Good

North Essex Partnership University NHS Foundation Trust

Community-based mental health services for adults

Quality Report

Trust Headquarters, Stapleford House, 103 Stapleford Close
Chelmsford, Essex CM2 0QX
Tel: 01245546400
Website: www.nep.nhs.uk

Date of inspection visit: 24 – 28 August 2015
Date of publication: 26/01/2016

Locations inspected

Location ID	Name of CQC registered location	Name of service (e.g. ward/ unit/team)	Postcode of service (ward/ unit/ team)
RRDW11	The Gables Braintree	Mid Essex specialist psychosis service	CM7 9AE
RRDW5	C&E Centre Chelmsford	Mid Essex specialist recovery service	CM2 0QH
RRDX10	Herrick House Colchester	Specialist mental health team	CO1 1ST
RRDW13	Rectory lane Health Centre Loughton	Epping Forest specialist mental health recovery team	IG10 3RU
RRDW6	Aylmer House Harlow	Early intervention and assertive recovery service	CM20 1DG
RRDW4	Latton Bush Harlow	Harlow specialist mental health team	CM18 7BL
RRDX11	Reunion House Clacton-on-Sea	Specialist psychosis team	CO15 1JA

Summary of findings

This report describes our judgement of the quality of care provided within this core service by North Essex 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 North Essex Partnership University NHS Foundation Trust and these are brought together to inform our overall judgement of North Essex 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?	Good
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 community based services for adults as good overall because:

- The teams worked to a comprehensive lone working practice protocol. Staffing levels were safe and recruitment was in progress to fill vacancies. Staff were trained in and aware of safeguarding requirements and used the appropriate referral process. Clinical areas were clean and well maintained and infection control information was on display. Caseloads were managed proactively, re-assessed regularly and discussed in individual supervision.
- There was an effective incident reporting system in place and staff knew how to report an incident.
- Medicines were managed safely and there was learning from medication incidents.
- Comprehensive assessments were completed in a timely manner. Most care records showed personalised care which was recovery oriented.
- Staff followed National Institute for Health and Care Excellence (NICE) guidance. The community transformation changes had ensured that this guidance was followed regarding access to psychological therapy, family interventions and appropriate medication management. Physical healthcare needs were considered during assessment and during treatment.
- The teams were multi-disciplinary and consisted of psychiatrists, psychologists, nurses, social workers, occupational therapists and support workers. There was effective working with other agencies and services.
- Staff were consistently respectful and caring when they spoke with people. People who used the services and their carers gave positive feedback about staff. Several individual staff members were highly praised by people who used the services and their family members.
- People said they felt involved in their care planning and treatment and this was documented in the care records. Information on advocacy was available in waiting rooms.
- Staff were flexible about timing of appointments to meet patient need. The specific needs of people were considered, for example cultural and disability needs. There was access to interpretation services when required. Teams responded to and learned from complaints. Local resolution was tried wherever possible.
- There was access to a psychiatrist when required. There was joint working with crisis services. Carers' assessments were completed within the team by identified staff.Waiting lists for the teams and psychological therapies were kept to an absolute minimum. The community teams had no waiting list and psychological therapy had a wait of between one and eight weeks.
- Managers monitored performance and addressed any issues. Most staff were aware of the trust's vision and values and could describe them. Most staff knew who the senior managers and executive directors were. They had met the chief executive and executive and non-executive directors. Staff said they had raised issues with the chief executive and felt they had been heard and action had been taken. All staff said they could raise issues with their manager if required and action would be taken. Clinical and managerial supervision was taking place.
- Sickness rates were low, poor attendance was addressed using the relevant policies. Managers said they had received advice and support from human resources.
- Teams could add items to local risk registers when necessary. Literature on the community transformation was comprehensive and well consulted on. The clinical model and care pathways were well laid out.

Summary of findings

- Despite concerns arising from the changes, and the size and significance of the community transformation, the teams were organised and delivering an effective service.

However:

- Risk assessments were not always detailed and updated.
- Evidence that medical equipment, such as weighing scales, had been checked and re-calibrated according to the manufacturer's instructions was incomplete.
- 80% of staff were up to date with their mandatory training. This is short of the trust target of 90% for mandatory training.
- Teams did not always hold de-brief sessions post incidents.
- The electronic record system was at times slow to use and as records were placed into different places on the system this made it difficult to track information easily.
- The level of detail in care plans, including information about personalisation and the recovery approach, was inconsistent. This increased the risk of key information being missed by professionals who may not be familiar with the person receiving care.
- In two teams the legal documentation relating to the Mental Health Act was disorganised and not readily available.
- There was some tension around the community transformation implementation. Some senior doctors felt isolated and not included and they said there was a lack of medical leadership and support.
- The teams had little confidence in the accuracy of data quality reports taken from the electronic care record system. Managers had no access to the electronic staff records system. This led to different processes and ways of monitoring team performance. The three areas, North East, Mid and West Essex, had developed different structures which led to staff confusion about the different models of care used across the trust. Teams and services had adopted different titles which further compounded this issue. This could be confusing for people using the services.

Summary of findings

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

Are services safe?

Good

We rated community based services for adults as good for safe because:

- The teams worked to an effective lone working practice protocol.
- Staffing levels were safe and vacancies were in the process of being filled. Staff were trained in and aware of safeguarding requirements and used the appropriate referral process.
- Clinical areas were clean and well maintained and infection control information was on display.
- Caseloads were managed proactively, re-assessed regularly and discussed in individual supervision.
- There was an effective incident reporting system in place and staff knew how to report an incident.
- Medicines were managed safely and there was learning from medication incidents.

However

- Risk assessments were not always detailed and updated.
- Evidence that medical equipment, such as weighing scales, had been checked and re-calibrated according to the manufacturer's instructions was incomplete.
- Teams did not always hold de-brief sessions post incidents.
- 80% of staff had received and were up to date with mandatory training. This is short of the trust target of 90%for mandatory training.

Are services effective?

Good

We rated community based services for adults as good for effective because:

- Comprehensive assessments were completed in a timely manner. Most care records showed personalised care which was recovery oriented.
- Staff were aware of and followed NICE guidance. The community transformation changes had ensured that this guidance was followed regarding access to psychological therapy, family interventions and appropriate medication management.
- Physical healthcare needs were considered during assessment and treatment.

Summary of findings

- The teams were multi-disciplinary, consisting of psychiatrists, psychologists, nurses, social workers, occupational therapists and support workers. Joint working with other agencies and services was effective.

However

- The electronic record system was at times slow to use and as records were placed into different places on the system this made it difficult to track information easily.
- The level of detail in care plans, including information about personalisation and the recovery approach, was inconsistent.
- In two teams the legal documentation relating to the Mental Health Act was disorganised and not readily available.

Are services caring?

Good

We rated community based services for adults as good for caring because:

- Staff were consistently respectful and caring when they spoke with people. People who used the services and their carers spoke positively about staff.
- Several individual staff members were highly praised by people who used the services and their family members.
- People said they felt involved in their care planning and treatment. This was documented in the care records.
- Information on advocacy was available in waiting rooms.

Are services responsive to people's needs?

Good

We rated community based services for adults as good for responsive because:

- People were seen promptly for assessment. Staff were flexible about timing of appointments to meet the needs of patients.
- The specific needs of people referred were considered, for example cultural and disability needs. There was access to interpretation services when required.
- Teams responded to, and learned from complaints; local resolution was tried wherever possible.
- There was access to a psychiatrist when required. There was joint working with crisis services when required.
- Staff reported carers' assessments were completed within the team by identified staff.

Waiting lists for the teams and psychological therapies were kept to a minimum

Summary of findings

Are services well-led?

Good

We rated community based services for adults as good for well-led because:

- Managers monitored performance and addressed any issues.
- Most staff were aware of the trust's vision and values and could describe them. Most staff knew who the senior managers and executive directors were. They had met the chief executive, and executive and non-executive directors. Staff said they had raised issues with the chief executive and felt they had been heard and action had been taken.
- Staff could raise issues with their manager if required and action would be taken. Clinical and managerial supervision was taking place.
- Sickness rates were low, poor attendance was addressed using the relevant policies and managers said they had received advice and support from human resources. Teams could add items to the local risk register when necessary.
- Literature on the community transformation was comprehensive and well consulted on. The clinical model and care pathways were well laid out. Despite concerns arising from the changes, and the size and significance of the community transformation, the teams were organised and delivering an effective service, morale was good and little disruption to patient care took place.

However

- There was some tension around the community transformation implementation. Some senior doctors felt isolated and not included and they said there was a lack of medical leadership and support.
- The teams had little confidence in the accuracy of data quality reports taken from the electronic care record system. Managers had no access to the electronic staff records system. This led to different processes and ways of monitoring team performance. The three areas, North East, Mid and West Essex, had developed different structures which led to staff confusion about the different models of care used across the trust. Teams and services had adopted different titles which further compounded this issue. This could be confusing for people using the services.

Summary of findings

Information about the service

North Essex Partnership University NHS Foundation trust had embarked on a complete transformation of community mental health services over the preceding two years, called 'the journeys programme' which was fully implemented in April 2015 following local stakeholder, patient and staff consultation.

The trust managed 34 community teams covering a number of core services including; crisis services, community services for older adults and community services for adults, substance misuse services, services for veterans, children's mental health and learning disability services.

The community based services offered people with identified mental health needs a range of community based treatments, psychological support and interventions, medication and advice across the West, Mid and North East areas of Essex. We visited seven of the nine community teams for adults of working age. The mid Essex specialist psychosis service, mid Essex specialist recovery service and North East specialist mental health team, the Epping Forest specialist mental health recovery team, early intervention and assertive recovery service, the Harlow specialist mental health team and the North East specialist psychosis team.

People could access services from the age of 18 years and from 14 years for early intervention services. The community services we inspected were based in a variety of urban and rural settings, within a wide geographical area. The population served was diverse and included significant areas of deprivation. In addition to these services, the trust provided a wide range of other community based services including a single point of access and assessment service.

We had not inspected these services previously.

Our inspection team

Our inspection team was led by:

Chair: Dr Moira Livingston.

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

Inspection manager: Peter Johnson, Inspection Manager, mental health hospitals, CQC.

The team that inspected the community-based mental health services for adults consisted of 13 people, divided into two smaller teams. These teams consisted of two inspectors, one inspection manager, one Mental Health Act reviewer, four nurses, one social worker, one psychologist, one psychiatrist in training and two experts by experience. An expert by experience is someone who has had personal experience of using or caring for someone who uses the type of services we were inspecting.

The team would like to thank all those who met and spoke to inspectors during the inspection and were open and balanced with the sharing of their experiences and their perceptions of the quality of care and treatment at the trust.

Why we carried out this inspection

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

Summary of findings

How we carried out this inspection

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

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

Before the inspection visit, we reviewed information that we held about these services, asked a range of other organisations for information and sought feedback from people using the services at focus groups. We received no comment cards.

During the inspection visit, the inspection team:

- Visited seven community-based mental health services. We looked at the quality of the environments and observed how staff were caring for people.
- Spoke with 43 people who were using the service, seven in their own homes.
- Met with eight carers of people using the service.
- Interviewed seven clinical team managers.
- Spoke with 100 staff members including doctors, nurses and support time recovery workers.
- Interviewed the senior management team with responsibility for these services, including the chief nurse and deputy director.
- Attended and observed three multi-disciplinary clinical meetings.
- Reviewed 129 care and treatment records.
- Examined 44 records specifically for Mental Health Act documentation.
- Inspected 25 medication administration charts.
- 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 used services and their relatives. Most people were positive and complimentary about their experience of care from the community services. They found staff to be caring, kind, professional and supportive towards them.
- People felt that they were actively involved in looking at choices for and making decisions about their care and treatment. They told us that staff were particularly empathetic and developed quality relationships with their patients, which supported their recovery.

Good practice

- Ten staff from across community teams were undergoing training to participate with patients in a multi-site, national research project implementing the 'open dialogue approach', led by University College London.
- Community teams were using family group conferencing as a good practice model for working with whole families. The approach uses a facilitated group conferencing process to bring together significant people in a person's life to contribute to devising a support plan.
- Integrated employment specialists working with people using services across all community teams meant that employment was given a high priority in the recovery of people using services.
- The personality disorder pathway in the North East and West areas was effective and staff were trained in psychological approaches for people with this diagnosis.

Summary of findings

- Peer support workers had been re-deployed within the community team in the Mid Essex area and evaluations had been positive.

Areas for improvement

Action the provider SHOULD take to improve
Action the trust SHOULD take to improve:

- The trust should ensure that risk assessments are sufficiently detailed, personalised and kept up to date.
- The trust should ensure there is a system in place to check and re-calibrate medical equipment, such as weighing scales, according to the manufacturer's instructions.
- The trust should review the efficacy of the electronic record system in community bases and ensure accurate inputting of data.
- The trust should ensure all Mental Health Act documentation is readily available and in good order.
- The trust should review the accuracy of the data quality reports taken from the electronic care record system.
- The trust should ensure that all informal complaints are logged and reported centrally.
- The trust should ensure that managers have access to all information they require to manage their team, including the electronic staff records system.

North Essex Partnership University NHS Foundation Trust

Community-based mental health services for adults

Detailed findings

Locations inspected

Name of service (e.g. ward/unit/team)	Name of CQC registered location
The Gables, Braintree	Mid Essex specialist psychosis service
C&E Centre, Chelmsford	Mid Essex specialist recovery service
Herrick House, Colchester	Specialist Mental Health Team
Rectory lane Health Centre, Loughton	Epping Forest specialist mental health recovery team
Aylmer House, Harlow	Early intervention and assertive recovery service
Latton Bush, Harlow	Harlow specialist mental health team
Reunion House, Clacton-on-Sea	Specialist psychosis team

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.

- We inspected 44 care records specifically in relation to the Mental Health Act, including those people receiving services who were subject to community treatment orders. The documentation was found to be in good order and readily available in all but two teams. Staff we spoke with providing care and treatment to people subject to a community treatment order were aware of the conditions stipulated within the order. They were aware of the statutory requirements of the Act.
- Each team had approved mental health professionals integrated within the teams. The duty staff member co-ordinated and arranged any Mental Health Act

assessments required. Staff said there were no specific delays in carrying out the assessments but that there were sometimes delays in accessing a local bed if admission to hospital was required.

Mental Capacity Act and Deprivation of Liberty Safeguards

- Staff were able to explain the process to follow should they have to make a decision about or on behalf of a person lacking mental capacity to consent to proposed decisions, in accordance with the Mental Capacity Act. People had access to independent mental capacity advocates if required.
- 80% of eligible staff were up to date with refresher training in the use of the Mental Capacity Act 2005 and Deprivation of Liberty Safeguards.
- No patients were subject to the Mental Capacity Act or court of protection.

Good

Are services safe?

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

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

Our findings

Safe and clean environment

- Access to centres for appointments and clinics were through staffed reception areas with comfortable waiting areas. We saw that the environments were safe and well maintained. We noted some inconsistencies in the quality of environments across the seven sites, with Aylmer House requiring some re-decoration and Herrick House requiring sound proofing to some interview rooms.
- Personal call alarms were available to all staff within the team bases. However, except for approved mental health professionals, none were available for staff to use on home visits. There was a lone working policy and all of the staff we spoke with knew about it and could describe what was done in relation to staff safety while working in the community and in people's homes. Where there were concerns about risks to staff, staff would visit in pairs or arrange to see people in safer alternative venues.
- Each centre was equipped with a clinic room where the necessary equipment to carry out physical examinations was available. There were some inconsistencies across the seven sites with the procedures for checking medical equipment, how regularly they were calibrated, and the frequency of monitoring and recording required fridge temperatures.
- Clear information on infection control protocols was available throughout this service.

Safe staffing

- The staffing skill mix had been reviewed as part of the trust's community transformation project which was implemented in April 2015. The teams in the North East and Mid Essex had a range of fully integrated professions, including doctors, nurses, support workers, social workers, occupational therapists and psychologists. The teams in the West had a separate team of psychologists and occupational therapists which could be accessed on a referral basis.
- Caseload numbers had been agreed during the community transformation project using service mapping to assess and reflect the daily operations and future activity projections of all of the community teams. The transformation project determined the safe staffing levels required for the teams and had been set on population demands. Caseload numbers for care co-ordinators ranged from 15 to 35 and numbers were monitored in team meetings and supervision. Caseload numbers for consultant psychiatrists were considerably higher, ranging from 60 to 200, due to outpatient clinics where people using services may only be seen by the doctor two to four times each year. Clinics were planned to review the caseloads of consultants and re-allocate as necessary.
- Nursing recruitment had been identified as a risk. This was identified on the trust's risk register and the local risk register for the community transformation project. A variety of recruitment initiatives, such as an ongoing and rolling recruitment programme were underway in an attempt to fill vacancies.
- Staffing figures across all community teams before the community transformation were 662 whole time equivalent posts. Following the community transformation this figure had reduced to 614 posts, a reduction of 48 posts.
- Community staff vacancies had been held before the implementation of the transformation and were at 16% in September 2014. Following the implementation of the changes and where staff vacancies existed recruitment was actively pursued. Current vacancy levels were 10%.
- Sickness absence rates for the year to February 2015 across the trust were 4%. Sickness absence rates for the community teams were lower than the trust average at 3%.
- 80% of staff in the community teams had received and were up to date with mandatory training. This is short of the trust target of 90% for mandatory training.
- All seven teams had access to a consultant psychiatrist and approved mental health professional when required and in an emergency.

Good

Are services safe?

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

Assessing and managing risk to patients and staff

- Comprehensive risk assessments were completed and reviewed regularly, including at multidisciplinary team meetings. The assessments used the care programme approach template, and followed a zoning or 'RAG (red, amber, green) rating' system to make the level of risk clearly identifiable. The level of risk was then reviewed regularly, and adjusted as necessary. Each person was discussed at the regular staff handovers, and their level of risk and care plan reviewed. In all of the teams, with the exception of Rectory Lane, Aylmer House and Reunion House, we found variable quality of risk assessments. For example, at Latton Bush we found that six out of 12 risk assessments were overdue a review.
- Staff told us that they discussed caseload management in both group and individual supervision and that this included strategies for managing risk.
- Joint visits between staff were undertaken at times and other precautions were undertaken by staff when required. These were supported by risk assessments and reviewed regularly.
- Staff were clear about appropriate procedures to follow if people did not attend their appointments. These included telephone contact, making home visits and sending letters. Contingency plans were in place and staff were aware of these.
- The trust had a safeguarding policy, which followed the county-wide multi-agency policies. Over 80% of community team staff had completed safeguarding training, and those we spoke with demonstrated that they could identify safeguarding concerns, and knew what action to take in response. All teams had appointed a safeguarding champion. There were safeguarding leads within or accessible by the teams, and staff knew who they were and how to contact them for advice. We observed a discussion about an existing safeguarding investigation underway, in one team, and saw that additional safeguarding concerns were highlighted. The local authority was contacted to discuss further action to be taken to protect people using services.
- The trust had a lone working policy. Staff were familiar with this, and confidently gave examples of what they did to keep one another safe. For example, if they had particular concerns about a person using services they might visit in pairs or arrange for the patient to be seen at the office.
- Each team had at least one qualified nurse prescriber or more in training. The teams had suitable arrangements in place for the safe and appropriate management of medicines. This included the safe receipt, storage, administration and recording of medicines.

Track record on safety

- Within the previous year to March 2015 there were 39 serious incidents, across 34 community services covering several core services; all were unexpected deaths. There were a total of 56 reported deaths across the trust during the same period of time and 15 were substance misuse deaths.

Reporting incidents and learning from when things go wrong

- Staff knew how to recognise and report incidents on the trust's electronic recording system. Incidents were reviewed by the manager, given a risk grading and forwarded to senior managers and the trust's patient safety team for further review. The system ensured that senior managers within the trust were alerted to incidents in a timely manner and could monitor the investigation and response to these. The action taken was also recorded on the electronic system.
- Where serious incidents had occurred within the teams, serious incident investigations had been completed and dated action plans implemented. For example, following incidents in the community teams, the process for monitoring those people who did not attend for their appointment had been reviewed. Another example, involved a medication error and staff underwent a refresher, competency based training before resuming medication administration. Significant incidents were discussed in staff meetings and handovers. However, staff were not always offered debrief sessions following serious incidents.

Are services effective?

Good

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

Our findings

Assessment of needs and planning of care

- Individual needs were assessed and people told us care was delivered in line with their individual care plans. However, the standard of care records was variable. The care plans at the Gables, the C&E Centre and Herrick House were basic and not always personalised or recovery focused. The Rectory Lane, Aylmer House, Latton Bush and Reunion House teams care plans were more detailed and the entries into the daily records were completed to a high standard.
- Each team held meetings either daily or three times a week, some of which we attended. The team discussed people's care and the support they required. Staff were aware of the needs of people and were putting plans in place to address these needs.
- On being taken on by the community teams, with their agreement, patients received a physical health assessment by their general practitioner. Risks to physical health were identified and managed effectively. Care plans were available for those patients with an identified risk associated with their physical health. The community teams offered physical health checks for people using services where this was considered more accessible and appropriate. The teams ran regular physical health clinics as well as administering injections and monitoring the associated risks to people's physical health.
- The electronic record system was at times slow to use and as records were placed into different places on the system this made it difficult to track information easily.

Best practice in treatment and care

- The trust audited against the National Institute for Health and Care Excellence guidelines to monitor compliance, for example with treatment for schizophrenia, depression and prescribing medication. The 2014 audit outcomes reported poor monitoring of, and intervention for, risk factors associated with diabetes and cardiovascular disease. People using services were waiting too long to be started on certain medication and there were significant gaps across community services in the availability of cognitive behavioural therapy and family interventions. The audit did however report high levels of service user satisfaction with the care that they received, and 100% of people using services said they had a care plan. The community transformation programme had set out to address these areas of variable compliance and apparent inequities in service provision. A range of psychological therapies, including family interventions were available across all community teams. Physical health care planning was evident in all of the care records we looked at and medication reviews had been carried out with each patient.
- There was a range of psychology led interventions available. For example, we saw that psychological interventions were available in the STEPPS (systems training for emotional predictability and problem solving) approach which was available in a group programme to assist people using services in their recovery.
- Staff were using 'family group conferencing' as a good practice model for working with whole families. The approach used a facilitated group conferencing process to bring together the significant people in a person's life to contribute to devising a support plan.
- Occupational therapists were using evidence based assessment tools and outcome measures.
- Patients were assessed using the Health of the Nation Outcome Scales. These covered twelve health and social domains and enabled clinicians to build up a picture over time of their people's responses to interventions.
- There was no local clinical audit activity by the community teams, however, staff told us that following a formal evaluation of the effectiveness of the community transformation the clinical audit programme would be established.

Skilled staff to deliver care

- Staff told us how well supported they were with their learning and development needs and professional development. For example, we saw that the certificate in care was going to be offered to support workers working within the community teams from September 2015.

Are services effective?

Good

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.

- Temporary staff received a good induction to the service. Checks were made to ensure that temporary staff received the required training prior to starting work in the community teams.
- 85% of staff had received regular one to one supervision and an annual appraisal. Some teams did report that due to the community transformation and movement of teams around the county that some supervision slots had been delayed. 70% of staff had received an appraisal.
- Clinical lead managers said they monitored staff performance regularly and were managing a small number of cases where performance was being monitored for improvement.

Multi-disciplinary and inter-agency team work

- A full range of mental health disciplines worked within each team, except in the West of the county where psychology and occupational therapy was provided by a separate therapies team. The community teams were integrated between health and social care staff and included; nurses, support workers, support time and recovery workers, social workers, doctors, approved mental health professionals and employment specialists. Nurses and social workers had trained as approved mental health professionals.
- We observed three multi-disciplinary meetings which were all well planned and organised. We saw the use of electronic interactive boards to enable access directly into the care records. Each patient was discussed and staff discussed their caseloads and the complexities of people's needs. Staff worked well together and respected one another's contributions. A voluntary organisation providing specialist employment advice to people using the services was fully integrated into the care planning and reviewing processes.
- There was appropriate sharing of information to ensure continuity and safety of care across teams, including involvement of external agencies, for example the local authority and the Care Quality Commission. The trust widely advertised why information about patients was collected and the ways in which it might be used, for example in the teaching and training of healthcare professionals.
- The community transformation programme, whilst in planning and under consultation for the preceding two years, had been implemented fully in April 2015. Whilst acknowledging the sizable changes the programme had made, most staff said that they felt increasingly settled and integrated and felt that the new arrangements were working well. Staff reported that their main objective had been to cause as little disruption as possible for the people using services.
- Teams allocated duty staff to work each day on a rota basis. This role was primarily to add additional support for care co-ordinators, triage phone calls, carry out urgent assessments and enable patients to receive prompt treatment.

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

- We inspected 44 care records specifically in relation to the Mental Health Act, including those people receiving services who were subject to community treatment orders. The documentation was found to be in order and up to date, except in two teams. Staff providing care and treatment to people subject to a community treatment order were aware of the conditions stipulated within the order. They were aware of the statutory requirements of the Mental Health Act.
- Each team had approved mental health professionals integrated within the teams. The duty staff member co-ordinated and arranged any Mental Health Act assessments required. Staff said there were no specific delays in carrying out the assessments but there were sometimes delays in accessing a local bed should admission to hospital be required.

Good practice in applying the Mental Capacity Act

- Staff were able to explain the process to follow should they have to make a decision about or on behalf of a person lacking mental capacity to consent to proposed decisions, in accordance with the Mental Capacity Act. People had access to independent mental capacity advocates if required.
- 80% of eligible staff were up to date with refresher training in the use of the Mental Capacity Act 2005 and Deprivation of Liberty Safeguards.
- No people using services of the community teams were subject to the Mental Capacity Act or court of protection.

Good

Are services caring?

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

Our findings

Kindness, dignity, respect and support

- Staff were kind, caring and compassionate. This was demonstrated by the staff we observed. When we spoke with people receiving support they were generally very positive about the support they had been receiving. With only two exceptions, all people we spoke with and their carers reported that they were treated with respect and found staff to be supportive and helpful.
- The majority of people and their carers highly praised individual staff and gave examples of how they had been cared for and assisted towards their recovery. Administrative staff were also praised highly by the people we spoke with, particularly in regards to their helpfulness, professionalism and approachability.
- The trust widely advertised a feedback form, written by the chief executive, which asked and encouraged comments for people to feedback their views on the service received by community teams. We saw for example that people had commented on the community transformation programme and that some of their suggestions had been taken on board.
- Suggestion and comment boxes seeking patient and family feedback were available in each service.
- Staff demonstrated a good knowledge and understanding of patients. We attended home visits and it was clear that staff had a good understanding of individual needs. Staff communicated with people in calm and professional manner using an empathetic approach.
- People's confidentiality was maintained by all the community teams. When we accompanied staff on home visits the staff members asked, prior to the visit, if the person was content for a CQC team member to be present. All staff we spoke with were aware of the need to ensure a person's confidential information was kept securely. Staff access to electronic case notes was password protected.

The involvement of people in the care that they receive

- During our community visits we saw that carers were invited to attend discussions with their relatives. The meeting provided an opportunity for the carer to be involved with any potential changes to the care plan. Carers had been offered the opportunity of a carer's assessment.
- Patients told us they had received a copy of their care plan.
- Individual recovery goals had been set and people were involved in their care planning. For example, one patient told us they were asked on each visit whether their needs had changed and whether they were happy with the recovery goals set.
- Patients were offered a variety of therapies both individually and on a group basis which actively included their involvement. For example, we spoke to patients who had participated in groups to help with mood stabilisation, others who had joined groups to learn about recovery principles, health and wellbeing and to help build self-esteem and confidence.
- We attended two care review meetings and saw that both of these involved the patient. Records showed that they had received at least a six monthly review of their care under the care programme approach protocols.
- The trust ran a service user forum which met monthly and carried out regular family and friends test to survey their experiences of the services.
- Patients had access to a wide and relevant range of information which included information on; employment support services, support following a bereavement, alcohol and drugs advisory service, support for people suffering from domestic abuse, signs and support if elder abuse is suspected, stepping stones support for people with anxiety and depression and the care programme approach. There was access to leaflets in different languages if needed. The trust provided interpreting services, advocacy services were available if required and contact numbers were advertised.
- Patients were encouraged to participate with staff recruitment processes.

Are services responsive to people's needs?

Good

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

Our findings

Access and discharge

- Referrals into the trust came from a variety of sources. These included; primary care services, social care, the non-statutory sector, accident and emergency departments, crisis line self-referrals, the police and the criminal justice system.
- The trust had developed a single point of access and assessment as part of the community transformation process. All people referred to the community teams were triaged through this team; this ensured that a detailed assessment of their emotional, psychological and social needs had taken place prior to being seen by the community teams. According to data provided by the trust people were seen within 14 days of referral into the adult teams and within two days of referral to the assertive outreach teams.
- Each team held a weekly meeting where all referrals were discussed based on the information received by the access and assessment service. This avoided assessment duplication. One overarching referrals meeting took place in West Essex and included representatives from external agencies, such as primary care, housing and the local authority. Urgent referrals would be prioritised and processed, by the duty staff member, on a daily basis across all community teams. No teams had a waiting list.
- The community transformation programme had redesigned individual care and treatment pathways based on the mental health cluster model. A cluster is a global description of a group of people with similar characteristics as identified in a holistic assessment and then rated against the mental health clustering tool. This model ensured that patients received the most appropriate interventions; treatments and support which best met their needs, provided by suitably trained and qualified staff.
- The newly developed and implemented care pathways model offered care packages and interventions for individuals based on a particular care cluster. The three care clusters were for those people with identified needs associated with symptoms of psychosis, for example schizophrenia or bi-polar illness; those with needs associated with a non-psychotic condition, for example anxiety or depression; and those with an organic condition, for example dementia.
- Interventions offered to people across the three care clusters included; medication monitoring and review, support with physical health needs and on going monitoring, support with returning to work, a range of psychological therapy, advice on coping with symptoms of illness and support with accessing community facilities and resources.
- Several staff were concerned about the length of travel required to visit some people in their own homes, who lived at the furthest point of either the West, Mid or North East of Essex. Staff could have to cover 50 miles which, with traffic conditions, could take up to one and a half hours to reach from the community team base.

The facilities promote recovery, comfort, dignity and confidentiality

- The facilities in all but one of the community bases we visited promoted recovery, dignity and confidentiality. One interview room required better sound proofing at Herrick House. Patients had access to clean, tidy and well maintained clinical settings. Furniture was in good condition and most areas were decorated to a good standard.

Meeting the needs of all people who use the service

- A wide selection of patient information literature was available in all reception areas, with the exception of the team in Mid Essex. This information included: how to raise a concern or complaint, access to advocacy services, mental health diagnosis defined, treatment options available, medication explained, access to self-help groups and voluntary sector mental health support organisations such as the Samaritans and Rethink.
- Disability access was available in all of the team bases.
- Good signage, including pictures, symbols and hearing loops, was in place for those people who may have difficulty communicating.
- People's diverse needs, such as ethnicity and religion, were recorded in their care records.

Are services responsive to people's needs?

Good

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

Listening to and learning from concerns and complaints

- Information about how to complain was on display in reception areas and on the trust's website. Reception areas also had information available about the patient advice and liaison service which supported people in raising concerns. Patients were given information about how to make a complaint as part of their introductory information leaflets.
- There had been some complaints that a person's care co-coordinator had changed as a result of the community changes.
- Staff described the complaints process and how they would process any complaints. Staff knew how to respond to anyone wishing to complain. Clinical lead managers demonstrated how both positive and negative feedback was used to improve the quality of services provided. For example, we heard that one team had received a complaint about how busy the reception area was and that at times people would prefer to sit quietly. The reception staff listened to the complainant and set up a room booking system to enable people to sit quietly in a smaller interview room whilst waiting for their appointment.
- Patients told us they were confident to raise any concerns or complaints and that they thought they would be listened to and their complaints taken seriously. Many said they would feel confident to ring the clinical lead manager if they had any concerns.
- We reviewed some complaints received and the related correspondence. We found complaints were taken seriously and responded to promptly in line with the trust's complaints policy and associated procedures. All complainants received an individual response to their complaint, as well as contact details of other bodies they could approach if they were unhappy about the outcome. Local resolution of complaints in the teams was always attempted, although a record of this was not always sent to the 'making experiences count' team for central logging.
- Staff team meeting minutes demonstrated that complaints were discussed and actions taken to ensure any lessons highlighted were learnt. Discussions took place in one team meeting to agree to install a water fountain in the reception area following a complaint received about the facilities provided.
- Patients were given the opportunity to participate in an annual satisfaction survey in addition to feeding back their experiences at care review and planning meetings.

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.

Our findings

Vision and values

- The trust's vision and values were on display in each site. Staff were familiar with these and the quality star which listed areas teams considered their strong points and weaker points in delivering the values of the trust. We saw examples of good practice which included: anxiety management packs; flexible working practices dependent on people's need, recovery focus, access to psychiatrists, access to employment specialists and skilled staff.
- Examples of areas requiring improvement included: introducing an effective audit programme, responsiveness to general practitioners, and increasing availability to spend more quality time with people using services.
- A newly developed clinical model had been implemented as part of the community transformation plan and staff were positive about improving the quality of services provided.
- Staff shared their views about the services and the transformation programme in an open, constructive and balanced way. They consistently showed a professional, caring and passionate approach to their services and the quality of the experience of people using the services.
- Most staff knew who the senior managers and executive directors were. They had met the chief executive, and executive and non-executive directors. Staff said they had raised issues with the chief executive and felt they had been heard and action had been taken. All staff said they could raise issues with their manager, if required, and action would be taken.
- Clinical and managerial supervision was taking place.
- Sickness rates were low; poor attendance was addressed using the relevant policies and managers said they had received advice and support from human resources.
- Teams could add items to the local risk register when necessary.
- Literature on the community transformation was comprehensive and well consulted on. The clinical model and care pathways were well laid out. Given the size and significance of the community transformation we found the teams organised and delivering an effective service, morale was good and there was little disruption for patients.
- However, there was some tension around the community transformation implementation; some senior doctors felt isolated and not included and they said there was a lack of medical leadership and support.

Good governance

- Each team had access to locally developed governance systems that enabled them to monitor and manage performance and provide information to senior staff in the trust, in a timely manner. These systems were developed by local managers. However, trust-wide governance systems did not enable managers to receive timely or accurate information. For example, we looked at the North East performance dashboard which had been produced corporately. The dashboard reported that 88% of care records had incomplete entries for the top five key performance indicators. The lead manager at Reunion House showed us the locally developed dashboard which showed that 5% of care records had incomplete entries.
- We reviewed the community teams' performance management framework and saw that data was collected regularly but this was individually collated by each team. The trust's key performance indicators included: people receiving a yearly review under the care programme approach, risk and crisis plans in place for everyone, care plans shared with the person using services and care plans reviewed for people receiving services under Section 117 of the Mental Health Act. This system made it difficult for managers to compare their performance with that of other teams and this potentially provided a disincentive for improvement.
- Clinical lead managers did not have access to the electronic staff record system to update and maintain the training records for their teams and to keep accurate records of key staff performance indicators, such as sickness, vacancy and turnover information. Senior managers told us that access had been stopped as a temporary measure during the implementation of the community transformation programme.

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.

Leadership, morale and staff engagement

- The teams were well-led and had clinical lead managers in post. Managers were visible within the service during the day-to-day provision of care and treatment. They were accessible to staff and proactive in providing support. Managers had been particularly responsive and supportive during the various office moves and integration of the community teams during the programme of change. Staff spoke positively about the active leadership.
- Most of the staff we spoke with were enthusiastic and engaged with developments within the service. Those who were not so positive spoke openly about the changes within community services and that it had had an adverse effect on their morale. Most staff said that the level of disruption and stress had reduced after several weeks into the changes.
- We received three comments about poor medical leadership in the trust.
- Staff were able to report incidents, raise concerns and make suggestions for improvements. They were confident they would be listened to by their line managers. Some staff gave us examples of when they had spoken out with concerns about the care of people and said this had been received positively as a constructive challenge to practice.
- Each team had a regular team meeting and had planned a future away day. Most staff described morale as very good, with their team leaders being highly visible, approachable and supportive.
- Sickness and absence rates were 2.9% in the community teams; compared to a trust wide figure of 4.3%.
- Staff were aware of the whistleblowing process if they needed to use it.Some concerns had been raised about the community transformation programme.
- Local leadership was aware of the issues and concerns that were raised by some staff, because of the implementation of the community changes. We saw a robust local risk register and action plan had been developed prior to our visit which set out a credible plan to address those concerns.

Commitment to quality improvement and innovation

- Ten staff were undergoing training to participate, alongside people using services, in a multi-site, national research project implementing the open dialogue approach, led by University College London.
- The community teams were using family group conferencing as a good practice model for working with whole families. The approach used a facilitated group conferencing process to bring together significant people in a person's life to contribute with devising a support plan.