1%
Rosanne House	Community Services E & SE Herts	3.4%	4.6%
Rosanne House	Targeted Treatment E & SE Herts	n/a	4.4%
Saffron Ground	AMH Comm Services Saffron Ground	0.4%	4.2%
Colne House	AMH Comm Services SW Herts Watford	3.7%	3.8%
Cygnet House	AMH Comm Services Cygnet House	1.5%	3.8%
HMP The Mount	Prison In-Reach HMP The Mount	1.4%	3.1%
Waverley Road	AMH Comm Services NW Herts St Albans	3.7%	2.7%
Borehamwood Civic Offices	Civic Centre	30.0%	2.3%
Colne House	AMH Comm Services SW Herts	0.4%	2.1%
Kingsley Green	Criminal Justice & Forensic	0.0%	1.9%
Lister Hospital	ADTU East & North	0.5%	1.6%
Waverley Road	ADTU CATT Medical	0.0%	1.5%
Centenary House	Centenary House Site Costs	n/a	1.1%
The Orchards	PATH West Herts	1.0%	1.1%
Centenary House	Community Services N Herts	0.0%	0.9%
Rosanne House	AMH Community Medical East	5.1%	0.9%

Location	Ward/Team	Total % staff sickness (at latest month)	Ave % permanent staff sickness (over the past year)
Waverley Road	AMH Community Medical NW	0.0%	0.8%
Cygnet House	Cygnet House Site Costs	0.0%	0.8%
Cygnet House	CLOSED Support & Treatment E & SE Herts	n/a	0.8%
Centenary House	AMH Comm Services Centenary & Jubilee	0.2%	0.7%
Waverley Road	Holly Lodge Site Costs	0.0%	0.6%
Waverley Road	AMH Community Medical SW	2.9%	0.5%
Saffron Ground	Saffron Ground Site Costs	0.0%	0.3%
Waverley Road	Community Services NW Herts	0.7%	0.1%
Saffron Ground	AMH Community Medical North	0.5%	0.0%
Waverley Road	AMH Community Medical Trainees	n/a	0.0%
The Stewarts	CLOSED The Meadows Inpatient MHSOP	n/a	0.0%
Bowlers Green	Criminal Justice Mental Health	0.0%	0.0%
Rosanne House	Family Safeguarding Team	0.0%	0.0%
Marlowes Health Centre	Marlowes Health Centre HPFT	0.0%	0.0%
Shrodells Unit	Reception 99 Waverly Road	0.0%	0.0%
Centenary House	Support & Treatment N Herts	n/a	0.0%
Core service total		**2.9%**	**4.3%**
Trust Total		**3.7%**	**4.5%**

Medical staff

Between 1 November 2017 and 31 October 2018, of the 66,918 total working hours available, <1% were filled by bank staff to cover sickness, absence or vacancy for medical locums.

The main reason for bank and agency usage for the wards/teams was vacancies.

In the same period, agency staff covered 16% of available hours and <1% of available hours were unable to be filled by either bank or agency staff.

Ward/Team	Total hours available	Bank Usage		Agency Usage		NOT filled by bank or agency	
		Hrs	%	Hrs	%	Hrs	%
Acute Day Treatment Unit	8640	0	0%	1639	19%	0	0%
Adult Community MH Team - South West	5760	0	0%	2201	38%	0	0%

Ward/Team	Total hours available	Bank Usage		Agency Usage		NOT filled by bank or agency	
		Hrs	%	Hrs	%	Hrs	%
Adult Community MH Team - South West	20512	1	<1%	2152	10%	0	0%
Adult Community MH Team E&SE	7296	0	0%	1701	23%	0	0%
Adult Community MH Team - East and South East	9216	1	<1%	2181	24%	0	0%
Adult Community MH Team - North	15494	0	0%	1036	7%	1	<1%
Core service total	**66918**	**2**	**<1%**	**10909**	**16%**	**1**	**<1%**
Trust Total	**146022**	**418**	**<1%**	**21401**	**15%**	**1**	**<1%**

Managers ensured there were sufficient staff with the right experience and knowledge to deliver safe care and treatment for patients. Managers had determined safe staffing levels by calculating the number and grade of members of the multidisciplinary team required using a systematic approach.

The numbers, profession and grades of staff in post did not match the trust's staffing plan for all teams. Managers reported a high turnover of staff in some of the bases. However, managers were taking part in active recruitment campaigns. Managers matched the number of staff in post with the use of agency staffing.

Managers had assessed the size of the caseloads of individual staff regularly, and helped staff manage the size of their caseloads. Managers provided support both in case management supervision and in the weekly team meeting. Staff had caseload sizes depending on their level of experience, other duties and seniority. Managers gave newly qualified staff lower caseloads which were protected, and slowly increased caseload sizes depending on skills, experience and competencies, to a maximum of 25 patients for junior staff. However, experienced staff had an average caseload of 30 patients. Staff told us that these were caseload sizes were in line with trust policy.

Managers had ensured that cover arrangements were in place for sickness, leave and vacant posts in each of the teams, to ensure patient safety. This included support from duty, reallocation of higher risk patients and the use of courtesy calls. Staff conducted these calls to assess patients' current mental health status, level of risk and took immediate action where required. Managers used locum and agency staff on long term contracts, where additional staff were required. This ensured that staff knew the service and promoted continuity of care.

Staff and patients had rapid access to a psychiatrist when required. Staff reported that psychiatrists could be accessed the same day for urgent enquiries, and they were always accessible for advice and support.

Mandatory training

The compliance for mandatory and statutory training courses at 30 September 2018 was 84%. Of the training courses listed 23 failed to achieve the trust target and of those, six failed to score above 75%.

The trust set a target of 92% for completion of mandatory and statutory training.

The trust reports a year end figure for training compliance.

The training compliance reported for this core service during this inspection was the same as the 84% reported in the previous year.

Key:

Below CQC 75%	Met trust target ✓	Not met trust target ✗	Higher ↑	No change →	Lower ↓

Training Module	Number of eligible staff	Number of staff trained	YTD Compliance (%)	Trust Target Met	Compliance change when compared to previous year
Equality, Diversity & Human Rights [3 Years]	539	501	93%	✓	↓
Safeguarding Adults Level 1 [3 Years]	136	126	93%	✓	↑
Safeguarding Adults Level 2 [3 Years]	403	366	91%	✗	↑
Safeguarding Children Level 1 [3 Years]	119	108	91%	✗	↑
Infection, Prevention & Control Level 1 [2 Years]	136	123	90%	✗	↑
Mental Capacity Act and Deprivation of Liberty Safeguards [3 Years]	295	260	88%	✗	↓
Care Records and Confidentiality Awareness [3 Years]	280	245	88%	✗	↓
Health, Safety & Welfare [3 Years]	539	467	87%	✗	↓
Data Security Awareness [1 Year]	539	465	86%	✗	↓
Infection, Prevention & Control Level 2 [2 Years]	403	347	86%	✗	↑
Fire Safety [2 Years]	437	374	86%	✗	↑
Mental Health Act [3 Years]	284	242	85%	✗	↓
Clinical Risk Assessment and Management [3 Years]	290	247	85%	✗	↓
Safeguarding Children Level 2 [3 Years]	352	298	85%	✗	↑

Training Module	Number of eligible staff	Number of staff trained	YTD Compliance (%)	Trust Target Met	Compliance change when compared to previous year
Preventing Radicalisation (WRAP) [Once]	342	280	82%	✗	↑
Fire Safety [1 Year]	44	36	82%	✗	↑
Moving and Handling L1 [3 Years]	292	230	79%	✗	↓
Intermediate Life Support (includes BLS) [1 Year]	52	40	77%	✗	↓
Basic Life Support [1 Year]	291	220	76%	✗	↓
Moving and Handling L2 [2 Years]	247	185	75%	✗	↓
Ligature Awareness [3 years]	16	11	69%	✗	↓
Relating to People Mod 3b [1 Year]	306	203	66%	✗	↑
Relating to People Mod 3a [3 Years]	83	55	66%	✗	↓
Safeguarding Children Level 3 [3 Years]	13	8	62%	✗	↓
Relating to People Mod 4 [1 Year]	3	1	33%	✗	→
Total	**6441**	**5438**	**84%**	✗	↑

Staff advised that they had received and were up to date with appropriate mandatory training. However, we were unable to see the overall mandatory training figure for each team. Managers advised that this was due to the introduction of a new learning and development database. The trust was aware of this and were actively taking steps to address this.

Assessing and managing risk to patients and staff

Assessment of patient risk

Staff had completed a comprehensive risk assessment for every patient at initial assessment and when patients were assessed for treatment. Staff discussed the outcome of risk assessments at the weekly multi-disciplinary meetings, where the team agreed risk management plans. Managers also attended regular risk panels where the outcome of serious incident investigations and subsequent learning was discussed and shared.

Staff updated risk assessments and risk management plans every six months and after any incident. We saw that all patient risk assessments were comprehensive and up to date.

Staff used the risk assessment tool embedded in the electronic health record. The risk assessment tool was dynamic, examined current and historic risk, protective risk factors and contained a risk management plan.

Some staff had created and made use of crisis safety plans and advance decisions called 'my emergency plan', using a toolkit for advanced decisions for some patients. However, these were not widely utilised.

Management of patient risk

Staff responded promptly to sudden deterioration in a patient's health. Staff rated the patients' current level of risk and discussed any deterioration in the weekly multidisciplinary meeting. Staff escalated any concerns to the consultant psychiatrist, managers and senior staff where needed.

Staff robustly monitored patients who were on waiting lists for treatment or psychology. Managers had introduced a system in all teams, for ensuring that staff made courtesy calls and visits to higher risk patients whilst they were awaiting team allocation. The number of patients awaiting allocation was 108. The average wait for allocation was 67 days, and the longest wait for allocation was 353 days.

The service had developed good personal safety protocols. These included a lone working policy, lone working devices, arrangements for visiting higher risk patients in pairs or at the team bases, and signing in and out boards, which was proactively used.

Safeguarding

A safeguarding referral is a request from a member of the public or a professional to the local authority or the police to intervene to support or protect a child or vulnerable adult from abuse. Commonly recognised forms of abuse include: physical, emotional, financial, sexual, neglect and institutional.

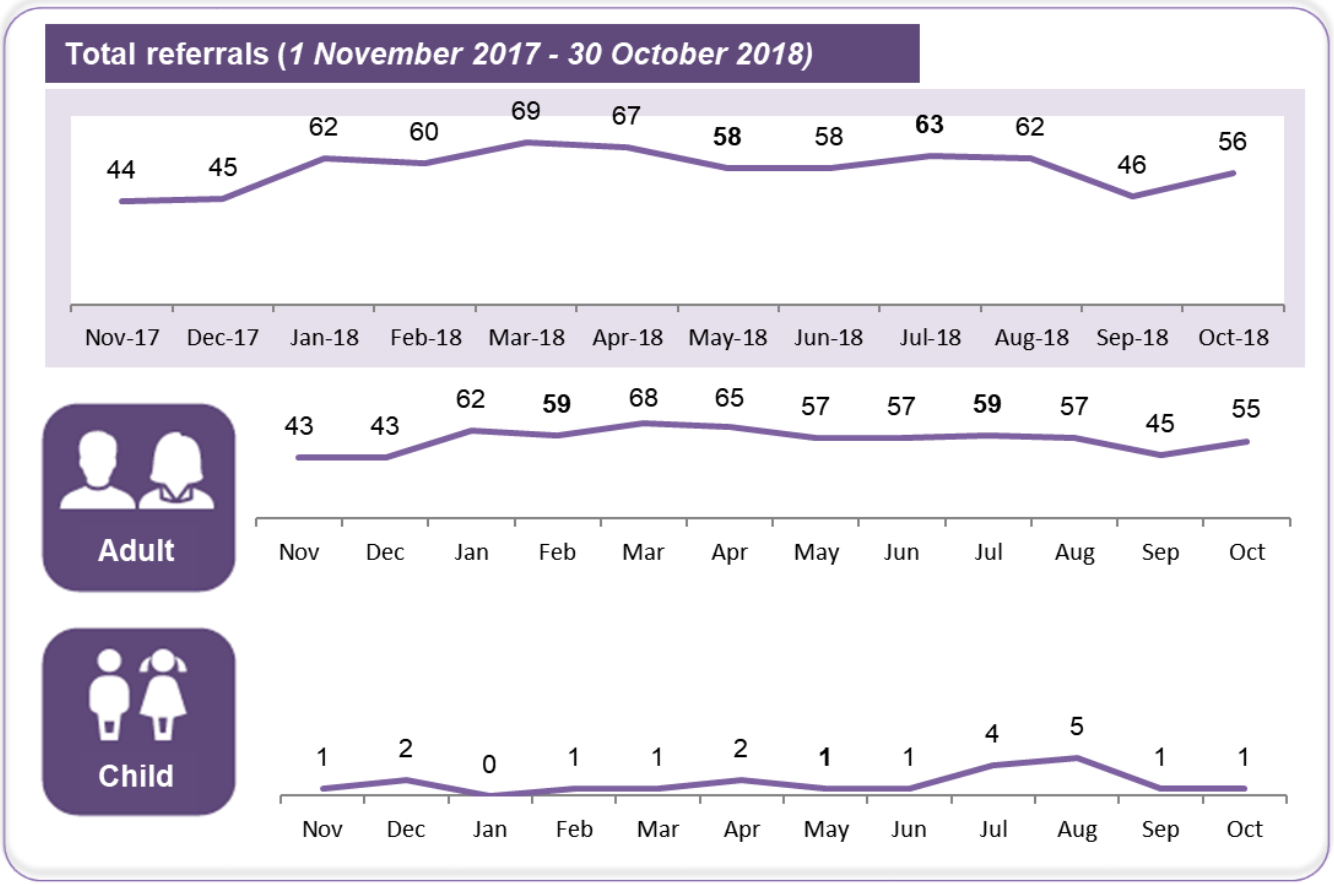
Each authority has their own guidelines as to how to investigate and progress a safeguarding referral. Generally, if a concern is raised regarding a child or vulnerable adult, the organisation will work to ensure the safety of the person and an assessment of the concerns will also be conducted to determine whether an external referral to Children's Services, Adult Services or the police should take place.

This core service made 690 safeguarding referrals between 1 November 2017 and 31 October 2018, of which 670 concerned adults and 20 children. This was not comparable to the data used at the last inspection (between September 2015).

	Number of referrals		
Core service	**Adults**	**Children**	**Total referrals**
MH - Community-based mental health services for adults of working age	670	20	690

The number of adult safeguarding referrals in a month ranged from 44 to 69 (as shown below).

The number of child safeguarding referrals ranged from zero to five (as shown below).



The trust had robust safeguarding arrangements in place. Staff were trained in safeguarding, knew how to make a safeguarding alert, and did so when appropriate. The trust had taken over full responsibility from the county council for adult safeguarding. This involved the investigation and progression of safeguarding concerns and alerts, and the chairing of safeguarding meetings.

Staff were trained to identify, log and investigate safeguarding concerns. Senior team staff were trained to chair safeguarding meetings. Managers held a weekly safeguarding meeting where staff discussed ongoing safeguarding cases.

Staff could give examples of how to protect patients from harassment and discrimination, including those with protected characteristics under the Equality Act.

Staff knew how to identify adults and children at risk of, or suffering, significant harm. This included working in partnership with other agencies, including the police, multi-agency safeguarding hub (MASH), probation and child safeguarding.

The trust has submitted details of one serious case review commenced or published in the last 12 months (1 November 2017 and 20 November 2018) that relate to this service.

Reference Number	Team/Ward/Unit	Recommendations	Actions Taken	Outstanding Actions
SAR 'Stanley'	Adult Community Mental Health Team – East and South East	1. Assurance to be sought that there is evidence across the Trust of use of Wellbeing Plans to support full consideration of Wellbeing outcomes in keeping with the principles of the Care Act 2014.	1. Wellbeing Plan Audit	No outstanding actions

Reference Number	Team/Ward/Unit	Recommendations	Actions Taken	Outstanding Actions
		2. Seek assurance that psychiatric liaison teams are inviting the care co-ordinator and/or other involved professional/agencies to Frequent Attender meetings. This will ensure a holistic approach to dealing with crises when they occur in situations where a person is resistant to support	2. psychiatric liaison teams provided minutes and case examples as evidence	No outstanding actions
		3. In complex cases, when more than one agency is involved, ensure HPFT are working to Delivery of Care Policy incorporating principles of the Care Programme Approach.	3. Audit of adult mental health service users who are on CPA to ensure that the policy is being adhered to.	No outstanding actions
		4. In line with work undertaken in the East & South East Improvement Project ensure that learning from this case is shared and considered with the project lead.	4. Learning note circulated across Herts. Rolling programme of self-neglect workshops for staff in investigating teams	No outstanding actions
		5. Review risk assessment documentation and systems on PARIS to ensure that the risk assessment is personalised and integrates the person's perspective and their wishes throughout in keeping with the principles of the Wellbeing Plan and the Emergency Care Plan.	5. Audit of risk assessment and crisis planning.	No outstanding actions

Staff access to essential information

The service used an electronic health record. All information needed to deliver patient care was available to all relevant staff (including agency staff) when they needed it, and in an accessible form. This included when patients moved between teams. However, several staff described the electronic health record as slow and time consuming.

Staff could access information from previous records. However, staff described this process as difficult and time consuming. Managers had reported this concern and told us that the trust was aware and was actively addressing this issue.

Medicines management

Staff followed good practice in medicines management (that is, transport, storage, dispensing, administration, recording, disposal). Staff did this in line with national guidance in most of the teams. However, we saw one isolated incident when a staff member took some medication out of the medication cabinet. Staff have access to lockable bags for transportation of medication. The staff member had not signed the medication out, and transported it to the patient in their handbag.

Staff reviewed regularly the effects of medication on patients' physical health. This included reviews of patients who were prescribed antipsychotic medication or mood stabilisers. Staff ran a physical health clinic, and conducted physical checks in line with best practice, utilising the Lester tool, which focused on patient cardiometabolic health. Staff undertook physical health checks prior to every care programme approach meeting. These reviews were line with guidance from the National Institute for Health and Care Excellence. Managers distributed a bi-monthly medication training updates and guidance electronically.

The trust had a robust new clinical model in place for the management of patients who were on clozapine medication. This included the taking and analysing of patient bloods on site in the clinic, enabling staff to interface to the denzapine monitoring system. This has enabled staff to monitor, prescribe and administer medication the same day. Managers have provided updated and improved e-learning for staff and pharmacy has delivered education and training for all. Patient feedback following the introduction of this new model has been positive, and that medication management had improved. We saw the outcome of one survey which showed that 70% of patients had reported waiting times for the clozapine clinic had significantly improved. Ninety-three per cent of patients reported that the clinic was much better than before as they could collect their medication. Patients told us that this was a positive change and that they found the continuity of staff in the clinic beneficial.

Track record on safety

Between 1 November 2017 and 31 October 2018 there were 45 serious incidents reported by this service. Of the total number of incidents reported, the most common type of incident was 'unexpected death' with 27.

We reviewed the serious incidents reported by the trust to the Strategic Executive Information System (STEIS) over the same reporting period. The number of the most severe incidents recorded by the trust incident reporting system was mostly comparable with STEIS with 44 incidents reported for this core service, although one serious incident could not be reconciled with the STEIS data.

A 'never event' is classified as a wholly preventable serious incident that should not happen if the available preventative measures are in place. This service reported zero never events during this reporting period.

This was not comparable to the data used at the last inspection (September 2015).

	Number of incidents reported								
Type of incident reported (SIRI)	Unexpected Death	Apparent/actual/suspected self-inflicted harm meeting SI criteria	Violence & aggression meeting SI criteria	Abuse/alleged abuse of adult patient by third party	Adverse media coverage or public concern about the organisation or the wider NHS	Apparent/actual/suspected homicide meeting SI criteria	Apparent/actual/suspected self inflicted harm meeting SI criteria	Homicide	**Total**
The Support and Treatment Team (North)	4	3	0	0	0	0	0	0	7
The Support and Treatment Team (South West)	3	0	0	1	0	0	0	0	4
The Targeted Treatment Team (East and South East)	3	0	0	0	1	0	0	0	4
The Targeted Treatment Team (North)	1	1	1	1	0	0	0	0	4
Initial Assessment Team East and South East	1	0	0	0	0	0	0	1	2
North Support & Treatment Team	1	0	1	0	0	0	0	0	2
The Support and Treatment Team (North West)	2	0	0	0	0	0	0	0	2
Targeted Treatment Team North West	2	0	0	0	0	0	0	0	2

	Number of incidents reported								
Type of incident reported (SIRI)	Unexpected Death	Apparent/actual/suspected self-inflicted harm meeting SI criteria	Violence & aggression meeting SI criteria	Abuse/alleged abuse of adult patient by third party	Adverse media coverage or public concern about the organisation or the wider NHS	Apparent/actual/suspected homicide meeting SI criteria	Apparent/actual/suspected self inflicted harm meeting SI criteria	Homicide	**Total**
Acute Day Treatment Unit - East and North Herts (Lister)	1	0	0	0	0	0	0	0	1
East & South-East Community Mental Health Team Holly Lodge	1	0	0	0	0	0	0	0	1
East & South-East Community Mental Health Team Rosanne house	1	0	0	0	0	0	0	0	1
Initial Assessment Team North	0	1	0	0	0	0	0	0	1
Initial Assessment Team North west	1	0	0	0	0	0	0	0	1
Initial Assessment Team South West	1	0	0	0	0	0	0	0	1
North West Adult Mental Health Services	1	0	0	0	0	0	0	0	1
North West Adult Mental Health Services Dacorum	1	0	0	0	0	0	0	0	1

	Number of incidents reported								
Type of incident reported (SIRI)	Unexpected Death	Apparent/actual/suspected self-inflicted harm meeting SI criteria	Violence & aggression meeting SI criteria	Abuse/alleged abuse of adult patient by third party	Adverse media coverage or public concern about the organisation or the wider NHS	Apparent/actual/suspected homicide meeting SI criteria	Apparent/actual/suspected self inflicted harm meeting SI criteria	Homicide	**Total**
North West Targeted Treatment Team	1	0	0	0	0	0	0	0	1
North West Targeted Treatment Team	0	0	1	0	0	0	0	0	1
Psychosis Prevention Assessment & Treatment in Hertfordshire East and North	0	1	0	0	0	0	0	0	1
Psychosis Prevention Assessment & Treatment in Hertfordshire WEST	1	0	0	0	0	0	0	0	1
The Support and Treatment Team (North West)	0	1	0	0	0	0	0	0	1
The Support and Treatment Team (East and South East)	0	0	0	0	0	0	1	0	1
The Support and Treatment Team (East and South East), Crisis Assessment & Treatment Team	0	1	0	0	0	0	0	0	1

	Number of incidents reported								
Type of incident reported (SIRI)	Unexpected Death	Apparent/actual/suspected self-inflicted harm meeting SI criteria	Violence & aggression meeting SI criteria	Abuse/alleged abuse of adult patient by third party	Adverse media coverage or public concern about the organisation or the wider NHS	Apparent/actual/suspected homicide meeting SI criteria	Apparent/actual/suspected self inflicted harm meeting SI criteria	Homicide	**Total**
The Support and Treatment Team (South West) - Borehamwood	0	0	0	0	1	0	0	0	1
The Targeted Treatment Team (East and South East) - Cygnet House	0	0	0	0	0	1	0	0	1
The Targeted Treatment Team South West	1	0	0	0	0	0	0	0	1
Total	**27**	**8**	**3**	**2**	**2**	**1**	**1**	**1**	**45**

Reporting incidents and learning from when things go wrong

Staff knew which incidents to report and reported these on the electric reporting system. Staff reported all incidents as required. Staff knew how to raise safety concerns.

Staff learnt from incidents and told us they valued the lessons learning process which was embedded in the teams. Staff showed an understanding of lessons learnt from incidents both within the team, community services and the organisation. Staff and managers provided examples of where practice had changed, and processes improved following learning from incidents. Staff

told us of one example, where investigation had highlighted problems with record keeping. The outcome of an investigation highlighted that all relevant communication had not been entered into the patients' electronic health. The learning was that all communication about patient's, including correspondence via e-mail, must be entered onto the electronic health record. We saw evidence of this in-patient records. Staff received feedback from investigations of incidents both internal and external to the service. The service analysed and discussed these at their business and governance meetings. Managers shared learning from incidents with staff electronically, via incident learning posters which we saw in all team bases, through shift handovers, team meetings, and in supervision.

Managers told us that the risk section of the electronic health record had been amended in order to improve communication of patient risk. Managers had also provided clinical risk management refresher training.

Staff and managers were committed to ensuring they worked within an open and transparent culture. We saw examples of where staff had met the principles of duty of candour and told people when things had gone wrong. We found that staff had identified errors quickly and provided verbal and written apologies to patients and their families.

Staff reported that they had been de-briefed and supported after a serious incident. Managers provided team debriefs and reviewed serious incidents via a multidisciplinary team reviews.

The Chief Coroner's Office publishes the local coroners Reports to Prevent Future Deaths which all contain a summary of Schedule 5 recommendations, which had been made, by the local coroners with the intention of learning lessons from the cause of death and preventing deaths.

In the last two years, there have been no 'prevention of future death' reports sent to Hertfordshire Partnership University NHS Foundation Trust.

Is the service effective?

Assessment of needs and planning of care

We inspected 36 care records. Records were comprehensive, detailed, clear, and contained information relevant to the patient. Staff had identified actions within care records and documented when they completed them.

Staff completed a comprehensive biopsychosocial mental health assessment for each patient. We found that assessments were robust, and attended by a senior clinician including a psychiatrist or psychologist. Staff discussed all assessments at a multidisciplinary post assessment meeting. These took place three times per week.

Staff undertook any necessary assessment of the patient's physical health. Staff recorded any physical health problems. Staff conducted full assessments for patients who were on enhanced care programme approach, and checked the outcome of physical health assessments for patients who were on standard care programme approach.

Staff had not developed care plans for all patients. We found that in one team only 50% of patients had care plans in place. However, staff had met with patients and agreed their plan of care. Managers were monitoring this situation via the electronic team performance database and were taking active steps to address this. Completed care plans met the patient needs identified during assessment.

Patient care plans contained evidence of clinical formulation, holistic and recovery-orientated interventions. These took into account cultural and recovery orientated interventions. Staff updated care plans with patients when necessary.

Best practice in treatment and care

This service participated in 20 clinical audits as part of their clinical audit programme 2017-2018.

Audit name	Audit scope	Core service	Audit type	Date completed	Key actions following the audit
POMH-UK Topic 15b:Prescribing valproate for bipolar disorder	Adult Inpatient/Community/CATT/ADTU	MH - Acute wards for adults of working age and psychiatric intensive care units, MH - Community-based mental health services for adults of working age, MH - Mental health crisis services and health-based places of safety	Clinical	19/07/2018	Medicines management to re issue email reminder regarding use of sodium valproate for women of child bearing age. To promote the use of HPFT choice and medication websites. Also, a presentation at the medical staff committee.
POMH-UK Topic 17a: Use of depot/LAI Antipsychotic Injections for Relapse Prevention	Adult Community Services	MH - Community-based mental health services for adults of working age	Clinical	22/02/2018	Send to all teams the updated depot SOP and discuss the key changes. Staff to be aware that all service users on depot medication must have a face to face review, at least every 6 months.
Safeguarding Adults (Q1)	Adult Community	MH - Community-based mental health services for adults of working age	Clinical	10/08/17	Implement spike reporting tool. Review how teams use safeguarding and admin resources. Produce learning note and circulate to all investigating managers and officers. Guidance and workshops to be made available to help staff understand the principles of making safeguarding personal. Staff to be trained in mental capacity act through HCC training courses.

Audit name	Audit scope	Core service	Audit type	Date completed	Key actions following the audit
Safeguarding Adults (Q2)	Adult Community	MH - Community-based mental health services for adults of working age	Clinical	26/10/17	As above
Safeguarding Adults (Q3)	Adult Community	MH - Community-based mental health services for adults of working age	Clinical	22/02/18	Safeguarding form to include mandatory fields. Share report with key staff. To conduct spot checks in Q4. To send reminder to investigating teams of strategy discussion documents.
CQUIN Physical Health Part A (FEP)	Adult Community	MH - Community-based mental health services for adults of working age	Clinical	10/05/2018	Recruiting performance management post, establish a physical health task and finish group, deliver training and spike report to be development.
Service User Finances	Adult Community Service	MH - Community-based mental health services for adults of working age	Clinical	22/02/18	Local action plans were devised by each SBU.
Risk Assessment Assurance	Adult Community Service	MH - Community-based mental health services for adults of working age	Clinical	15/03/2018	Share audit findings with teams. Team base training to be organised. Conduct risk assessment audit in 2018/19.

Audit name	Audit scope	Core service	Audit type	Date completed	Key actions following the audit
Did Not Attend (DNA) Audit	Adult Community Service	MH - Community-based mental health services for adults of working age	Clinical	08/03/2018	• Re-audit in 2018/19 • PACE to also look at Initial Assessment • DNA Policy to be updated to incorporate standard operating procedure. • Further work to be completed on standard operating procedure. To monitor use of text messaging service.
AMHP Audit	Adult Community Service	MH - Community-based mental health services for adults of working age	Clinical	29/03/18	Communicate findings to AMHP's. Liaise with HCC to approve AMPH report format. Develop links with care act work streams across the partnership. Develop referral flow chart and to develop a monitoring system to assess the number of reports that are incomplete. Specific AMHP step by step guides to be created.
Transition from Specialist Child & Adolescent Mental Health Services to Adult Mental Health Services	Adults Community/CAMHS	MH - Specialist community mental health services for children and young people MH - Community-based mental health services for adults of working age	Clinical	03/05/2018	Guidance document to be finalised and circulated. Communicate findings with service. Launch transition page. Create guide for recording options. Conduct re-audit.
Communication to GP	Inpatient & Adult Community	MH - Acute wards for adults of working age and psychiatric intensive care units MH - Wards for older people with mental health problems MH - Community-	Clinical	17/5/2018	To present findings at medical staffing committee. To be discussed at Physical health committee and agree dissemination route. Communicate findings to services. Communicate to CPA admin of the requirement to include date letter was sent to the GP.

Audit name	Audit scope	Core service	Audit type	Date completed	Key actions following the audit
		based mental health services for adults of working age			
Review on attendance at CPA Reviews and correspondence sent post and prior to CPA Meeting	Adult Community	MH - Community-based mental health services for adults of working age	Clinical	12/07/2018	Share findings at Adult community patient safety meeting and SBU QRM's. Guidance on adding associated people to be circulated to community teams via SBU leads. To discuss with Paris team to amend section for external agencies and further audit to be conducted.
Re-audit Did Not Attend (DNA) Rate in Adult Community Outpatients Clinic	Adult Community Services	MH - Community-based mental health services for adults of working age	Clinical	(19/07/2018)	Revising the DNA policy. To request the Inclusion and Engagement team for SMS reports for further analysis. Audit report & SOP to be shared across teams/admin staff and other forums i.e. Practice Governance & Patient Safety Meeting / QI Groups
DNA's in Adult Community Initial Assessment Appointments	Adult Community	MH - Community-based mental health services for adults of working age	Clinical	16/08/2018	Communication of SOP implementation & Policy to be sent across all IA and OPA Clinics. Teams to monitor DNA rate within Post Assessment Meetings and report on monthly basis to ensure learning

Audit name	Audit scope	Core service	Audit type	Date completed	Key actions following the audit
Appointeeship (Supervision of SU's in managing their finances)	Adult Community Services and LD&F inpatient units	MH - Wards for people with learning disabilities or autism MH - Community-based mental health services for adults of working age	Clinical	23/08/2018	The development of a user-friendly step by step guide for care coordinators. To investigate cases identified within the audit without up to date documentation. Quadrant workshops for care coordinators with service users on appointeeship about using these above tools To consider SPIKE report for appointeeship
Service Users being informed and consent attained prior to participating in Research Projects	Adult & CAMHS	MH - Specialist community mental health services for children and young people MH - Community-based mental health services for adults of working age	Clinical	20/09/2018	To develop checklist and conduct spot check audits. To create a learning note which will be attached to the updated policy.
Adult Safeguarding Audit	Adult Community	MH - Community-based mental health services for adults of working age	Clinical	06/09/2018	Share audit findings with teams. Resend timelines to investigating managers. Design new minutes pro forma.
Initial Assessment Outcome Letters	Adult Community Services	MH - Community-based mental health services for adults of working age	Clinical	13/09/2018	To discuss potential changes to the Adult Mental Health Community Services Operation Policy
Looked After Children (LAC) Audit (Q2)	CAMHS & Adult Community	MH - Specialist community mental health services for children and young people MH - Community-based mental health services for adults of working age	Clinical	13/09/2018	LAC liaison nurse to 'dip sample' new referrals for LAC to CAMHS during quarter 3 to review clinicians recording of CSE risks within the risk management plan. Identified cases across services to be re-audited on a 6-monthly basis. Themes to be collated in report form with recommendations for

Audit name	Audit scope	Core service	Audit type	Date completed	Key actions following the audit
					actions which target specific areas of non-compliance.

We examined 36 care records. Staff provided a wide range of care and treatment interventions suitable for the patient group. The interventions were those recommended by, and were delivered in line with National Institute for Health and Care Excellence guidance. Treatments included medication management, psychotherapy and a wide range of psychological therapies. Therapies included cognitive behavioural, dialectic, eye movement desensitization and reprocessing, schema, interactive behavioural therapy, mindfulness, and art and drama therapies. Patients were given when needed, support for employment, housing and benefits, and interventions that enabled patients to acquire living skills.

Staff ensured that patients' physical healthcare needs were being met, including their need for an annual health check. Where the GP was responsible for physical health checks, the community health staff checked that the GP had completed.

Staff supported patients to live healthier lives. Staff provided patients with advice on healthy eating, managing cardiovascular risks, and dealing with issues relating to substance misuse. Staff also offered healthy lifestyle working as part of occupational therapy groups.

Staff used recognised rating scales and other approaches to rate severity and to monitor outcomes. We saw evidence that the Health of the Nation Outcome Scale was undertaken for all patients. A range of outcome measurements were also in use by psychology and occupational therapy.

Staff used technology to support patients effectively. Staff were proactively exploring options for online assessments with patients. Patients received appointment reminders via text messages. Patients had also been signposted to online resources where needed.

Staff participated in clinical audit activity, including audits on physical health, medication management, care programme approach, community treatment orders and record keeping. However, we found that the amount of clinical audit activity undertaken by staff was limited in some teams.

Skilled staff to deliver care

The trust's target rate for appraisal compliance is 95%. At the end of last year (31 March 2018), the overall appraisal rate for non-medical staff within this service was 92%. This year so far, the overall appraisal rates was 95% (as at 30 September 2018). The teams with the lowest appraisal rate at 30 September 2018 were 'AMH Community Services Holly Lodge' with an appraisal rate of 83%, the 'Family Safeguarding Team' with an appraisal rate of 86% and 'AMH Community Services Oxford House at 86%.

This was not comparable to the data used at the last inspection (September 2015).

Ward name	Total number of permanent non-medical staff requiring an appraisal	Total number of permanent non-medical staff who have had an appraisal	% appraisals (as at 30 September 2018)	% appraisals (previous year 1 April 2017- 31 March 2018)
Cygnet House Site Costs	7	7	100%	80%
ADTU Orchards	1	1	100%	n/a
Marlowes Health Centre HPFT	1	1	100%	100%
AMH Comm Services NW Herts St Albans	13	13	100%	93%
MH OT Adult Services North Herts	6	6	100%	n/a
Carers Development Team	35	35	100%	100%
First Episode Psychosis FEP	1	1	100%	89%
Colne House Reception	1	1	100%	100%
Home First E&N	1	1	100%	100%
ADTU East & North	1	1	100%	100%
MH Administration East & North Herts	13	13	100%	100%
Community Services NW Herts	11	11	100%	92%
MH Medical Secretaries	3	3	100%	0%
Criminal Justice & Forensic	6	6	100%	89%
Criminal Justice Mental Health	5	5	100%	100%
Community Services N Herts	4	4	100%	100%
AMH Comm Services Centenary & Jubilee	3	3	100%	100%
AMH Comm Services Saffron Ground	1	1	100%	100%
AMH Comm Services SW Herts	36	35	97%	100%
AMH Comm Services SW Herts Borehamwood	31	30	97%	100%
AMH Comm Services SW Herts Watford	21	20	95%	94%
AMH Comm Services NW Herts Dacorum	21	20	95%	65%
AMH Comm Services Cygnet House	39	37	95%	81%
AMH Community Services Rosanne House	35	33	94%	93%
Community Services E & SE Herts	17	16	94%	86%
AMH Community Services Oxford House	27	25	93%	95%
Family Safeguarding Team	23	20	87%	100%
AMH Comm Services Holly Lodge	7	6	86%	100%
Family Safeguarding Team	7	6	86%	100%
AMH Comm Services Holly Lodge	12	10	83%	89%
Core service total	**389**	**371**	**95%**	**92%**
Trust total	**1467**	**1350**	**92%**	**88%**

The team included a full range of specialists to meet the needs of patients. As well as doctors and nurses, the teams included occupational therapists, clinical psychologists, psychotherapists, social workers, drama therapist, art therapist, pharmacist, support workers, and peer support workers.

Staff were experienced and qualified, and had the right skills and knowledge to meet the needs of the patient group.

Managers provided all new staff with appropriate induction. Newly appointed staff attended the trust induction and were provided with a buddy. Managers provided all new staff with an induction handbook. Staff completed these with their allocated supervisor in their teams.

Staff reported that managers provided them with supervision, and that this took place every four to six weeks. Managers ensured that staff had access to regular team meetings. Staff attended weekly multi-disciplinary meetings to discuss case management, to reflect on and learn from practice, and for personal support and professional development. Staff also attended a monthly practice governance and reflective practice meeting.

Staff received an annual appraisal of their work performance. The percentage of staff that had had an appraisal in the last 12 months as of September 2018 was 92%.

Managers identified learning needs of staff via annual appraisals and supervision, and provided them with opportunities to develop their skills and knowledge. Managers ensured that staff received the necessary specialist training for their roles. A range of inhouse and external courses were available to staff, who reported that these could be accessed easily. Managers also arranged regular presentations for staff at business meetings. However, some staff reported that they had no protected time for training. A number of staff reported that they undertook e-learning in their own time.

Managers dealt with poor staff performance promptly and effectively.

Managers recruited volunteers in some of the teams, although the use of volunteers during the time of inspection was limited.

The trust has not provided appraisal data for medical staff.

The trust has not provided clinical supervision data however they have advised they will be recording clinical supervision data from September 2018. The percentage of staff that received regular supervision across the four geographical areas at the time of inspection was 85%.

Multi-disciplinary and interagency team work

Staff attended regular and effective multi-disciplinary meetings. Staff reported that these meetings were informative, supportive and had a set agenda. There was a clear framework via a set agenda, of what must be discussed at team level in team meetings. This ensured that essential information, such as learning from incidents and complaints, was shared and discussed at business meetings. Managers also produced a quarterly summary of all learning from complaints.

There were effective handovers within the team for when staff were unavailable. Staff rated patient current risk status, and staff were allocated to undertake visits or conduct courtesy calls as required.

The community mental health teams had very effective working relationships, including good handovers with other teams within the organisation (for example, community to crisis team or inpatient services). Staff undertook regular joint assessments with the local drug and alcohol trust. Teams held bi-monthly meetings with child and adolescent mental health services. We saw evidence of cohesive working with in-patient and crisis services.

The community teams had good working links, including effective handovers, with primary care, social services, and other teams external to the organisation.

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

As of 30 September 2018, 85% of the workforce in this service had received training in the Mental Health Act. The trust stated that this training is mandatory for all services for inpatient and all community staff and renewed three years.

This was lower than the 90% reported for the previous year (1 April 2017 to 31 March 2018).

Staff were trained and had a good understanding of the Mental Health Act (particularly relating to Community Treatment Orders), the Code of Practice and the guiding principles.

Staff had easy access to administrative support and legal advice on implementation of the Mental Health Act and its Code of Practice. Staff told us that they could also contact approved mental health professionals and senior social workers for advice. Staff knew who their Mental Health Act administrators were.

The trust had relevant policies and procedures that reflected the most recent guidance. Staff had easy access to local Mental Health Act policies and procedures and to the Code of Practice, which were available via the trust's intranet.

We reviewed community treatment order records for thirteen patients. A community treatment order is a legal order, which sets out terms under which a person must accept treatment whilst living in the community. Staff explained to patients who were subject to a community order, their rights in a way that they could understand, repeated it as required, and recorded that they had done it. Patients who were subject to a community treatment order had easy access to information about independent mental health advocacy (IMHA) services.

Managers told us that the community treatment order paperwork had recently been revised and was much improved. Staff had completed community treatment order paperwork correctly and it was up to date and stored appropriately. Managers had robust checks in place to ensure that the management of community treatment orders met the required standards. This included weekly audits conducted by the clinical nurse specialist, and monthly audits by the pharmacist. Managers ensured that any learning from the audits was disseminated to staff. However, examination of eleven community treatment orders by Mental Health Act reviewers identified discrepancies. Patients' rights had not always been presented in line with national guidance. There was also a delay in requesting Mental Health Act capacity assessments.

Care plans referred to identified Section 117 aftercare services to be provided where applicable.

Good practice in applying the Mental Capacity Act

As of 30 September 2018, 88% of the workforce in this service had received training in the Mental Capacity Act. The trust stated that this training is mandatory for all services for inpatient and all community staff and renewed three years.

This was lower than the 90% reported for the previous year (1 April 2017 to 31 March 2018).

Staff were trained in the Mental Capacity Act 2005. The trust had a policy on the Mental Capacity Act. Staff were aware of the policy and had access to it. Staff knew where to get advice from within the trust regarding the Mental Capacity Act.

Staff took all practical steps to enable patients to make their own decisions. For patients who might have impaired mental capacity, staff had assessed and recorded capacity to consent appropriately. They did this on a decision-specific basis with regard to significant decisions. When patients lacked capacity, staff made decisions in their best interests, recognising the importance of the person's wishes, feelings, culture and history. This included financial arrangements under appointeeship.

The service had arrangements to monitor adherence to the Mental Capacity Act. Staff audited the application of the Mental Capacity Act and took action on any learning that resulted from it.

Is the service caring?

Kindness, privacy, dignity, respect, compassion and support

Staff attitudes and behaviours when interacting with patients showed that they were consistently discreet, respectful and responsive. Staff provided patients with help, emotional support and advice at the time they needed it. We observed a strong, visible person-centred culture. Patients gave very positive feedback about staff. These comments included the following; 'the service is utterly amazing', 'after decades of long term depression I am feeling a difference in my mental health', 'staff are amazing' 'staff go the extra mile' and 'I owe staff my life'.

Staff and leaders were fully committed to working in partnership with patients and finding innovative ways to make patient partnership a reality. Staff supported patients to understand and manage their care, treatment or condition. Staff consistently took measures to empower patients to have a voice, and demonstrated the importance of involving patients and their carers in decisions about their care. Staff provided patients with a range of education leaflets and signposted patients to on-line resources where appropriate.

Staff directed patients to other services when appropriate and, if required, supported them to access those services. Staff signposted patients to a wide range of other agencies as required and supporting them to make and maintain contact.

Staff interactions and relationships with patients were strong, caring and supportive. Patients said staff treated them very well and behaved appropriately towards them. Patients described staff as highly motivated, polite, caring, respectful and going the extra mile for them.

Staff understood and where sensitive to the individual needs of patients, including their personal, cultural, social and religious needs. For example, staff considered the cultural needs relevant to individual patients and included their views when planning their care and treatment.

Staff said they could raise concerns about disrespectful, discriminatory or abusive behaviour or attitudes towards patients without fear of the consequences. The majority of staff described the teams as very cohesive and supportive.

Staff maintained the confidentiality of information about patients. However, we witnessed one information governance breach, which was immediately reported. Managers took immediate actions in a responsive and supportive manner.

Involvement in care

Involvement of patients

Staff involved patients in the development of care plans and formulation of risk assessments. This was demonstrated in patient care plans and in care programme approach reviews, which clearly evidenced the patients views and patient involvement. Care plans were written from the patient's perspective. Patients confirmed that they had access to a copy of their care plan.

Staff communicated with patients in a manner which ensured that they understood their care and treatment, including finding effective ways to communicate with patients with communication difficulties. Patients told us that staff had fully explained their care and treatment.

Staff involved patients when appropriate in decisions about the service. Patients had been involved in the recruitment of staff.

Staff enabled patients to give feedback on the service they received. Patients provided feedback via advocacy, individual meetings with staff members, via 'have your say 'surveys, 'have your say' forums, and via the compliments and, complaints processes.

Staff had enabled some patients to make advance decisions (to refuse treatment, sometimes called a living will) when requested. However, staff told us that these were not widely used.

Staff ensured that patients could access advocacy. Patients and staff told us that the advocacy was both responsive and very supportive.

Involvement of families and carers

Staff informed and involved families and carers appropriately and provided them with support when needed. Staff enabled families and carers to give feedback on the service they received.

Carers were provided with information about how to access a carer's assessment. We saw evidence of carers having a carers assessment. A carers support work led on carers assessments, ran a group for carers, and provided carers with a support booklet, advice and support.

Is the service responsive?

Access and waiting times

The trust has identified the below services in the table as measured on 'referral to initial assessment'. The service met the referral to assessment target in all the targets listed.

The service does not have a target for referral to treatment.

This was not comparable to the data used at the last inspection (between September 2015).

Name of hospital site or location	Name of Team	Please state service type	Days from referral to initial assessment		Days from referral to treatment	
			Target	Actual (median)	Target	Actual (median)
Community	E&SE Herts Quadrant	Adult Routine Referrals	28 Days	20	No	n/a
Community	North Herts Quadrant	Adult Routine Referrals	28 Days	22	No	n/a
Community	NW Herts Quadrant	Adult Routine Referrals	28 Days	24	No	n/a
Community	SW Herts Quadrant	Adult Routine Referrals	28 Days	25	No	n/a
Community	E&SE Herts Quadrant	Adult Urgent Referrals	24 hours	0 days	No	n/a
Community	North Herts Quadrant	Adult Urgent Referrals	24 hours	0 days	No	n/a
Community	NW Herts Quadrant	Adult Urgent Referrals	24 hours	0 days	No	n/a

Name of hospital site or location	Name of Team	Please state service type	Days from referral to initial assessment		Days from referral to treatment	
			Target	Actual (median)	Target	Actual (median)
Community	SW Herts Quadrant	Adult Urgent Referrals	24 hours	0 days	No	n/a

The service had clear criteria for which patients would be offered a service and, where waiting lists were used, who could be placed on them. The criteria did not exclude patients who needed treatment and would benefit from it.

The trust had set a target for time from referral to triage/assessment and from assessment to treatment. The target from referral to initial assessment was 28 days. This target was being met in the majority of cases. Within the six-month period first September 2018 to end February 2019, there had been 363 breaches. The highest number occurred in September 2018 when the number of breaches were 86. This number had reduced to 38 in February 2019.

The target from assessment to treatment was 18 weeks. The number of patient awaiting allocation at the end of March 2019 were 108. The average wait for allocation was 67 days, whilst the longest wait was 353 days. The trust was aware of hotspot areas and were working to address these, placing the demand on community services on the risk register. Mitigation was in place to ensure staff monitored individuals who were waiting for treatment, interventions or packages of care. Managers had introduced a system in all teams, for ensuring that staff made calls and visits to higher risk patients whilst they were awaiting team allocation to assess risk and prioritise as required. A few individuals (22) had been awaiting 100+ days. There were specific circumstances for each of these 22 individuals that had contributed to these delays. Staff worked with them to ensure that they received the correct packages of care either through the trust or partnering agencies. Some of these individuals had prolonged waiting periods as result of their cancellations or non-attendance of appointments. The trust worked with them to resolve this as soon as possible. The timescales involved for these 22 individuals meant the average was skewed and if these were removed, the average wait reduced from 353 days to 98 days.

Staff saw urgent referrals quickly and non-urgent referrals within an acceptable time. Staff responded promptly and adequately when patients telephoned the service. Teams had a duty working system in place during normal working hours which led on patient calls and urgent referrals and issues. Patients could contact the crisis service out of normal working hours.

The team tried to engage with people who found it difficult or were reluctant to engage with mental health services. Staff made active attempts to follow-up and contact people who did not attend appointments. The trust had recently revised their policy for responding to patients who did not attend appointments. The policy is now more streamlined and requires staff to actively engage with patients who did not attend appointments. Staff responded by telephoning patients and conducting visits for patients who presented with higher clinical risk.

Where possible, staff offered patients flexibility in the times of appointments. Patients gave overwhelmingly positive feedback about reception and administrative staff, who they described as kind, friendly and ‘fantastic’.

Staff cancelled appointments only when necessary and when they did, they explained why and helped patients to access treatment as soon as possible. Appointments usually ran on time and people were kept informed when they did not.

Managers could proactively monitor waiting times, key performance indicators and caseload via the trust's electronic database. Staff also used technology to support timely access to care and treatment, including the use of video conferencing and sending text reminders to patients.

Staff supported patients during referrals and transfers between services. This included supporting patients when they required temporary treatment in an acute hospital and in-patient placement in other areas.

The facilities promote comfort, dignity and privacy

The service had a range of rooms and equipment to support treatment and care. This included a clinic room to examine patients and sufficient chairs in the waiting area, as well as a number of therapy rooms. However, staff reported that the availability of rooms could be an issue at times.

We found that out of the six team bases visited, both Holly Lodge Cheshunt and Waverley Road St Albans did not have adequate soundproofing. Conversations could be heard in the corridors.

Staff reported that parking was a major issue at a few bases. Staff told us that this had an adverse effect on their time management.

Patients' engagement with the wider community

Staff ensured that where appropriate, patients had access to education and work opportunities. Patients had access to an employment advisor in each team. Patient care plans included access to education, development and training. The Trust had run a 12-month pilot scheme on sourcing eight-week work placements for patients, as part of their recovery goals. This was open to service users currently under the adult Community Mental Health Teams. Staff told us that three patients had been supported into full time employment within the trust, four patients had been supported into other paid employment and two into full time education.

Staff supported patients to maintain contact with their families and carers. We received positive feedback from many carers who told us that staff had kept them fully involved and informed. Staff encouraged patients to develop and maintain relationships with people that mattered to them, both within the services and the wider community.

Meeting the needs of all people who use the service

The service had made adjustments for patients with disabilities. These included ramps, disabled toilets and lifts. Each of the team bases had disabled access and a loop system was in place for patients with hearing difficulties.

Staff had ensured that patients could obtain information on treatments, local services, self-help, patients' rights and advocacy. We saw a wide range of information available in each of the team bases. Managers ensured that information provided was in a form accessible to the particular patient group, and could be accessible in easy-read form for people with a learning disability. Staff could access and made information leaflets available in languages spoken by patients.

Managers ensured that staff and patients had easy access to interpreters and/or signers. Staff told us that these services were responsive and could be accessed the same day where required.

Listening to and learning from concerns and complaints

This service received 125 complaints between 1 November 2017 and 31 October 2018. Twenty-four (19%) of these were upheld, 37 (30%) were partially upheld and 42 (34% were not upheld. No complaints were referred to the Ombudsman.

Ward name	Total Complaints	Fully upheld	Partially upheld	Not upheld	Under Investigation	Withdrawn
Adult Community Mental Health Service - East & South East	**19**	2	8	6	1	2
Adult Community Mental Health Service – North	**15**	3	2	8	2	0
Adult Community Mental Health Service - North West	**21**	5	3	7	4	2
Adult Community Mental Health Service - South West	**25**	3	10	7	3	2
Adult Community MH Team - South East	**1**	1	0	0	0	0
PATH - First Episode Psychosis Team	**1**	1	0	0	0	0
Support and Treatment and Targeted Treatment Adult Community Mental Health Services – North	**3**	0	1	2	0	0
Support and Treatment and Targeted Treatment Adult Community Mental Health Services - East & South East	**8**	0	3	4	0	1
Support and Treatment and Targeted Treatment Adult Community Mental Health Services - North West	**14**	5	3	5	1	0
Support and Treatment and Targeted Treatment Adult Community Mental Health Services - South West	**10**	1	6	1	0	2
Targeted Treatment / Support and Treatment Community Teams - East and South East	**2**	1	1	0	0	0
Targeted Treatment / Support and Treatment Community Teams - North West	**3**	1	0	1	1	0
Targeted Treatment / Support and Treatment Community Teams - South West	**3**	1	0	1	1	0
Core service total	**125**	**24**	**37**	**42**	**13**	**9**

Patients knew how to complain or raise concerns and felt able to do so. Patients were treated with respect when they complained or raised concerns, and they received feedback. Staff protected patients who raised concerns or complaints from discrimination and harassment. Staff knew how to handle complaints appropriately.

Staff received feedback on the outcome of investigation of complaints and acted on the findings. Staff identified several changes in practice, which had been made in response to complaint investigations. For example, staff told us of one example where a patient had raised concerns that correspondence regarding medication was being sent in the post. Staff now communicate via e-mail wherever possible.

This service received 202 compliments during the last 12 months from 1 November 2017 and 31 October 2018 which accounted for 12% of all compliments received by the trust as a whole.

Is the service well led?

Leadership

Leaders had the skills, knowledge and experience to perform their roles. It was pleasing to see that 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 were highly visible in the service and approachable for patients and staff.

Leadership development opportunities were available, including opportunities for staff below team manager level. Leaders confirmed that they had received training for their role and that a range of internal and external courses were available.

Vision and strategy

We were impressed that staff knew and understood the trust's vision and values and how they were applied in the work of their team. The trust's senior leadership team had successfully communicated the trust's vision and values to the frontline staff in this service. Staff were consistently committed to these values and applied these to the work in their team.

Staff told us that they had the opportunity to contribute to discussions about the strategy for their service, especially where the service was changing. Managers also involved staff in innovations and service improvements. Staff participated in the recently introduced daily skype meetings with in-patient wards. Staff also held weekly primary mental health clinics in GP surgeries.

Staff could explain how they were working to deliver high quality care within the budgets available.

Culture

Leadership and leadership development strategies were comprehensive and delivered the desired culture. Staff felt respected, supported and valued. Staff felt positive and proud about working for the trust and their team. Staff felt able to raise concerns without fear of retribution. Staff knew how to use the 'speaking up' process and about the role of the Speak Up Guardian.

Staff confidently exercised their decision-making authority and were clearly held to account. Managers dealt with poor staff performance when needed. Teams worked well together and where there were difficulties managers dealt with them appropriately.

Staff appraisals included conversations about career development and how it could be supported.

Staff reported that the trust promoted equality and diversity in its day-to-day work and in providing opportunities for career progression.

The services staff sickness and absence rates were similar to the trust target of four percent.

Staff had access to support for their own physical and emotional health needs through an occupational health service and a variety of wellbeing initiatives. Managers had also made arrangements for staff to have access to mindfulness sessions.

The trust recognised staff success within the service, through staff awards. We heard of three team members who had received an award. Staff reported that this made them feel valued and recognised the contribution of staff.

Governance

Managers had consistently ensured that there were systems and procedures in place, to ensure that the premises were safe and clean. Managers ensured that there were enough staff; trained and supervised. Where there were vacancies managers appointed agency staff on long term contracts.

Patients were assessed and treated well; referrals and waiting times were managed well. Staff knew how to report incidents, and all incidents were reported, investigated and learned from. Managers proactively reviewed governance and performance arrangements, and adapted these to take account of best models of practice.

There was a clear framework via a set agenda, of what must be discussed at team level in team meetings. This ensured that essential information, such as learning from incidents and complaints, was shared and discussed at business meetings. Managers also produced a quarterly summary of all learning from complaints.

Staff had implemented recommendations from reviews of deaths, incidents, complaints and safeguarding alerts at the service level.

Staff took part in national and local clinical audits. The audits were sufficient to give assurance and staff acted on the results when needed.

Managers took a systematic approach to working with others in the health and social care economy, to improve care outcomes, tackle health inequalities and obtain best value for money. The trust had a coherent strategy for engaging with key partners. Staff understood arrangements for working with other teams, both within the trust and external, to meet the needs of the patients.

Management of risk, issues and performance

Managers maintained and had access to the risk register at a team level and could escalate concerns when required from their team. Staff concerns matched those on the risk register, and staff said that their concerns had been escalated. Managers told us that examples of issues on the risk register included staffing retention and waiting times for treatment from initial assessment. concerns

The service had plans for emergencies – for example, adverse weather or a flu outbreak.

Where cost improvements had been made, they did not compromise patient care.

Information management

The service used robust systems to collect data from teams that were not over-burdensome for frontline staff.

Staff had access to the equipment and information technology needed to do their work. However not all staff had access to a laptop which they could take on visits. The information technology infrastructure, including the telephone system, worked well in most area and helped to improve the quality of care.

Information governance systems included confidentiality of patient records.

Team managers had access to information to support them with their management role via an electronic system. This included information on the performance of the service, staffing and patient care. Managers were complimentary about the benefits of the new system and highlighted the benefits to patient care. The system provided key information from the electronic patient record systems in one place. The information available included clinical data to help support informed decision making. This enabled staff to improve outcomes for service users, and make efficient and

effective use of resources by providing patients with the right care at the right time. Information was in an accessible format, and was timely, accurate and identified areas for improvement.

Staff made notifications to external bodies including safeguarding, police and the CQC as needed.

Engagement

Staff, patients and carers had access to up-to-date information about the work of the trust and the services they used. A range of information was available through the intranet, bulletins, newsletters and posters.

Patients and carers had opportunities to give feedback on the service they received in a manner that reflected their individual needs. The teams welcomed and acted upon rigorous and constructive challenge from patients and staff at all levels. Staff used innovative approaches to proactively gather feedback from patients, carers, the public, local patient and community groups and staff. Patients could give feedback via 'have your say' surveys and in 'have your say' forums. Managers produced a quarterly bulletin which highlighted all changes made in response to patient feedback.

Managers and staff had access to the feedback from patients, carers and staff and used it to make improvements. There were consistently high levels of constructive staff engagement and we found a climate of positivity with high levels of staff satisfaction.

Patients and carers were involved in decision-making about changes to the service.

Patients and staff could meet with members of the trust's senior leadership team and governors to give feedback. Staff told us that members of the executive team visited the teams. Staff were invited to attend breakfast meetings with the chief executive. The trust also ran quarterly 'big listen' events, which was open to all staff.

Directorate leaders engaged with a wide range of external stakeholders. This included housing, education establishments, commissioners and Healthwatch.

Learning, continuous improvement and innovation

NHS trusts are able to participate in a number of accreditation schemes whereby the services they provide are reviewed and a decision is made whether or not to award the service with an accreditation. A service will be accredited if they are able to demonstrate that they meet a certain standard of best practice in the given area. An accreditation usually carries an end date (or review date) whereby the service will need to be re-assessed in order to continue to be accredited.

The table below shows which services within this service have been awarded an accreditation together with the relevant dates of accreditation.

Accreditation scheme	Core service	Service accredited	Comments
Prison In- Reach team	MH - Community-based mental health services for adults of working age	MHP The Mount	Working towards accreditation – peer review took place June 2017

Staff were given the time, empowerment and support to consider proactive opportunities for improvements and innovation. This had led to positive, continuous improvement and changes within the teams. Managers had initiated a range of innovations in the service. These included projects relating to homelessness and video conferencing patients. There was a clear proactive approach to seeking out improvements in care, whilst maintaining high quality. Staff had

opportunities to participate in research projects. This included a research project on personality disorders.

There was strong collaboration and support within and across all functions, including with others external to the organisation with a focus om improving the quality of patient care and patient experiences.

Staff used quality improvement methods and knew how to apply them. Staff had strong links with the quality improvement team and spoke about the benefits of using improvement methodologies.

Staff took part in national audits relevant to the service and learned from them.

The teams had commenced participation in an accreditation scheme for community mental health teams relevant to the service.

MH – Mental health crisis services and health-based places of safety

Facts and data about this service

Location site name	Team name	Number of clinics	Patient group (male, female, mixed)
Cygnet House	South East Herts Crisis Assessment and Treatment Team (CATT)	n/a	Mixed
Rosanne House	Crisis Assessment and Treatment Team (CATT) - South East	n/a	Mixed
Colne House	Crisis Assessment and Treatment Team (CATT) - South West	n/a	Mixed
St Pauls	Crisis Assessment and Treatment Team (CATT) - North West	n/a	Mixed
Lister Hospital	Lister Mental Health Liaison Team	n/a	Mixed
Saffron Ground	Crisis Assessment and Treatment Team (CATT) - North	n/a	Mixed
Watford General Hospital	Watford Mental Health Liaison	n/a	Mixed
Kingsley Green (RWR96)	Oak Unit Health based place of safety S136 Suite	n/a	Mixed
Kingsley Green (RWR96)	S136 Suite 1	n/a	Mixed
Kingsley Green (RWR96)	S136 Suite 2	n/a	Mixed
Hertfordshire Constabulary Headquarters	Street Triage Team	n/a	Mixed

The methodology of CQC provider information requests has changed, so some data from different time periods is not always comparable. We only compare data where information has been recorded consistently.

Is the service safe?

Safe and clean environment

Staff carried out ligature audits and environmental risk assessments across the crisis assessment and treatment teams, the mental health liaison teams and the Health-Based Places of Safety. Risks identified had been mitigated.

Interview rooms at the section 136 health-based places of safety suites at Kingfisher Court had alarms for patients or staff to summon assistance in an emergency, staff also carried personal alarms. However, the suite based within Oak Unit did not have access to a dedicated interview room, interviews were carried out within the 136 suite. There was no alarm system within the suite, staff carried personal alarms and radios with them at all times, to summon assistance in an emergency. The Oak Unit 136 suite was monitored by two staff at all times, when in use. One member of staff observed via CCTV from the staff office; while the second remained outside the suite.

The health-based places of safety suites at Kingfisher Court were purpose built and were clean, well maintained and furniture was in a good state of repair. The suite located on Oak unit only contained a bed, the window had been smashed and replaced with a Perspex window and the room needed cleaning as a previous patient's belongings were still in the room. There was a blind spot within the ensuite facilities. Staff mitigated this by individual risk assessments and staff presence when required. The trust had plans for a rebuild of this suite, commencing August 2019. The rebuild included building a dedicated office area for staff use, within the suite.

Facilities used by the crisis assessment and treatment teams and the mental health liaison teams were clean and well maintained. Staff working within the crisis assessment and treatment teams could access interview rooms across the county. All rooms either had access to alarms within the room or staff were given a hand-held alarm to use whilst carrying out interviews. Crisis assessment and treatment team staff had access to a lone worker device where they could contact emergency assistance when in the community.

Mental health liaison teams at both acute hospitals had access to interview rooms with an alarm system. The assessment room used by the mental health liaison team at Lister Hospital had lightweight furniture and was not soundproof. Work was underway to provide an assessment room that met the Psychiatric Liaison Accreditation Network (PLAN) standards.

Each crisis assessment and treatment team had access to a clinic room, not all clinic rooms were located at the crisis assessment and treatment team office bases. The trust's operational policy stated that most patients were seen within their own home or encouraged to see their GP. The Health-Based Places of Safety did not have dedicated clinic rooms. However, staff accessed clinic equipment from nearby wards.

Staff at Cygnet House had not recorded the room temperature where medication was stored on 33 dates between December 2018 and March 2019. The room temperatures at all other sites were monitored and maintained within the recommended range, Staff were aware of what action should be taken if either the fridge or room temperature went out of range.

Infection control and handwashing posters were visible within clinical areas. Staff adhered to infection control principles.

Staff had access to emergency medicines and equipment bags across sites. Staff had calibrated and regularly checked all equipment.

Safe staffing

Nursing staff

Crisis assessment and treatment team caseloads ranged from 24 to 46 patients.

The trust had a computerised system to identify staffing needs for each team. Crisis assessment and treatment team managers adjusted staffing levels to take account of demands on the service. Staffing rotas showed that managers filled gaps on shifts by using bank staff who were familiar with the service.

Managers ensured patient safety by putting cover arrangements in place for sickness, leave and vacant posts in each of the teams. Crisis assessment and treatment team staff worked across teams when caseloads increased.

The health based places of safety (HBPoS) suites at Kingfisher Court met best practice for staffing. There was an allocated team leader and staff dedicated to working within the health-based place of safety. Managers had ensured staffing levels were sufficient to receive patients. If children were detained in the Kingfisher Court suite then staff from specialist child and adolescent mental health services offered additional support. The trust had begun work to build a dedicated health based place of safety suite specifically to meet the needs of children and young people.

All staff told us there was adequate staffing in place to ensure that patients had access to staff when needed and that activities and sessions took place. We looked at three weeks of duty rotas, the number of nurses present during the inspection matched the staffing rotas.

This core service has reported a vacancy rate for all staff of 11% as of 30 September 2018.

This core service reported an overall vacancy rate of 7% for registered nurses at 30 September 2018.

This core service reported an overall vacancy rate of 16% for nursing assistants at 30 September 2018.

		Registered nurses			Health care assistants			Overall staff figures		
Location	**Ward/Team**	**Vacancies**	**Establishment**	**Vacancy rate (%)**	**Vacancies**	**Establishment**	**Vacancy rate (%)**	**Vacancies**	**Establishment**	**Vacancy rate (%)**
Kingfisher Court	KC 136 Suite	0.0	5.0	0%	4.9	15.8	31%	4.3	21.2	20%
Shrodells Unit	Watford	3.4	14.5	24%	-0.6	2.4	-25%	4.8	24.1	20%
Lister Hospital	Lister	1.0	12.8	8%	2.0	3.0	67%	3.5	20.3	17%
Colne House	CATT South West Herts	1.6	12.0	13%	0.1	6.0	1%	2.7	21.2	13%
Lister Hospital	CATT North Herts	0.4	8.0	5%	1.2	4.9	25%	1.6	15.9	10%

		Registered nurses			Health care assistants			Overall staff figures		
Location	**Ward/Team**	**Vacancies**	**Establishment**	**Vacancy rate (%)**	**Vacancies**	**Establishment**	**Vacancy rate (%)**	**Vacancies**	**Establishment**	**Vacancy rate (%)**
Waverley Road	Street Triage	0.6	4.7	13%	0.0	0.8	0%	0.6	6.5	9%
Rosanne House	CATT - East Herts	0.2	7.6	3%	0.0	4.0	0%	1.2	14.6	8%
St Pauls	CATT North West	1.6	17.7	9%	-1.0	4.0	-25%	0.6	22.7	3%
Rosanne House	CATT East & South-East Herts	-2.2	8.4	-26%	0.3	2.8	10%	-1.9	13.2	-15%
	Core service total	**6.6**	**90.7**	**7%**	**6.8**	**43.7**	**16%**	**17.3**	**159.6**	**11%**
	Trust total	**178.1**	**853.7**	**21%**	**124.2**	**1063.0**	**12%**	**440.3**	**3375.9**	**13%**

NB: All figures displayed are whole-time equivalents

At the time of inspection managers told us that vacancy rates had improved due to recent recruitment.

Between 1 November 2017 and 31 October 2018, of the 32020 total working hours available, 19% were filled by bank staff to cover sickness, absence or vacancy for qualified nurses.

The main reasons for bank and agency usage for the wards/teams were vacancies and sickness absence.

In the same period, agency staff covered 2% of available hours for qualified nurses and 1% of available hours were unable to be filled by either bank or agency staff.

Wards	**Total hours available**	**Bank Usage**		**Agency Usage**		**NOT filled by bank or agency**	
		Hrs	**%**	**Hrs**	**%**	**Hrs**	**%**
CATT N/Herts	16575	1576	10%	159	1%	0	0%
CATT NW/Herts	34840	6966	20%	192	1%	0	0%
CATT SE / Herts	23790	2688	11%	0	0%	0	0%
CATT SW/ Herts	24248	4800	20%	912	4%	0	0%
KC 136	9750	1635	17%	128	1%	51	1%
Lister	23602	3152	13%	312	1%	457	2%
Watford	24375	3513	14%	860	4%	484	2%
Street Triage	8434	7691	91%	0	0%	67	1%
Core service total	**165614**	**32020**	**19%**	**2563**	**2%**	**1059**	**1%**
Trust Total	**n/a***	**n/a***	**n/a***	**n/a***	**n/a***	**n/a***	**1%**

*Unable to provide trust total hours and percentages due to inconclusive data provided by the trust.

Between 1 November 2017 and 31 October 2018, 16204 were filled by bank staff to cover sickness, absence or vacancy for nursing assistants.

The main reasons for bank and agency usage for the wards/teams were vacancies and sickness absence.

In the same period, agency staff covered 1808 available hours and 2635 hours were unable to be filled by either bank or agency staff.

Caveat: the total hours available data provided by the trust was inconclusive and therefore this, along with the percentages of bank, agency and not filled hours has not been included.

Wards	**Total hours available**	**Bank Usage**		**Agency Usage**		**NOT filled by bank or agency**	
		Hrs	**%**	**Hrs**	**%**	**Hrs**	**%**
CATT N/Herts	n/a	790	n/a	0	n/a	146	n/a
CATT NW/Herts	n/a	1499	n/a	0	n/a	73	n/a
CATT SE / Herts	n/a	583	n/a	0	n/a	0	n/a
CATT SW/ Herts	n/a	3478	n/a	272	n/a	23	n/a
KC 136	n/a	8095	n/a	728	n/a	2353	n/a
Lister	n/a	466	n/a	0	n/a	0	n/a
Watford	n/a	1045	n/a	808	n/a	41	n/a
Street Triage	n/a	248	n/a	0	n/a	0	n/a
Core service total	**n/a**	**16204**	**n/a**	**1808**	**n/a**	**2635**	**n/a**
Trust Total	**n/a***	**n/a***	**n/a***	**n/a***	**n/a***	**n/a***	**n/a***

*Unable to provide trust total hours and percentages due to inconclusive data provided by the trust.

This core service had 16.0 (12%) staff leavers between 1 October 2017 and 30 September 2018.

Location	**Ward/Team**	**Substantive staff (at latest month)**	**Substantive staff Leavers over the last 12 months**	**Average % staff leavers over the last 12 months**
Waverley Road	Street Triage	5.9	2.0	33%
Shrodells Unit	Watford	19.2	5.0	25%
Rosanne House	CATT - East Herts	13.4	1.0	15%
Lister Hospital	CATT North Herts	14.3	2.0	14%
Lister Hospital	Lister	16.8	2.0	13%
Colne House	CATT South West Herts	18.6	1.6	9%
Kingfisher Court	KC 136 Suite	16.9	1.0	6%
St Pauls	CATT North West	22.1	1.0	5%
Rosanne House	CATT East & South-East Herts	15.1	0.4	2%
Kingfisher Court	CATT Night Team	0.0	0.0	0%
Core service total		**142.3**	**16.0**	**12%**
Trust Total		**2903.4**	**461.5**	**16%**

The sickness rate for this core service was 6.0% between 1 October 2017 and 30 September 2018. The most recent month's data (September 2018) showed a sickness rate of 4.0%.

Location	Ward/Team	Total % staff sickness (at latest month)	Ave % permanent staff sickness (over the past year)
Kingfisher Court	KC 136 Suite	2.0%	10.8%
Shrodells Unit	Watford	8.0%	10.1%
St Pauls	CATT North West	6.3%	6.2%
Rosanne House	CATT - East Herts	0.5%	5.9%
Lister Hospital	CATT North Herts	7.2%	5.4%
Rosanne House	CATT East & South-East Herts	0.0%	5.1%
Waverley Road	Street Triage	0.0%	3.8%
Lister Hospital	Lister	7.3%	3.2%
Colne House	CATT South West Herts	0.8%	1.2%
Kingfisher Court	CATT Night Team	0.0%	0.0%
Core service total		**4.0%**	**6.0%**
Trust Total		**3.7%**	**4.5%**

Medical staff

The service had appropriate arrangements for access to medical staff. Staff told us that there was adequate medical cover day and night. This ensured that a doctor could attend quickly in an emergency. Teams had access to a doctor Monday to Friday at all locations. On weekends and evenings, senior nurses were responsible for any medicines reconciliation and could consult the duty doctor out of hours.

Between 1 November 2017 and 31 October 2018, of the 4224 total working hours available, 0% were filled by bank staff to cover sickness, absence or vacancy for medical locums.

The main reasons for bank and agency usage for the wards/teams was vacancies.

In the same period, agency staff covered 7% of available hours and 0% of available hours were unable to be filled by either bank or agency staff.

Ward/Team	Total hours available	Bank Usage		Agency Usage		NOT filled by bank or agency	
		Hrs	%	Hrs	%	Hrs	%
Mental health liaison teams	4224	0	0%	302	7%	0	0%
Core service total	**4224**	**0**	**0%**	**302**	**7%**	**0**	**0%**
Trust Total	**146022**	**418**	**<1%**	**21401**	**15%**	**1**	**<1%**

Mandatory training

The compliance for mandatory and statutory training courses at 30 September 2018 was 83%. Of the training courses listed 17 failed to achieve the trust target and of those, five failed to score above 75%.

The trust set a target of 92% for completion of mandatory and statutory training.

Trust completion is reported as a final figure at year end.

The training compliance reported for this core service during this inspection was higher than the 83% reported in the previous year.

Staff at the site inspection told us they had received and were up to date with appropriate mandatory training. However, we were unable to see the overall mandatory training figure for each team. Managers advised that this was due to the introduction of a new learning and development database.

Key:

Below CQC 75%	Met trust target ✓	Not met trust target ✘	Higher ↑	No change →	Lower ↓

Training Module	Number of eligible staff	Number of staff trained	YTD Compliance (%)	Trust Target Met	Compliance change when compared to previous year
Infection, Prevention & Control Level 1 [2 Years]	10	10	100%	✓	→
Equality, Diversity & Human Rights [3 Years]	125	122	98%	✓	↑
Care Records and Confidentiality Awareness [3 Years]	64	60	94%	✓	↑
Mental Capacity Act and Deprivation of Liberty Safeguards [3 Years]	82	77	94%	✓	↑
Safeguarding Adults Level 2 [3 Years]	115	108	94%	✓	↑
Safeguarding Children Level 2 [3 Years]	102	93	91%	✘	↑
Clinical Risk Assessment and Management [3 Years]	104	94	90%	✘	↑
Mental Health Act [3 Years]	80	72	90%	✘	↑
Safeguarding Children Level 1 [3 Years]	10	9	90%	✘	↑
Relating to People Mod 3a [3 Years]	8	7	88%	✘	↑
Health, Safety & Welfare [3 Years]	125	109	87%	✘	↓
Infection, Prevention & Control Level 2 [2 Years]	115	100	87%	✘	↑
Data Security Awareness [1 Year]	125	105	84%	✘	↓

Training Module	Number of eligible staff	Number of staff trained	YTD Compliance (%)	Trust Target Met	Compliance change when compared to previous year
Fire Safety [2 Years]	112	92	82%	✗	↑
Safeguarding Adults Level 1 [3 Years]	10	8	80%	✗	↑
Preventing Radicalisation (WRAP) [Once]	109	84	77%	✗	↑
Moving and Handling L1 [3 Years]	24	18	75%	✗	↑
Moving and Handling L2 [2 Years]	101	65	64%	✗	↓
Relating to People Mod 3b [1 Year]	101	65	64%	✗	↓
Intermediate Life Support (includes BLS) [1 Year]	7	4	57%	✗	↓
Basic Life Support [1 Year]	99	55	56%	✗	↓
Relating to People Mod 4 [1 Year]	2	0	0%	✗	→
Total	**1630**	**1357**	**83%**	✗	↑

Assessing and managing risk to patients and staff

Assessment of patient risk

Staff completed risk assessments for patients and updated these regularly. We reviewed 28 care records for patients within the crisis assessment and treatment teams and found that staff completed a risk assessment of every patient at the point of referral as part of the initial assessment. Staff used the trust risk assessment tool to assess and review risk. However, Cygnet House crisis assessment and treatment team's risk assessments of patients were less thorough and one did not identify that a patient assessed as high risk was required to be seen by staff in pairs. Another risk assessment at Roseanne House did not reference staff needed to monitor a patient with a low body mass index.

We reviewed 28 crisis plans for the crisis assessment and treatment team. Staff had not fully completed six patients' crisis plans. This could pose a risk that staff would not know how best to support the patient.

Staff at Cygnet House CATT did not complete clear entries in patients' care records. For example, notes did not always include the patient's mental health, assessed risks or plan of care. However, at St Paul's CATT a template was being piloted to provide a baseline standard for case note entries. Managers planned to introduce this to other teams. We reviewed four care records for patients detained under Section 136 Mental Health Act 1983. Care records were mostly completed to a high standard. However, one of the records did not include a risk assessment for a patient who had recently been discharged.

We looked at five care records for patients accessing the mental health liaison team. All had a comprehensive assessment and risk assessments completed along with a clear plan of care. Staff said a new section was added to the risk assessment form to ensure a risk formulation plan had been completed and in a team meeting they clarified what information should be included.

Management of patient risk

Staff responded promptly to any sudden deterioration in a patient's health. Any identified risks and patient progress was discussed at CATT twice daily handovers and reviewed daily. Staff increased patient observations when required to support patients in reducing the risk they posed.

The crisis assessment and treatment team had no waiting list. The service contacted patients within four hours of referrals and put arrangements in place to visit them.

Staff followed clear personal safety protocols, including for lone working. Lone working policies and procedures were in place for staff to follow to ensure safety. This included a lone working device when facilitating home visits which allowed staff to log their location, arrangements for visiting higher risk patients in pairs or at office bases and staff were required to sign in and out. Staff we spoke with were aware of the trust's lone working policy and said they felt safe using it.

Mental health liaison teams met with acute hospital staff and other agencies to develop management plans to reduce the need for patients frequently attending A&E or contacting emergency services.

Safeguarding

A safeguarding referral is a request from a member of the public or a professional to the local authority or the police to intervene to support or protect a child or vulnerable adult from abuse. Commonly recognised forms of abuse include: physical, emotional, financial, sexual, neglect and institutional.

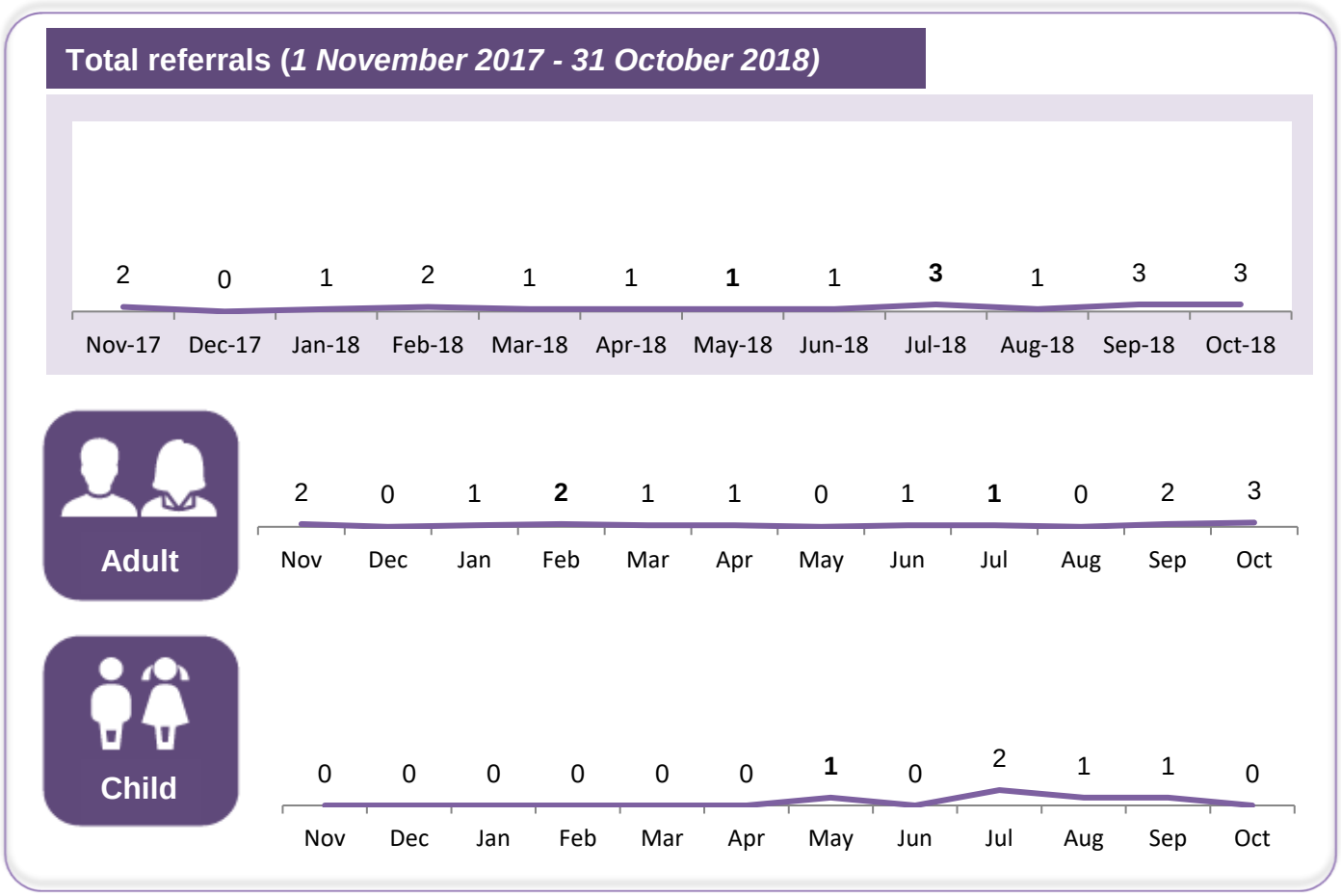
Each authority has their own guidelines as to how to investigate and progress a safeguarding referral. Generally, if a concern is raised regarding a child or vulnerable adult, the organisation will work to ensure the safety of the person and an assessment of the concerns will also be conducted to determine whether an external referral to Children's Services, Adult Services or the police should take place.

Staff received training in safeguarding that was appropriate for their role. Staff we spoke with showed detailed understanding of safeguarding and described how they identified and made a safeguarding referral. Managers and staff reported good relationships with the local authority safeguarding teams and other agencies such as acute hospital safeguarding leads. Posters identifying the safeguarding team and contact information were visible on staff notice boards.

This core service made 19 safeguarding referrals between 1 November 2017 and 31 October 2018, of which 14 concerned adults and five children.

	Number of referrals		
Core service	**Adults**	**Children**	**Total referrals**
MH - Mental health crisis services and health-based places of safety	14	5	19

The number of adult safeguarding referrals in month ranged from zero to three per month (as shown below). The number of child safeguarding referrals ranged from zero to two per month (as shown below)



The trust has submitted details of no serious case reviews commenced or published in the last 12 months (20 November 2017 and 20 November 2018) that relate to this service.

Staff access to essential information

The trust used an electronic patient record system that all staff, including agency staff could access. All information needed to deliver patient care was available. Staff access to electronic case notes was protected and any paper notes were securely locked away. Crisis assessment and treatment teams used paper referral forms. Team managers used a USB memory stick as a backup for computer records.

The mental health liaison teams used a different computer system to acute hospital staff. Staff told us they had logins but if they did not use them often they were often locked out of the system. Staff working within these teams said they found it challenging to access a computer within A&E and both trusts were working to resolve this.

Medicines management

Staff transported medicines to patients in the community in lockable bags along with sharps bins and other equipment when needed. Staff disposed of unwanted and returned medicines in medicines bins which were correctly dated at the start of use.

Staff managed controlled drugs effectively. They recorded regular stock checks in the controlled drugs register. No controlled drugs were in stock at the time of inspection.

Each crisis assessment and treatment team had a pharmacist visit every six to eight weeks to check medication stock and place any orders. The trust pharmacy team had completed recent medicines audits at all locations. Areas of actions were outlined for teams and we saw evidence that staff took appropriate action in a timely way. However, Cygnet House staff did not record their disposal of medicines and did not follow the trust's policy regarding this. Staff also did not record

when they removed medicines from stock to take on home visits until they returned. There was not a clear audit trail to show how much medicine had been left with a patient and how much staff held in the office.

Staff assessed the risks of leaving medicines at home with patients and adjusted plans regularly. Staff tried to accommodate patients, for example, giving them enough medicines when going away for a weekend, and supporting them to administer their own medication when possible.

Staff completed a medication history with patients which included medicines for their physical health, which were reviewed and prescribed onto the drug charts. Staff communicated any changes with GPs and community pharmacists.

Staff at Rosanne House and St Pauls crisis assessment and treatment team documented their monitoring of patients' physical health checks including their weight body mass index appropriate blood tests, efficacy of dose and patient led monitoring of side effects for patients prescribed high dose anti-psychotics.

Track record on safety

Between 1 November 2017 and 31 October 2018 there were 17 serious incidents reported by this service. Of the total number of incidents reported, the most common type of incident was 'Unexpected Death' with 11.

We reviewed the serious incidents reported by the trust to the Strategic Executive Information System (STEIS) over the same reporting period. The number of the most severe incidents recorded by the trust incident reporting system was comparable with STEIS with 17 reported.

A 'never event' is classified as a wholly preventable serious incident that should not happen if the available preventative measures are in place. This service reported zero never events during this reporting period.

	Number of incidents reported				
Type of incident reported (SIRI)	**Apparent/actual/ suspected self-inflicted harm meeting SI criteria**	**Confidential information leak/information governance breach meeting SI**	**Disruptive/ aggressive/ violent behaviour meeting SI criteria**	**Unexpected Death**	**Total**
Crisis Assessment & Treatment Team - North West - St Pauls	0	0	0	1	**1**
Crisis Assessment & Treatment Team - South East – The Orchards	0	0	1	0	**1**
Crisis Assessment & Treatment Team - South West	1	0	0	3	**4**
Crisis Assessment & Treatment Team East	2	0	0	0	**2**
Crisis Assessment & Treatment Team North	0	0	0	1	**1**

	Number of incidents reported				
Type of incident reported (SIRI)	**Apparent/actual/ suspected self-inflicted harm meeting SI criteria**	**Confidential information leak/information governance breach meeting SI**	**Disruptive/ aggressive/ violent behaviour meeting SI criteria**	**Unexpected Death**	**Total**
Herts/Initial Assessment Cheshunt					
Crisis Assessment & Treatment Team North West & Acute Day Treatment Unit	0	0	0	1	**1**
Crisis Assessment & Treatment Team South East	0	1	0	0	**1**
East Crisis Assessment & Treatment Team	0	0	0	1	**1**
Mental health liaison teams (Watford General Hospital)	0	0	0	2	**2**
Mental health liaison teams LISTER	0	0	0	1	**1**
South West Crisis Assessment & Treatment Team	0	0	0	1	**1**
South West Crisis Assessment & Treatment Team & Somerset HTT	1	0	0	0	**1**
Total	**4**	**1**	**1**	**11**	**17**

Reporting incidents and learning from when things go wrong

Staff knew how to report incidents and could give examples of where they had done this. The trust used an electronic system to record all incidents.

The trust had a system in place to investigate incidents. Staff said they received feedback to staff from the investigations of incidents via team meetings and supervision. We saw examples of the minutes of these meetings. Crisis assessment and treatment team leaders attended monthly team meetings where lessons learnt across teams was disseminated to staff. Colne House crisis assessment and treatment team had a learning lessons folder which staff utilised to review lesson learnt across the trust. The trust facilitated a bi-monthly police liaison meeting to oversee the operation of the health based places of safety and discuss learning from any incidents.

Staff understood the duty of candour and were open and transparent to patients and families if and when something went wrong.

Staff we spoke with told us they were supported by and debriefed with managers after serious incidents. Reflective practice sessions were taking place at the Colne House crisis assessment and treatment team.

Managers debriefed and supported staff after any serious incident. Staff told us that they received support following incidents.

The Chief Coroner's Office publishes the local coroners Reports to Prevent Future Deaths which all contain a summary of Schedule 5 recommendations, which had been made, by the local coroners with the intention of learning lessons from the cause of death and preventing deaths.

In the last two years, there have been no 'prevention of future death' reports sent to Hertfordshire Partnership NHS Trust.

Is this service effective?

Assessment of needs and planning of care

Staff completed a comprehensive mental health assessment of each patient. We reviewed 37 care plans, generally they were up to date, personalised, holistic, recovery orientated and included physical health checks. However, three care plans reviewed at Cygnet House crisis assessment and treatment team did not clearly detail the plan of care.

Staff working within the crisis assessment and treatment teams completed an initial care plan in collaboration with the person receiving care. Staff completed a more detailed care plan after the assessment and discussed and further developed the plan with the patient. Due to the nature of the core service, care plans were brief but relevant and focused on short term goals and crisis management. Staff reviewed and updated care plans regularly across the service.

At Cygnet House crisis assessment and treatment team staff had not completed physical health assessments for eight patients. The manager told us that one nurse identified as the team physical health care champion carried out the physical health assessments once a week and prioritised patients based on their risk.

Best practice in treatment and care

Staff provided a range of care and treatment suitable for patients within the service. Crisis assessment and treatment teams had a level of trained staff within their teams which enabled them to consider a range of psychosocial interventions such as cognitive behavioural therapy (CBT) and dialectical behavioural therapy (DBT).

Interventions included support for housing, employment and money advice assistance. Crisis assessment and treatment teams carried out joint assessments with the local substance misuse team or other community teams, as appropriate.

Staff used recognised rating scales and other approaches to rate severity and to monitor outcomes. We saw evidence that the Health of the Nation Outcome Scale clustering tool was undertaken for all patients.

Staff supported patients to live healthier lives, for example, through participation in smoking cessation schemes and dealing with issues relating to substance misuse.

Staff used technology to support patients effectively. Patients received appointment reminders via text messages. Patients were signposted to online resources where appropriate.

Staff participated in clinical audit activity, including audits on physical health, risk assessments and progress notes.

This service participated in seven clinical audits as part of their clinical audit programme 2017 – 2018.

Audit name	Audit scope	Core service	Audit type	Date completed	Key actions following the audit
CATT Gatekeeping (Q3)	CATT	MH - Mental health crisis services and health-based places of safety	Clinical	08/02/2018	Development of Gatekeeping form on PARIS. Continue with Quarterly Monitoring. Acute Inpatient Admissions to be validated
CATT Gatekeeping (Q4)	CATT	MH - Mental health crisis services and health-based places of safety	Clinical	17/05/2018	PARIS Form to be signed off and Rolled Out to Teams. Step by step guide to be created for recording on new form. Audit Gatekeeping in Q3 18/19.
POMH-UK Topic 15b: Prescribing valproate for bipolar disorder	Adult Inpatient/Community/CATT/ADTU	MH - Acute wards for adults of working age and psychiatric intensive care units, MH - Community-based mental health services for adults of working age, MH - Mental health crisis services and health-based places of safety	Clinical	19/07/2018	Medicines management to re issue email reminder regarding use of sodium valproate for women of child bearing age. To promote the use of HPFT choice and medication websites. Also, a presentation at the medical staff committee.
To Review the Effectiveness of Crisis Plans	Acute/ Crisis Services	MH - Mental health crisis services and health-based places of safety, MH - Acute wards for adults of working age and psychiatric intensive care units	Clinical	10/05/2018	Work to continue on mental health crises in Hertfordshire with Service Line Lead from HPFT and the Police in the Herts Crisis Care Concordat.

Audit name	Audit scope	Core service	Audit type	Date completed	Key actions following the audit
Frequent Attenders Care Plans	Crisis Services	MH - Mental health crisis services and health-based places of safety	Clinical	11/10/2018	Organise a developmental day to plan the next stages of project. Recruit staff to cover maternity leave. To agree a process for frequent attender, care plans to be attached on Paris.
Medically Unexplained Symptoms Care Plan	Crisis Services	MH - Mental health crisis services and health-based places of safety	Clinical	14/11/2018	Recruit staff to cover maternity leave. To develop protocol for MUS recording. Conduct spot checks against protocol.
Gatekeeping Audit	CATT	MH - Mental health crisis services and health-based places of safety	Clinical	07/11/2018	To inform staff of service users with insufficient information. To share findings

Skilled staff to deliver care

All teams had access to a range of mental health disciplines required to care for the patients that were using the service. This included psychiatrists, nurses, social workers and support workers. Some teams included student nurses and social workers on placement. However, the mental health liaison teams had two psychologist vacancies.

Staff we spoke with on-site were experienced and knowledgeable and had the essential skills to meet the needs of the patient group.

Staff received an appropriate induction. All staff received the trust induction which included reading relevant policies and shadowing experienced staff.

We saw evidence in individual supervision files that managers addressed poor staff performance and made reasonable adjustments for staff with additional needs. The manager at Cygnet House crisis assessment and treatment team had developed group supervision that was facilitated bi-weekly.

Staff received specialist training for their roles. Staff working within the health based places of safety had received specialist training, and four staff from the mental health liaison teams had

completed domestic violence training. Other staff were booked to attend. This was a recommendation following a serious incident.

The trust's target rate for appraisal compliance is 95%. At the end of last year (31 March 2018), the overall appraisal rate for non-medical staff within this service was 93%. This year so far, the overall appraisal rates was 97% (as at 30 September 2018). The wards with the lowest appraisal rate at 30 September 2018 were KC 136 Suite with an appraisal rate of 93% and CATT South West Herts team with an appraisal rate of 94%.

Team name	Total number of permanent non-medical staff requiring an appraisal	Total number of permanent non-medical staff who have had an appraisal	% appraisals as at 30 September 2018)	% appraisals (previous year 1 April 2017 – 31 March 2018)
CATT East & South-East Herts	13	13	100%	100%
CATT - East Herts	14	14	100%	n/a
CATT North Herts	12	12	100%	100%
CATT North West	22	21	95%	94%
CATT South West Herts	18	17	94%	100%
KC 136 Suite	15	14	93%	69%
Core service total	**94**	**91**	**97%**	**93%**
Trust wide	**1467**	**1350**	**92%**	**88%**

The trust has not provided appraisal data for medical staff.

At the time of inspection, the percentage of staff that received regular supervision across the core service was 91% at the end of February 2019.

Multi-disciplinary and interagency team work

Staff had access to a range of meetings across teams, these included multidisciplinary team meetings, team meetings, governance meetings, debriefs and reflective practice sessions. Managers changed the time of meetings monthly to ensure a wide range of staff on varying shifts could attend. They emailed minutes of meetings to staff and ensured they were accessible for staff to view.

Crisis assessment and treatment team staff shared information about patients at twice daily handover meetings. Cygnet House crisis assessment and treatment team had a weekly in-depth handover meeting that all staff attended. During inspection we observed staff handover meetings at Roseanne House and St Paul's where staff discussed patients fully in a professional manner. The crisis assessment and treatment teams also facilitated handovers to night staff at Kingfisher Court and to adult community teams.

Team leaders from across services attended a monthly meeting, we saw that staff used it share information and learning across teams.

Staff had good working relationships with other teams across the trust. Regular cross sector meetings took place with other services including the team leaders' meeting which was attended

by CATT team leaders, mental health liaison teams and the street triage team leader. Crisis assessment and treatment teams facilitated handovers with the acute day treatment units and referred patients to a wellbeing college which was delivered in partnership with the local acute trust. We saw joint working with specialist child and adolescent mental health services during inspection.

The crisis assessment and treatment teams provided in reach daily to the acute wards, facilitating early discharge to promote service flow through the acute pathway. Staff attended regular meetings to discuss patients and plans for their care. Staff told us this was working well but it was a pressure on staffing resources.

Staff engaged in activities and initiatives to improve joint-working and liaison across teams. Across all services we saw excellent links with the community voluntary sector. Staff carried out joint assessments with the local substance misuse team and worked closely with mental health charities, money advice services and homeless trusts.

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

As of 30 September 2018, 90% of the workforce in this service had received training in the Mental Health Act. The trust stated that this training is mandatory for all services for inpatient and all community staff and renewed every three years.

The training compliance reported during this inspection was the same as the 90% reported for the previous year.

Staff received training on the Mental Health Act 1983 and could describe the Code of Practice guiding principles. Staff demonstrated a good understanding of the Mental Health Act and the relevance to their patient group and their specific role.

When patients left hospital under Section 17 of the Mental Health Act, authorisation for leave of absence, the CATT teams supported patients whilst they were in the community.

Staff across all teams knew how to access the advocacy services. Patients detained under Section 136 Mental Health Act in a health based place safety and patients using the crisis assessment and treatment team, were given leaflets on how to access independent mental health advocacy.

Teams had access to approved mental health professionals should they need them to coordinate a Mental Health Act assessment for patients.

The trust had clear, accessible, relevant and up-to-date policies and procedures that reflected relevant legislation and the Mental Health Act Code of Practice.

Good practice in applying the Mental Capacity Act

As of 30 September 2018, 94% of the workforce in this service had received training in the Mental Capacity Act. The trust stated that this training is mandatory for all services for inpatient and all community staff and renewed every three years.

The training compliance reported during this inspection was lower than the 92% reported for the previous year.

Staff demonstrated a good understanding of the Mental Capacity Act 2005 and its five statutory principles. Staff knew how to access this knowledge and expertise within their teams.

Staff gave patients all possible support to make specific decisions for themselves before deciding a patient did not have the capacity to do so. Staff assessed and recorded capacity to consent.

The trust had a policy on the Mental Capacity Act. Staff were aware of the policy and had access to it. Staff knew where to get advice from within the provider regarding the Mental Capacity Act.

Is the service caring?

Kindness, privacy, dignity, respect, compassion and support

In all the teams we visited we observed staff were caring and respectful in their interactions with patients receiving care. Patients who used the services told us that the staff treated them with dignity and were professional.

Patients told us that they felt positive about the care they received from staff. They told us staff listened to them and knew their individual needs. Staff supported patients to understand their needs and manage their own care and treatment. Staff appropriately signposted patients to other services, including the voluntary sector for additional support and treatment.

We received 35 patient feedback cards for crisis assessment and treatment teams. Thirty-two were positive, patients said staff were friendly and helpful and they could be honest with staff who were caring and unjudgmental. Three were negative, one patient said they did not feel listened to by staff.

Staff discussed patients during handover in a respectful manner and showed a good understanding of individual needs.

Staff told us they could confidently raise concerns about disrespectful, discriminatory or abusive behaviour or attitudes towards patients and staff.

Staff followed the trust's policy to keep patient information confidential. Staff gave all patients using the services a 'protection and use of personal information' leaflet and gave carers and family members a 'guide to confidentiality' leaflet.

Involvement in care

Involvement of patients

Staff working in crisis assessment and treatment teams completed a care and support plan with patients and carers. Staff included patients are carers views in the care and support plans.

Staff enabled patients to give feedback on the service they received through 'having your say' leaflets. Patients were also given a leaflet on how to comment, complain or compliment the service they had received. Staff sent questionnaires to people who had attended the health based places of safety requesting feedback about their experience to improve the quality of care provided.

Staff gave patients detained under section 136 Mental Health Act 1983 in a health based place of safety a form detailing why they were there, how long they would stay there and information about their treatment. Staff gave patients leaflets on how to access independent mental health advocacy.

Involvement of families and carers

Staff enabled carers to give feedback on the service they received through 'having your say' leaflets. Carers were also given a leaflet on how to comment, complain or compliment the service they had received.

Roseanne House crisis assessment and treatment team had a carers champion based within the team. Crisis assessment and treatment teams referred to staff within the trust for a carers assessment or to a local voluntary organisation that provided advice, information and support to carers.

Carers told us they were appropriately involved in care planning and were kept up to date and offered support. Carers could contact staff directly if they had concerns regarding their relative.

Is the service responsive?

Access and waiting times

Crisis assessment and treatment teams could see urgent referrals quickly and had a first response team to assess patients within one hour of referral time. The crisis team was available 24 hours a day, 7 days a week.

The mental health liaison teams were available 24 hours a day, seven days a week and were based within the acute hospitals. The health based places of safety were staffed and able to accept patients detained under Section 136 of the Mental Health Act, 24 hours a day, seven days a week. The street triage team operated 17:00 to 04:00 hours, seven days a week.

In each of the crisis assessment and treatment teams we visited we saw that patients were given flexibility in when they could see staff and where, staff offered morning, afternoon or evening appointment slots. Staff had flexibility in where they could meet patients and facilitated office appointments or home treatment.

The crisis assessment and treatment teams took a proactive approach to engaging with patients who found it difficult or were reluctant to engage with mental health services. This included re-engaging with patients who did not attend their appointments. Action taken included ‘cold calling’, contacting other professionals and requesting a police welfare check.

Staff supported patients during referrals and transfers between services. Crisis assessment and treatment team staff could refer patients to the acute day treatment units which provided an alternative to an inpatient stay and the ‘host family’ scheme. A host family provides a caring family environment for a patient. This supports patients to develop relationships and work on social reintegration. Host family placements welcome patients in to their homes and are assessed to ensure they are a suitable match. Access to a host family is through crisis assessment and treatment teams, with both the hosts and guests receiving intensive support through the crisis assessment and treatment teams. The length of stay is usually for about three to six weeks with a maximum of eight weeks.

We looked at information for 23 patients detained under Section 136 Mental Health Act 1983 in a health based place of safety between 31 December 2018 and 7 January 2019. During this period there were two delayed discharges due to patients awaiting admission to an acute ward. Managers had completed an incident report for both delayed discharges. The trust provided further data which showed Between October and December 2018 8% (19 out of 231) of Section 136 detentions exceeded the 24 hours. Out of the 19 cases exceeding 24 hours, staff completed extension forms for 7 detentions. Where delays had occurred, the trust completed incident forms and advised all individuals in writing of the reasons for their delay and follow up actions they could take.

Between October and December 2018, the street triage attended 364 incidents, their input resulted in only 9.6% service users being detained under section 136 and 5.9% attended accident and emergency, with 80.6% diverted into appropriate health services.

The trust has identified the below services in the table as measured on ‘referral to initial assessment’. The service met the referral to assessment target in four of the targets listed.

Name of hospital site or location	Name of Team	Please state service type.	CCQ core service	Days from referral to initial assessment		Days from referral to treatment	
				Target	Actual (median)	Target	Actual (median)
Acute Hospital	E&N Herts Team	CATT	MH - Mental health crisis services and health-based places of safety	4 hours	0 days	N/A	N/A
Acute Hospital	West Herts Team	CATT	MH - Mental health crisis services and health-based places of safety	4 hours	0 days	N/A	N/A
Acute Hospital	E&N Herts Team	-	MH - Mental health crisis services and health-based places of safety	4 hours	0 days	N/A	N/A
Acute Hospital	West Herts Team	-	MH - Mental health crisis services and health-based places of safety	4 hours	0 days	N/A	N/A

The commissioned target response time from referral to initial contact with patients was four hours for the crisis assessment and treatment team. Managers told us when they did not meet these response times they completed an incident report. Staff told us on the few occasions when target response times were not met it was usually on patients' request, this could be due to the patient being referred by the mental health liaison teams and not wanting an immediate assessment following discharge from A&E.

The facilities promote comfort, dignity and privacy

Crisis assessment and treatment teams had a range of rooms and equipment to help support treatment and care, for example, access to a clinic room to examine patients and sufficient chairs in waiting areas. Staff usually saw patients within their own homes.

The health based place of safety at Kingfisher Court had been purpose built to optimise comfort and dignity during the assessment process. interview rooms were located within the suites and were adequately sound proofed. The health based place of safety based within Oak Unit had a blind spot in the ensuite facilities. Staff managed this with observation by dedicated staff. Female staff were available at all times. We noted there was no clock visible to the person in the suite. This meant patients would not always know how long they had been there. Staff accessed clean clothes and bedding for patients and offered a range of food and drinks. We saw building plans for refurbishment, due to commence in August 2019, to reconfigure the layout of the room, to include office facilities.

The mental health liaison team at Lister Hospital was accredited with the Psychiatric Liaison Accreditation Network (PLAN) in 2015 and was planned for renewal in April 2019. The team completed a self-assessment and PLAN assessment. A trust action plan had been developed.

Patients' engagement with the wider community

Staff ensured patients had access to opportunities for education and work as relevant.

Staff helped patients to stay in contact with families and carers. They encouraged patients to develop and maintain relationships both in the service and the wider community.

Meeting the needs of all people who use the service

All services could support and make adjustments for patients with disabilities, communication needs or other specific needs. Managers ensured staff and patients had access to interpreters or signers when needed.

Staff made sure patients could access information on treatment, local service, their rights and how to complain. All but one patient information leaflets we viewed stated that they could be provided in different languages. However, the leaflets were written in English. This meant if someone could not read or speak English they might not know leaflets in other languages were available.

Staff catered for patients with special dietary requirements, and allergies in the health based places of safety.

The mental health liaison teams were arranging staff training about how to best work with patients from traveling communities, with a learning disability or autistic spectrum disorder, and with children.

This service received eight complaints between 1 November 2017 to 31 October 2018. None of these were fully upheld, one was partially upheld and five were not upheld. None were referred to the Ombudsman.

Ward name	Total Complaints	Fully upheld	Partially upheld	Not upheld	Other	Under Investigation	Withdrawn	Referred to Ombudsman
Crisis Assessment and Treatment Team (CATT) - South West	**3**	0	0	2	0	1	0	0
Mental health liaison teams	**2**	0	0	2	0	0	0	0
Crisis Assessment and Treatment Team (CATT) - North	**1**	0	1	0	0	0	0	0
Crisis Assessment and Treatment Team (CATT) - North West	**1**	0	0	0	0	1	0	0
S136, Kingsley Green	**1**	0	0	1	0	0	0	0

Staff displayed posters and leaflets in communal areas informing patients how to make a complaint. Staff knew how to deal with complaints and described how they advised and supported patients to complain. All patients we spoke with knew how to make a complaint. In addition, staff

provided patients and carers with a ‘having your say ‘leaflet and a guide to making comments, compliments and complaints.

This service received 42 compliments during the last 12 months from 1 November 2017 and 31 October 2018 which accounted for 3% of all compliments received by the trust as a whole.

Teams displayed cards where patients or carers had written to thank staff for their support.

Is the service well led?

Leadership

Managers 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. Managers worked hard to improve the quality of care.

Managers were visible within the service, appeared well respected and had skills for role. Staff spoke positively about the accessibility and approachability of managers.

Managers we spoke with told us they had been promoted from within trust teams. Staff we spoke with said they had the opportunity to progress within the service. We saw evidence of internal recruitment and promotion.

Vision and strategy

Staff knew and understood the trust’s visions and values and could describe how they applied to their work. The trust had ensured staff were working to common goals and practices. Staff were consistently committed to these values and applied these to the work in their team.

The provider’s vision and values were displayed across teams notice boards.

Managers involved staff in innovations and service improvements. Staff told us that they had the opportunity to contribute to discussions about the strategy for their service, including the plans to remodel the crisis assessment and treatment team.

Staff could explain how they were working to deliver high quality care within budget.

Culture

Staff felt respected, supported and valued by their team and wider management.

Staff morale was high in all the teams we visited. Staff told us they were proud of the job they did and felt well supported in their roles.

Staff felt proud to work for their team and the trust. Staff could raise concerns without fear of reprisals. They understood the ‘speaking up’ policy and who the ‘speak up guardian’ was.

Crisis assessment and treatment teams worked well together supported other teams when they were experiencing high caseloads.

Most staff reported that the trust promoted equality and diversity in its day-to-day work and provided opportunities for career progression. Examples included managers allowing flexible working to attend religious prayer. Some staff had attended trust workforce race equality standards events.

Staff had access to support for their own physical and emotional health needs through an occupational health service and trust wide wellbeing initiatives. Managers addressed sickness and absence appropriately and supported staff to return to work.

Staff appraisals included conversations about career development and how the trust could support this.

Governance

Teams had regular team meetings. In addition, there was regular supervision, training and reflective practice meetings. Managers had a clear agenda of items they discussed at these meetings. Team leaders from across the services attended a monthly meeting which was utilised to learn and share information.

Staff gave examples of implementing recommendations from reviews of deaths, incidents, complaints and safeguarding alerts at the service level.

Staff understood arrangements for working with other teams, both within the trust and external, to meet the needs of the patients.

Management of risk, issues and performance

Team managers had access to the risk register and could tell us what items specific to their core service were included. Staff could escalate concerns when required from a team level.

Managers told us they had good support from their human resources department to manage staff sickness and recruitment.

The service had plans for emergencies, such as a flu outbreak, information technology failure or adverse weather. Team managers used a USB memory stick as a backup for computer records in case of information technology failure.

Information management

Staff had access to the equipment and information technology needed to do their work. However, staff did not have access to a laptop which they could take on visits. Staff completed paperwork when they returned to their office base.

Information governance systems included confidentiality of patient records.

Information was in an accessible format, and was timely, accurate and identified areas for improvement.

Staff made notifications to external bodies including safeguarding, police and the CQC as needed.

Engagement

Staff, patients and carers had access to up-to-date information about the work of the provider and the services they used, for example, through the intranet, bulletins and newsletters.

Patients and carers had opportunities to give feedback on the service they received in a manner that reflected their individual needs through ‘having your say’ leaflets. Patients and carers were also given a leaflet on how to comment, complain or compliment the service they had received.

Managers and staff had access to the feedback from patients, carers and staff and used it to make improvements. Feedback was discussed at team leader’s meetings and team meetings.

Patients and staff could meet with members of the trust’s senior leadership team and governors to give feedback. Staff told us that members of the executive team visited the teams. Staff were invited to attend breakfast meetings with the chief executive.

Directorate leaders engaged with a wide range of external stakeholders. This included housing, education establishments, commissioners and Health watch.

Learning, continuous improvement and innovation

Staff were given the time and support to consider opportunities for improvements and innovation and this led to changes. One staff member told us they had been given the opportunity to develop referral forms to include risk rating.

Teams participated in accreditation schemes relevant to the service. Lister General Hospital and Watford General Hospital mental health liaison teams were accredited with the Psychiatric Liaison Accreditation Network (PLAN) standards.

A mental health clinician from the crisis assessment and treatment team supported the call centre staff working within the Hertfordshire urgent care 111 mental health pilot, offering support and advice to both clinicians and health advisors when needed.

The trust provided a 'host family scheme'. The host family provide a caring family environment for a patient, supporting patients to develop relationships and work on social reintegration. Host family placements welcome patients in to their homes and are assessed to ensure they are a suitable match. Both the hosts and patients receive intensive support through the crisis assessment and treatment teams.

NHS trusts are able to participate in a number of accreditation schemes whereby the services they provide are reviewed and a decision is made whether or not to award the service with an accreditation. A service will be accredited if they are able to demonstrate that they meet a certain standard of best practice in the given area. An accreditation usually carries an end date (or review date) whereby the service will need to be re-assessed in order to continue to be accredited.

The table below shows which services within this service have been awarded an accreditation together with the relevant dates of accreditation.

Accreditation scheme	Core service	Service accredited	Comments
ECT Accreditation Scheme (ECTAS)	MH - Mental health crisis services and health-based places of safety	ECT Suite (Kingfisher Court) - end date 12.12.2019. First accredited 13.12.2016	n/a
Psychiatric Liaison Accreditation Network (PLAN)	MH - Mental health crisis services and health-based places of safety	CORE 24 based at Lister General Hospital and Watford General Hospital. accreditation started October 2015. The trust is currently in the process of submitting further evidence for ongoing accreditation to PLAN for accreditation renewal in Spring 2019.	n/a

MH – Specialist community mental health services for children and young people

Facts and data about this service

Location site name	Team name	Number of clinics	Patient group (male, female, mixed)
Saffron Ground	Child and Adolescent Mental Health Services - Child and Family Clinic (CAMHS North)	CAMHS Community Services don't have clinics as such – just appointments as when required	Mixed
Oxford House **Rosanne House**	Child and Adolescent Mental Health Services - Child and Family Clinic (CAMHS East)	CAMHS Community Services don't have clinics as such – just appointments as when required	Mixed
Borehamwood Civic Centre **Peace Children's Centre**	Child and Adolescent Mental Health Services - Child and Family Clinic (CAMHS South)	CAMHS Community Services don't have clinics as such – just appointments as when required	Mixed
The Marlowes Health and Wellbeing Centre **Waverley Road**	Child and Adolescent Mental Health Services - Child and Family Clinic (CAMHS West)	CAMHS Community Services don't have clinics as such – just appointments as when required	Mixed
Kingsley Green	CAMHS Crisis, Assessment & Treatment Team (C-CATT)	n/a	Mixed
Kingsley Green	Child and Adolescent Mental Health Services - Targeted Team	n/a	Mixed
Kingsley Green	Children Looked After Service	n/a	Mixed
Kingsley Green	Youth Offending Teams	n/a	Mixed
Kingsley Green	Child and Adolescent Mental Health Service - Eating Disorders	n/a	Mixed
Downs Farm Centre	Adolescent Drug and Alcohol Team (ADASH)	n/a	Mixed
Hoddesdon Health Centre	Child and Family Clinic (CAMHS East)	CAMHS Community Services don't have clinics as such – just appointments as when required	Mixed

The methodology of CQC trust information requests has changed, so some data from different time periods is not always comparable. We only compare data where information has been recorded consistently.

Is the service safe?

Safe and clean environment

Although staff carried out regular risk assessments of the care environment, and staff knew where the risk hot spots were, the mitigation for ligature anchor points in the public toilets was not adequate. Following the outcome of an incident investigation at Kingsley Green, ligature points in public toilet areas had been identified as high risk, and the mitigation to cover ligature risks in community settings i.e. staff always accompanying patients, was not relevant to these areas. Following the inspection, and within the post inspection period, the trust submitted detailed plans showing how all ligature risks would be managed going forward. These plans also included anti ligature works that were to be completed across all community sites.

Interview rooms did not have fitted alarms and while personal alarms were available for staff use in most team bases staff had not checked the alarms to see that they were present and working. CAMHs South did not have personal alarms and staff had to use their personal mobile phones to obtain help in an emergency.

Clinic rooms had all the necessary equipment to carry out physical examinations. The equipment was clean, and cleaning and calibration stickers were in date. Staff adhered to infection control principles including relevant hand washing.

All environments, except Kingsley Green, were clean, tidy, bright and well maintained. At Kingsley Green, a building occupied by several trust services including children's crisis assessment and treatment team, targeted team and eating disorder teams, the environment was tired and dull. While cleaning records were present and up to date, the public use toilets and some of the therapy rooms were not clean. The corners of the floors were not clean, and there was a layer of dirt around the window frames. Décor in all public and communal areas was poor, with plaster was coming off the walls in the communal corridor, and paintwork was discoloured.

Safe staffing

Nursing staff

This core service has reported a vacancy rate for all staff of 20% as of 30 September 2018. This was not comparable to the data used at the last inspection (September 2015).

This core service reported an overall vacancy rate of 36% for registered nurses at 30 September 2018.

This core service reported an overall vacancy rate of 5% for nursing assistants.

Since January 2019 staffing levels had improved. A successful recruitment drive and more proactive strategies, to keep existing staff, meant that staffing levels for substantive, except for systemic family therapists and consultant psychiatrists, had increased.

The trust had established safe staffing levels by calculating the number and grade of members of the multidisciplinary team needed using a systematic approach. Staffing levels could be flexed across the quadrants to meet patient needs and complexity in each locality at a given point in time.

The trust ensured there were adequate staff, with the right skills and experience for safe care and treatment of patients. The number, profession and grade of staff in post matched the trusts staffing plan. The average case load for individual staff members was 20-45. This varied across the different parts of the service and according to the staff members' experience, and the patients risk and complexity. Managers reviewed the size of the caseloads for individual staff through

management supervision and team allocation meetings. Managers helped staff manage the associated risk of their caseloads through clinical supervision.

The caseloads for doctors was higher, ranging from 116 to 305. Managers were aware of the higher caseloads for doctors due in part to how often the team had locum doctors in place. Where caseloads were very high managers had been trying different strategies to bring the numbers down. One locum doctor we spoke with told us there was a reluctance for locum doctors to discharge patients, as they did not know them or what was available for the patient as an alternative.

There were no waiting lists in the service for assessment. All teams, with the exception of CAMHs South and West teams meeting their assessment to treatment targets. Where patients were waiting for allocation to specialist therapists the patient was allocated to a named staff member with the skills and experience to support that patient and their family.

Managers ensured that existing staff or other known staff within the teams covered sickness, leave, and vacant posts to ensure continuity of care.

The service block booked locum, bank and agency staff appropriately.

		Registered nurses			Health care assistants			Overall staff figures		
Location	**Ward/Team**	**Vacancies**	**Establishment**	**Vacancy rate (%)**	**Vacancies**	**Establishment**	**Vacancy rate (%)**	**Vacancies**	**Establishment**	**Vacancy rate (%)**
Forest Lane, Kingsley Green	CAMHS Home Treatment Team	6.8	7.8	87%	4.7	8.7	54%	16.5	21.5	77%
Rosanne House	CAMHS East Herts	1.0	1.8	56%	0.0	3.0	0%	7.9	20.7	38%
Peace Children's Centre	CAMHS South Herts	2.9	4.6	64%	0.0	4.0	0%	5.2	20.4	25%
Forest Lane, Kingsley Green	CAMHS Targeted Team	1.8	5.4	33%	0.0	1.0	0%	3.6	16.1	22%
2a McDonald Court, High View, Hatfield	A-DASH	0.0	0.0	n/a	0.0	0.0	n/a	1.4	6.5	21%

		Registered nurses			Health care assistants			Overall staff figures		
Location	**Ward/Team**	**Vacancies**	**Establishment**	**Vacancy rate (%)**	**Vacancies**	**Establishment**	**Vacancy rate (%)**	**Vacancies**	**Establishment**	**Vacancy rate (%)**
Forest Lane, Kingsley Green	C-CATT	3.4	9.0	38%	-3.0	1.0	-300%	2.1	16.0	13%
Forest Lane, Kingsley Green	Eating Disorder CAMHS Community	0.0	8.7	0%	0.7	2.7	26%	1.8	15.3	12%
Marlowes Health Centre	CAMHS West Herts	0.0	2.0	0%	0.0	6.6	0%	2.8	24.3	11%
Waverley Road	CAMHS Medical	0.0	0.0	n/a	n/a	n/a	n/a	1.6	16.1	10%
Forest Lane, Kingsley Green	CAMHS Forensics	0.3	4.0	8%	n/a	n/a	n/a	0.3	4.0	8%
Saffron Ground	CAMHS North Herts	0.0	1.0	0%	0.2	3.7	7%	0.9	16.7	5%
Forest Lane, Kingsley Green	CAMH Services Management	0.8	2.8	27%	-1.1	0.9	-122%	-5.6	10.3	-54%
Rosanne House	CYP IAPT	0.0	0.0	n/a	0.0	0.0	n/a	-1.0	0.0	above establishment
	Core service total	17.0	47.1	36%	1.5	31.6	5%	37.4	187.9	20%
	Trust total	**178.1**	**853.7**	**21%**	**124.2**	**1063.0**	**12%**	**440.3**	**3375.9**	**13%**

NB: All figures displayed are whole-time equivalents

Between 1 November 2017 and 31 October 2018, 3,984 working hours were filled by bank staff to cover sickness, absence or vacancy for qualified nurses.

The main reason for bank and agency usage for the wards/teams was vacancies.

In the same period, agency staff covered 13,530 hours for qualified nurses and all available hours were able to be filled by either bank or agency staff.

Caveat: the total hours available data provided by the trust was inconclusive and therefore this, along with the percentages of bank, agency and not filled hours has not been included.

Wards	**Total hours available**	**Bank Usage**		**Agency Usage**		**NOT filled by bank or agency**	
		Hrs	**%**	**Hrs**	**%**	**Hrs**	**%**
A-DASH	n/a	141	n/a	0	n/a	0	n/a
CAMHS East Herts	n/a	515	n/a	766	n/a	0	n/a
CAMHS North Herts	n/a	355	n/a	2877	n/a	0	n/a
CAMHS Service Management	n/a	3	n/a	0	n/a	0	n/a
CAMHS South Herts	n/a	0	n/a	307	n/a	0	n/a
CAMHS West Herts HH	n/a	121	n/a	606	n/a	0	n/a
CAMHS West Herts St A	n/a	462	n/a	789	n/a	0	n/a
C-CATT	n/a	1007	n/a	8096	n/a	0	n/a
Eating Disorder CAMHS Comm	n/a	155	n/a	90	n/a	0	n/a
CATT East Herts	n/a	1135	n/a	0	n/a	0	n/a
Core service total	**n/a**	**3894**	**n/a**	**13530**	**n/a**	**0**	**n/a**
Trust Total	**n/a**	**225857**	**n/a**	**99260**	**n/a**	**12096**	**n/a**

Between 1 November 2017 and 31 October 2018, 897 working hours were filled by bank staff to cover sickness, absence or vacancy for nursing assistants.

The main reason for bank and agency usage for the wards/teams was vacancies.

In the same period, agency staff covered 3003 hours for nursing assistants and all available hours were able to be filled by either bank or agency staff.

Caveat: the total hours available data provided by the trust was inconclusive and therefore this, along with the percentages of bank, agency and not filled hours has not been included.

Wards	**Total hours available**	**Bank Usage**		**Agency Usage**		**NOT filled by bank or agency**	
		Hrs	**%**	**Hrs**	**%**	**Hrs**	**%**
A-DASH	n/a	22	n/a	0	n/a	0	n/a
CAMHS East Herts	n/a	9	n/a	22	n/a	0	n/a
CAMHS South Herts	n/a	90	n/a	0	n/a	0	n/a
CAMHS West Herts HH	n/a	0	n/a	489	n/a	0	n/a

Wards	Total hours available	Bank Usage		Agency Usage		NOT filled by bank or agency	
		Hrs	%	Hrs	%	Hrs	%
CAMHS West Herts St A	n/a	86	n/a	58	n/a	0	n/a
C-CATT	n/a	133	n/a	2433	n/a	0	n/a
Core service total	**n/a**	**897**	**n/a**	**3003**	**n/a**	**0**	**n/a**
Trust Total	**n/a**	**386308**	**n/a**	**52970**	**n/a**	**32577**	**n/a**

This core service had 32.8 (24%) staff leavers between 1 October 2017 and 30 September 2018. This was not comparable to the data used at the last inspection (September 2015).

Location	Ward/Team	Substantive staff (at latest month)	Substantive staff Leavers over the last 12 months	Average % staff leavers over the last 12 months
2a McDonald Court, High View, Hatfield	A-DASH	4.7	2.9	46%
Saffron Ground	CAMHS North Herts	14.7	5.2	41%
Waverley Road	CAMHS Medical	14.5	6.0	41%
Forest Lane, Kingsley Green	C-CATT	13.9	3.8	35%
Forest Lane, Kingsley Green	CAMH Services Management	15.9	4.0	30%
Forest Lane, Kingsley Green	CAMHS Targeted Team	12.0	2.0	19%
Peace Children's Centre	CAMHS South Herts	15.2	2.6	18%
Rosanne House	CAMHS East Herts	12.8	2.0	15%
Marlowes Health Centre	CAMHS West Herts	20.6	2.7	14%
Forest Lane, Kingsley Green	Eating Disorder CAMHS Community	14.0	1.6	12%
Forest Lane, Kingsley Green	CAMHS Forensics	3.7	0.0	0%

Location	Ward/Team	Substantive staff (at latest month)	Substantive staff Leavers over the last 12 months	Average % staff leavers over the last 12 months
Forest Lane, Kingsley Green	CAMHS Home Treatment Team	5.0	0.0	0%
Rosanne House	CYP IAPT	1.0	0.0	0%
2a McDonald Court, High View, Hatfield	A-DASH	4.7	2.9	46%
Core service total		**147.9**	**32.8**	**24%**
Trust Total		**2903.4**	**461.5**	**16%**

The sickness rate for this core service was 2.7% between 1 October 2017 and 30 September 2018. The most recent month's data (30 September 2018) showed a sickness rate of 2.3%. This was not comparable to the data used at the last inspection (September 2015).

Location	Ward/Team	Total % staff sickness (at latest month)	Ave % permanent staff sickness (over the past year)
2a McDonald Court, High View, Hatfield	A-DASH	0.0%	6.3%
Peace Children's Centre	CAMHS South Herts	7.2%	6.2%
Forest Lane, Kingsley Green	C-CATT	0.2%	5.1%
Saffron Ground	CAMHS North Herts	1.2%	3.8%
Rosanne House	CAMHS East Herts	5.9%	2.7%
Forest Lane, Kingsley Green	CAMHS Targeted Team	3.5%	1.7%
Forest Lane, Kingsley Green	CAMHS Home Treatment Team	2.7%	1.6%
Marlowes Health Centre	CAMHS West Herts	0.7%	1.2%
Forest Lane, Kingsley Green	CAMH Services Management	0.0%	0.5%

Location	Ward/Team	Total % staff sickness (at latest month)	Ave % permanent staff sickness (over the past year)
Rosanne House	CYP IAPT	0.0%	0.1%
Waverley Road	CAMHS Medical	0.6%	0.1%
Forest Lane, Kingsley Green	CAMHS Forensics	0.0%	0.0%
Waverley Road	CAMHS Medical Trainees	n/a	0.0%
Core service total		**2.3%**	**2.7%**
Trust Total		**3.7%**	**4.5%**

Medical staff

Between 1 November 2017 and 30 October 2018, of the 52224 total working hours available, 1% were filled by bank staff to cover sickness, absence or vacancy for medical staff.

In the same period, agency staff covered 12% of available hours and all available hours were able to be filled by either bank or agency staff.

The service had rapid access to a psychiatrist when needed.

Ward/Team	Total hours available	Bank Usage		Agency Usage		NOT filled by bank or agency	
		Hrs	%	Hrs	%	Hrs	%
Child and adolescent Mental Health Services - Child and Family Clinic (CAMHS South)	3264	0	0%	75	2%	0	0%
Child and adolescent Mental Health Services - Child and Family Clinic (CAMHS West)	9792	0	0%	787	8%	0	0%
CAMHS Crisis, Assessment & Treatment Team (C-CATT)	3264	0	0%	1033	32%	0	0%
Child and Adolescent Mental Health Services - Child and Family Clinic (CAMHS East)	3264	0	0%	390	12%	0	0%
Forest House Adolescent Unit	3264	0	0%	704	22%	0	0%
Child and Adolescent Mental Health Services - Child and Family Clinic (CAMHS West)	13056	416	3%	1210	9%	0	0%
Child and Family Clinic (CAMHS East)	3264	0	0%	227	7%	0	0%

Ward/Team	Total hours available	Bank Usage		Agency Usage		NOT filled by bank or agency	
		Hrs	%	Hrs	%	Hrs	%
Child and Adolescent Mental Health Services - Child and Family Clinic (CAMHS North)	6528	0	0%	900	14%	0	0%
Crisis Assessment and Treatment Team (CATT) - South East	6528	0	0%	811	12%	0	0%
Core service total	**52224**	**416**	**1%**	**6135**	**12%**	**0**	**0%**
Trust Total	**146022**	**418**	**<1%**	**21401**	**15%**	**1**	**<1%**

Mandatory training

The compliance for mandatory and statutory training courses at 30 September 2018 was 79%. Of the training courses listed 23 failed to achieve the trust target and of those, eight failed to score above 75%.

The trust set a target of 92% for completion of mandatory and statutory training.

The trust reports a year end figure for training compliance.

The training compliance reported for this core service during this inspection was higher than the 77% reported in the previous year.

Key:

Below CQC 75%	Met trust target ✓	Not met trust target ✗	Higher ↑	No change →	Lower ↓

Training Module	Number of eligible staff	Number of staff trained	YTD Compliance (%)	Trust Target Met	Compliance change when compared to previous year
Safeguarding Adults Level 2 [3 Years]	153	140	92%	✓	↑
Infection, Prevention & Control Level 1 [2 Years]	32	29	91%	✗	↑
Equality, Diversity & Human Rights [3 Years]	185	165	89%	✗	↓
Safeguarding Children Level 3 [3 Years]	140	122	87%	✗	↑
Health, Safety & Welfare [3 Years]	185	161	87%	✗	↓

Training Module	Number of eligible staff	Number of staff trained	YTD Compliance (%)	Trust Target Met	Compliance change when compared to previous year
Care Records and Confidentiality Awareness [3 Years]	48	41	85%	✘	↑
Safeguarding Adults Level 1 [3 Years]	32	27	84%	✘	↑
Preventing Radicalisation (WRAP) [Once]	152	126	83%	✘	↓
Data Security Awareness [1 Year]	185	153	83%	✘	↓
Fire Safety [2 Years]	144	118	82%	✘	↑
Mental Capacity Act and Deprivation of Liberty Safeguards [3 Years]	122	99	81%	✘	↓
Clinical Risk Assessment and Management [3 Years]	122	97	80%	✘	↑
Safeguarding Children Level 1 [3 Years]	28	22	79%	✘	↑
Relating to People Mod 3a [3 Years]	26	20	77%	✘	↑
Intermediate Life Support (includes BLS) [1 Year]	17	13	76%	✘	↑
Mental Health Act [3 Years]	120	91	76%	✘	↑
Infection, Prevention & Control Level 2 [2 Years]	153	110	72%	✘	↑
Moving and Handling L2 [2 Years]	56	39	70%	✘	↑
Moving and Handling L1 [3 Years]	130	89	68%	✘	↑
Basic Life Support [1 Year]	119	81	68%	✘	↓
Relating to People Mod 3b [1 Year]	117	62	53%	✘	↑
Safeguarding Children Level 2 [3 Years]	2	1	50%	✘	↑
Fire Safety [1 Year]	4	2	50%	✘	n/a

Training Module	Number of eligible staff	Number of staff trained	YTD Compliance (%)	Trust Target Met	Compliance change when compared to previous year
Ligature Awareness [3 years]	5	2	40%	✗	↓
Core service total	**2,277**	**1,810**	**79%**	✗	↑

Staff received appropriate training for their roles. At the time of inspection, we saw evidence showing that all teams had achieved the trusts target of 92%.

Assessing and managing risk to patients and staff

Assessment of patient risk

Staff completed a risk assessment for every patient at triage. Staff repeated this at the choice appointments and updated the risk assessments regularly, including after any incident. Staff used recognised risk assessment tools, including junior marzipan in the Eating Disorder team. We reviewed 46 patient risk assessments. All but two of the records were of good quality. One record had not detailed the risk crisis plan, and the other had not reflected the additional risks the patient had because of their physical health needs and access to insulin medication.

Management of patient risk

Staff responded promptly to sudden deterioration in a patient's health. Staff discussed any deterioration or new risk in team meetings, supervision and SWARM meetings. Staff held SWARM meetings when needed that engaged as many staff as possible to review a particular risk and agree a risk management plan.

Staff monitored all patients on waiting lists to detect and respond to increases in level of risk, or changes of need. However, each team had their own systems for doing this. In some teams the patients' named staff member initiated contact with the patient and or their family at set intervals either by telephone or text; while in other teams the duty workers contacted the patient every two or three weeks. Some teams sent a letter to the patient and or carer updating them on the progress of their referral; and, other teams invited the patient or family member to contact the team if problems arose, at which point the named worker returned the call or responded accordingly.

The service had developed good personal safety protocols, including lone working practices, and there was evidence that staff followed them.

Safeguarding

A safeguarding referral is a request from a member of the public or a professional to the local authority or the police to intervene to support or protect a child or vulnerable adult from abuse. Commonly recognised forms of abuse include: physical, emotional, financial, sexual, neglect and institutional.

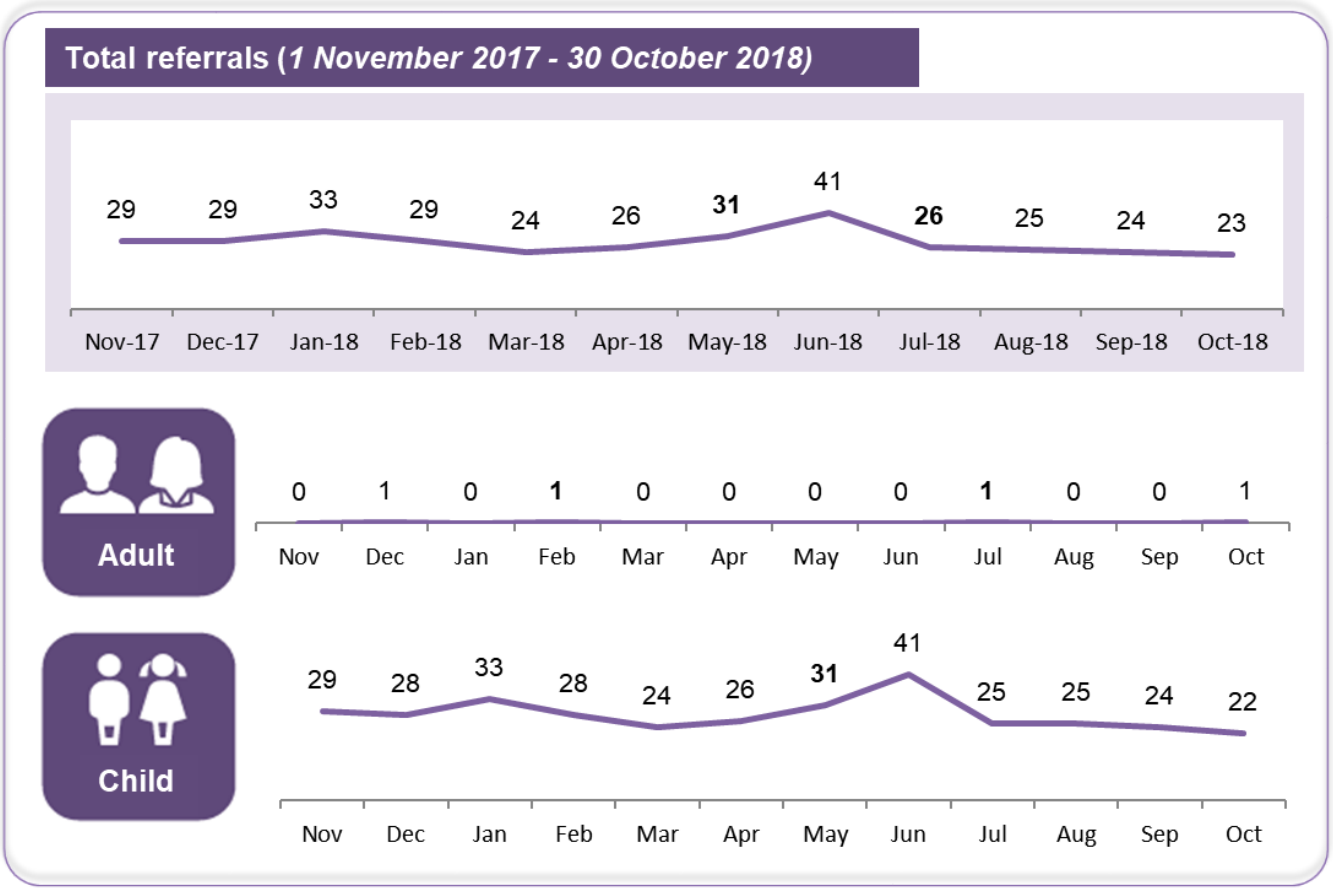
Each authority has their own guidelines as to how to investigate and progress a safeguarding referral. Generally, if a concern is raised regarding a child or vulnerable adult, the organisation will work to ensure the safety of the person and an assessment of the concerns will also be conducted to determine whether an external referral to Children's Services, Adult Services or the police should take place.

This core service made 340 safeguarding referrals between 1 November 2017 and 31 October 2018, of which four concerned adults and 336 children. This was not comparable to the data used at the last inspection (September 2015).

	Number of referrals		
Core service	**Adults**	**Children**	**Total referrals**
MH - Specialist community mental health services for children and young people	4	336	340

The number of adult safeguarding referrals in a month ranged from zero to one (as shown below).

The number of child safeguarding referrals ranged from 22 to 41 (as shown below).



Safeguarding had high priority in this core service. There were clear safeguarding policies and procedures that followed Local Safeguarding Children Board procedures and national guidance such as the Children's Act. Staff received training in safeguarding, knew how to raise a safeguarding concern, and did so when appropriate. Each team had a safeguarding lead and the trust had a robust safeguarding group. Staff knew how and where to get extra help and advice with safeguarding queries if needed.

Staff could give examples of how to protect young people from harassment and discrimination, including those with protected characteristics under the Equality Act 2010.

Staff knew how to identify children at risk of, or suffering, significant harm, including child trafficking and sexual grooming. They often worked in partnership with other agencies such as social care and the police.

All staff including temporary staff, had undergone a disclosure and barring service check, and checked against the Protection of Children Act register before appointment.

The trust has submitted details of no serious case reviews commenced or published in the last 12 months (November 2017 to November 2018) that relate to this service.

Staff access to essential information

This core service used electronic patient records. The trust had developed a system known as SPIKE 2. The system allowed key information from electronic patient record systems to be in one place, reducing staff time searching for information. The system enabled teams and individuals to prioritise work, review caseloads and guide conversations around supervision. All information needed to deliver patient care was available to all staff including agency staff when they needed it and in an accessible form. That included when patients moved between teams. Staff reported the system was easy to use and reliable.

Medicines management

Staff followed best practice and national guidance in medicines management both on site and in patient's homes. This included transport, storage, dispensing, administration, recording, and disposal.

Staff reviewed regularly or ensured that other healthcare professionals reviewed the effects of medication on patients' physical health. These reviews were line with guidance from the National Institute for Health and Care Excellence.

Track record on safety

Between 1 November 2017 and 31 October 2018 there were seven serious incidents reported by this service. Of the total number of incidents reported, the most common type of incident was 'apparent / actual / suspected self-inflicted harm' with three.

We reviewed the serious incidents reported by the trust to the Strategic Executive Information System (STEIS) over the same reporting period. The number of the most severe incidents recorded by the trust incident reporting system was comparable with STEIS with seven reported.

A 'never event' is classified as a wholly preventable serious incident that should not happen if the available preventative measures are in place. This service reported zero never events during this reporting period.

This was not comparable to the data used at the last inspection (September 2015).

	Number of incidents reported					
Type of incident reported (SIRI)	Apparent/actual/suspected self-inflicted harm meeting SI criteria	Apparent/actual/suspected homicide meeting SI criteria	Disruptive/ aggressive/ violent behaviour meeting SI criteria	Incident threatening organisations ability to continue to deliver an acceptable quality of healthcare services	Unexpected Death	Total
Child & Adolescent Mental Health Services West - St Albans, Hemel Hempstead	1	1	1	0	0	3
Child & Adolescent Mental Health Services North	1	0	0	0	1	2
Crisis Assessment & Treatment Team	0	0	0	1	0	1
Child & Adolescent Mental Health Services Eating Disorder Service	1	0	0	0	0	1
Total	**3**	**1**	**1**	**1**	**1**	**7**

Reporting incidents and learning from when things go wrong

All staff knew what incidents to report and how to report them. Staff reported all incidents that they should report.

Staff understood duty of candour. They were open and transparent, and gave full explanation to patients and families, when, something went wrong.

Evidence in multidisciplinary team minutes, handover meetings and quality leadership meetings, showed staff received feedback from investigation of incidents both internal and external to the service. Staff met to discuss that feedback.

There was evidence that managers had made changes because of feedback. Examples included reviewing the use, supply and checking of personal emergency call alarms and providing additional staff training around people smuggling and sexual grooming.

Staff received debriefing and support after any serious incident. We heard about the exceptional lengths one manager took to ensure staff wellbeing after a serious incident at their team base.

The Chief Coroner's Office publishes the local coroners Reports to Prevent Future Deaths which all contain a summary of Schedule 5 recommendations, which had been made, by the local coroners with the intention of learning lessons from the cause of death and preventing deaths.

In the last two years, there have been no 'prevention of future death' reports sent to Hertfordshire Partnership University NHS Foundation Trust.

Is the service effective?

Assessment of needs and planning of care

We reviewed 46 patient care records. Staff developed care plans that met the needs of the patient during the assessment. Care plans were complete, holistic, personalised and recovery-oriented. Staff updated care plans when necessary.

Most records showed clear evidence that patients and their families had been involved in their creation. The service had opted to use a letter format for the sharing of care plans. The plan of care, including risk management, followed a formulation, and, although this included key information with recovery focussed goals, they were not as detailed or personalised as those within the care record.

Staff completed a comprehensive mental health assessment of each patient at the first point of contact.

Staff ensured that any necessary assessment of the patient's physical health had been undertaken, and in some cases, this had been completed by the GP on behalf of the service.

There were no waiting lists in this service. Once a patient had been assessed they were allocated to a named worker, usually the person who had assessed them. The named worker continued to work with the patient offering either treatment, or appropriate support, if they were waiting for specialist treatment.

Best practice in treatment and care

Staff provided a range of care and treatment interventions suitable for the patient group. The interventions were those recommended by, and delivered in line with National Institute for Health and Care Excellence guidance. Interventions included medication and medication management, a full range of psychological therapies including systemic family therapy and interventions that enabled patients to develop living skills. When needed, interventions included support for education, training and employment, housing and benefits.

Staff ensured that they met patients' physical healthcare needs, including their need for an annual health check, and if the GP handled this, staff ensured that it was done on time.

Staff supported patients to live healthier lives, for example, through participation in stress management strategies, smoking cessation schemes, acting on healthy eating advice, and dealing with issues relating to substance misuse.

Staff used recognised rating scales, and other approaches, to assess severity of presenting problems and outcomes for treatment, such as health of the nation outcome scales for children and adolescents (HONOSCA). They also used specialist outcomes scales such as FEP (first episode psychosis guidelines), and DAWBA (development and wellbeing assessment) to help identify common emotional behavioural and hyperactivity disorders in children. Staff received support for completion and analysis of outcome measures from the assistant psychologists in the teams.

Staff used technology to support patients effectively such as online access to resources, texting and face time when safe to do so.

Staff took part in a range of clinical audits as detailed below, benchmarking and quality improvement initiatives, such as the pilot to revise the services referral pathway, and improved support for patients waiting for the specialist treatment pathway.

Staff worked in partnerships with schools, colleges, children's services, primary care services, and other relevant services to ensure that young people with needs such as autistic spectrum disorder or sensory impairment received co-ordinated care and intervention.

This service took part in 11 clinical audits as part of their clinical audit programme 2017 - 2018.

Audit name	Audit scope	Core service	Audit type	Date completed	Key actions following the audit
Looked After Children (LAC) Audit (Q3)	CAMHS	MH - Specialist community mental health services for children and young people	Clinical	15/02/18	Reports of admission and discharges to be reviewed on a monthly basis. Workshop to be held with CAMHS target team and LAC health team. Disseminate care leaver briefing sheet. Change request for Paris to implement CSC.
Looked After Children (LAC) Audit (Q4)	CAMHS	MH - Specialist community mental health services for children and young people	Clinical	24/05/2018	Monthly reporting on referrals and discharges, redesigning training sessions and deliver to CAMHS and Adult services. Re audit on a 6-monthly basis.
Transition from Specialist Child & Adolescent Mental Health Services to Adult Mental Health Services	Adults Community/CAMHS	MH - Specialist community mental health services for children and young people MH - Community-based mental health services for adults of working age	Clinical	03/05/2018	Guidance document to be finalised and circulated. Communicate findings with service. Launch transition page. Create guide for recording options. Conduct re-audit.
CAMHS DNA	CAMHS	MH - Specialist community mental health services for children and young people	Clinical	19/07/2018	Share audit at service and local meetings. To device local action plans. To amend letter template. To re issue DNA policy and checklist at all team meetings. To commence regular audits of all DNA cases at Team level. Staff to discuss issues of poor data recording at supervision.

Audit name	Audit scope	Core service	Audit type	Date completed	Key actions following the audit
Children Safeguarding Supervision Audit	CAMHS	MH - Specialist community mental health services for children and young people	Clinical	19/07/2018	Share report at PG meeting. Send reminder to staff to ensure they are recording safeguarding recommendations on Paris. Update safeguarding checklist. Share learning from audit findings with service. To prioritise cases of concern in supervision.
CQUIN CAMHS Transition Q2	CAMHS	MH - Specialist community mental health services for children and young people	Clinical	07/11/2018	Cab request to be made outlining changes to the Paris form. Share findings with CAMHS PG meeting. Workshops to be arranged. To develop tracker and share with CAMHS and adult community services.
CAMHS ADHD	CAMHS Community	MH - Specialist community mental health services for children and young people	Clinical	20/09/2018	Guidance to be developed on physical health for children diagnosed with ADHD and monitoring tool to be created and utilised.
Patients being informed and consent attained prior to participating in Research Projects	Adult & CAMHS	MH - Specialist community mental health services for children and young people MH - Community-based mental health services for adults of working age	Clinical	20/09/2018	To develop checklist and conduct spot check audits. To create a learning note which will be attached to the updated policy.
Children Safeguarding Audit	CAMHS	MH - Specialist community mental health services for children and young people	Clinical	20/09/2018	To include case conferences in new Paris form. To share findings and to remind staff to upload meeting minutes onto Paris. To update safeguarding database and to conduct spot checks. To discuss possibility of activity on Paris

Audit name	Audit scope	Core service	Audit type	Date completed	Key actions following the audit
Looked After Children (LAC) Audit (Q2)	CAMHS & Adult Community	MH - Specialist community mental health services for children and young people MH - Community-based mental health services for adults of working age	Clinical	13/09/2018	LAC liaison nurse to 'dip sample' new referrals for LAC to CAMHS during quarter 3 to review clinicians recording of CSE risks within the risk management plan. Identified cases across services to be re-audited on a 6-monthly basis. Themes to be collated in report form with recommendations for actions which target specific areas of non-compliance.
Clinical Risk Management following Choice Appointment	CAMHS Community	MH - Specialist community mental health services for children and young people	Clinical	14/11/2018	Contact to be made with y/p to ensure safety whilst waiting for partnership Choice letters to be sent out within the Trust Standard of 10 working days on completion of assessment Improve the communication of the risk assessment to GP/family whilst waiting for partnership to commence.

Skilled staff to deliver care

Although it had been difficult to recruit experienced systemic family therapists, and permanent consultant psychiatrists, teams included, or had access to, the full range of specialists needed to meet the needs of patients. As well as doctors and nurses, there were clinical psychologists, social workers, pharmacists, paediatric nurses, participation workers, speech and language therapists, and dieticians.

Staff had the experience, qualifications, skills and knowledge to meet the needs of the patients they worked with. Where managers had experienced a skills deficit, they were proactive at encouraging existing staff to up skill and adapt that part of their intervention.

Managers provided new staff and all agency staff with an induction using the care certificate standards as the benchmark for healthcare assistants.

Managers ensured that staff had access to regular team meetings, safety huddles and swarms to discuss any high-risk cases and receive feedback from previous incidents.

The trust's target rate for appraisal compliance is 95%. At the end of last year (31 March 2018), the overall appraisal rate for non-medical staff within this service was 84%. This year so far, the overall appraisal rates was 84% (as at 30 September 2018).

This was not comparable to the data used at the last inspection (September 2015).

Ward name	Total number of permanent non-medical staff requiring an appraisal	Total number of permanent non-medical staff who have had an appraisal	% appraisals (as at 30 September 2018)	% appraisals (previous year 1 April 2017- 31 March 2018)
Eating Disorder CAMHS Community	15	15	100%	100%
CAMHS Targeted Team	9	9	100%	100%
CAMHS Forensics	4	4	100%	67%
CAMHS East Herts	14	13	93%	92%
CAMHS North Herts	14	13	93%	88%
CAMHS West Herts	25	23	92%	91%
CAMH Services Management	16	14	88%	78%
CAMHS South Herts	16	11	69%	50%
A-DASH	5	3	60%	100%
C-CATT	15	9	60%	63%
CAMHS Home Treatment Team	1	0	0%	n/a
CYP IAPT	1	0	0%	100%
Core service total	**135**	**114**	**84%**	**84%**
Trust wide	**1467**	**1350**	**92%**	**88%**

At the time of inspection managers showed us evidence that the appraisal rate across this service was 100%.

While the trust had not provided appraisal data for medical staff, the doctors we spoke with said they did receive regular supervision and all had revalidated in the previous twelve months.

Supervision data provided by the trust for this core service and for the period up to February 2019 showed that, apart from the CAMHs East team, compliance rates were 100%. While in CAMHs East the compliance rate was 80%.

Managers provided staff with management supervision and ensured they received clinical supervision relevant to their expertise and clinical specialism. Supervision included individual discussions and peer group support. Staff we spoke with said their supervision was regular protected time, planned, recorded and of high quality. Supervision allowed staff to discuss case management, risk management and time to reflect on and learn from practice. Supervision also included opportunities for staff to gain personal support, professional development, and appraisal of their work performance.

Managers used supervision and appraisal to identify the learning needs of staff and provided them with opportunities to develop their skills and knowledge.

Managers ensured that staff received the necessary specialist training for their roles.

Managers dealt with poor staff performance promptly and effectively.

This service did not use volunteers, but did recruit peer supporters for specific projects who received payment for the work they did.

Multi-disciplinary and interagency team work

Staff held regular and effective multidisciplinary team meetings. Staff shared information about patients at effective handover meetings and used daily safety huddles and SWARMS to discuss specific risks and other key information that could not wait until the next scheduled meeting. A safety huddle was a short, planned daily meeting involving just a few relevant staff, to review immediate risk issues within the team. While a SWARM was a larger, as and when needed, meeting involving a wider range of staff and managers to discuss cross service, and cross sector safety and risk issues.

All teams within this core service had effective working relationships, including multidisciplinary handovers, joint working with other teams within the organisation. for example, the crisis team and young people's council. All teams had excellent links with social care, schools and other partner organisations. Some teams such as the targeted team and Eating Disorders team had won awards for their partnership working.

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

As of 30 September 2018, 76% of the workforce in this service had received training in the Mental Health Act. However, at the time of inspection the compliance rate had risen to 89%. The trust stated that this training is mandatory for all services for in-patient and all community staff and renewed every three years.

This was the same as the 76% reported for the previous year (1 April 2017 to 31 March 2018).

As of 31 December 2017, 80% of the workforce in this core service had received training in the Mental Health Act. The trust stated that this training is mandatory for all core services for in-patient and all community staff and renewed every three years.

Staff we spoke with had a good understanding of, the Mental Health Act particularly that relating to community treatment orders, the Code of Practice and the guiding principles.

Staff had easy access to administrative support and legal advice about implementation of the Mental Health Act and its Code of Practice. Staff knew where to find Mental Health Act policies and who their Mental Health Act administrators were.

The trust had relevant policies and procedures available for staff reference on the intranet.

Where patients were subject to a community treatment order, staff explained their rights in a way that they could understand, repeated it as needed, and recorded that they have done it.

Good practice in applying the Mental Capacity Act

As of 30 September 2018, 81% of the workforce in this service had received training in the Mental Capacity Act. The trust stated that this training is mandatory for all services for in-patient and all community staff and renewed three years.

This was lower than the 83% reported for the previous year (1 April 2017 to 31 March 2018).

However, at the time of inspection the compliance rate had risen to 92%. Staff showed a good understanding of the Mental Capacity Act, in particular the five statutory principles as it applied to young people, aged 16 years and over. Staff knew how to seek advice from specialist advisers or a national professional adviser when needed. Staff were aware of the need to conduct all patients' examinations and treatment with the appropriate consent and consultation, where a local authority had parental responsibility because of a care order. Staff ensured that each patient had a named key worker and patients knew the names of the staff team looking after them.

The trust had a Mental Capacity Act policy, staff were aware of the policy and had access to it. Staff routinely considered Gillick competence, a test in medical law to decide whether a child of 16 years or younger is competent to consent to medical examination or treatment without the need for parental permission or knowledge. The service had arrangements to monitor adherence to the Mental Capacity Act. Staff audited the application of the Mental Capacity Act and acted on any learning that resulted from it.

Staff gave patients every possible assistance to make a specific decision for themselves before they assumed that they lacked the mental capacity to make it. For patients who might have impaired mental capacity, staff assessed and recorded capacity to consent appropriately. They did this on a decision-specific basis regarding significant decisions. When patients lacked capacity, staff collaborated with carers and guardians before making decisions that were in the best interest of the young person, recognising the importance of the person's wishes, feelings, culture and history. As part of their duties under the Mental Capacity Act, staff provided all patients with a written care plan as part of the care programme approach. Staff ensured that personal information about their patients was kept confidential, unless this was detrimental to their care and taking into consideration relevant guidelines, such as Gillick competency, and Fraser guidelines.

Is the service caring?

Kindness, privacy, dignity, respect, compassion and support

Staff attitudes and behaviours when interacting with patients showed that they were discreet, respectful and responsive, providing patients with help, emotional support and advice at the time they needed it. Staff were highly motivated and inspired to offer care that promoted patients' dignity. Relationships between patients, those close to them and staff were strong, caring and supportive. These relationships were highly valued by staff and promoted by leaders.

Staff supported patients to understand and manage their care, treatment or condition. Patients were truly valued as individuals and empowered as partners in their care. There was a strong, visible and person-centred culture. Staff always took patients personal, cultural, social and religious needs into account.

Staff directed patients to other services when appropriate and, if required, supported them to access those services.

Staff told us they could raise concerns about disrespectful, discriminatory or abusive behaviour or attitudes towards patients without fear of the consequences.

Staff maintained the confidentiality of information about patients.

Involvement in care

Involvement of patients

We spoke with nine patients now using the service, sought feedback from focus groups held prior to the inspection, and reviewed patient feedback comments displayed on walls in the team bases.

Patients were active partners in their care. Staff were committed to working in partnership with patients to make their goals a reality for each person. Staff always empowered patients to have a voice and to realise their potential

Staff involved patients in care planning and risk assessment as shown by evidence in care plans and participation in care programme approach reviews. We saw how, in some teams, staff had encouraged patients to write their own care plans. Care plans and case notes showed how patients emotional and social needs were highly valued by staff and were embedded in their care and treatment.

Staff ensured that, unless specifically asked not to, patients always received a copy of their care plan, and sought their permission before sharing the care plan with families' carers and other relevant professionals.

Staff communicated with patients to ensure they understood their care and treatment, including finding effective ways to communicate with patients who had concentration or communication difficulties, examples such as using creative therapy, texting or face time where safe to do so.

Staff showed determination and creativity to overcome obstacles to delivering care to ensure patients individual preferences and needs were reflected in how treatment interventions were delivered, for example, meeting in places preferred by the patient, subject to safety and ability to maintain confidentiality.

Staff and managers at all levels of the trust involved patients in decisions about service developments. There were active forums and groups within the service that were used for consultation, and where information and ideas were discussed. For example, the young people's council; a young people's lesbian, gay, bi-sexual, and transgender group; and a young people's representative on the board of governors. Examples of where patients had been involved in service improvements included, representation on interview panels; the design and refurbishment of waiting areas and communal spaces, and consultation with the young people's lesbian, gay, bi-sexual, and transgender group regarding use of the communal space at CAMHs South team base.

Patient groups had contributed to the redesign of simplified care plans; removal of excessive information in waiting areas, and the production of information booklets for new patients, families and carers, including grandparents and siblings. The information booklets were designed to inspire, and engage new patients and reassure families and carers. We saw the booklets were of high quality and used the patients' own ideas, handwritten and typed stories, poems, and thoughts to explain how therapy had worked for them.

Staff enabled patients to give feedback on the service they received via surveys. Staff ensured that patients could access an advocate when needed and that they knew how to raise concerns or queries.

Involvement of families and carers

We spoke with ten family members and carers and reviewed family and carers feedback comments displayed on walls in the team bases.

In most cases feedback from family members, carers using the service was continually positive about the way staff treated people. Carers felt that staff went the extra mile, and the care they received exceeded their expectations. Most of the carers we spoke with felt staff informed and involved families and carers appropriately and provided them with support when needed. However, three carers told us that communication with the Children's Crisis, Assessment and Treatment team was not effective. One carer felt they had not received enough information about a child's level of risk, one other carer said staff were often difficult to get hold of and did not return their calls, and the third carer said communication between the doctors was not consistent.

Other carers and family members said they felt supported by staff in the service and staff kept them informed throughout their child's treatment. Eight out of ten people said staff provided them with information about how to access a carer's assessment.

Staff enabled families and carers to give feedback on the service they received via surveys, staff gave all family members and carers comment cards at the point of discharge for them to complete and return to the service anonymously.

Staff and managers were keen to involve family members and carers in service developments achieved through the family and carers council. Staff also told us about how they were supporting the graduate parents group to make a promotional video designed to supplement their program of promotional and training presentations.

Is the service responsive?

Access and waiting times

The service had clear criteria for which patients would be offered a service and, if waiting lists were used, who could be placed on them. The criteria did not exclude patients who needed treatment and would benefit from it.

While the national target from referral to treatment for community services was 18 weeks total, the trust had reduced these target times, for this core service to, referral to assessment, also known as choice appointment, 4 weeks, and assessment to treatment 8 weeks, a total of 12 weeks.

The trust has identified the below services in the table as measured on 'referral to initial assessment' and 'referral to treatment'. The service met the referral to assessment target in eight of the targets listed.

This was not comparable to the data used at the last inspection (September 2015).

Name of hospital site or location	Name of Team	Please state service type	CCQ core service	Days from referral to initial assessment		Days from referral to treatment	
				Target	Actual (median)	Target	Actual (median)
Community	West Quadrant	CAMHS Routine Referrals	MH - Specialist community mental health services for children and young people	28 Days	20	No	40
Community	East Quadrant	CAMHS Routine Referrals	MH - Specialist community mental health services for children and young people	28 Days	24	No	47

Name of hospital site or location	Name of Team	Please state service type	CCQ core service	Days from referral to initial assessment		Days from referral to treatment	
				Target	Actual (median)	Target	Actual (median)
Community	North Quadrant	CAMHS Routine Referrals	MH - Specialist community mental health services for children and young people	28 Days	16	No	43
Community	South Quadrant	CAMHS Routine Referrals	MH - Specialist community mental health services for children and young people	28 Days	21	No	32
Community	West Quadrant	CAMHS Priority 1 Referrals	MH - Specialist community mental health services for children and young people	7 Days	6	No	30
Community	East Quadrant	CAMHS Priority 1 Referrals	MH - Specialist community mental health services for children and young people	7 Days	7	No	29
Community	North Quadrant	CAMHS Priority 1 Referrals	MH - Specialist community mental health services for children and young people	7 Days	4	No	20
Community	South Quadrant	CAMHS Priority 1 Referrals	MH - Specialist community mental health services for children and young people	7 Days	5	No	14

We reviewed the trust compliance with referral to assessment and assessment to treatment waiting times. We found at CAMHS South, 41 patients breached the local referral to assessment target (28 days) with the longest wait being 32.5 days. Twenty-seven patients breached the trust's

assessment to treatment target (56 days) the longest wait being 98.5 days. Of these, six patients were also waiting longer than the national target of 18 weeks (126 days) from referral to treatment, the longest being 138 days.

At CAMHS West we found some patients also waiting longer than the local or national targets. However, we found that the trust had robust systems and processes in place to manage waiting lists safely. For example, at CAMHS South, managers had implemented a "care of waiters' protocol". All patients on waiting lists were RAG rated and prioritised based on risk. All patients waiting for assessment received a minimum of two weekly telephone calls from the duty workers, who update them on the waiting times, reviewed risk and re-prioritised if needed. All patients waiting for allocation to specialist treatment had a named case worker within the team and received weekly contact (face to face, SKYPE or telephone) for skills training or support.

At CAMHS West, the manager had allocated the high-risk nurse to maintain contact and support with those patients at highest risk. The duty worker rang all patients waiting for assessment on a weekly basis; team case workers maintained weekly telephone or text contact with those patients waiting for allocation to specialist therapy, and all patients waiting were given self-help advice and on-line resources. If risks increased the case worker reprioritised as very urgent. Patients who had been assessed and were waiting for specialist therapy were invited to attend a weekly skills training group. We considered that whilst targets were not achieved for a small number of patients; the trust had appropriate risk management processes in place to keep patients safe.

Teams saw urgent referrals quickly. The crisis team, had skilled staff who were available to assess patients immediately.

Teams usually responded promptly and adequately when patients telephoned the service. Most patients and carers we spoke with supported this.

Teams made all attempts to engage with people who found it difficult, or were reluctant to engage with mental health services. This included making information about the service and what people could expect interesting, inspiring, and focussed on hope and recovery. Teams used experts by experience, as speakers to promote the work of the service. An expert by experience is someone with lived experience of the service,

Teams were proactive in following up contact with people who did not attend appointments. Managers had tried to identify reasons for non-attendance and put in place measures to address their findings, such as offering a range of choice appointments and having direct engagement with referrers.

Where possible, staff offered patients flexibility in the times of appointments. Staff only cancelled appointments when necessary and when they did, they explained to patients and carers why, and rearranged appointments as soon as possible.

Appointments usually ran on time and staff kept people informed when they did not.

Where safe to do so, staff used texting and e mail reminders to support timely access to care and treatment.

Staff supported patients during referrals and transfers between services. For example, if they needed temporary treatment in an acute hospital, or other CAMHs team.

The service followed transfer of care standards such as those set in the national Children and Young People Mental Health Transitions Commissioning for Quality and Innovation.

The facilities promote comfort, dignity and privacy

Teams within this service were co located with other teams and services, and staff sat in shared offices, where hot desking was a routine practice. Most teams within the CAMHs service had adequate rooms and equipment to support treatment and care for example, enough chairs in the waiting area and soundproofed interview and group therapy rooms. However, this was not the case for those teams located at Kingsley Green and CAMHs West. In these buildings space was not adequate and we observed an impact on patient care. For example, staff could not always accommodate urgent and drop in appointments without first asking another clinician and their patient to move half way through their booked session. Staff had to make sure that rooms were available before they arranged appointments and staff told us that this meant they did not carry out as many appointments as they could have done.

At Kingsley Green and CAMHs West there was no cooling down space for distressed patients to stay after their appointments and before leaving. Two members of staff told us this was a worry for them as they would have preferred to know their patient was feeling safe before they left. There was no quiet space for students and staff to undertake private study or have down time during the working day. In several recent formal and informal staff surveys lack of space and rooms had been the highest cause of staff stress. While managers were aware of this, and told us they had escalated the issue to the highest level possible, they were not aware of any firm plans to ease the situation.

Patients' engagement with the wider community

When appropriate, staff ensured that patients had access to, and maintained their links with education training and work opportunities. Staff encouraged patients to maintain and develop routines that were beneficial for their health and mental wellbeing.

Staff supported patients to keep contact with their families and carers. Staff encouraged patients to develop and support relationships with people that mattered to them, both within the services and the wider community.

Meeting the needs of all people who use the service

Managers ensured there was access for people with disability, by ensuring easy flat access to premises and by meeting patients' specific communication needs.

Staff ensured that patients could obtain information about the available treatments, local services, and their rights. Patients had reviewed and developed a lot of the information available to ensure it was in a form accessible to the people who used the service.

Staff made information leaflets available in other languages upon request, and the young people's council had redesigned the service web site.

Managers ensured that where staff used texting, face time and e mail to communicate with patients this was safe and secure to do so. Staff had easy access to interpreters and/or signers.

Listening to and learning from concerns and complaints

This service received 21 complaints between 1 November 2017 and 31 October 2018. No complaints were upheld, six were partially upheld and 13 were not upheld. None were referred to the Ombudsman.

Ward name	Total Complaints	Fully upheld	Partially upheld	Not upheld	Under Investigation	Withdrawn	Referred to Ombudsman
CAMHS Crisis, Assessment & Treatment Team (C-CATT)	1	0	0	1	0	0	0
Child and Adolescent mental health services - Child and Family Clinic	17	0	5	10	1	1	0
Child and Adolescent Mental Health Services - PALMS	1	0	0	1	0	0	0
Child and Adolescent mental health services - Targeted Team	1	0	0	1	0	0	0
PALMS Psychiatry	1	0	1	0	0	0	0
Core service total	**21**	**0**	**6**	**13**	**1**	**1**	**0**

This service received 237 compliments during the last 12 months from 1 November 2017 to 31 October 2018 which accounted for 14% of all compliments received by the trust as a whole.

Patients, carers and their families knew how to complain or raise concerns, this information was available in the patient and carers hand books. When patients complained or raised concerns, they received feedback from the relevant managers.

Staff knew how to handle complaints appropriately, and protected patients who raised concerns or complaints from discrimination and harassment.

Staff received feedback about the outcomes of investigations and complaints and acted on the findings. Managers gave staff this feedback at team meetings, safety huddles, and as part of supervision, depending on what was the most appropriate format.

Is the service well led?

Leadership

Although some of the leaders in this core service were very new to their roles, and still learning about the trust's information data bases and practices, all leaders we spoke with had the skills, knowledge and experience to perform their roles.

Leaders had a good understanding of the services they managed. They could explain how the teams worked to provide high quality care. Staff had respect for their team leaders and managers at local and board level.

Leaders were visible in the service and approachable for patients and staff. Most staff referred to the chief executive officer by his first name and he was very highly respected. Other team leaders were well respected within the wider child and adolescent mental health services network and often asked to speak at conferences and on the radio.

Leadership development opportunities were available within the trust, including opportunities for staff below team manager level. Two managers explained how the trust had encouraged them to develop as managers within the service.

Vision and strategy

Staff knew and understood the trust's vision and values and how they applied in the work of their team. We saw examples of how the trusts values had shaped the service, such as when consulting with the young people's council, family and carers council and the graduate parents group on service plans. The service had enabled patients to design the content of information booklets about the service, and listened to their ideas and views about room design. We saw evidence of staff being open and honest with patients when they were unable to take forward their ideas.

The trust's senior leadership team had successfully communicated the trust's vision and values to the frontline staff in this service. One member of staff commented that the chief executive was the embodiment of the trust's values.

Staff had the opportunity to contribute to discussions about the strategy for their service, especially where the service was changing. Trust managers often held staff focus groups and consultations for staff to contribute their ideas.

Staff could explain how they were working to deliver high quality care within the budgets available.

Culture

Staff felt respected, supported and valued. A recent staff survey showed that staff felt positive and proud about working for the trust and their team. Managers recognised that their staff were the trust's most valuable asset and did everything they could to make staff feel valued.

Staff felt able to raise concerns without fear of retribution. Staff knew how to use the 'speaking up' process and about the role of the Speak Up Guardian.

Managers dealt with poor staff performance when needed, and could rely on support from the human resources team when needed.

Teams worked well together and where there were difficulties managers dealt with them appropriately.

Staff appraisals included conversations about career development and how the trust would support those developments.

Staff reported that the trust promoted equality and diversity in its day-to-day work and provided opportunities for career progression. One staff member explained how due to their dyslexia they did not believe they could achieve the same high standards as their colleagues. However, with the encouragement of their manager, and support from colleagues, they had been able to progress through a rewarding career pathway.

The service's total staff sickness and absence rates were 2.7%, this was lower that the trusts total rate of 4.5%. and lower than the trusts target rate.

Staff had access to support for their own physical and emotional health needs through an occupational health service and a variety of wellbeing schemes.

The trust recognised staff success within the service through staff awards. Two teams within the service were proud to show us their awards for partnership working, employee recognition, and team of the year.

Governance

Governance systems within this core service were good. There were systems and procedures to ensure that the premises were safe, and except for Kingsley Green, clean. Managers ensured that staff treated patients with respect and kindness.

Two of the seven teams we visited, CAMHs West and CAMHs South, were not meeting the trusts assessment to treatment target times of 8 weeks, or the national referral to treatment target time frames of 18 weeks. Managers in CAMHs South and West were aware they were not always meeting their assessment to treatment targets, and had put in place temporary measures to address the issues.

While recruitment to specialist posts in some teams was challenging, there were enough trained staff, across the service to meet patient needs with minor impact, and team leaders had managed those vacancies well. Staff received relevant training to enable them to perform well in their work roles, and all staff received supervision to help them manage their caseloads and feel confident to provide high quality care.

There were robust systems in place to ensure that all incidents were reported, investigated and learned from. There was a clear framework of what must be discussed at a local or directorate level team meeting to ensure that essential information, such as learning from incidents and complaints, was shared, and discussed.

Staff had implemented recommendations from reviews of deaths, incidents, complaints and safeguarding alerts at the service level. Staff undertook, or took part in clinical audits, and the audits were sufficient to provide assurance. Staff acted on the results when needed. Staff understood arrangements for working with other teams, both within the trust and external, to meet the needs of the patients.

Management of risk, issues and performance

Staff maintained and had access to the risk register either at a team or directorate level and could escalate concerns when needed from a team level. Staff concerns matched those on the risk register.

The service had plans for emergencies, such as adverse weather or a flu outbreak.

Where cost improvements were taking place, they did not compromise patient care.

Information management

Team managers had access to information to support them with their management role. This included information on the performance of the service, staffing and patient care. Information was in an accessible format, and was timely, accurate and identified areas for improvement.

While team leaders highly recommended the SPIKE2 management dashboard developed by the trust, some managers struggled to use the new discovery electronic data base. Despite this staff we spoke with confirmed that the service used systems to collect data from teams and directorates that were not over-burdensome for frontline staff.

Staff had access to the equipment and information technology needed to do their work. The information technology infrastructure, including the telephone system, worked well and helped to improve the quality of care. The patient information system was effective and easy for staff to use. Information governance systems included confidentiality of patient records.

Staff made notifications to external bodies as needed.

Engagement

Staff, patients and carers had access to up-to-date information about the work of the trust and the services they used, for example, through the intranet, bulletins, and newsletters.

Patients and carers had opportunities to give feedback on the service they received in a manner that reflected their individual needs. Managers and staff had access to the feedback from patients, carers and staff and used it to make improvements.

Patients and carers were involved in decision-making about changes to the service. Patients and staff met with members of the trusts senior leadership team and governors to give feedback

There were several official forums that patients and their families could be involved in to help influence the direction of services within the trust including the patient and youth council; becoming a peer experience listener or expert by experience and, sharing personal stories at staff training sessions and public meetings. Furthermore, patients had the opportunity to join project groups to shape trust policy or be involved in the trusts research and development program. We saw flyers and information for patients and their families about how to apply for and access some of these official forums.

Directorate leaders engaged with external stakeholders – such as commissioners and Healthwatch.

Learning, continuous improvement and innovation

Managers gave staff time and support to consider opportunities for improvements and innovation and this had led to changes within the service. Changes included improved waiting times for patients, different ways of engaging patients,

Innovations were taking place in the service such as finding ways to make patients feel valued and inspired like the painted stones around Kingsley Green which patients and their carers could take away with them, and the positive thought jars, which staff had decorated for their patients and filled with hand written positive and inspiring messages. Staff used quality improvement methods and knew how to apply them. Staff took part in national audits relevant to the service and learned from them, such as waiting time audits, and case load weighting. All the teams took part in accreditation schemes relevant to the service as detailed below and learned from them.

NHS trusts can take part in a number of accreditation schemes whereby the services they provide are reviewed and a decision is made whether or not to award the service with an accreditation. A service will be accredited if they are able to demonstrate that they meet a certain standard of best practice in the given area. An accreditation usually carries an end date (or review date) whereby the service will need to be re-assessed in order to continue to be accredited.

The table below shows which services within this service have been awarded an accreditation together with the relevant dates of accreditation.

Accreditation scheme	Core service	Service accredited	Comments
CAMHS Community Eating Disorder - Quality Network Community CAMHS (QNCC - ED)	Specialist community mental health services for children and young people	CAMHS Eating Disorder	This service is working towards accreditation and was peer reviewed on 10 May 2017