The Zone

Quality Report

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This report describes our judgement of the quality of care at this location. It is based on a combination of what we found when we inspected and a review of all information available to CQC including information given to us from patients, the public and other organisations

Ratings

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

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

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

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

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

Summary of findings

Overall summary

We rated The Zone as requires improvement because:

- There was a long waiting time for the Icebreak service (for clients with difficulties relating to personality disorder). All Icebreak clients had a fixed two-year treatment time regardless of their individual needs. The provider did not monitor whether this timeframe was effective, the wellbeing of clients on the waiting list for Icebreak or that appropriate health care professionals monitored clients who had self-referred to the service. The Zone was in the process of redesigning the Icebreak service to reduce the number of clients on the waiting list.
- Children and young people, who might be unaccompanied (from the age of 13 years) shared a waiting room with adults who could be distressed or may exhibit challenging behaviour. There were no clear procedures or policies to enable staff to protect children or adults from challenging behaviour. Staff did not always have access to alarms when consulting with clients in the building.
- Staff reused Paleperidone (a medicine used to treat schizophrenia) which should only be given to the client it has been prescribed for. This was against good practice guidance and the provider's policy.
- There was a lack of incident reporting, investigation and learning from incidents which could help prevent future incidents. Staff did not know the full range of incidents they should report.
- Staff had not all completed training in the Mental Capacity Act and did not understand their responsibilities under the Act. There was no policy on the Mental Capacity Act. Clients and carers were not aware of advocacy services available to them.
- Staff working in the Insight service (for clients experiencing a first episode of psychosis) had not had appraisals or performance reviews and therefore had not had the opportunity to discuss their goals and development.

However

- The service was fully staffed and staff sickness and absence rates were low. Staff received supervision and training for their roles, they were driven and motivated to provide good care. Staff said they enjoyed their jobs and had good job satisfaction.
- Clients said staff treated them with respect and dignity and that they were professional, helpful, kind and caring. Clients could contact the service while they were on the waiting list for advice and signposting information. Staff reached out to clients who missed appointments in case it was a sign of a decline in the client's mental health.
- Safeguarding policies and procedures were in place. Safeguarding is the action that is taken to promote peoples' welfare and protect them from harm. Staff completed safeguarding training to help them keep clients safe. Staff made safeguarding alerts when needed.
- Care plans and risk assessments were of good quality. Clients and staff wrote care plans together and they included goals and information on physical health and wellbeing. Staff kept care plans up to date. Families and carers were involved in clients' care if the client wanted.
- The service followed best practice guidelines by offering effective talking therapies. Staff ran a variety of groups that clients liked and found helpful. Teams included a range of mental health disciplines to meet the needs and preferences of clients.
- The service had good working links with other agencies to help it provide holistic care. Staff liaised with GPs and other health professionals to support clients' physical and mental health needs. Staff provided employment, housing and benefits support for clients.

Summary of findings

Our judgements about each of the main services

Service	Rating	Summary of each main service
Community-based mental health services for adults of working age	Requires improvement 	

Summary of findings

Contents

Requires improvement

The Zone

Services we looked at

Community-based mental health services for adults of working age

Summary of this inspection

Background to The Zone

The Zone is a charity based in Plymouth city centre.

The Zone provides two distinct services that are registered with CQC:

Icebreak is for young people aged 16 to 22 who are experiencing personality disorder related symptoms that are influencing day-to-day lives and mental well-being.

Insight is an early intervention in psychosis service for adults aged 18 to 65 who are experiencing their first episode of psychosis. Insight is the secondary mental health service for people experiencing first episode psychosis in Plymouth.

The Zone and Livewell Southwest, working in partnership, deliver Insight. Livewell Southwest is a Plymouth based provider who provides community and inpatient mental health services. The Zone Insight staff were care co-ordinators, an employment worker, a welfare rights worker, family therapists and psychology assistants. The Zone employs the operations director and board for Insight. Livewell Southwest Insight staff provided the supervision, psychiatry and leadership. This inspection was for the Insight services provided by The Zone only. There is a memorandum of understanding between the two organisations. This is an agreement about how Livewell Southwest and The Zone work together.

The Zone is registered with CQC for treatment of disease, disorder or injury.

The Zone was inspected in March 2013 and January 2014 and was compliant in all areas.

As well as the two CQC registered services, The Zone provides services that are not within the scope of CQC: a sexual health service and a housing and accommodation service. The Zone and its commissioners aim to provide holistic care in one place to make them easily accessible.

Our inspection team

Team leader: Francesca Haydon

The team that inspected the service comprised two CQC inspectors and a specialist nurse.

Why we carried out this inspection

We inspected this 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?

Before the inspection visit, we reviewed information that we held about the location and asked a range of other organisations for feedback and information.

During the inspection visit, the inspection team:

- visited the service and looked at the quality of the environment including the clinical rooms and reception area
- spoke with eight clients who were using the service and nine carers

Summary of this inspection

- collected feedback from three clients using comment cards
- spoke with the chief executive officer and the operations director
- spoke with 10 other staff members; including care co-ordinators and a nurse clinical team leader
- spoke with staff from Livewell Southwest to get their feedback on the Zone service
- received feedback about the service from three stakeholders
- attended and observed a multi-disciplinary meeting
- looked at 10 care and treatment records of clients, five from Insight and five from Icebreak
- carried out a specific check of medication management
- looked at a range of policies, procedures and other documents relating to the running of the service.

What people who use the service say

We spoke to eight clients and nine carers and received three comments cards. Comments were generally positive. Clients said staff were understanding, non-judgmental, polite, friendly and helpful. They said staff listened to them and they felt safe. Clients said the service benefitted their mental and physical health and staff helped by signposting them to other services to support their holistic needs. All but one client said they could get hold of staff when they phoned in for additional support.

Summary of this inspection

The five questions we ask about services and what we found

We always ask the following five questions of services.

Are services safe?

Requires improvement 

We rated safe as requires improvement because:

- Children and young people from the age of 13 shared a waiting room with adults up to 65 years old. Staff were on duty in the waiting room but there was no clear procedure or policy to enable staff to protect children at all times from challenging behaviour.
- Staff did not always have access to alarms when seeing clients because there were no fixed alarms in interview rooms, staff only took alarms with them if there was a known risk. This was against the provider's own policy.
- Paliperidone, a medicine used to treat schizophrenia is prescribed for an individual patient's sole use. However, because of its cost, it was given to a different client it was not specifically prescribed to if a client stopped taking it. This was against good practice guidelines.
- Risk assessments that had been completed were of a good standard. However, the Icebreak service staff did not complete an initial risk assessment for clients that were not on the care programme approach but developed a risk assessment over a three-month period to develop their understanding of the client. Staff completed a threshold assessment for all Icebreak clients when they were first referred to the service to determine if the client was suitable for the service but this was not a full assessment. Staff did not triage Icebreak clients to identify those that needed to be seen quickly; this was against the provider's own waiting list management policy and procedure.
- Staff did not formally report the full range of incidents. This meant the provider did not review and learn from the full range of incidents to prevent them happening again in future.
- Although premises were clean, the building smelt mouldy in places. The provider planned to make repairs and replace carpets and a kitchen.

However

- Clinic rooms were clean, tidy and appropriately equipped.
- The service was fully staffed. Staff had manageable caseloads, managers monitored them, and ensured staff had equal caseloads.
- Clients and staff wrote crisis plans and advance decisions together to help them know what to do if the client felt worse or needed extra support.

Summary of this inspection

- Staff completed safeguarding training and made alerts when they needed to. There were comprehensive policies and procedures on safeguarding adults and children.

Are services effective?

Requires improvement

We rated effective as requires improvement because:

- Insight staff had not had appraisals and therefore had not had performance reviews or been given the opportunity to discuss their goals and development.
- Staff had not all trained in the Mental Capacity Act and did not have a good understanding of their responsibilities under the act. They did not know what to do if clients had impaired capacity or how to support clients to make decisions. There was no policy on the Mental Capacity Act.
- The majority of staff were not trained in the Mental Health Act.

However

- Care plans were comprehensive and up to date. Clients and staff wrote care plans together and they included goals and information on physical health and wellbeing. Medicines records contained clients' medication history and information about medicines.
- Staff received comprehensive supervision and specialist training for their roles.
- The provider followed national best practice guidelines by offering effective talking therapies. Staff ran a variety of groups that clients liked and found helpful.
- Teams included a range of mental health disciplines to meet the needs and preferences of clients. Staff provided employment, housing and benefits support for clients. Staff encouraged clients to have physical health checks and liaised with GPs and other health professionals to support clients' physical health needs.
- The service had good working links with other agencies to help them provide holistic care.

Are services caring?

Good

We rated caring as good because:

- Clients gave good feedback about staff. They said staff treated them with respect and dignity and that they were professional, helpful, kind and caring.
- Clients said staff went out of their way to help with practical matters associated with their health such as delivering prescriptions.

Summary of this inspection

- Clients and staff wrote care plans and crisis plans together and clients told us these were helpful.
- Families and carers were involved in clients' care when the client wanted them to be and carers had their own support group.
- Clients took part in interview panels for new staff.

However

- Clients and carers were not aware of advocacy services that were available to them.

Are services responsive?

Requires improvement 

We rated responsive as requires improvement because:

- The Icebreak service did not have a target time to assess clients. There was a 65 week waiting time for the Icebreak service. There were 146 clients awaiting allocation of a care co-ordinator for the Icebreak service at the time of our inspection. There was no target waiting time. The service did not monitor the wellbeing of clients on the waiting list for Icebreak. Staff wrote to referrers to tell them about the waiting time and to explain that the service would not monitor the client until they reached the top of the waiting list. This meant the referrer could continue to support and monitor the client. However, because clients who had self-referred to the service did not have a health care professional to write to, the provider could not be sure these clients were receiving alternative support or monitoring for any deterioration in their mental health or wellbeing.
- The provider did not monitor how effective the treatment provided by Icebreak was. It offered all clients a fixed two year treatment time regardless of their individual needs and progress. The provider was in the process of redesigning the Icebreak service to try to reduce the number of clients on the waiting list and introduce a more flexible treatment length.

However

- Insight clients started their treatment within 15 days of referral and the provider was meeting the target set by their commissioner to begin treating at least 50% of Insight clients within 14 days.
- The Zone was not responsible for clients' safety and mental health until Icebreak could assess them. Although there was a long waiting time for Icebreak clients, staff wrote to the referrer to tell them.

Summary of this inspection

- Clients that referred themselves to Icebreak received sign posting information to access other services while they waited. All clients could contact the service while they were waiting for advice and signposting information. Clients and carers reported that staff were responsive to their needs and that staff respond promptly to phone calls and drop ins.
- Staff tried to contact clients who missed appointments with them. Clients and staff agreed what would happen if they missed an appointment in case it was a sign of a decline in the client's mental health.
- Clients had access to information in the building and staff gave them information leaflets that also told them how they could complain if they needed to.

Are services well-led?

Good

We rated well-led as good because:

- The provider had a clear mission statement and team objectives were in line with the values.
- The Zone worked closely with Livewell Southwest and the two organisations shared resources to work efficiently together.
- Staff sickness and absence rates were low and staff retention was good. Staff knew what to do if they had difficulties at work and the provider offered supervision, counselling and mediation to support staff.
- Staff were driven and motivated to provide good care. Teams worked well together and had the opportunity to discuss the dynamics of the team in a monthly supervision group.
- Morale was generally good and most staff felt involved in and asked about changes before they happened. Staff said they enjoyed their jobs and had good job satisfaction.
- Team leaders provided reports directly to the board and attended board meetings.

However

- There was a lack of incident reporting, investigation and learning and therefore opportunities to improve were missed.
- Insight staff had not had appraisals and therefore had not had performance reviews or been given the opportunity to discuss their goals and development.
- The provider had not undertaken staff surveys to enable staff to give formal feedback.

Detailed findings from this inspection

Mental Capacity Act and Deprivation of Liberty Safeguards

- Records showed only one member of staff had completed Mental Capacity Act training but the records were not up to date.
- Staff did not have an understanding of the Mental Capacity Act and were not aware of their responsibilities under the act. They knew about Gillick competence and correctly assumed capacity but we could not be sure they knew what to do if a client lacked capacity.
- Staff did not know what to do if clients had impaired capacity or how to support clients to make decisions.
- There was no policy on the Mental Capacity Act.

Overview of ratings

Our ratings for this location are:

	Safe	Effective	Caring	Responsive	Well-led	Overall
Community-based mental health services for adults of working age	Requires improvement	Requires improvement	Good	Requires improvement	Good	Requires improvement
Overall	Requires improvement	Requires improvement	Good	Requires improvement	Good	Requires improvement

Notes

Requires improvement

Community-based mental health services for adults of working age

Safe	Requires improvement
Effective	Requires improvement
Caring	Good
Responsive	Requires improvement
Well-led	Good

Are community-based mental health services for adults of working age safe?

Requires improvement

Safe and clean environment

- Alarm systems were available but staff did not always carry them with them when seeing clients. There were no fixed alarms but staff had access to alarms to use in the building. According to the emergency procedure, staff were required to take alarms into appointments when seeing clients in the building and managers confirmed this was the practice. However, staff said they only took alarms into appointments with clients if there was a known risk. There was a panic alarm in reception for use in an emergency. Staff tested alarms regularly.
- There was no formal policy or procedure for the management of the waiting room to ensure children, young people and adults were not exposed to clients' challenging behaviours. A duty worker and reception staff were on duty in the reception area and the area was always staffed. However, staff told us incidents of aggression took place in the waiting room. There was an evacuation procedure that was used on approximately a monthly basis.
- The provider allowed young people to use the waiting room unaccompanied. There was one waiting room for all clients from the age of 13 upwards. This included adult clients from Insight, Icebreak clients from aged 16 and over and clients from other services not regulated by CQC for people aged 13 upwards. Staff were concerned about children and adults sharing the waiting room.
- A risk assessment was in place for the waiting area that covered bullying, theft and taking photographs. Reception staff reported concerning behaviour to the duty worker who completed an incident form. However, there was no formal review or investigation of these incidents.
- Administration of depot and long acting injection medication took place in two clinic rooms. The clinic rooms were clean, tidy and appropriately equipped. Weighing scales and blood pressure monitors were present in the clinic rooms but the provider had not calibrated or serviced the equipment. Staff advised clients to go to their GPs for physical health. There was a plan to increase physical health monitoring at The Zone in line with the national early interventions in psychosis model. Medicines were appropriately stored in the staff office.
- First aid boxes were available and 73% of Insight staff were trained in first aid and basic life support. Icebreak staff had not taken this training but a member of staff who was qualified as a first aid trainer planned to roll out the training to all staff.
- Cleaning records showed that cleaners cleaned the premises regularly. However, the building smelt damp in staff areas and mould was visible in some areas. There were exposed wires in the ceiling of a corridor between reception and areas accessed by clients and staff. The manager told us the wires would be encased once the maintenance task that had begun in the area was completed. There was no building maintenance programme but the provider told us it would be replacing the kitchen and carpets. A ligature risk assessment was in place and contained appropriate detail. The provider put handwashing signs up during

the inspection and alcohol hand gel was available. The provider planned to replace the carpets in November 2017. The toilets and staff kitchen were also due for renovation.

Safe staffing

- The staffing establishment was 10 Icebreak staff and 10 Insight staff. The staff sickness rate from 1 August 2016 to 1 August 2017 was 3.2% for insight and 2% for Icebreak. The staff vacancies rate from 1 August 2016 to 1 August 2017 was 10% for insight and 30% for Icebreak. However, at the time of our inspection there were no vacancies. Three Icebreak staff left in the same period and one Insight staff.
- The service based its staffing establishment on data about the expected numbers of people with mental health difficulties in Plymouth and the commissioned contract.
- Average caseloads were 13 for Icebreak and 12 for Insight. Managers adjusted staff caseloads for part time working and for new staff. Clinical team leaders provided caseload management and caseloads were weighted to ensure a fair balance of clients with high needs, those on standard care and those due for discharge. The highest caseload for Insight was 18 compared to a recommended 15. Staff reported this had an impact on their ability to offer all the interventions they would like to and their ability to complete assessments within the two-week target set by the national early interventions in psychosis model.
- At the time of our inspection, there were 10 cases awaiting allocation to a care co-ordinator for Insight and 146 clients waiting for a care co-ordinator for Icebreak.
- There were no specific cover arrangements for sickness, leave, or vacancies. Staff and clients did not report difficulties in covering absences. The provider did not employ agency or bank staff.
- Access to psychiatry was through Livewell Southwest. Staff, clients and carers told us psychiatrists were responsive and accessible.
- The average mandatory training rate for staff was 93% for Icebreak and 81% for Insight.

Assessing and managing risk to clients and staff

- We looked at 10 care records in total, five from each service. Risk assessments were completed and up to date for all Insight clients. Three Icebreak clients risk assessments were complete and up to date. These clients were on a 'care programme approach' which is a way that services are assessed, planned, co-ordinated and reviewed for someone with severe mental health problems. You might be offered care programme approach support if you: are diagnosed as having a severe mental disorder. The two remaining Icebreak clients were not subject to care programme approach so staff did not complete formal risk assessments for these clients. Some risk information was included in the client records for these clients. Staff completed a threshold assessment for all Icebreak clients to determine if the client was suitable for the service but this was not a full assessment. Clients assessed as being a risk to themselves or others were highlighted by staff on the records system as an alert to all staff.
- Staff did not monitor clients on the waiting list to detect increases in the level of their risk. Staff began treating Insight clients within 15 days. However, Icebreak clients remained the responsibility of the referrer until their assessment with Icebreak service, at the end of their time on the waiting list. The waiting time was currently 65 weeks. Staff wrote to referrers to advise them of this policy so they could continue to monitor the client.
- Staff were trained in safeguarding, knew how to make safeguarding alerts and gave examples of when they had done so. Staff worked actively with the local authority. There were comprehensive policies and procedures on safeguarding adults and children.
- A lone working policy contained guidance for staff and procedures to ensure their safety. Staff had alarms for use while working in the building and in the community when seeing clients. However, staff did not always take alarms into appointments with clients in the building.
- The provider stored medicines securely. Staff completed medicines audits but only on an irregular basis. There were no audit systems in place to check the delivery or dispensing of medicines to ensure there were no errors.
- Staff gave Paliperidone, an individually prescribed medication, to clients it was not specifically prescribed to. If a client stopped taking Paliperidone, staff gave it to another client for whom the medicine was also prescribed to save money, time and resources. This practice was not in line with best practice and there was a risk of clients taking the wrong dose of Paliperidone.
- Livewell Southwest medicines management policies and procedures did not cover the practice of reusing Paliperidone. During the inspection the operations

Requires improvement

Community-based mental health services for adults of working age

director advised that unused medicines that had been kept to issue to another client would be disposed of. Following our inspection, the providers arranged to meet to review the practice and the policy.
- Clients went to the local mental health NHS trust to have medicines, such as Clozapine that require monitoring after they have been administered.

Track record on safety

- In the year from 17 October 2016 to 19 October 2017, the Zone reported 17 incidents of clients causing serious harm to themselves to CQC. They also reported 21 notifications of incidents reported to or investigated by the police to CQC.
- During the period September 2016 to October 2017, there were three serious incident investigations. These incidents were investigated jointly with Livewell Southwest.
- The provider did not routinely report or investigate untoward incidents not meeting the criteria for serious incident investigation. An incident log contained three other incidents: two accidents and a client suffering an episode of ill health in the building.
- There was some evidence of improvements in safety following serious incidents. For example, an incident investigation found a client's care plan was not up to date with changes in their medicines. The investigation resulted in actions to ensure care plans were up to date with changes in medicines. However, these actions were not signed off as completed. The provider told us in the past incidents had led to changes to the way staff dispensed medicines, checked letters to clients and an evacuation policy for the waiting room.

Reporting incidents and learning from when things go wrong

- Staff did not know the full range of incidents they should report. The system for recording incidents was not clear and staff did not know how to report incidents or how to formally escalate risks arising from incidents. Since our inspection, the registered manager told us they had a new draft incident and near miss reporting form and log that they planned to roll out across the service. They planned to provide training for staff in what constitutes an accident, incident and near miss and how they should be recorded.
- The provider only reported and investigated serious untoward incidents. It did not formally or routinely report or investigate other untoward incidents. We heard about incidents of aggression, clients self-harming, accidents in the building, incidents leading to the evacuation of the reception area and lack of private meeting spaces to see distressed clients who dropped in. None of these had been formally reported or investigated. Managers told us incidents in reception happened frequently and they were confident they were managed well. The duty worker sent senior management the incidents as they occurred but there was no system for monitoring these incidents. This is because it was the provider's policy only to investigate serious incidents where there were significant consequences or a significant potential for learning.
- Investigations into incidents that met the threshold for reporting to the Strategic Executive Information System were reported and investigated in partnership with Livewell Southwest.
- The incident reporting and management system was not on the provider's risk register.
- There was an 'openness and duty of candour policy'. Staff understood their duty to be open and transparent and explain to client if they made a mistake. Serious incident reports showed staff carried out the duty of candour.
- Incident reporting and investigation were not robust and incidents and opportunities for staff to learn from and prevent future incidents were limited. There was limited evidence of improvements to the service in response to learning from incidents.
- Staff told us incidents were discussed in supervision and debrief was provided by a psychologist.

Are community-based mental health services for adults of working age effective?

(for example, treatment is effective)

Requires improvement

Assessment of needs and planning of care

- We looked at 10 care records in total; five Icebreak clients and five Insight clients care records. Care plans were comprehensive and up to date.
- Staff completed assessments for all clients but Icebreak clients' assessments took up to 12 weeks to complete.

Insight clients and some Icebreak clients had enhanced care programme approach care plans. Some Icebreak clients had standard care plans and these were less comprehensive but they included a risk history and an action plan. Staff used assessment measures, for example, the generalised anxiety disorder assessment, the patient health questionnaire, the alcohol use disorders identification test and drug use screening tool.

- Care plans were person-centred and collaborative with the client. Care plans were goal oriented and holistic. They included physical health and wellbeing as well as mental health.
- Client records were stored securely and they were available to staff when they needed them. Most records were electronic as the provider was phasing out paper-based systems. Staff had mobile working facilities so they could read client records when they were working in the community or on call.

Best practice in treatment and care

- Livewell Southwest prescribed medicines as required for The Zone clients and these were prescribed within the British National Formulary guidelines. We reviewed 90 prescribing records and they were of a good standard. They contained clients' medication history and information about medicines.
- Staff provided therapies in line with National Institute for Health and Care Excellence recommendations and followed guidelines for personality disorder, depression, anxiety and post-traumatic stress disorder. Staff offered clients experiencing their first episode of psychosis, cognitive behavioural therapy in accordance with best practice guidance. Staff provided family therapy and dialectic behavioural therapy for Icebreak clients. Talking therapies were delivered in groups and individually. There were a variety of groups that clients said they found helpful. These included gardening therapy, crafts, cooking, art and cooking. A weekly 'fit for life' group went on walks and visits.
- Clients and carers told us staff supported them with employment, housing and benefits.
- Staff directed all clients to their GP for physical health checks. Clients told us staff actively reminded them to see their GP as required. Client assessments included consideration of physical health needs. Staff encouraged clients to have physical health checks and liaised with GPs, the local hospital and the Livewell Southwest psychiatrist to share information about physical health and mental state when required.
- The GP visited the Zone to talk to clients about health concerns. Staff also talked to clients about physical health difficulties such as weight gain caused by prescribed medicines.
- Clients who were taking antipsychotic medicines had blood tests completed by Livewell Southwest staff in a variety of places, including at The Zone.
- Insight clients required specific physical health monitoring as the service was based on a national model. The provider was reviewing their practice against National Institute for Health and Care Excellence recommendations with a view to extending physical health monitoring undertaken within the service. It said it would train staff to undertake physical health monitoring.
- Staff assessed clients using the mental health clustering tool, which was a means of determining the severity of clients' symptoms and the best treatment to provide for them. When we reviewed care records, we found staff were not using any other assessment tools.
- The provider had completed a self-assessment against the National Institute for Health and Care Excellence guidelines for Borderline Personality Disorder. The assessment informed service development. Livewell Southwest, in collaboration with The Zone, had audited clinical records to ensure they were being fully completed.

Skilled staff to deliver care

- Teams included a range of mental health disciplines including care co-ordinators, psychology assistants, family therapists, welfare and employment workers and a GP with special interests. Working with the Insight team were Livewell Southwest staff including psychologists, psychiatrists, cognitive behavioural therapists and family therapy leads.
- Staff were qualified and some of the care co-ordinators also had professional qualifications, for example, in social work. There were a mix of experienced and newer staff.
- The service had a comprehensive induction programme and staff generally said the induction was good.
- Staff received the supervision they needed for their roles and attended team meetings. Staff had individual line

Requires improvement

Community-based mental health services for adults of working age

management supervision every four to six weeks, individual caseload supervision, monthly group supervision and monthly team dynamic supervision. Staff did not have an appraisal until they had worked in the service for a year. Icebreak staff had not had recent appraisals and therefore had not had performance reviews or been given the opportunity to discuss their goals and development. However, the new clinical team leader for Icebreak planned to complete appraisals by the end of the 2017.

- Staff received specialist training for their roles including training in dialectic behavioural therapy and compassion focussed therapy. The whole Insight team planned to have 'mentalisation' training in January 2018. Mentalisation is a recommended treatment for clients who have difficulties with personality disorder.
- Managers addressed staff performance and sickness effectively.

Multi-disciplinary and inter-agency team work

- Each team had a weekly multi-disciplinary meeting for each team that all staff in the teams attended.
- There were good working links with services external to the organisation including GPs, housing and benefits agencies. There was a working relationship with the local mental health trust and inpatient wards. The Zone housed a sexual health service for young people aged 13 to 25 years. There were links with community mental health services. One carer told us they had handover meetings with adult mental health services as part of the discharge process from The Zone. In an emergency, staff contacted mental health teams, as the provider did not offer a crisis service. One client gave an example of a good handover of their care from The Zone to another service out of area that enabled their care to continue when they moved.

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

- Training in the Mental Health Act was not mandatory. Training in the Mental Health Act was completed by 35% of staff. Insight staff had a good knowledge of the Mental Health Act.
- Staff obtained consent to treatment for each client and documented it on the care records.
- Insight clients were sometimes on Mental Health Act section 17 leave from hospital. The team leader and clinical care co-ordinators from the Insight service were Livewell Southwest staff and they oversaw these clients.
- Advice and support regarding the Mental Health Act was available for staff from the local mental health trust's Mental Health Act office.

Good practice in applying the Mental Capacity Act

- One member of staff, from the Insight service, had trained in the Mental Capacity Act. However, the provider told us that at least six staff had completed Mental Capacity Act training. Staff did not have an understanding of the Mental Capacity Act and were not aware of their responsibilities under the act. They knew about Gillick competence and correctly assumed capacity but we could not be sure they knew what to do if a client lacked capacity.
- There was no policy on the Mental Capacity Act.
- None of the staff completed Mental Capacity Act assessments. The psychiatrist from Livewell Southwest completed these. Staff did not know what to do if clients had impaired capacity or how to support clients to make decisions.

Are community-based mental health services for adults of working age caring?

Good

Kindness, dignity, respect and support

- We observed caring staff attitudes and behaviours towards clients. Staff were respectful and supportive.
- Clients and carers gave good feedback about how staff treated them. They said staff treated them with respect and dignity and that they were professional, helpful, kind and caring. Clients told us staff took their physical health seriously.
- Clients said staff responded promptly to their individual needs. Clients said staff went out of their way to help, for example, several clients said staff picked them up for appointments or delivered prescriptions if they needed help.

The involvement of people in the care they receive

Requires improvement

Community-based mental health services for adults of working age

- Clients told us they were involved in their care planning and that they had copies of their care plans. Clients said they discussed their crisis and contingency plans within staff. All clients and carers reported that they had contact numbers for their care coordinators and the team. The insight team had an out of hour telephone service. Clients told us they had crisis plans in place and that they were useful.
- Families and carers were involved in clients' care when the client wanted them to be. Carers had their own monthly forum that they told us was helpful and supportive. Staff signposted carers to adult social care to have carers' assessments if they needed them.
- Clients and carers were not aware of the advocacy services available to them.
- The provider involved clients and carers in decision making about the service. Clients had taken part in interview panels for new staff. The provider had trained them in how to make judgments about candidates. They could choose to have their own panel or be part of the interview panel.

Are community-based mental health services for adults of working age responsive to people's needs?

(for example, to feedback?)

Requires improvement

Access and discharge

- Insight clients' began their treatment within 15 days. There were 10 clients awaiting allocation to a care co-ordinator in the Insight. Insight was part of a national model for early interventions in psychosis with a target time of 14 days from referral to starting a National Institute for Health and Care Excellence concordant treatment. The service achieved 14 days 82% of the time; this was above its current target of 50%. The Icebreak service did not have a target.
- There were long waiting times for the Icebreak service and no target times from referral to treatment. There were 146 service users awaiting allocation to a care co-ordinator for the Icebreak service and the waiting time was 65 weeks. The Icebreak service did not have a target time to assess clients. The provider did not monitor the efficacy of the treatment provided to understand if the fixed two-year treatment time was effective and necessary.
- The provider was in the process of redesigning the Icebreak service to try to reduce the number of clients on the waiting list. It was currently working with the Peninsula collaboration for health operational research and development (PenCHORD) to research patient flow through the Icebreak service to develop efficiencies and to provide individualised care packages to clients.
- Referral rates fluctuated throughout the year. This was partly because of Plymouth's student population, which increased the population by an additional 45,000 during term times.
- Icebreak did not accept urgent referrals and clients were not triaged until they were near the top of the waiting list. This was contrary to the provider's waiting list management policy and procedure. The manager of the service said it would be unfair to prioritise clients. Staff made it clear to referrers of Icebreak client that the referrer remained responsible for the client during the waiting period. Staff gave clients that self-referred information about other services. All clients could contact the service while they were waiting for advice and signposting information. However, staff did not make any active contact with clients while they were waiting.
- Clients, families and carers told us staff were generally responsive when they phoned in for advice and support. One Icebreak client said their care co-ordinator did not always return their calls. The insight and Icebreak services had an out of hours telephone service. Clients and carers reported that staff were responsive to their needs and were able to respond promptly if required.
- Both Insight and Icebreak had clear admission and exclusion criteria in agreement with the service commissioners.
- Staff took active steps to engage clients who disengaged from the service. They made advance directives with clients that included what they would each do if there were signs the client was becoming unwell. For example, if disengaging from the service was a sign of a decline in the client's mental health. Staff texted and emailed clients to remind them about appointments.

Requires improvement

Community-based mental health services for adults of working age

- Staff offered clients appointments at times and in places to suit them as far as possible. Staff accommodated clients that needed appointments outside of working hours.

The facilities promote recovery, comfort, dignity and confidentiality

- The Zone had a full range of rooms including booths to meet with clients and two clinic rooms. However, staff told us they could not always find a space to see a client in, especially at short notice.
- Young people and adults used the same waiting room. This arrangement did not promote dignity, safety or confidentiality for clients.
- There was a supply of information about local services, including crisis phone lines and drug and alcohol support services. The Zone had its own range of leaflets about its services.

Meeting the needs of all people who use the service

- The building was at street level and consulting booths were on the ground floor so the building was accessible for clients with disabilities who required adaptations.
- A translation service was available for staff to facilitate treatment of clients for whom English is not their first language.

Listening to and learning from concerns and complaints

- The service had received eight complaints in the year leading up to our inspection. One complaint was not upheld. None of the complaints needed to be referred to the ombudsman.
- Staff gave clients information on how to make comments or complaints when joining the service. Clients we spoke to were not all familiar with the complaints process but they felt able to complain if they needed to. Clients could make comments about the service via the service website or the comments box in reception. The Insight service took part in a peer review programme where an inspection team from other early interventions in psychosis service, including clients and carers, met with and sought feedback from clients and carers from The Zone.
- Staff tried to resolve complaints informally where possible. There was a clear complaints process for complaints involving both The Zone and Livewell Southwest. There was an example of a complaint that the two providers jointly investigated. Both providers wrote to the complainant.
- There was no specific forum for staff to receive feedback on the outcome of investigation of complaints.

Are community-based mental health services for adults of working age well-led?

Good

Vision and values

- The provider had a mission statement that gave the aims and values of the organisation. These were covered during the induction programme.
- Team objectives were in line with the vision and values of the service. The provider aimed to provide person centred advice, guidance, early intervention and support for sustainable wellbeing and self-development and staff were working towards this aim.
- The operational manager and chief executive officer worked in the building with staff. They were involved in the day-to-day running of the service, for example, both provided on call support. This ensured they were available to staff.

Good governance

- The Zone worked closely with Livewell Southwest and both organisations shared resources to support each other. For example, Livewell Southwest provided information technology equipment and training to The Zone staff without charge and the Zone provided rooms to Livewell Southwest staff without charge.
- The provider missed opportunities to develop its staff and services and did not always ensure staff needs were met. Systems and processes were in place to ensure staff received appropriate training but managers had not ensured staff had completed training in and understood the Mental Capacity Act. The provider had missed opportunities to develop the service by their lack of incident reporting and investigation. These meant opportunities for learning and service

development to prevent future incidents were missed. The provider had not developed audit systems or systems for seeking and evaluating feedback from clients and staff. There was a lack of auditing to determine the safety and effectiveness of the service. Half of the staff had not had a recent appraisal. The Zone had a risk register but it did not include the long waiting times for the Icebreak service.

- The Insight service had key performance indicators that were in line with national guidelines for early interventions in psychosis services. However, the icebreak service did not have key performance indicators or targets. Waiting times were long and all clients received two years of care regardless of their presentation. The provider had not tested the efficacy of a two-year treatment for all clients regardless of need.
- The operational manager and team leaders had sufficient authority and administrative support to enable them to undertake their duties.

Leadership, morale and staff engagement

- The Zone's leadership focussed on good quality client care and treatment to provide a sustainable service that met the complex and diverse needs of the population.
- There had not been any staff surveys in the year before our inspection.
- Staff sickness and absence rates were low and staff retention was good. The provider funded brief counselling for staff if they needed it.
- Staff told us there had been a bullying case that had been resolved through mediation. Staff we spoke to knew how to use whistle-blowing process and felt willing to do so.
- Morale was generally good. The Icebreak team were undergoing a service redesign but the team members felt involved in and consulted about the developments. Staff had the opportunity to give feedback on services and input into service development. Icebreak staff had recently been on an away day to talk about the redesign of their service. Team leaders consulted with staff when writing their bi-monthly reports to the Board. This enabled staff to influence the strategic direction of the service.
- Staff told us there were no opportunities for leadership development within the service.
- Teams worked well together. Staff were driven and motivated to provide good care. They felt supported by the duty system in place. Teams had team dynamic supervision to enable them to address any concerns. There was a good culture of being open and apologising to clients when something went wrong. Staff reported feeling that they were working to capacity and expressed concerns about the increasing numbers of referrals. Staff were frustrated about not always being able to access a room to see clients in and that there was pressure to find a confidential place to meet with their clients. They said they felt management had not listened to them and the issues was not resolved. However, all staff said they enjoyed their jobs and had good job satisfaction.

Commitment to quality improvement and innovation

- The Zone was developing a new model for their Icebreak service to reduce the waiting times. In the new model, the provider would offer information and encouragement to people on the waiting list by sending them information by email, such as breathing exercises and information about events in the city. The work it was doing with the University of Exeter was to enable them to determine if the waiting list could be reduced or if the commissioners needed to be engaged in a funding review.
- The Zone did not participate in any national quality improvement programmes

Outstanding practice and areas for improvement

Areas for improvement

Action the provider MUST take to improve

- The provider must monitor the safety and wellbeing of clients on the waiting list who have self-referred to the service to ensure the Zone or an appropriate health care professional monitors any deterioration in their mental health and the need to access the service quickly.
- The provider must consider how it protects clients who access the service from challenging behaviour at all times, including while they are using the waiting room and consider how children and adults use the waiting room.
- The provider must continue with its plans to address the waiting times for the Icebreak service to ensure clients who need the service can access it in a timely manner.
- The provider must provide staff with annual appraisals to monitor staff performance, encourage and enable development and progression.
- The provider must ensure staff report all incidents. It should investigate and learn from all incidents and share learning with staff.

Action the provider SHOULD take to improve

- The provider should ensure staff have access to alarms at all times when they are seeing clients.
- The provider should consider how it audits the safety and effectiveness of the service.
- The provider should consider auditing medicines and review their practice of giving individually prescribed Paliperidone to clients it was not specifically prescribed for.
- The provider should ensure staff assess all clients' risks when they first access the service.
- The provider should ensure there is a policy staff can refer to and that staff have completed training in the Mental Capacity Act. It should ensure staff are able to demonstrate a good understanding of the act and when and how they would apply it.
- The provider should review the Icebreak programme and ensure it follows national good practice guidance to meet the needs of clients. It should measure the suitability of the fixed two-year programme for the client group. It should use the information gathered to tailor treatment to clients' needs rather than providing a fixed term treatment time. The provider should develop monitoring tools to ensure that the programme is effective for the individual needs of clients.
- The provider should ask staff to complete regular staff surveys and act upon the results.

This section is primarily information for the provider

Requirement notices

Action we have told the provider to take

The table below shows the legal requirements that 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
Treatment of disease, disorder or injury	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment • The provider did not monitor the wellbeing of service users on the waiting list who had self-referred to the service and could therefore not provide assurance these service users were not at risk or that their mental health was monitored by an appropriate health care professional. This was a breach of regulation 12(2)(a)

Regulated activity	Regulation
Treatment of disease, disorder or injury	Regulation 13 HSCA (RA) Regulations 2014 Safeguarding service users from abuse and improper treatment • Service users, who might be unaccompanied (from the age of 13 years) shared a waiting room with adults who could be distressed or may exhibit challenging behaviour. There was a lack of formal systems and processes to protect service users from challenging behaviour in the waiting room. There was no formal policy or procedure for the management of the waiting room. Incidents of aggression took place in the waiting room and the provider did not have formal systems and processes in place to investigate the incidents and to prevent further incidents. This was a breach of regulation 13 (1), (2), (3)

Regulated activity	Regulation

This section is primarily information for the provider

Requirement notices

Treatment of disease, disorder or injury	Regulation 18 HSCA (RA) Regulations 2014 Staffing • Insight staff had not had appraisals and therefore had not had performance reviews or been given the opportunity to discuss their goals and development. This was a breach of regulation 18 (2)(a)

Regulated activity	Regulation
Treatment of disease, disorder or injury	Regulation 17 HSCA (RA) Regulations 2014 Good governance • Systems and processes were not in place to investigate the full range of untoward incidents, learn from incidents and the to improve the service. This was a breach of regulation 17 (2)(a)