Good

North Essex Partnership University NHS Foundation Trust

Specialist community mental health services for children and young people

Quality Report

Trust HQ, Stapleford House
103 Stapleford Close, Chelmsford, Essex, CM2 0QX
Tel: 01245 546 400
Website: www.nep.nhs.uk

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Locations inspected

Location ID	Name of CQC registered location	Name of service (e.g. ward/ unit/team)	Postcode of service (ward/ unit/ team)
RRD	Trust HQ	CAMHS Tier 3 Harlow	CM20 1DL
RRD	Trust HQ	CAMHS Tier 3 Chelmsford	CM2 0GH
RRDC2	Holmer Court, Essex St, Colchester	Childrens Learning Disability Service	CO3 3BT
RRDY1	St Aubyn Centre, Severalls, Colchester	Crisis Outreach Team	CO4 5HG

This report describes our judgement of the quality of care provided within this core service by North Essex Partnership University. 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.

Summary of findings

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

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

Contents

Summary of findings

Overall summary

We rated community mental health services for children and young people as good overall because:

- Staff were knowledgeable about safeguarding and they were trained to level four. They appropriately identified risks and recorded referrals.
- Each care and treatment record contained detailed risk assessments and risk management plans. These were reviewed at every contact.
- There was a good range of disciplines within the multi-disciplinary teams.
- Patients had access to a wide range of treatment options.
- There was a good level of understanding about the Mental Capacity Act and staff understood how to assess capacity and make best interest decisions, if necessary, with patients over 16 years old.
- Patients had access to advocacy services and staff knew how to support patients to make sure they got this.
- Patient information leaflets explaining how to complain were available in all locations and many locations also had suggestions boxes. Staff knew how to respond to complaints.
- Staff felt their managers were approachable and supportive.

Summary of findings

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

Are services safe?

Good

We rated community based mental health services for children and young people as good for safe because:

- Staff accessed mandatory training and completion rates were above 85% which was the trust standard.
- Each team had a lone working policy and arrangements were in place in each team to protect staff.
- Staff received safeguarding training to level four. Staff understood the safeguarding processes and showed us examples of referrals made.
- 'PREVENT' training was being undertaken by the teams and the crisis team had recently utilised this training to support a young person using services who they believedwas at risk of radicalisation.
- Each care and treatment record contained detailed risk assessments and risk management plans. These were reviewed at every contact.
- There was good medical cover and patients had rapid access to a psychiatrist.

However:

- Systems for ensuring lessons were learned across the service were not fully implemented

Are services effective?

Good

We rated community based mental health services for children and young people as good for effective because:

- Each care and treatment record contained comprehensive assessments which began when the patient was first reviewed by staff.
- Care records contained holistic, detailed and recovery orientated care plans. These were reviewed at each contact
- Each team had electronic records and all incoming correspondence was scanned onto the electronic system. This ensured that all information was stored securely and was easily accessable to staff.
- The multidisciplinary team provided a range of psychological therapies, including access to a psychologist, psychotherapy, family therapy and eye movement desensitization and reprocessing therapy.

Summary of findings

- Staff had received Mental Capacity Act training and demonstrated an understanding of the five principles. Where appropriate, staff had assessed and recorded capacity. This included Gillick competence in young people under 16.

Are services caring?

Good

We rated community based mental health services for children and young people as good for caring because:

- Staff demonstrated a respectful, caring and compassionate attitude towards patients and their families.
- Clear information about the service was available for carers.
- Care and treatment plans demonstrated involvement from people who used services. Plans were individualised and reflected the views of patients and their families, as appropriate.
- There was good availability to independency advocacy and staff supported patients and families to access this service.

Are services responsive to people's needs?

Good

We rated community based mental health services for children and young people as good for responsive because:

- Responsive systems were in place to triage referrals and urgent referrals could be seen within 24 hours.
- There was cohesive joint working with the adult crisis team to ensure 24 hour access to services.
- Teams actively engaged with patients who were reluctant to participate in support and treatment. For example, Harlow community team gave positive examples of outreach work to build trust in the service.
- The crisis team had completed a piece of work to identify the most common types of referral and the geographical area these came from. They then developed an educational programme aimed at reducing self harm and suicidal thoughts and delivered this in local schools.
- Interpreters were available and were used.
- Patient information leaflets explaining how to complain were available in all locations and many locations also had suggestions boxes. Staff knew how to respond to complaints.

Are services well-led?

Good

We rated community based mental health services for children and young people as good for well led because:

Summary of findings

- Staff were aware of and agreed with the organisation's values. Teams had developed their own objectives in line with these values.
- Staff received regular supervision and appraisal.
- Incidents were reported appropriately by all staff.
- Safeguarding procedures were followed appropriately and staff worked in compliance with the Mental Health Act and the Mental Capacity Act.
- Team managers told us they had sufficient authority and felt supported by senior managers.

However:

- Some staff did not feel senior managers had a visible presence in the teams.
- Staff felt opportunities to learn more widely from incidents in other parts of the trust were being missed.

Summary of findings

Information about the service

The child and adolescent mental health community service (CAMHS) provided outpatient assessments, support and treatment for emotional and behavioural difficulties in children up to the age of 16 and adolescents aged between 16 and 18. The service provided support and treatment to children and to the wider family.

The CAMHS learning disability (LD) community team provided outpatient assessments and treatments to the child/young person. Further support was provided to the wider family where necessary.

Our inspection team

Our inspection team was led by:

Chair: Professor 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 children and young people consisted of two inspectors, one Mental Health Act reviewer, two nurse specialist professional advisors and one expert 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.

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 patients through comment cards.

During the inspection visit the inspection team:

- Visited four community based teams based within different trust locations.
- Reviewed the quality of the environment and observed how staff were caring for patients.
- Spoke with 16 patients.
- Spoke with two carers.
- Interviewed the managers or acting managers for each of the teams.
- Met with 19 other staff members; including doctors, nurses and psychologists.

Summary of findings

- Attended and observed a multi-disciplinary meeting.
- Inspected 28 care and treatment records.

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

Patients and their carers spoke positively about the service. They told us staff were friendly, approachable and understood their needs.

Patients and their carers told us they felt listened to and valued, and that staff involved them and their families in decisions about their individual support and care needs.

Good practice

The crisis team designed an educational programme which was then delivered to schools in areas of highest need. The aim was to promote good mental health and self-esteem, and to reduce the incidents of self harm and attempted suicides.

Areas for improvement

Action the provider MUST take to improve

Action the provider SHOULD take to improve

The trust should ensure that there are robust trust-wide systems in place for sharing lessons learned and that these are integrated into each team's practice.

North Essex Partnership University NHS Foundation Trust

Specialist community mental health services for children and young people

Detailed findings

Locations inspected

Name of service (e.g. ward/unit/team)	Name of CQC registered location
CAMHS Tier 3 Harlow	Trust HQ
CAMHS Tier 3 Chelmsford	Trust HQ
Childrens Learning Disability Service	Holmer Court, Essex St, Colchester
Crisis Outreach Team	St Aubyn Centre, Severalls, Colchester

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.

- Staff had been trained on the use of the Mental Health Act and the Mental Health Act code of practice as part of their mandatory training.
- Staff had a good understanding of the use of the Mental Health Act and their responsibilities in delivering services in compliance with the Act.
- Information about patients' consent to treatment and capacity to consent to this were recorded. These were completed in all the records we checked.

Detailed findings

Mental Capacity Act and Deprivation of Liberty Safeguards

- Staff had received training relating to the Mental Capacity Act as a part of their mandatory training.
- Assessments relating to capacity to consent to admission and treatment were completed appropriately.
- The trust had a Mental Capacity Act policy and staff knew how to access this if required.
- Support was available from the safeguarding team to support staff with applying the Mental Capacity Act and staff felt confident approaching them for this.
- We saw good recording of capacity assessments for specific decisions and examples of patients being supported to make decisions regarding their care.
- Gillick competency was assessed and recorded in care and treatment records. Gillick competence is used to decide whethere a child (15 years or younger) is able to consent to treatment without the need for parental permission.

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

- None of the premises used by child and young people's community services had clinic rooms. However, all the premises contained blood pressure monitoring machines and scales to weigh patients in the rooms used by doctors.
- Cleaning schedules were fully completed and showed that regular cleaning took place. All the locations were clean and well maintained.
- Infection control was part of the mandatory training programme and there was an infection control policy in place.
- Interview rooms contained appropriate alarm systems and staff had received training in breakaway techniques.

Safe staffing

- The number and grades of staff had been estimated by the trust based on previous service demand and in agreement with commissioners. Staff did not know if a specific evidence based tool had been used to determine staffing levels.
- There were five vacancies within the teams. The community team in Chelmsford had a vacancy for a team leader. The vacancy was being managed between the two team leaders from Harlow and Colchester as an interim measure. This ensured there was continuity of leadership and staff had access to supervision and appraisal.
- The learning disability team had a member of staff on long term sick and this vacancy had not been recruited to.
- The Chelmsford community team had four agency administrative staff to cover vacancies. They knew the team and understood the role.
- The crisis team was fully staffed.
- All patients had an allocated care co-ordinator.
- There was appropriate use of locum staff. For example, a locum psychologist had been employed in the Chelmsford community team on a fixed term contract to cover maternity leave.
- Apart from the crisis team, psychiatrists formed a part of all the teams. Staff from the community teams told us they were accessable and they felt there was adequate medical cover.
- The crisis team had access to the inpatient psychiatrists when they needed it. They felt this was appropriate for the patients they were treating.

Assessing and managing risk to patients and staff

- Each care and treatment record showed that patients had a risk assessment carried out at initial assessment across all the teams. These were reviewed at every contact as part of the treatment package.
- Crisis plans were formulated as part of the treatment plan. For example, the learning disability team had thorough behaviour management plans which included crisis plans.
- Waiting lists for assessment and for specific therapeutic interventions were monitored on a regular basis.Carers and other professionals were encouraged to contact the teams if levels of risk changed. This enabled the team to respond appropriately to changing levels of risk.
- Staff were trained to level four in safeguarding. They had also completed the PREVENT training as part of this. This is training to identify young people at risk of radicalisation. Evidence of this training had been applied to practice in the crisis team. The team had identified a patient at risk of radicalisation and taken appropriate steps to raise these concerns and protect thepatient.

Trust-wide robust lone working policies were in place and staff were observed to be following these as part of their daily routine. These included a written record of visits carried out and a buddy system to make telephone contact after visits were completed.

Track record on safety

Good

Are services safe?

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

There was one serious incident reportedfrom April 2014 to April 2015, relating to specialist community mental health services for children and young people. A full trust investigation had taken place.

Reporting incidents and learning from when things go wrong

- Staff knew how to report incidents. Incidents were reported on the trust electronic recording system. Each incident was reviewed and investigated by the management team.
- Trust-wide incidents had informed community based risk assessments
- Each team reported incidents appropriately and there was evidence of this in all the teams.
- An incident had occurred in the Chelmsford team base. This led to a patient requiring medical treatment. The parent of the patient had made a complaint. This was being dealt with in an open and transparent way. The lessons learned and changes to practice were shared with the team via the team meeting. For example, the team had changed their practice to ensure an ambulance was always called to transport patients in an emergency.
- Feedback from incidents were shared with staff at meetings. This meant staff were able to discuss incidents and learn from them.
- The trust had recently implemented a lessons learned bulletin to share learning from trust-wide incidents. This was shared in team meetings. However, staff told us this was not yet an embedded part of the culture of the organisation. Staff felt opportunities to learn more widely from incidents in other parts of the trust were being missed.
- There were staff de-brief procedures in place and staff understood these processes.

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

- Each care and treatment record contained comprehensive assessments which began when the patient was first reviewed by staff.
- Care records contained holistic, detailed and recovery orientated care plans. These were reviewed at each contact
- Each team had electronic records and all incoming correspondence was scanned onto the electronic system. This ensured that all information was stored securely and was easily accessable to staff.

Best practice in treatment and care

- Staff were trained in and using NICE recommended therapies such as EMDR and Family therapy and this was documented in care records. Care plans made reference to NICE guidelines.
- There was a wide range of therapies available, including systemic therapy, eye movement desensitization and reprocessing (EDMR), family therapy and psychotherapy.
- Each team had a psychologist.
- Physical healthcare checks took place at initial assessment. Clear arrangements were in place for partnership working around physical healthcare needs with primary care.
- As part of the trust's management supervision framework there were monthly audits of patient care and treatment records.

Skilled staff to deliver care

- Each team had access to a full range of disciplines. This included psychiatrists, nurses, psychologists, family therapists and psycotherapists. The learning disability team had access to a speech and language therapist.
- Although the crisis team was a nurse led service, they had access to and reported a good working relationship with, the multi-disciplinary team which covered the inpatient unit. This meant they could access specialist advice as required.
- Staff were experienced in working with children and young people experiencing mental health issues. There were opportunities for staff to access specialised training for their role. Staff had received additional training in specific therapies such as family therapy and EMDR.
- Staff told us they received six weekly supervision and annual appraisals. Records confirmed this. An appraisal matrix was in place to schedule appraisals annually.
- Managers knew the processes to address staff individual performance issues if required.

Multi-disciplinary and inter-agency team work

- Each team held regular multi-disciplinary meetings. We observed staff sharing information and discussing cases to inform best practice in care and treatment.
- Effective communication took place between each team and with the wider trust. For example, the crisis team acted as a gatekeeping service for inpatient beds and had developed good relationships with the inpatient wards.
- Staff reported that working relationships with primary care and the services provided by Essex County Council were positive. For example, the referrals to this service were being triaged effectively by the local authority.
- Staff reported good relationships with the local authority safeguarding team and with the trust's safeguarding lead who provided support and supervison where required.

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

- Staff had been trained on the use of the Mental Health Act and the Mental Health Act code of practice as part of their mandatory training.
- Staff had a good understanding of the use of the Mental Health Act and their responsibilities in delivering compliant services.
- Information about patients' consent to treatment and capacity to consent to this were recorded. These were completed in all the records we checked.
- There were no patients on community treatment orders.

Good practice in applying the Mental Capacity Act

- Staff had received training relating to the Mental Capacity Act as a part of their mandatory training.

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.

- Assessments relating to capacity to consent to admission and treatment were completed appropriately.
- The trust had a Mental Capacity Act policy and staff knew how to access this if required.
- Support was available from the safeguarding team to support staff with applying the Act and staff felt confident approaching them for this.
- We saw good recording of capacity assessments for specific decisions and good examples of patients being supported to make decisions regarding their care.
- Gillick competency was assessed and recorded in care and treatment records. Gillick competence is used to decide whethere a child (15 years or younger) is able to consent to treatment without the need for parental permission.

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 responded to patients in a respectful, kind and compassionate manner.They spoke to patients with empathy.
- Patients and carers told us they felt listened to and valued by staff.
- Staff demonstrated a good understanding of the individual needs of patients. Staff listened to the views ofpatients and responded to these in a supportive way. Care was planned and delivered in response to patient views.
- Appropriate systems were in place to ensure records were stored securely. Paper records were locked in filing cabinets in a locked room when not in use. Electronic records were accessed via the trust's computer system and these were appropriately password protected.

The involvement of people in the care that they receive

- Patients had access to leaflets about treatment options. These were displayed in waiting rooms at all the sites we visited, except for the crisis team because they did not see patients at the base.
- Patients and their families or carers were involved in the care programme approach process and reviews about their treatment. Care plans demonstrated patient involvement and reflected the views of patients and carers.
- Patients had access to advocacy. Posters in reception areas displayed contact details for local advocacy services. Staff were aware of how to contact advocacy and would support patients in doing this if necessary. Advocacy was provided by MIND.
- Carers assessments were not carried out by the teams. There was a referral process in place for carers assessments by a carer's service and staff spoke about this process with confidence.
- Patient feedback was actively sought. There were suggestion boxes in the reception at Harlow community team base. Other teams sought feedback via trust leaflets and referred patients to patient advice and liaison service, as appropriate.

However:

- Patients were not formally involved in the development of services nor in staff interviews. Managers recognised this as an area for development.
- There was no evidence of teams carrying out clinical audits.

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

- The community teams had a target time from referral to treatment of 18 weeks. We requested information on waiting times. We were told they met this 99% of the time. This was set by commissioners. Teams had set their own targets to see routine referrals for assessment within eight weeks. Referrals were processed by the duty professional via a single point of access. Urgent referrals were seen within two weeks.
- Working arrangements across the community teams and crisis team were good. Teams shared information and the crisis team responded quickly to concerns regarding patients from the community teams. The crisi team operated from 8am to 6pm across 7 days. There was cohesive working with the adult crisis team to ensure 24 hour access to services. Care records demonstrated this.
- The crisis team had a variety of appropriately skilled staff in place to assess patients immediately. All referrals to the crisis team were seen on the same day or the next day, based upon risk and service user preference.
- We observed staff responding to phone calls in a prompt, sensitive and compassionate manner.
- There were arrangements for patients in crisis to be seen out of hours. Urgent out of hours referrals would be seen by the adult crisis team at the emergency department. The referral would then be passed on to the CAMHS crisis team as soon as possible.
- The teams had a clear criteria for who would be offered a service. Staff had a good knowledge of other local services in order to signpost inappropriate referrals to other local services.
- We saw examples of staff in the Chelmsford CAMHS team working in a flexible and creative way in order to engage with specific patients who were reluctant to access the base. All the teams provided outreach work to schools and showed flexibility in appointment times.
- Appointments usually ran on time and we observed patients and carers being kept informed of waiting times whilst accessing services.
- Staff told us appointments would only be cancelled because of staff sickness and then only if another staff member could not carry out the appointment or it was not appropriate to do this. An example of this would be if the appointment was part of a therapeutic intervention that required continuity of care such as psychotherapy.

The facilities promote recovery, comfort, dignity and confidentiality

- There were adequate rooms for seeing patients at all the locations we visited. The rooms offered a variety of settings designed to make children and young people comfortable. Holmer Court had rooms with beanbags in them and a water play area.
- All the interview rooms we saw were adequately soundproofed to protect patient confidentiality.
- The waiting rooms at all locations we visited displayed patient information posters and there was a wide variety of leaflets available. These included how to complain, PALS, sibling groups, behavioural support strategies, learning disability diagnosis, patients rights and treatment choices. Photographs of team members with their name and job role were displayed in waiting areas.

Meeting the needs of all people who use the service

- All the locations we visited were accessible to people with physical disabilities.
- Staff at the learning disability community team were all trained in makaton, this enabled them to communicate with patients who used this communication system.
- There were systems in place touse interpreters and signers and all the staff we spoke to knew how to access them.
- Information leaflets were available in all locations. Staff could access a translation service for the leaflets, when required. There were easy read leaflets on display at all sites. However, pictorial leaflets were not provided at a trust level. Staff in individual locations had developed local systems to address this. The learning disability community team had developed their own leaflets to ensure they were accessable to their client group.
- The crisis team had carried out an audit to identify the highest category of referrals they received by diagnosis.

Are services responsive to people's needs?

Good

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

They then mapped this to geographical areas. An educational package about self esteem and good mental health was then developed by the team and delivered to local schools to try to reduce the incidents of self harm and suicide attempts.

Listening to and learning from concerns and complaints

- Patients knew how to complain and information posters and leaflets were displayed in all locations to support them with this.
- Staff were knowledgeable and confident when discussing the complaints procedure and expressed the importance of dealing with complaints proactively. They told us that complaints would be managed locally initially and patients kept informed of timescales. Feedback would be given via telephone or letter and escalated through the formal complaints process if necessary.
- Staff received feedback from complaints at team meetings. However, staff told us that shared learning from complaints in other services was a new initiative and was not yet embedded in the culture.

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

- Staff were aware of the organisation's values and agreed with these.
- Staff knew who the most senior managers in the organisation were. The presence of senior managers varied across the teams. The crisis team felt valued and felt that senior managers listened to their concerns, particularly around the transfer of services to another provider. However, the other community teams did not feel so supported.

Good governance

- Teams had good systems in place for monitoring mandatory training, supervision and appraisals. Records indicated staff were up to date with these.
- The team managers told us that they had enough time and autonomy to manage the services. They also said that they could raise any appropriate concerns with their senior managers.
- Due to a new tender process for the service, and other recent changes, some staff had left teams. Vacancies were managed appropriately and staff were experienced in their roles.
- There was a clear system for reporting incidents and all members of staff we spoke to had access to this and knew both what to report and how to report it.
- Staff demonstrated learning from complaints within their own service through team meetings. However, learning form across the trust was not embedded.
- Key performance indicators were used to gauge team performance across the service. The teams used these as a monitoring tool to analysetheir performance.
- Team managers told us they felt supported and able to make decisions with sufficient authority. Each team had full time administrative support.
- When necessary, managers could submit items to the trust risk register and the service lead had oversight of this.

Leadership, morale and staff engagement

- Managers were clear on how to address bullying or harassment cases should they ever arise.
- Staff knew the whistleblowing process for the organisation and felt confident to use this.
- Job satisfaction was high amongst staff. However, morale was affected by the transfer of the service to a new provider, which was due to take place later in the year.
- Staff had opportunities to develop their leadership skills and told us they could access additional specialist training if they needed it. They told us they felt supported by their managers to access training opportunities.
- Staff spoke very positively about their relationships with each other. They spoke of feeling supported and also being able to challenge each other appropriately.
- All the staff told us they felt team leaders were approachable and supportive.
- We saw an example of staff having explained to patients when things had gone wrong in the Chelmsford community team. All the staff we spoke to understood the importance of being honest and transparent when things had gone wrong and they felt this would be supported by team managers.
- Staff told us they felt senior managers were not a visible presence in the community teams.
- Staff felt opportunities to learn more widely from incidents in other parts of the trust were being missed.

Commitment to quality improvement and innovation

N/A

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.

This section is primarily information for the provider

Enforcement actions

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.