Care Quality Commission

Good ●

Hertfordshire Partnership University NHS Foundation Trust

Community-based mental health services for adults of working age

Quality Report

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Locations inspected

Location ID	Name of CQC registered location	Name of service (e.g. ward/unit/team)	Postcode of service (ward/unit/team)
RWR99	Trust Headquarters	Rapid assessment interface and discharge (RAID) team, Lister Hospital, Stevenage	WD18 0HB
RWR99	Trust Headquarters	Adult day treatment unit, The Orchards, Hemel Hempstead	AL3 5TL
RWR99	Trust Headquarters	North Community Adult Mental Health Team, Saffron Ground, Stevenage	AL3 5TL

Summary of findings

RWR99	Trust Headquarters	East & South East Community Mental Health Team, Rosanne House, Welwyn Garden City	AL3 5TL
RWR99	Trust Headquarters	East & South East Community Mental Health Team, Holly Lodge, Cheshunt	AL3 5TL
RWR99	Trust Headquarters	North West Community Adult Mental Health Team, 99 Waverley Road, St Albans	AL3 5TL

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

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

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

Summary of findings

Ratings

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

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

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

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

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

Summary of findings

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Summary of findings

Overall summary

We rated Hertfordshire University Partnership NHS Foundation Trust community-based mental health services for adults of working age as **Good** because:

- Staff had completed safeguarding training and could explain safeguarding procedures and examples of recent safeguarding concerns. There were good examples of multi-disciplinary working across the teams including collaborative working between professions.

- There was a good range of psychological therapies available including dialectical behaviour therapy, cognitive behaviour therapy, drama and art therapy. Most staff were up to date with their supervision and appraisals and could access specialist training.

- Staff demonstrated a good understanding of people's individual needs. Most people who use services and their carers we spoke with gave positive feedback about the care and support they received.

However:

- There was a high number of vacancies and use of agency staff across the teams we visited that impacted on people's continuity of care.

- We found a high number of cases that had not been allocated a care coordinator within 28 days. People who use the services experienced a delay in allocation and high frequency of change in care coordinators.

- All staff did not have lone working devices, or were not aware of what the lone working procedures were.

- Following a serious incident at Hertford County Hospital, all staff were not aware of the learnings or outcomes. Staff at Hertford County Hospital and Waverley Road also were not all provided with a debrief after serious incidents.

- In the care records we reviewed, risk assessments did not always identify people's risk including histories of self harm. People's care plans were not always up to date. They also lacked evidence of how the person who uses the service and/or their carer were involved with the person's care and treatment. We also found that people did not always have a completed physical health assessment.

- Staff we spoke with found the trust's electronic database system difficult to use and they could not access people's information easily.

- Staff were unhappy with the recent transformation and this affected their morale. However, they felt supported by their team and manager. Despite issues with staffing, we observed staff providing high quality care to people who use services.

Summary of findings

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

Are services safe?

We rated safe as **good** because:

- Staff had completed safeguarding training and could explain safeguarding procedures and examples of recent safeguarding concerns. There were good examples of multi-disciplinary working across the teams including collaborative working between professions.

However

- There were a high number of vacancies and use of agency staff that impacted on people's continuity of care.

- Not all staff were equipped with lone working devices and did not know the lone working procedures.

Good ●

Are services effective?

We rated effective as **requires improvement** because:

- People's records were not complete or accurate across the services visited. This included Community Treatment Orders, risk assessments, care plans and physical health assessments. The trust's electronic patient database system was difficult to use and people's information was not easily accessible or always available.

- People did not always have up-to-date care plans that evidenced the person who uses the service and/or their carer's involvement with their care and treatment.

However:

- There was a good range of psychological therapies available including dialectical behaviour therapy (DBT), cognitive behaviour therapy, drama and art therapy.
- Most staff were up to date with their supervision and appraisals and could access specialist training.

Requires improvement ●

Are services caring?

We rated caring as **good** because:

- We observed caring and respectful interactions between staff and people who use services.
- Staff demonstrated a good understanding of people's individual needs.

Good ●

Summary of findings

- Most people who use services and their carers we spoke with gave positive feedback about the care and support they received.

However:

- Some people who use services did not always feel consulted with service changes or that their views were listened to.
- People who use services and their carers' involvement with their care and treatment were not always documented in their care plans.

Are services responsive to people's needs?

We rated effective as **good** because:

- Most of the teams' facilities promoted recovery, comfort, dignity and confidentiality. Staff were flexible around meeting the individual needs of people who use services.
- Most people and their carers knew how to make a complaint and their complaints had been responded to appropriately, although there was no evidence of staff being informed of themes or learning from complaints.

However:

- People who use services experienced a delay in allocation and high frequency of changes in care coordinators.

Good ●

Are services well-led?

We rated well-led as **good** because:

- Teams were well managed locally. Most staff felt supported by their manager, that they could voice any concerns and these would be acted upon. Most staff knew the trust's visions and values.

However:

- Some staff were unhappy with the recent transformation of services and felt they had not been consulted or that their views had not been listened to by the trust.

Good ●

Summary of findings

Information about the service

During the inspection we visited the following teams:

The Single Point of Access Team, St Albans

The single point of access (SPA) team provides telephone triage for all referrals to mental health and learning disability services in Hertfordshire including young people, adults and older people. Referrals can be made by GPs, other health professionals or through carer or self referrals. SPA operates from 8am to 7pm Monday to Friday.

Support and Treatment Teams and Targeted Treatment Teams at:

Saffron Ground, Stevenage

Roseanne House, Welwyn Garden City

Hertford County Hospital, Hertford

Holly Lodge, Cheshunt

Waverley Road, St Albans

The community mental health teams are divided into two multidisciplinary teams across four quadrants in Hertfordshire. The service is provided to people 18 – 65 years old. People with non-psychotic disorders are seen by the Support and Treatment Team. People with a psychotic or mood disorder are seen by the Targeted Treatment Team.

Obsessive Compulsive Disorder Service, Welwyn Garden City

This is a national service that delivers care and treatment in outpatient and inpatient settings. This service is for people who have failed to respond to both pharmacological and psychological treatments.

Acute Day Treatment Unit, Hemel Hempstead

The acute day treatment unit (ADTU) team provides a community based, multi-disciplinary service as an acute resource for adults as an alternative to hospital admission. The ADTU operates seven days a week and receives referrals from the crisis assessment and treatment team (CATT).

Our inspection team

The team was comprised of: two CQC inspectors, two mental health act reviewers, two social workers, two mental health nurses, an occupational therapist, a psychologist, a psychiatrist and an Expert by Experience.

Why we carried out this inspection

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

How we carried out this inspection

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

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

During the inspection visit, the inspection team:

Summary of findings

- Visited seven community mental health team locations
- Spoke with 18 people who use services and/or their carer
- Spoke with the managers or acting managers for each of the teams
- Spoke with 47 other staff members; including administration staff, doctors, nurses, occupational therapists, social workers, support workers, and temporary staff
- Attended and observed one hand-over meetings, one team meeting and one multi-disciplinary meeting

- Attended and observed a care review meeting and a care planning recovery group
- Attended 6 home visits with staff
- Held a focus group with 8 nurses
- Held a focus group with 5 people who use services

We also:

- Looked at 41 treatment records of people who use services
- Looked at a range of policies, procedures and other documents relating to the running of the service

What people who use the provider's services say

We spoke with people who use services and their carers. Most were positive about their experience of care from the community mental health teams. They told us that they found staff to be caring and supportive and that they were involved in decisions around their care. Some people who use services felt at times they were not listened to and were worried about the changes that had taken place.

Areas for improvement

Action the provider MUST take to improve

- The trust must recruit to fill vacancies, decrease the number of agency staff and increase permanent staff within the community teams
- The trust must ensure that people's risk assessments are comprehensive and include previous risk histories
- The trust should ensure that all care plans are up to date, personalised, holistic and recovery orientated and evidence the person's and their carer's involvement
- The trust must ensure that staff keep people's records accurate and up to date including Community

Treatment Orders paperwork, risk assessments, care plans and physical health assessments. Records should be stored appropriately, recorded consistently and easily accessible to all staff

Action the provider SHOULD take to improve

- The trust should ensure that there is adequate working space for staff and confidential meeting rooms for people who use services
- The trust should ensure that all staff have the appropriate equipment for lone working, are aware of and follow lone working procedures
- The trust should ensure that there is appropriate learning from serious incidents and opportunities for debrief and reflective practice available to staff

Care Quality Commission

Hertfordshire Partnership University NHS Foundation Trust

Community-based mental health services for adults of working age

Detailed findings

Locations inspected

Name of service (e.g. ward/unit/team)	Name of CQC registered location

Mental Health Act responsibilities

We do not rate responsibilities under the Mental Health Act 1983. We use our findings as a determiner in reaching an overall judgement about the Provider.

- Most staff were up to date with their Mental Health Act mandatory training across the teams. Staff told us that people's rights were read at the beginning of their section or Community Treatment Orders and then routinely after.

- At Saffron Ground and Roseanne House, case notes showed that staff had a good understanding of the Mental Health Act and Community Treatment Orders. However, this information was not documented within the care plans or risk assessments. We saw at Roseanne House that Community Treatment Orders reviews were discussed at review, however the doctors and care coordinators were unsure of their roles regarding people's rights.

- We visited the Mental Health Act administration team to view Community Treatment Orders records that were difficult to locate electronically for people who use services at Waverley Road. We saw the statutory forms were filed legibly and chronologically along with capacity to consent to treatment and capacity to appeal or instruct a solicitor forms. There was evidence of renewal reminders and consent to treatment reminders being sent in good time to clinical teams.

- There was Mental Health Act administrative support within the trust available to staff across all teams when needed. Staff we spoke with said that this support was very good and that the administration staff were helpful with keeping everything on track.

- Community Treatment Orders paperwork was filled in correctly, up to date and stored appropriately at Saffron Ground and Roseanne House. However, people's crisis

Detailed findings

plans did not make reference to their Community Treatment Orders and recall options. Paragraph 29.37 of the Mental Health Act Code of Practice states, "appropriate action will need to be taken if the patient becomes unwell." The Community Treatment Order 1 application that included the conditions of the Community Treatment Order was not available on the electronic database system. The accompanying AMHP report was also often missing on the electronic database system. During the inspection, staff were unable to locate this information for us. At Holly Lodge, we could not locate the Community Treatment Order application and conditions on people's files. Conditions of people's Community Treatment Order were not included on their care plans.

- In people's care notes, there was good evidence of prompts for renewals, rights, consent to treatment and expiration dates by the Mental Health Act administration team.

- People's records at Saffron Ground and Roseanne House evidenced that they had access to an independent mental health advocacy service. There were notices with information about the service in the reception area. The service could be contacted by staff and people who use services directly during visits or by telephone. Staff told us that they used their team's knowledge if there were any Mental Health Act issues or they contacted the trust's Mental Health Act team.

Mental Capacity Act and Deprivation of Liberty Safeguards

- Staff were aware of the Mental Capacity Act policy which was available on the trust intranet. They told us the advice and support regarding the Mental Capacity Act from the trust was helpful.

- Staff at the acute day treatment unit told us that nurses did not undertake mental capacity assessments as this is a medical job. We saw a Mental Capacity Act in one of the care records that was completed by a doctor.

- We found evidence in the records at Saffron Ground and Roseanne House that people's mental capacity had

been considered and assessed when needed. At Holly Lodge, there was no evidence of a doctor's assessment of capacity, consent to treatment and certificate of authority. Staff at Holly Lodge provided examples of when they carried out a Mental Capacity Act assessment.

- At Waverley Road, there was documentation of capacity to consent to treatment and assessment forms in the care records we reviewed. Two forms had not been signed by the people who use the service.

Are services safe?

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

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

Summary of findings

We rated safe as **good** because:

- Staff had completed safeguarding training and could explain safeguarding procedures and examples of recent safeguarding concerns. There were good examples of multi-disciplinary working across the teams including collaborative working between professions.

However

- There were a high number of vacancies and use of agency staff that impacted on people's continuity of care.

- Not all staff were equipped with lone working devices and did not know the lone working procedures.

Our findings

Safe and clean environment

- The environment at Saffron Ground was clean and furnishings were well maintained in the reception area. There were interview rooms, group rooms and a clinic room. Equipment was well maintained with up-to-date records. The interview room was fitted with alarms. Hand washing facilities were available.

- People we spoke with who use the services at Roseanne House said the building was pleasant and the waiting was comfortable with drinking water facilities and a fish tank.

- St Albans was a newly refurbished environment that was clean and accessible. There was a clinic room and numerous interview rooms available. During our visit, the alarm in reception on the ground floor went off. However, staff in the upstairs office was unable to hear this. The provider was aware of this issue and told us they were in the process of addressing it.

- The acute day treatment unit was also a newly refurbished facility. There was a well-equipped clinic room and interview room. Hand washing facilities were

available. Some people who use the service said the environment felt "clinical". In particular, one person said they felt the doors were quite clinical, bulky and similar to a ward environment. They did not feel there was service user involvement in the design of the new environment. They had been consulted about choosing the carpet colour and painting of the garden fence.

- We reviewed an infection control audit for a team in the north west quadrant from November 2014 and saw that highlighted issues were addressed and had improved for the follow up audit in January 2015.

- The clinic room at Saffron Ground was equipped with ECG machines, an examination bed, and refrigerator for medication. The interview rooms had adequate sound proofing.

- Roseanne House had a new treatment room. It was spacious and clean with new equipment, examination bed, phlebotomy chair and ECG machine. The meeting and therapy rooms were clean and tidy. The walls were not sound proofed. If a person using the rooms was distressed, they could be heard in the adjoining room.

- The acute day treatment unit, support and treatment and targeted treatment team at Hemel Hempstead and the support, treatment and targeted treatment team at Waverley Road also had new clinic rooms that were clean and well equipped.

- People we spoke with at Holly Lodge said they thought the facilities were good and they felt safe there. One person did not like to attend for personal reasons so the team arranged to visit them at home.

Safe staffing

- The average caseload across the teams was between 30 – 35 cases per care coordinator. Care coordinators with other duties such as approved mental health practitioner (AMHP), initial assessments or delivering groups held a smaller case load. Some staff said their high caseload meant they did not get enough time to nurse their patients or complete assessments. Despite this, the Department of Health guidance (2002) stated this should be a maximum of 35.

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- There were high staff vacancies and agency use across most of the teams we visited. The east and south east quadrant had the most vacancies in the county, including 11.55 whole time equivalent (WTE) posts for the targeted treatment team and the support and treatment team had 11.16 WTE vacancies. Both teams combined used 9 WTE agency staff. The targeted treatment team and support and treatment team at Waverley Road used 12 WTE agency staff.

- Staff told us there was only one permanent community psychiatric nurse (CPN) on the support and treatment team at Hertford County Hospital and the rest were agency staff. The single point of access had four referral advisor vacancies and were in the process of interviewing for these positions during our visit. They were using 13 WTE agency staff. Some agency staff had been with the teams for extended periods of time. However, other staff and people who use services were concerned that they could suddenly leave and the impact that would have on the team and people's care.

- Lack of permanent and adequate administrative staff meant that tasks such as appointment letters were not sent in a timely manner. The east and south east quadrant had 8.5 administration vacancies. At Waverley Road, the lack of staffing caused delays in referral letters for therapy being sent out. For example, one person who was referred on 05/01/15. Their letter was sent out on 17/02/15. Another person who was referred on 24/02/15, their letter was sent out on 16/03/15. Some staff said that their work with people who use services was interrupted by having to answer the door and phone and this added to their work pressures.

- Managers described ongoing recruitment strategies including recruitment fairs to address difficulties with recruitments. However, they struggled to get appropriate applicants for permanent roles. Staff retention was also a challenge, particularly for the support and treatment teams due to the complex cases and job stress. Some staff felt a lost sense of team due to the geography of the smaller teams and a lack of sense of belonging to a team.

- The single point of access triage team hosted the county wide duty desk and out of hours for approved mental health practitioners (AMHPs). There was only one AMHP on duty who was responsible for the whole county where there should be two. This occasionally resulted in a backlog of referrals during the night. A member of staff on another team commented on the shortage of AMHPs, which sometimes delayed mental health act assessments.

- At Saffron Ground, there was no psychiatrist on-site during our visit. Management informed us that there would be access if required. The psychiatrist at Hertford County Hospital was accessible, joined assessments and was available for advice and support. The single point of access team had an eight-month pilot project providing a part-time consultant psychiatrist to the triage team. The role was advisory and non-prescribing and provided a consultative role to the team on medication and physical health issues. This was aimed to reduce referrals to secondary care, facilitate closer working with GPs and provide advice to GPs on medication. Service users spoke positively about the psychiatrists at Hertford County Hospital and the acute day treatment unit.

- We saw team records that showed 81% and above staff had completed mandatory training. Most staff we spoke with said that they were up-to-date with training. However, agency staff were not able to access the trust's internal mandatory training sessions. Some teams had developed local training courses that agency staff could access.

Assessing and managing risk to patients and staff

- We found risk assessments were completed across the teams, however the quality was variable. Staff completed new risk assessments on admission incorporating historical and known assessment information. People's risk assessments were reviewed regularly and updated after incidents. Clinical decisions about risk appeared to be responsive and staff could articulate rationale for restrictions. However, some risk assessments did not include people's history of self harm. For example, at the acute day treatment unit, we saw that risk was assessed daily for one person who uses the service and another person had a completed crisis plan. The risk assessment for another person did not include their history of self harm. One risk assessment at Saffron Ground failed to record the history of an overdose.

- Allocated duty workers covered emergency calls and dealt with a crisis when required. They had a clear

Are services safe?

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protocol in place to manage this. At Roseanne House, when a patient showed early warning signs they had a folder which they log all interaction including increased phone calls or visits with named staff to complete. These patients were discussed in the morning meeting in order to monitor the risk and support required.

- Staff on all teams completed safeguarding training and were able to explain the safeguarding procedures and could discuss recent safeguarding cases. The team meetings at Holly Lodge had safeguarding on the agenda and any issues were discussed within the team, including issues that needed to be raised to external agencies. We saw the electronic documentation of a safeguarding alert for a person at the acute day treatment unit. Safeguarding concerns were also discussed in a review meeting we observed at this service which included multi-agency involvement.
- At the single point of access service, we observed triage phone calls with people who use the service. Risk assessments were undertaken appropriately and staff considered previous known risks to determine the urgency of referrals. Any attempts to make contact were documented immediately on the electronic database system.
- Most staff we spoke with could explain the lone working procedures. However, this was not consistent across all the teams we visited. Not all staff had lone worker devices, including permanent and agency staff. A few members of staff were not able to describe procedures for monitoring staff whereabouts or out of hours working. Staff at Saffron Ground and Hertford County Hospital were required to sign in and out of the building and used electronic diaries for appointments. At Hertford County Hospital, staff usually attended the initial assessment with another person for safety, this could include the person's housing officer, GP or psychologist.
- All medicines were stored correctly at Roseanne House. When dispensing medication, there were two qualified nurses present. Medication charts were checked, prescription were written correctly and all medication administered was signed for. The fridge was locked and all temperature checks were completed recorded daily.

Track record on safety

- The trust reported between November 2013 – May 2014 there were eight serious incidents on the community

mental health teams. There was one serious incident on the east and south east support and treatment team in August 2014. There were three serious incidents on the south east targeted treatment team and one serious incident on the north targeted treatment team between September – November 2014.

- In the last month there were two serious incidents at Roseanne House and two recent incidents at Waverley Road. Staff at Roseanne House told us there was a debrief for one of the incidents. Outcomes of these were discussed in team meetings and practice governance meetings.
- Management told us that following a serious incident, they completed a seven-day report and root cause analysis, interviewed people involved including family and shared learning and recommendations.

Reporting incidents and learning from when things go wrong

- Staff knew how to report incidents through the electronic database system, which then alerted the ward manager, matron, other appropriate professionals and senior management. One member of staff on the single point of access team reported that they had received a debrief following an incident which was to their satisfaction. Staff could seek support from their team, manager and trust counselling service.
- A recent serious incident had a task and finish group including the various teams involved to share review the incident and identify opportunities for shared learning. Some staff we spoke with said there was a process in place for de-briefing after incidents. Incidents were discussed in team meetings, monthly business meetings, monthly patient safety meetings and clinical supervision. However, it was unclear how learning and outcomes were formally disseminated consistently to all staff across the teams, particularly part-time and agency staff. Not all staff were aware of actions or outcomes from serious incidents. One member of staff at Hertford County Hospital told us about a recent serious incident. They were not aware of the outcomes or lessons learned from the incident or if there were any debriefing provisions available. Another member of staff at Waverley Road told us there had been a recent incident and no formal debriefing had been provided.

Are services safe?

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

- An incident occurred within the north west support and treatment team during the week of our inspection. A patient made a suicide attempt in their own home and was found by a member of staff. The team had responded appropriately and the trust investigated appropriately. The incident was reviewed the following day by the NW community service manager. The service users care co-ordinator and assistant therapy practitioner were aware of the incident and added details to PARIS. The Trust liaised with the family and with South Essex Partnership Trust clinical lead who were taking over the care of the service user.

Are services effective?

Requires improvement 🟠

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

Summary of findings

We rated effective as **requires improvement** because:

- People's records were not complete or accurate across the services visited. This included Community Treatment Orders, risk assessments, care plans and physical health assessments. The trust's electronic patient database system was difficult to use and people's information was not easily accessible or always available.

- People did not always have up-to-date care plans that evidenced the person who uses the service and/or their carer's involvement with their care and treatment.

However:

- There was a good range of psychological therapies available including dialectical behaviour therapy (DBT), cognitive behaviour therapy, drama and art therapy.
- Most staff were up to date with their supervision and appraisals and could access specialist training.

Our findings

Assessment of needs and planning of care

- People's records were not complete or accurate across the services visited. This included their Community Treatment Order, risk assessments, care plans and physical health assessments. The quality of care plans varied between teams we visited. For example, at Saffron Ground three out of thirteen records did not have care plans and three other care plans were not fully completed..

- At Hertford County Hospital, one person had a comprehensive risk assessment that identified a historical risk of self ham that was not reflected in their care plan. Another person said they did not have a care plan but were given a form to fill in a few months ago to ask their opinion about their care.

- At Roseanne House, two of the ten care records reviewed did not have care plans in place for people who were on a community treatment order. Two of the

care plans were not risk related, holistic or recovery orientated. Case records held most of the information in regards to support treatment plans, consent, medication, involvement with the Multi-Disciplinary Team, housing, and employment.

- The acute day treatment unit delivered a care planning group where people were encouraged to write their own recovery plans. Staff told us that one person was not well enough to join the care planning group to write their own recovery care plan at present so a care plan was given to them. However, there was no documented evidence of this in the person's care record. Two other care plans were written in the third person, generic and did not evidence the person's involvement. Two people's recovery plans that they had written in the group had not been scanned onto their electronic record and staff were unable to locate one of the plans.

- Staff at Saffron Ground had completed or been involved in people's comprehensive assessments after admission. Staff had a good understanding of the process and could identify all documentation that need to be completed. There was good evidence of practice in the case notes, MDT and multiagency working, seeking legal advice, attendance at core group meetings, discussion at risk management meeting panels and referrals for forensic assessments. However, these were not included in the person's risk assessments or care plans

- Records of physical health assessments and monitoring were generally poor across the teams. There was inadequate monitoring for people who were prescribed lithium or antipsychotic medication at Saffron Ground. We reviewed four care records that did not have evidence of completed physical health assessments. Management told us that physical health checks were completed at depot clinics. However, no physical health check assessments were found in their care records. We only found one good recorded review of a person's physical health needs out of the four care plans reviewed at Hertford County Hospital. Staff told us that clinics completed annual health checks for people on depot and clozapine. Two of the four care records at Waverley Road had evidence of a health check, however one was completed on 06/02/14 and had not been reviewed.

Are services effective?

Requires improvement 🟠

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

- Physical health forms found in ten care records at Roseanne House were blank or incomplete. The team was delivering a physical health clinic every Thursday afternoon and had a plan in place to improve in this area. Staff reported that this information was stored in the clinic room and once all physical health checks were completed, this information would be scanned onto the electronic database. One care record of the three reviewed at the acute day treatment unit had a HoNOS and two had documentation of a physical health check. The acute day treatment unit completed the Liverpool University Neuroleptic Side Effect Rating Scale (LUNSERS) for the side effects from psychotropic medication. The doctors also completed a physical health check on admission and got past medical history from the person's GP.

- The trust used an electronic database system called Paris. Agency staff had access to Paris. The Paris system was difficult to navigate around, however staff could track a patient through different teams. There was a helpline to support staff using Paris and this was reported as a very useful tool to have. It was difficult to track a person through a continuous care record as their information was stored separately by team. People's records and information were not easily accessible. Most staff we spoke with said they did not like the system and that it was difficult to use.

- One person we spoke with who was referred to psychological services at Roseanne House described being provided the wrong postcode in their referral letter. This person also had issues with rearranging the appointment and was eventually discharged for non attendance.

Best practice in treatment and care

- At Holly Lodge, staff told us that they completed physical health checks when people came to a clinic. If they did not attend a clinic, then staff requested the person's GP to monitor. The psychiatrist requested blood tests for lithium and antipsychotics from the GP. Physical health was on the agenda for the team meeting. The team was working with the GP to have an integrated meeting to set an action plan to improve in this area.

- The AMHP service and model that was based at the single point of access service diverted needs effectively to the various teams. The team completed a service review and developed an action plan based on recommendations. They also developed a "Peer Experience Listening" project to get feedback people who use services around their experiences of the Mental Health Act assessment process to improve services. An evaluation report was completed in 2013 to highlight good practice and areas for improvement.

- The acute day treatment unit were shortlisted for a Health Service Journal award in the Innovation in Mental Health category. This was based on how the team managed acutely ill service users in a community environment that focused on recovery and independence.

- There was a range of specialist skills available in the support and treatment and targeted treatment teams with leadership in specialisms. Consultant psychologists had lead roles in quadrants and lead on specialisms such as personality disorder, psychosis, cognitive behavioural therapy (CBT), and psychotherapy to ensure appropriate provision in each quadrant. The target for assessment was 28 days and for treatment was 18 weeks from opt-in. Records that evidenced teams were meeting these target times. A pre-therapy group was offered for people who were waiting for therapy.

- Psychological therapies offered at Saffron Ground included dialectical behaviour therapy (DBT), drama and art therapy. The team worked together to run groups and individual sessions. Two people we spoke with at Roseanne House said their therapy was supportive and complemented each other, for example psychology and medication. The team meeting at Holly Lodge discussed the psychologist supporting the support, time and recovery worker (STAR) worker to provide behavioural activation interventions.

- Across the east and south east quadrant, psychological therapies were developed and provided as interventions and pathways in accordance with evidence-based guidance. For example, Psychological interventions for psychosis (PIP) and a mindfulness group for relapse prevention in depression. Staff were expected to follow NICE guidelines, where there were exceptions to these the reasons should be documented. Clinical supervision also monitored adherence to NICE guidelines.

Are services effective?

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

- Interventions included support around employment, benefits and housing. At Saffron Ground, there was an employment and welfare advisor and a vocational adviser. Citizens Advice Bureau delivered a weekly drop-in service and the team also accessed support from MIND and Shelter. The acute day treatment unit had a chaplain attend weekly and worked with the Department of Work and Pensions (DWP) to support people with their benefits. One person we spoke with spoke positively about being referred to this service which they found helpful. We saw good evidence of support for employment, housing and benefits in the patient records reviewed at Roseanne House. There were two accommodation and housing support and treatment workers in post. One covered the north west quadrant, the other in the east and south east. These roles supported people with housing-related issues and worked with local councils and housing associations.

- The single point of access team completed monthly audits. This selected 100 random cases every month and reviewed the risk assessments, type of referral received, triage process and whether targets were met. This audit has not been completed since October 2014.

Skilled staff to deliver care

- Most staff across all teams spoke positively about the specialist training they could access including solution-focused therapy, mentorship training, and counselling. Staff were required to be 100% compliant with mandatory training to be considered for specialist training. Additional courses were included in their professional development plan. Not all staff were accessing specialist training due to high workloads.

- Staff in the east and south east quadrant and the support and treatment and targeted treatment teams at Waverley Road in the north west did not have access to formal or protected reflective practice. They could access support during their regular supervision sessions. Regular reflective practice sessions were provided to the single point of access team and acute day treatment unit, which staff spoke positively about.

- New staff attended a corporate induction and local team induction. The local induction checklist at the single point of access team included health and safety, IT, role's responsibilities, facilities and human resources.

- Most staff were up to date with their supervision and appraisals. Each team had supervision trees outlining the supervision structure. One supervision record we reviewed at the single point of access team was relevant and comprehensive and evidenced discussion regarding safeguarding, risk and caseload.

- Management told us about performance issues that were being managed accordingly.

- Agency staff we spoke with said they felt included and supported by their teams and managers.

Multi-disciplinary and inter-agency team work

- We found good examples of multi-disciplinary working across the teams we visited. Staff told us that multi-disciplinary team meetings were valued and attendance was expected. However, issues did not have to wait until the meeting and cases could be discussed within the team outside of the meetings.

- Staff we spoke with had good links with external services including the council housing department, drug and alcohol service, children's services, Citizens' Advice Bureau, domestic violence services, local GPs and the police.

- Staff attended monthly practice governance meetings (attended by single point of access, community mental health service, and acute teams). During these meetings, they shared learning across service business unit and also discussed referrals and delays.

- We observed a multi-disciplinary meeting at Waverley Road that was well attended by a wide variety of disciplines. The team discussed a new referral from the single point of access team, potential discharges, case load issues, high risk patients, ward feedback, carers, and safeguarding. The discussions were straight forward and case managed appropriately. There was collaborative working and good interactions between staff.

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

- Most staff were up to date with their Mental Health Act mandatory training across the teams. Staff told us that people's rights were read at the beginning of their section or Community Treatment Orders and then routinely after.

Are services effective?

Requires improvement 🟠

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

- At Saffron Ground and Roseanne House, case notes showed that staff had a good understanding of the Mental Health Act and Community Treatment Orders. However, this information was not documented within the care plans or risk assessments. We saw at Roseanne House that Commuinty Treatment Order reviews were discussed at review, however the doctors and care coordinators were unsure of their roles regarding people's rights.

- We visited the Mental Health Act administration team to view Community Treatment Order records that were difficult to locate electronically for people who use services at Waverley Road. We saw the statutory forms were filed legibly and chronologically along with capacity to consent to treatment and capacity to appeal or instruct a solicitor forms. There was evidence of renewal reminders and consent to treatment reminders being sent in good time to clinical teams.

- There was Mental Health Act administrative support within the trust available to staff across all teams when needed. Staff we spoke with said that this support was very good and that the administration staff were helpful with keeping everything on track.

- Community Treatment Order paperwork was completed correctly, up to date and stored appropriately at Saffron Ground and Roseanne House. However, people's crisis plans did not make reference to their Community Treatment Order and recall options. Paragraph 29.37 of the Mental Health Act Code of Practice states, "appropriate action will need to be taken if the patient becomes unwell." The Community Treatment Order 1 application that included the conditions of the Community Treatment Order was not available on the electronic database system. The accompanying AMHP report was also often missing on the electronic database system. During the inspection, staff were unable to locate this information for us. At Holly Lodge, we could not locate the Community Treatment Order application and conditions on people's files. Conditions of people's Community Treatment Order were not included on their care plans.

- In people's care notes, there was good evidence of prompts for renewals, rights, consent to treatment and expiration dates by the Mental Health Act administration team.

- People's records at Saffron Ground and Roseanne House evidenced that they had access to an independent mental health advocacy service. There were notices with information about the service in the reception area. The service could be contacted by staff and people who use services directly during visits or by telephone. Staff told us that they used their team's knowledge if there were any Mental Health Act issues or they contacted the trust's Mental Health Act team.

Good practice in applying the Mental Capacity Act

- Most staff were aware of the Mental Capacity Act policy which was available on the trust intranet. They told us the advice and support regarding the Mental Capacity Act from the trust was helpful.

- Staff at the acute day treatment unit told us that nurses did not undertake mental capacity assessments as this was a medical job. We saw a mental capacity assessment in one of the care records that was completed by a doctor.

- At Waverley Road, there was documentation of capacity to consent to treatment and assessment forms in the care records we reviewed. Two forms had not been signed by the people who use the service.

- We found evidence in the records at Saffron Ground and Roseanne House that people's mental capacity had been considered and assessed when needed. At Holly Lodge, there was no evidence of a doctor's assessment of capacity, consent to treatment and certificate of authority. Staff at Holly Lodge provided examples of when they carried out a Mental Capacity Act assessment.

Are services caring?

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

Good 🟢

Summary of findings

We rated caring as **good** because:

- We observed caring and respectful interactions between staff and people who use services.
- Staff demonstrated a good understanding of people's individual needs.
- Most people who use services and their carers we spoke with gave positive feedback about the care and support they received.

However:

- Some people who use services did not always feel consulted with service changes or that their views were listened to.
- People who use services and their carers' involvement with their care and treatment were not always documented in their care plans.

Our findings

Kindness, dignity, respect and support

- Across the teams visited, we observed that staff had a good understanding of people's individual needs and were motivated to provide the best care possible. Most people who use services we spoke with gave positive feedback about the care and support they received.

- On an initial assessment in Hertford we observed caring, respectful, sensitive and supporting interactions with staff and the person who uses the service. Staff explained their role, confidentiality and obtained consent. Staff also regularly checked for understanding and agreement if English was not the person's first language.

- We observed triage calls at the single point of access service. The interactions were respectful and considerate. The purpose of the triage call was explained and consent was sought for undertaking the risk assessment.

- People we spoke with at the acute day treatment service spoke positively about staff and said they were very caring. One person said they always felt treated with dignity and respect and staff were always friendly.

Staff supported them with balance and control with their thoughts and life. Another person said they were happy with how staff maintained their confidentiality by having personal discussions in private. One person described how they felt anxious in large groups of people and staff tried to split the groups where possible. Another person said staff were flexible in meeting their needs not to attend groups that they had completed on previous admissions and instead focused on their more specific needs.

- A carer we spoke with at Saffron Ground said that staff valued them as part of the team and they felt included and involved. They said they could always talk to the team and found them very supportive. If the person's care coordinator was not available, other staff were always willing to listen and offer support to their carer.

- People we spoke with at the Obsessive Compulsive Disorder service said that staff were welcoming and friendly. They could access their psychologist and consultant regularly. If they needed support at any time, they could access their care coordinator immediately or arrange an appointment when required.

- At Waverley Road, we observed a home visit and the member of staff showed compassion, kindness, respect and active listening skills. Staff presented the person with choices and offered to accompany them to a medical appointment which they were anxious about.

- At Holly Lodge, one person we spoke with said that the service was not supportive and staff did not return their phone calls. Another person said that their care coordinator was supportive but as they were an agency worker, this person was concerned that they could leave at any time and was worried about continuity.

The involvement of people in the care that they receive

- Most people we spoke with and their carers felt involved with their care. However, this was not always evidenced in the person's care records. Carers had been offered carers' assessments. However, the level of support for carers such as forums and groups varied between teams. There was a carer peer support worker in post at Waverley Road. People and carers were invited to meetings regarding the transformation, but many felt their views were not listened to.

Are services caring?

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

- The single point of access service offered carers groups, carers assessments and sent standard letters for carers to be referred to the team. One person we spoke with at Hertford County Hospital said that their carer had joined the carer's group but this had been cancelled and they did not know why. A carer we spoke with said they had been offered a carer's assessment.

- We reviewed 13 care records at Saffron Ground that evidence people were involved in their care and treatment. Most of the care plans were up to date, holistic and recovery orientated. We saw some inclusion of people's views in the care records we reviewed. It was also recorded if a person was refusing to engage with their care plan. A carer we spoke with said they were fully involved with the care planning process. One person said their family member had been offered a carer's assessment.

- People's records at Roseanne House showed good evidence of involvement. However this information was found in their care notes and not repeated in their care plans.

- At the Obsessive Compulsive Disorder service, people we spoke with said they were fully involved in their care planning had copies of their care plans. One person's carer was also involved in their care plan and could phone the service for advice and support. Another person's care coordinator facilitated them to being involved with on-going medical research in OCD and they told us this was the best thing that has happened to them and was "life changing".

- The acute day treatment unit held weekly community meetings and staff encouraged people to provide regular feedback about the service. People who use the service felt they could raise any issues. Sometimes some issues took a while to get addressed, for example getting mirrors installed in the toilets and more cigarette bins. The staff were aware of these issues and kept people up to date with the progress as much as possible. People also told us about how their family members were encouraged to be involved with their care. One person we spoke with said their views were considered in regards to their medical issues and medication.

- We observed a care planning recovery group at the acute day treatment unit that was attended by seven people who use the service. All interactions were consistently respectful, sensitive, encouraging and supportive. People who attended were explained the aim of the group, which was to put care planning into their hands, in order to take responsibility for their recovery and support needed. Individual support was provided to enable people to engage with the group. Prompt sheets and different written formats were used to support people to write their own care plans. The exercise focussed on helping people identify strategies for their recovery. However, we did not find these care plans were always available in the person's electronic record. There was also a lack of evidence that staff had evaluated or reviewed goals with the person.

- One care plan we reviewed at Hertford County Hospital was brief and did not have evidence of participation with the person who used the service. The case note entries by the care coordinator were descriptive. There were dates in the person's case notes recorded that CPA meetings were planned but there was no evidence whether the meetings took place or the outcomes. In another care plan, the last CPA meeting was dated 17/02/14, there was no documentation of the person's view of their care plan. There was also no record of the next CPA meeting that was planned for 11/08/14.

- On a home visit we attended for a person who uses the service at Hertford County Hospital, we observed staff checking the person's physical health needs and providing support, advice and health education. Staff also checked with their carer about their views on the person's health. There was a discussion with the person around moving forward with their recovery.

- One person we spoke with at Hertford County Hospital said they had to wait a long time after being referred to the anxiety group. Their psychiatrist gave them NICE guidelines to provide rationale for stopping their medication. They had been able to access support from the DBT group, which has helped them to gain a lot of helpful skills. Another person had been referred to the art therapy group, which they really enjoyed. They also said their medication had been explained to them but not about side effects.

- A person at Holly Lodge showed us a copy of their wellbeing and recovery plan but had not had a care

Are services caring?

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

plan in two years. Another person also reported they did not have a care plan and that they were not involved in their care. For example, they had a discussion with their doctor but felt they were not listened to.

- Access to advocacy was variable across the teams. One person at Roseanne House said that they had accessed an advocate. At Holly Lodge, one person had used an advocate to support them to make a complaint. Other

people we spoke with at Holly Lodge had not been provided any information about an advocacy service. We saw posters for advocacy services at most of the teams we visited.

- At Waverley Road, one person who uses the services we spoke with said they were not consulted with the recent relocation of the service and found the move "disconcerting".

Are services responsive to people's needs?

Good ●

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

Summary of findings

We rated effective as **good** because:

- Most of the teams' facilities promoted recovery, comfort, dignity and confidentiality. Staff were flexible around meeting the individual needs of people who use services.
- Most people and their carers knew how to make a complaint and their complaints had been responded to appropriately, although there was no evidence of staff being informed of themes or learning from complaints.

However:

- People who use services experienced a delay in allocation and high frequency of changes in care coordinators.

Our findings

Access and discharge

- The target time from referral to assessment was 28 days and for assessment to treatment was 18 weeks. We found a high number of cases that had not been allocated a care coordinator within 28 days. Teams were provided with a weekly tracker for cases awaiting allocation beyond 28 days. The tracker we reviewed dated 27 April 2015 indicated there were 387 unallocated cases across the county. Management told us this was not 100% accurate due to data errors e.g. double counting of cases, some carers inappropriately included. There were 82 unallocated cases for the east and south east region, 15 of which were not relevant. For example, the case had since been allocated or a carer had incorrectly been identified requiring allocation on the database system. Staff told us the tracker was reviewed daily by the duty team and contact is made where required. If there was an increased risk, then the person was tracked in order of priority. For example, in the north quadrant, the teams kept a list of people on the waiting list and they were contacted regularly. People were also followed up with by the duty desk while people are awaiting allocation. The teams had a weekly conference call involving performance team, senior manager, team managers where breaches for those who have not been allocated within the 28 day target was discussed.

- As of 27 April 2015, there were 44 breaches across the county where people who use the services on a care programme approach had not been reviewed within 12 months. The trust told us that their data base highlights anyone who is due an updated review prior to the target date.

- The single point of access team was meeting their targets to turn around urgent referrals within four hours to have an assessment within 24 hours. Routine referrals had 14 days to have an appointment booked within 28 days.

- Staff and people who use services told us there were delays in care coordinator allocation and that people could experience a high frequency of change in care coordinators. In a care record we reviewed at the acute day treatment unit, a person who uses the service had experienced a delay in care coordinator allocation. The person had been allocated a care coordinator on two different occasions, both of whom had left and the person was still awaiting allocation. Another person we spoke at had been attending the service for two months and was awaiting the allocation of a care coordinator.

- Staff we spoke with at the single point of access said it could be difficult to arrange appointments outside of 9am to 5pm with the community mental health service teams. They could negotiate with teams to make appointments out of hours, but found this to be the exception. We saw a few appointments booked out of hours with the community teams visited. This varied by team and staff we spoke with said this was assessed on an individual basis. One person who uses the service at Hertford County Hospital said they could schedule their appointment after 5pm so their carer could attend with them. Staff at Holly Lodge said they offer flexible time and locations to the person's preference.

- The single point of access team were responsible for assessing criteria at triage based on risk, symptoms and history. If the person was allocated to the wrong team, the team will refer them so they did not have to be triaged again.

Are services responsive to people's needs?

Good ●

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

- The teams took steps to engage people who were reluctant to engage with services. The teams operated on the policy that if a person did not attend for two appointments, they would be discharged. At Holly Lodge's team meeting, they discussed a person who was not responding to calls and strategies how to engage with them. At Hertford County Hospital, there were procedures in place when people did not attend their initial assessment. The person's referral information and history were considered and discussed with the referrer. The team would write to the person inviting them to contact the team for a second appointment or to arrange a home visit. If contact was unable to be made by the single point of access team, there were clear procedures in place. Non-urgent referrals were sent a letter that day and a follow up phone call was made if there was no response in seven days. Strategies were in place to contact people who use services who did not have a phone. For example, staff would contact their GP, family/carer, or hostel.

- The capacity at the acute day treatment unit was for 30 people, during our visit, there were 18 people on their books. Management told us that they were not getting referrals from the crisis assessment and treatment team. They were working to increase referrals by doing in-reach on the wards and going to clinical governance meetings to raise the profile of the service.

- Appointments at Saffron Ground had been cancelled due to a lack of room availability. Staff told us when this occurred an incident form was completed.

- Urgent referrals could be seen on the same day if required and based on staff availability. During out of hours, there was a mental health helpline, out-of-hours team or people could be seen by the duty team. People requiring additional support during a crisis could access the Flexible Assertive Community Treatment Team (FACT) that operated seven days a week and until 10pm.

- Some staff we spoke with on a targeted treatment team expressed concern that the transformation of community mental health services has resulted in the loss of specialist provision for first episode psychosis. They felt there had been a loss of the early intervention in psychosis (EIP) model. This meant that people who use services were not getting the same level of service compared to the previous model due to significantly reduced access and flexibility with response of home

visits. Staff were concerned that reduced access to psychiatry for first episode psychosis following the transformation meant that people whose mental state were deteriorating experienced delays with getting a medical assessment and were at risk of further deterioration. There has also been a loss of the carer's group and family intervention provision for first episode psychosis.

- The single point of access team, community mental health teams and child and adolescent mental health teams had weekly teleconferences to discuss triage updates, feedback any issues and discuss key learning such as inappropriate referrals.

The facilities promote recovery, comfort, dignity and confidentiality

- The teams at Hertford County Hospital were located at the back of the neurology department. One person told us they sometimes had to wait when attending an appointment and the noisiness of the waiting room was not helpful for their anxiety. There was no clinic room available for people who use the service. This meant that there were no facilities to store medication on site. Staff had to pick up and return medications from other locations. Staff told us the office was due to be relocated within a few months. We observed staff tell a group of people who use the service that they would be consulted regarding the relocation.

- The acute day treatment unit had a therapy and music room, assisted kitchen and outside garden area. Waverley Road had a large art therapy room and numerous interview rooms available.

- We saw information leaflets in the teams' reception areas for a variety of services including mental health, treatments, local services, patients' rights, help line details, how to complain and advocacy. There were no leaflets or information for physical health issues.

Meeting the needs of all people who use the service

- There was disabled access to the building and a disabled toilet at Saffron Ground. However, there was limited space in the reception area. This was being

Are services responsive to people's needs?

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

addressed by the trust. At Roseanne House, there was disabled access to the mail building. St Albans, the Orchards and Hertford County Hospital all had disabled access and toilets.

- Teams told us they had access to an interpreting service that they could book. Staff spoke positively about this service and that it worked well.

Listening to and learning from concerns and complaints

- Most people who use services we spoke with and their carer said they knew how to make a complaint. A carer we spoke with said they would use the Patient Advice and Liaison Service (PALS) to support them with the process if required.

- At Roseanne House, one person told us that their carer and family member had complained as they were misdiagnosed at their initial assessment and discharged. As a result, they were re-assessed and treatment was offered to them. Staff said they received feedback in team meetings and learning lessons were emailed. De-briefing sessions were held by the investigator or manager.

- People at the OCD service said they knew how to complain and would be confident if they had to but felt they never would have to as they were satisfied with the service they received.

- The acute day treatment service provided people with a booklet on admission about how to complain. One person who uses the service we spoke with was positive about the support she had received from staff in making a complaint about her treatment from another service.

- At Saffron Ground, complaints were logged onto a tracker that was updated and monitored by staff. However, the tracker was not up to date with the complaints' outcomes or how the complaint was being dealt with. There was no evidence of how staff received feedback from the outcome of complaint investigations. Teams we spoke with did not have overall data from complaints to analyse common themes and trends.

- We saw that teams recorded complaints appropriately. Teams received a weekly complaints report that provided updates on the status of teams' complaints. We saw recommendations, action and learning from individual complaints. For example, the single point of access service were working on improving quality of correspondence and reducing breaches of data loss as a result of recent complaints. The acute day treatment unit installed carpet as a response to flooring of the unit being too noisy.

- In the north west quadrant, there had been a complaint around communication where a person who uses the service had difficulties contacting their care coordinator. They were unable to be connected by telephone to leave a message due to IT issues and the turnover of staff. A system was implemented where the receptionist emailed their care coordinator when the message was received. If it was during out of hours the email was forwarded to the duty team to establish contact.

Are services well-led?

Good ●

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

Summary of findings

We rated well-led as **good** because:

- Teams were well managed locally. Most staff felt supported by their manager, that they could voice any concerns and these would be acted upon. Most staff knew the trust's visions and values.

However:

- some staff were unhappy with the recent transformation of services and felt they had not been consulted or that their views had not been listened to by the trust.

Our findings

Vision and values

- Most staff we spoke with knew the trust's visions and values. However, some felt that these were not being demonstrated by the senior management team. Staff across teams felt the organisation's values were having a negative impact on them and people's care. The vision of the transformation did not take into account the views of staff and that has reduced morale. Some staff told us that some of the changes were positive and things were slowly starting to improve.

- The teams' objectives were clear throughout the teams to provide the best possible care. However, staff said that achieving this has been difficult due to the changes that have been made. Some staff felt stressed and teams were short staffed.

- Most staff knew who the senior managers were by name but not in person, especially the junior staff. Senior managers were visible at corporate events but staff could not always attend these events.

Good governance

- The single point of access team felt they were supported by the trust and were given recognition for their work. The team was a recipient of the John Lewis Customer Service Award and the Chief Executive Award (2013).

- There had been changes across the trust last year that made improvements in governance of the service. For example, complaints and risk registers were implemented across the teams which helped with management and monitoring. The risk assessments on the electronic database had also been simplified based on staff feedback.

- Some of key performance indicators we reviewed were inaccurate. For example, the number of people awaiting care coordinator allocation over 28 days. At Saffron Ground, 195 people with the team did not have a risk assessment. The manager explained that this figure was high because it included people that had yet to be assessed. Management could identify the incorrect figures and provide updates. However, the process for correcting the data was time consuming.

Leadership, morale and staff engagement

- We found most teams were well managed on a local level. Most staff we spoke with said that they felt supported by their manager, could raise any issues and they would be listened to and actioned upon.

- The structure of teams varied between quadrants. For example, in the north west at Waverley Road, staff from the support and treatment team and targeted treatment team were based in the same location and worked cohesively, while the teams in the north were based separately. The east and south east quadrant had the largest geographical area that required team leaders to travel to five different locations where their teams were based.

- The level of morale varied across the teams. Staff expressed difficulties they experienced with the recent transformation of community services. Some were unhappy about the team changes and the way they were implemented which resulted in high levels of staff loss and excessive agency use. Staff felt the teams lost experienced staff with specialised skills which had been replaced with agency staff. They were concerned about the difficulties with recruitment and retention. Some felt their skills had been "watered down" following the transformation and expressed a loss of professional identity and a lack of scope for professional development. Staff said they felt "de-skilled" due to the change from locality to diagnostic working. One member of staff said they felt their team was fragmented, there was a lack of team development and opportunities to build team cohesion.

Are services well-led?

Good ●

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

- Staff did not always feel consulted with previous and current changes to their teams or office locations. With regards to the transformation of the community teams, staff said they were told the message they had from senior management was "it has to work". Some staff said they was a lack of clarity about the new model and purpose of the targeted treatment team. There was information provided at meetings prior to the transformation. However, some staff said their comments regarding the transformation were not taken on board by the trust. Staff felt that the model worked better in some quadrants rather than others, particularly the east and south east that covered the largest geographic area. They viewed the support and treatment team as the most challenging team due to the complex and higher risks cases involved. As a result, these teams in particular had difficulty with recruitment and retention of staff.

- The single point of access team completed a Stress Audit Survey (October 2014) and the results were finalised in February 2015. This found a 13% sickness levels connected to work-related stress. There was a 33% response rate from the team and an action plan developed. The team expressed there had been an improvement to staffing and sickness levels and it would be useful to repeat the audit for comparison.

- Most staff were aware of the whistle blowing policy. However, some staff told us they would not use the policy due to fear of repercussions if they spoke out. Managers told us that their teams were open and readily expressed any concerns. One staff member we spoke with said they have highlighted their concerns to their line manager and sometimes did not receive a response for a long time.

Commitment to quality improvement and innovation

- A member of staff at the OCD service supported a person who uses the service to participate in medical research. This person told us the positive impact the experience it has been for them. The team were also applying for funding from the National Institute for Health Research.

Action we have told the provider to take

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

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Treatment of disease, disorder or injury	Regulation 9 HSCA (RA) Regulations 2014 Person-centred care **The trust did not ensure that people who use services had up-to-date care plans that evidenced the involvement of the person and/or their carer.** This was a breach of Regulation 9(3)(a)(b)

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Treatment of disease, disorder or injury	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment **The trust did not ensure that people's risk was appropriately assessed including a history of self harm.** This was a breach of Regulation 12(1)(2)(a)

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Treatment of disease, disorder or injury	Regulation 17 HSCA (RA) Regulations 2014 Good governance **The trust did not maintain an accurate, complete and contemporaneous record for each patient and other records necessary for the management of the regulated activity.** **The records across the teams were not consistent and accurate especially in terms of updating risk assessments, medication records and care plans. This could potentially place patients at risk of not having their current needs met.** This was a breach of Regulation 17 (1)(2)(a)(b)(c)(d)

Regulated activity	Regulation

Requirement notices

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

Treatment of disease, disorder or injury

Regulation 18 HSCA (RA) Regulations 2014 Staffing
The trust had not recruited to fill vacancies and used a high number of agency staff.

This was a breach of Regulation 18(1)