The Retreat - York

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?	Good
Are services caring?	Good
Are services responsive?	Requires improvement
Are services well-led?	Requires improvement

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 Retreat York as requires improvement because:

- Clinical premises where patients received care were not compliant with internal fire safety processes and did not maintain the confidentiality of patients. Clinic rooms were not soundproof so confidential conversations could be overheard.
- Staff had not completed all the necessary checks on blood pressure monitoring and weighing equipment that was used in the service. The service did not have effective processes in place to safely manage a medical emergency.
- Staffing levels were not high enough to meet the demands on the service. There was not a fully integrated system between primary care and the attention deficit hyperactivity disorder (ADHD) service to ensure patients received all care and treatment identified at the assessment.
- Mandatory training was not well managed in the service. The service was unable to evidence if staff had met the service's training requirements.
- The service did not manage risks to patients or staff in line with organisational policies. Staff did not always use the format specified or update risk assessments in the timeframes stated.
- Staff could not access all patient information quickly. Staff were not always able to locate paper or electronic files that held patient information.
- Access to the service was difficult. Patients were not able to contact the service easily on the phone and staff didn't always respond to patients that left messages.
- Waiting times to access an assessment were 18 months and the referral criteria excluded patients that would have benefitted from care. The 'did not attend' policy and the process to expedite patients was not considerate of the challenges faced by this patient group.
- Leaders lacked the skills and knowledge to oversee and implement daily operational tasks. There was a lack of clarity and ownership about the responsibilities of managers, clinical staff and business support staff.
- Not all staff felt respected, supported and valued. They did not always feel able to feedback honestly to managers in the service. The service's lone working protocols and policy were not fully implemented and did not offer support to all staff groups. The induction process did not meet staff needs.
- Governance processes did not operate effectively, and processes were not always well managed.

However:

- Clinical premises where patients received care were clean, well-furnished and well maintained. There were enough clinic rooms at the service and the service had made adjustments for disabled patients.
- Staff worked with patients, families and carers to develop individual care assessments that were personalised, holistic, function-based and recovery-oriented. Staff supported patients to live healthier lives
- Staff understood how to protect patients from abuse and the service worked well with other agencies to do so. Staff had training on how to recognise and report abuse, and they knew how to apply it.
- The service used systems and processes to safely prescribe, secure and audit prescriptions. Staff reviewed the effects of medicines on each patient's mental and physical health.
- Staff from different disciplines worked together as a team to benefit patients. Staff were supportive of each other and understood the challenges the different roles faced.
- Staff had the skills, or access to people with the skills, to communicate in the way that suited the patient. Reports were easily understood by patients. Staff supported patients to access additional treatment out with the contract. They recommended that patients seek additional funding from the local clinical commissioning groups via their GP for additional services.
- The service managed complaints well and shared learning with staff. Managers supported staff with appraisals, probationary reviews, supervision and opportunities to update and further develop their skills.

Summary of findings

- Managers from the service worked with commissioners, local authorities and mental health providers to try to improve services for the local population.

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 Retreat - York

Services we looked at

Community-based mental health services for adults of working age

Summary of this inspection

Background to The Retreat - York

The Retreat York opened in 1796. William Tuke and the Society of Friends (Quaker) set up the hospital to provide compassionate care in contrast with the treatment that was being provided at that time. It continues to operate as a voluntary sector provider of community based mental health services. The Retreat York have been registered with the CQC since October 2010. In 2018 they withdrew from delivering inpatient services. In January 2019 The Retreat York revised their registration with the Care Quality Commission (CQC) to provide the regulated activity of treatment of disease, disorder or injury for their outpatient services. Although The Retreat has provided Attention Deficit and Hyperactivity Disorder (ADHD) assessments to adults since 2014, this was the first inspection of the service due to a change in the commissioning contract.

The Retreat York offers NHS and privately funded community services that include the assessment, diagnosis and treatment of adults with ADHD. NHS ADHD services were commissioned by the Vale of York, Harrogate and Ripon District, Scarborough and Ryedale and Hambleton, Richmondshire and Whitby clinical commissioning groups.

Additionally, The Retreat York offer assessment and psychological therapies for trauma and stress, eating disorders and counselling via the therapy services and Autism Spectrum Disorder assessment, diagnosis and treatment at Aldgarth House. These services are not within the CQC's scope of regulation.

We inspected the adult ADHD service at Aldgarth House only.

There was a registered manager in post at the time of the inspection.

Our inspection team

The team that inspected the service comprised of one lead CQC inspector, one CQC assistant inspector, one nurse specialist adviser with professional experience of mental health services for people with ADHD and one expert by experience with experience of ADHD.

Why we carried out this inspection

We inspected this service as part of our ongoing comprehensive mental health inspection programme following the change in service provision and commissioning contract.

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?

Summary of this inspection

Before the inspection visit, we reviewed information that we held about the location and asked a range of other organisations for information including Healthwatch, the local authority and commissioning groups.

During the inspection, the inspection team:

- looked at the quality of the environment and observed how staff were caring for patients;
- spoke with six patients and one carer who were using the service;
- spoke with the team manager of the service;
- spoke with nine other staff members; including the registered manager, contracts manager, psychiatrist, specialist nurse, occupational therapist, psychologists and receptionists;
- received feedback about the service from the lead commissioner and Healthwatch;
- attended and observed one multi-disciplinary meeting and team meeting;
- looked at seven care and treatment records of patients;
- carried out a specific check of the medicine's management; and
- 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 with six patients and one carer that used the service. Feedback from people that used the service was mixed.

Patients described attempting to contact the service and speak with staff after appointments or with queries but not being able to get through. Some left messages that were not responded to. Patients also experienced long waits for an assessment and delays in accessing treatment and follow up appointments.

Patients felt unsupported because they did not get psychological support to help them to manage their condition when they had chosen medicines as treatment. Although patients told us this was due to a restriction in funding for ADHD services, patients felt psychological support would be beneficial. The service was not commissioned to provide additional psychological support.

However, patients also felt that the assessment and reports were thorough and useful. Patients they always contributed fully, and their families and carers were involved. Patients said the diagnosis and treatment options provided by the service had greatly improved their quality of life.

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:

- Clinical premises where patients received care were not compliant with internal fire safety processes and did not maintain the confidentiality of patients. Staff at Aldgarth House were unable to raise alarms in the event of an unforeseen incident. Clinic rooms were not soundproof.
- Staff had not completed all the necessary checks on blood pressure monitoring and weighing equipment that was used in the service. There were no equipment audits in place.
- Staffing levels were not high enough to meet the demands on the service.
- Mandatory training was not well managed in the service. The service could not evidence that all staff had met the service's training requirements.
- The service did not manage risks to patients or staff in line with organisational policies. Staff did not always use the format specified or update risk assessments in the timeframes stated. The service's lone working protocols and policy were not fully implemented and did not offer support to all staff groups.
- The service did not have effective processes in place to safely manage a medical emergency. There was no overall assessment of what emergencies may occur onsite or detailed description of how staff should respond.
- Staff could not access all patient information quickly. Patient data was stored electronically in a care records system, on shared drives and in paper records. Staff were not always able to locate files that held patient information.
- Staff did not fully understand the incident reporting process. Managers were concerned staff might not be reporting all incidents.

However:

- Clinical premises where patients received care were clean, well-furnished and well maintained. The service had completed environmental risk assessments of the premises.
- Staff were able to give each patient the time they needed during assessments and follow up appointments.
- Staff understood how to protect patients from abuse and the service worked well with other agencies to do so. Staff had training on how to recognise and report abuse, and they knew how to apply it.

Summary of this inspection

- The service used systems and processes to safely prescribe, secure and audit prescriptions. Staff reviewed the effects of medicines on each patient's mental and physical health.
- Managers investigated incidents and shared lessons learned with the whole team and the wider service.

Are services effective?

Good

We rated effective as good because:

- Staff took a function-based approach to assessing the needs of all patients. They worked with patients and with families and carers to develop individual care assessments that were personalised, holistic, function-based and recovery-oriented.
- Staff provided treatment and care interventions that were informed by best-practice guidance and suitable for the patient group. They supported patients to live healthier lives.
- Staff used recognised rating scales to assess and record severity and outcomes. They also participated in clinical audit, benchmarking and quality improvement initiatives.
- Staff supported patients to access additional treatment. They recommended that patients seek additional funding from the local clinical commissioning groups via their GP for additional services.
- The team included or had access to the full range of specialists required to meet the needs of patients under their care. Managers supported staff with appraisals, probationary reviews, supervision and opportunities to update and further develop their skills.
- Staff from different disciplines worked together as a team to benefit patients. The team had mostly effective working relationships with other relevant teams within the organisation and with many relevant services outside the organisation.

However:

- Staff did not always follow up to confirm if routine tests had been completed.
- Some staff had not completed an induction for their role. Managers provided an induction programme for new staff. However, this did not fully equip staff to perform in all areas of their roles.
- Staff did not work to close gaps in care.

Are services caring?

Good

We rated caring as good because:

Summary of this inspection

- Staff treated patients with compassion and kindness. They understood the individual needs of patients and mostly supported patients to understand and manage their care, treatment or condition.
- Staff involved patients in their assessment and treatment and sought their feedback on the quality of care provided. Patients with communication difficulties found assessment reports understandable.
- Staff informed and involved families and carers fully in assessments and in the design of care and treatment interventions.
- Carers were provided with information about how to access a carer's assessment.

However:

- Patients didn't feel supported after receiving their diagnosis and didn't feel supported in contacting the service.
- Patient privacy was not always maintained because rooms were not soundproof.

Are services responsive?

Requires improvement

We rated responsive as requires improvement because:

- Waiting times to access an assessment was 18 months and the referral criteria excluded patients that would have benefitted from care.
- Communication with the service was difficult. Patients were not able to contact the service easily on the phone and staff didn't always respond to patients that left messages.
- The "did not attend" procedure was not considerate of the challenges faced by this patient group.
- There were no checks in place to confirm if physical health checks had been completed or if medicines had started with their GP.
- There were insufficient cover arrangements for sickness and leave.

However:

- Staff had the skills, or access to people with the skills, to communicate in the way that suited the patient.
- The service treated concerns and complaints seriously, investigated them and learned lessons from the results, and shared these with all staff.
- Managers had reconfigured the pathway to try to improve patient waits within the existing contract.
- There were enough clinic rooms at the service and the service had made adjustments for disabled patients.

Summary of this inspection

Are services well-led?

Requires improvement 

We rated well-led as requires improvement because:

- Leaders lacked the skills and knowledge to oversee and implement daily operational tasks. There was a lack of clarity and ownership about the responsibilities of managers, clinical staff and business support staff.
- Not all staff felt respected, supported and valued. They did not always feel able to feedback honestly to managers in the service.
- Our findings from the other key questions demonstrated that governance processes did not operate effectively and that processes were not always well managed.
- Staff did not have access to all the information they needed to provide safe and effective care.
- There was not a fully integrated system between primary care and the ADHD service to ensure patients received all care and treatment identified at the assessment.

However:

- Managers and trustees were visible in the service.
- Staff knew and understood the provider's vision and values and how they were applied in the work of their team.
- Managers from the service worked with commissioners, local authorities and mental health providers to try to improve services for the local population.

Detailed findings from this inspection

Mental Capacity Act and Deprivation of Liberty Safeguards

The service considered the Mental Capacity Act and where it could be applied for this patient group. Informed consent was a requirement for admission to the service and staff had received training. However, there was no policy in place to help staff determine if patient had a fluctuating capacity and what to do if this happened.

Deprivation of Liberty Safeguards was not applicable to this service.

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	Good	Good	Requires improvement	Requires improvement	Requires improvement
Overall	Requires improvement	Good	Good	Requires improvement	Requires improvement	Requires improvement

Notes

Requires improvement

Community-based mental health services for adults of working age

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

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

Requires improvement

Safe and clean environment

The service did not meet the required standards for fire safety. The service had an in-date fire safety management policy, but the service was not acting in line with the policy. The fire risk assessment, dated April 2018, identified safety actions that had not been implemented. Fire doors were propped open (which caused damage to the hinges) and there was no escape route signage upstairs. This could adversely impact on the safety of patients and staff as the doors would not maintain the environment and keep patients and staff safe. Staff also confirmed they had never had a fire alarm test. These should have occurred weekly. A test was scheduled during the inspection and this did not occur. Staff could not confirm who the fire warden for the building was and there was no sign in book to ensure that staff could safely evacuate all visitors in the building. No fire emergency plan could be found for Aldgarth House. Staff had recently raised fire safety concerns with managers. Actions in the quality improvement plan related to staff training for fire safety and not actions required by the provider. The policy stated that all staff should have fire safety training, but some staff said that they had not received it. The service could not accurately confirm training figures because there were issues with how these were recorded. Management team meeting minutes indicated that the service did not understand their responsibilities for fire safety checks. The service had contracted facilities management to a third-party property management company. Notes queried who was responsible for checking fire alarms and extinguishers and confirmed checks had not taken place. This meant that the provider did not have a clear understanding of what the property management's role was or their own and neither were meeting their duties in fire safety. The property management company for completing safety checks and the service for following their policy and action plan.

The premises did not meet the overall needs of patients using the service. Interview rooms in Aldgarth house were not soundproof. Staff described how noise from other rooms could be disruptive as the walls were thin. The service was planning on moving to a different building in 2021.

Interview rooms at Aldgarth House were not fitted with alarms. The referral criteria for the service specified that the service did not accept patients with a high risk of harming themselves or others. If a patient was deemed to be of increased risk, they would be seen at another building located five minutes away which had alarms. Staff explained that if necessary, they attended appointments with a colleague. However, should an unforeseen incident occur at Aldgarth House, staff had no way to raise an alarm.

The service had not completed all necessary checks on equipment used in the service. Staff completed physical health checks on patients. They would measure the patient's weight and blood pressure at assessments and follow up appointments. Checks had not been completed on weighing scales since March 2018 and the blood pressure cuff had no sticker to confirm the date last checked. We asked the service for a copy of the equipment checks audit. The service confirmed that they had not

completed any checks and had no audit in place as the service expected patients' blood pressure and weight to be monitored by their GP. Following the inspection, the service agreed to audit equipment.

The service did not keep cleaning records onsite to evidence cleanliness was monitored, however a cleaner attended daily, and the premises were visibly clean. Furnishing and fittings were well-maintained. Staff adhered to infection control principles, including handwashing, and the service had a policy in place.

The service completed regular environmental risk assessments of the care environment to identify high risk areas. This included ligature points. A ligature risk (point) is defined as anything which could be used to attach a cord, rope, or other material for hanging or strangulation. The service did not accept referrals from patients at risk of harm to self.

Safe staffing

The ADHD service had 13 staff in employment, many of whom worked between ADHD and other services at The Retreat. The ADHD service employed a 0.2 whole time equivalent consultant psychiatrist who worked two afternoons a week and a 0.8 whole time nurse prescriber who worked four days a week. Clinics to assess, diagnose and treat patients were held two afternoons a week. There were also three clinical psychologists, three managers and three business support staff that worked into the service. Sessional staff were employed by the provider to meet additional needs. Sessional staff included a consultant psychiatrist and a clinical psychologist.

Staffing levels were not enough to meet the demands on the service. Staffing levels were restricted by the financial constraints on the service. The provider was paid to deliver one psychiatrist led patient assessment and up to three medical follow up appointments. Simpler, follow up appointments could be led by the specialist nurse. If medicines were not appropriate, patients would access two psychology or occupational therapy led appointments. Additional funding, if required, could be arranged via a patient's GP on a case by case basis.

The service could not confirm the caseload of the consultant psychiatrist. The consultant completed seven medicines reviews and two assessments each week. As of 8 August 2019, there were 313 patients on the ADHD waiting list. The specialist nurse saw patients once stabilised, for example for follow up medicines' appointments.

Mandatory training was not well managed in the service. We requested training information from the provider prior to the inspection. Except for information governance including General Data Protection Regulation (GDPR), we were informed that all staff had completed the eight mandatory training courses. During the inspection we requested updated figures to determine if compliance with information governance had improved. The figures that were provided to us at the inspection indicated the following completion rates for mandatory training for the 13 staff in the service:

- Complaints procedure – 15%
- Equality and diversity – 38%
- Health & Safety (Including fire) – 46%
- Information Governance (Including GDPR) – 85%
- Duty of candour – 38%
- Infection prevention & Control – 23%

These staff compliance figures were significantly lower than the previous figures and did not meet the provider target of 80%. This meant that the service could not be assured that all staff were adequately trained to provide care to patients safely. Some staff said that they had not completed their mandatory training. Another staff member said that the previous training manager normally monitored compliance. The service's quality improvement plan highlighted that the service was not able to ensure that all training packages were up to date, and it was difficult to monitor compliance. The service was seeking an alternative provider. To establish accurate figures the service was extracting data from a previous recording system and reviewing staff supervision and appraisal forms where training was discussed. However, this did not provide total assurance or oversight of staff training.

Following the inspection, we received additional figures for mandatory safeguarding training as there had been a change in safeguarding training provider. All clinical staff had completed training in safeguarding adults and children levels one to three. This included the Mental Capacity Act.

The service did not have effective processes in place to safely manage a medical emergency. The service said that there were no physical treatment procedures or

administration of medicines undertaken on site, so associated risks were low. We requested details of the physical health policy however the service did not have one. The service's incidents management policy specified that in the event of a medical emergency, staff should notify emergency help and provide support for those involved in the incident. There was no overall assessment of what emergencies may occur onsite or detailed description of how staff should respond. For example, details where the nearest AED was or planned actions that may be required in any other medical emergency. An AED is a portable electronic device that analyses life threatening irregularities of the heart and delivers an electric shock to attempt to restore a normal heart rhythm in an emergency.

Training figures provided during the inspection showed that only one member of administrative staff had level three emergency first aid at work training. Following the inspection, the provider confirmed that 79% of staff had in date training.

There were no staff vacancies and data provided by the service in June 2019 showed that the average sickness rate between January 2019 to June was 3%. One member of staff had left in the previous six months.

Assessing and managing risk to patients and staff

Assessment of patient risk

Staff screened referrals. This included indicators of risk. If necessary, additional information was requested from the referring organisation or the patient's GP. Although the service did not accept higher risk patients, patient records indicated that patients had histories of suicidal thoughts or previous suicidal attempts, substance abuse and history of violence. The psychiatrist took a full risk history, based on a recognised risk assessment tool, at the assessment appointment and recorded these details in the assessment report that was shared with the patient and their GP.

Staff did not manage patient risk in line with the service's policy. Five of the seven records did not have a risk profile attached, and none of the records had an updated risk assessment. These were due every three months. Staff in the service were not aware that they had to update the risk assessment at appointments. The service's policy stipulated that staff used a recognised risk assessment tool. We reviewed five files and could not locate a separate copy of the risk assessment in either the paper files, electronic records or shared drives where patient information was kept. Instead these were recorded in rough handwritten notes in the care record and converted using a speak to text app to the assessment report. Handwritten notes were not always legible. The service had completed a defensible documentation audit in July 2019 that had identified similar issues and recommended that the risk tool should be used for all first appointments and risk to self, others, any changes, or no known risks should be documented for every therapy session or appointment. It was too early to confirm if these recommendations had been implemented.

Some patients felt unsupported in times of crisis. Crisis support service information was provided on the assessment appointment letter, however, there was no advice recorded or contact details provided on the assessment report. Staff explained that patients contacted the service in crisis and that they had started to provide crisis service details when patients phoned in. The provider's quality improvement plan identified that there was a possibility that people in crisis may not get access to the advice they need as the service's phone system was poor. The service planned to resolve this and had a meeting with a telephony supplier arranged. The action plan also identified that the service would change the out of hours answering machine to provide this information. However, this had not been completed when we called the service following the inspection on the 6th of August 2019. Suicide awareness was discussed at a team meeting and one receptionist had recently completed suicide awareness training. The registered manager said that the service is only commissioned to work on a patient's neurodevelopmental condition and items relating to mental health conditions were managed via GPs or mental health teams.

Management of risk

Staff did not manage patient risks other than recording these in the assessment report. The registered manager felt additional risk management was unnecessary because the service would not accept patients with greater risk into the service. If a patient's health deteriorated, and staff were aware, staff would inform the patient's GP so that care could be given. If this related to a mental health condition the patient may no longer meet the referral criteria for the service.

The service's lone working protocols and policy were not fully implemented and did not offer support to all staff groups. Staff raised concerns about lone working.

Assurances identified on the risk register were focussed on staff working outside of The Retreat's premises, not isolated staff in Retreat premises even though this staff group were identified in the policy. The risk register identified that a signing in and out procedure should be in place. However, there was no process implemented. The risk assessment asked if a sign-in book was used, however there was no associated guidance in the policy or follow up action taken to ensure that this procedure had been implemented.

We requested a copy of the lone working register and copies of the associated risk assessments as detailed in the policy. The registered manager was unaware of the lone working register. The manager confirmed they had not completed any lone working assessments for staff at the ADHD service. The policy stated that the registered manager and service managers were responsible for identifying staff who are lone workers, creating and maintaining a register of such workers and assessing the need for working alone. Managers were not acting in accordance with the policy.

Safeguarding

All staff were trained in safeguarding and knew how to make a safeguarding alert. Staff considered how to protect patients with protected characteristics under the Equality Act. The service had safeguarding policies for adults and children and safeguarding flowcharts were visible in staff offices. There had been no safeguarding alerts raised by the service between January and July 2019. Staff described how to identify adults and children at risk or suffering harm and had good working relationships with other agencies such as community mental health teams and local authorities.

Staff access to essential information

Staff could not access all patient information quickly. Patient information was available in an electronic care records system, paper files and within patient folders on the shared drive. We requested to see a patient's paper file and staff were not sure if the clinician had it or if it had been filed incorrectly as staff could not locate it. The recent record keeping audit had also identified filing as an issue and staff confirmed access to records as an issue.

The service had upgraded its electronic records system in December 2018. Some patient records had migrated across from the two previous electronic records systems and all new patients to the service had an electronic record created. However, we saw that one patient returning to the service did not have all accompanying documentation uploaded from their other files. There was a backlog of care records that were to be updated onto the new care system by the end of August 2019. The service had employed an additional business support staff member to complete this work.

Medicines management

The service held a small prescribing contract, so they could issue prescriptions to NHS patients whose GP would not agree to a shared care agreement. A shared care agreement outlines suggested ways in which the responsibilities for managing the prescribing of a drug can be shared between the specialist and GP. A shared care agreement facilitates the transfer clinical responsibility from a specialist service to general practice in which prescribing by the GP is supported by a shared care agreement. Where a patient's GPs had agreed to shared care, the psychiatrist would recommend what medicines they should prescribe. They requested that the GP arrange physical checks such as blood tests and electrocardiograms (ECGs) to be completed before any prescriptions were issued. Patients returned to The Retreat for up to three appointments, and then annually, when the clinicians reviewed the effects of treatment.

Staff followed good practice in medicines management. The service had standard operating procedures that staff followed for the safety, security and management of prescriptions. The service kept clear records of what prescriptions were issued that identified the patient and the prescriber. Monthly audits of these were completed by the deputy manager of the service.

Reporting incidents and learning from when things go wrong

The service had an incident management policy and incident reporting system. However, we were not confident that all incidents were reported. Two members of staff were unable to find the incident reporting form when we asked, and the organisation's risk register highlighted that there was a possibility that not all incidents were being reported. There were 14 incidents recorded on the organisation's risk and incident register for all The Retreat's services over a six-month period. Incidents included the doorbell not working, concerns over fire safety, a patient being locked in the building (which was immediately resolved), a patient

needing emergency medical assistance, inappropriate or aggressive phone calls, confidential reports being sent by another organisation and interruptions to assessments. The log did not categorise the type of incident.

All incidents were reviewed by the management team and feedback mechanisms were in place to share lessons from incidents. Staff received feedback in a six weekly email update, supervision and team meetings. Staff also had the opportunity for a debrief following incidents if they occurred.

Duty of candour training was mandatory, and staff were aware of their responsibilities. However, only 38% of staff had completed this training based on the training figures supplied on inspection. We saw posters in the service reminding staff of their responsibilities and the service had a policy in place.

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

(for example, treatment is effective)

Good

Assessment of needs and planning of care

Assessment reports were comprehensive and appropriate for the type of service. We reviewed seven patient care records. All were personalised, holistic and recovery orientated with clear patient input. Reports included details about patient history, risks, physical health needs, mental health needs, review of daily challenges and suggested interventions including medicines, therapies, lifestyle advice and guidance.

The psychiatrist considered patients' physical health needs. For example, requesting appointments with specialist cardiology services to get the reassurance needed to progress with medicines or requesting additional information on seizures. The assessment also requested routine physical tests to be completed by the patients' GP before medicines could start. The service struggled to confirm if these had been completed. The registered manager explained that the responsibility lay with the GPs under the shared care agreement. This meant that some patients were not able to start medicines because their physical checks had not been completed. For example, one patient, referred in January 2017, was assessed in May 2018. At the time of inspection July 2019, the patient had not been issued with any medicines from their GP. Another patient's annual review was delayed by six months.

When a patient contacted the service, or staff contacted the patient, we saw that their electronic records had been updated.

Best practice in treatment and care

The service provided care and treatment interventions suitable for the patient group and in line with best practice. Prior to assessment, patients and family members completed recognised assessment tools. Patients then attended a specialist assessment appointment to diagnose their condition and received a recommended course of treatment; either medicines or therapy sessions. The number of treatment sessions and medical follow ups provided was impacted by the commissioning contract. If a patient required additional treatment, staff would recommend that patients seek additional funding from the local clinical commissioning groups via their GP.

The care provided supported patients to live healthier lives. For example, we saw advice given to patients surrounding sleep, relaxation techniques, substance misuse and physical fitness. The service used text reminders and tried to schedule appointments around the patient, for example on the same dates, times or months.

Staff used technology to support patients. The assessment reports and information leaflets recommended websites that patients could use to help understand their condition.

Staff participated in clinical audit, benchmarking and quality improvement initiatives. The service had visits from other ADHD services and had built and expanded professional networks. Psychologists completed audits and the service had an in-progress quality improvement plan that aligned with the organisational risk register.

Skilled staff to deliver care

The team included, or had access to, the full range specialists required to meet the needs of patients. These included psychiatrists, psychologists, a nurse and an occupational therapist.

Staff were experienced and professionally qualified. However, some staff felt that they did not have the right skills and knowledge to complete the tasks they were

asked to do in the service. Not all staff had received an induction, and some that had, felt it wasn't enough to prepare them for their role. We asked to see the human resource system to confirm if all staff had completed inductions; records were not visible for all staff. The service had outsourced its human resource management to a specialist organisation. We asked to see staff files and records during the inspection to verify that all staff had correct checks in place. The information on the human resource management system indicated that two staff did not have Disclosure and Barring Service checks or a full set of references in place. One trustee also did not have a Disclosure and Barring Service check recorded. However, confirmation was provided by the registered manager following the inspection that these were in place.

Managers supported staff to develop their skills and knowledge. Attendance at additional training courses and conferences was encouraged and staff developed their knowledge by using external online training resources. Clinical staff had attended ADHD training days at local universities and the manager had delivered some training on ADHD to business support staff. The psychiatrist attended ADHD special interest groups and the team manager worked with the local authority as an external adviser. One member of staff had attended suicide awareness training. The service also ran a weekly journal club. Staff would read journal articles and discuss them in a group setting.

The Retreat provided staff with effective clinical and management supervision. At clinical supervision staff discussed case management and reflected on their practice. Staff also received management supervision which offered personal support, professional development and an ongoing appraisal of their work performance. Clinical staff had supervision a minimum of nine times per year. The service encouraged staff to have external supervision as this promoted a more objective approach which encouraged more openness and honesty. The provider said that 98% of staff had received supervision between 1 January 2019 and 31 May 2019. Staff confirmed that they received regular, effective supervision.

Staff received appraisals and probationary reviews. Medical staff at The Retreat had practising privileges. This meant they work as an independent doctor for The Retreat and have a substantive post in another organisation. The main employer sent evidence of their revalidation, appraisal and continuous professional development to The Retreat. The provider was implementing a new appraisal system following the reorganisation of The Retreat services. Three staff were in their probationary period and had probationary reviews, four had practicing privileges or worked for external organisations and the others had their appraisals completed or scheduled by the end of August 2019.

The service had multiple ways to communicate with staff via bulletins, email and team meetings. Team meetings were effective. The service had changed from a whole team meeting format where staff from all Retreat services attended to smaller individual team meetings. Team meetings now occurred before the weekly multidisciplinary team meeting and staff said it worked well.

Managers told us they had good links with an external human resource service and senior managers who supported them when they needed to manage poor staff performance.

Multidisciplinary and inter-agency team work

The service held patient centred weekly multidisciplinary team meetings. Attendees included the psychiatrist, specialist nurse, team manager, occupational therapist and psychologists. We attended a multidisciplinary team meeting and reviewed previous minutes. Staff knew patients well and spoke respectfully about their needs. Staff worked well together. They identified patients that needed additional input from the team for discussion. Staff discussed patients' mood and anxieties, communication with families, those that needed additional funding arranged, treatment options and patients that were having trouble getting medicines from their GP.

The service had mostly good working relationships, including the handover of care, with external services. We saw effective communication with local mental health services, primary and secondary care in patient care records. Commissioners confirmed this. Commissioners were aware of the issue surrounding shared care with some York GPs and had agreed that The Retreat could issue prescriptions for NHS patients where necessary. However, this did not support the needs of private patients at these practices and added unnecessary delays and complications to some patients' journeys. During the MDT, staff suggested that one patient would have to change GPs to receive treatment that would improve their quality of life.

Requires improvement

Community-based mental health services for adults of working age

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

The service did not accept patients that were on Community Treatment Orders. If a patient was identified as having additional mental health needs staff referred the patient to an appropriate mental health service or contacted the patient's GP.

Good practice in applying the MCA

The service considered the Mental Capacity Act and where it could be applied for this patient group. The referral criteria did not accept patients with a moderate or severe learning disability. The referral form also specified that they could not accept any patient where a person's substance and/or alcohol use would interfere with observational assessments or ability to engage in the assessment process. Informed consent was a requirement for admission to the service. However, there was no policy in place to help staff determine if patient had a fluctuating capacity and what to do if this happened.

Mental Capacity Act training was included in one of the safeguarding training modules. The manager confirmed that all staff had completed this training in July 2019.

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

Good

Kindness, privacy, dignity, respect, compassion and support

We spoke with six patients and one carer. Staff treated patients well and behaved appropriately towards them. Staff understood the individual needs of patients, including their personal, cultural and social needs. One patient described how the service helped them to get additional funding for additional cognitive behavioural therapy and had given them effective coping strategies.

It was difficult to contact the service. This impacted negatively on the patient experience. Patients described attempting to contact the service and speak with staff after appointments or with queries. Three patients left messages but were not called back. We were also unable to contact the service via telephone on multiple occasions as did internal staff from other parts of The Retreat. The service had identified issues with their telephone system and were meeting with an external supplier in August to identify a solution. The manager also said that where the issue related to staff performance, it had been dealt with using human resource procedures.

Patients that had opted for medicines explained that the after the initial assessment, the service was only responsible for their medicine's reviews. Patients did not get additional psychological support to help them to manage their condition. Although this was a restriction in the commissioning contract, patients didn't always feel supported after the diagnosis. Staff directed patients to other services via their GP when needed.

Patients raised concerns with the waiting times and some patients paid privately to lessen these delays. We were assured that the service prioritised NHS patients within the constraints of the contract and managed private patients in a way that did not impact NHS patients care and treatment. Patients said they were informed of the long waits and that this was caused by was insufficient funding.

Staff did not always maintain the confidentiality of information about patients. Clinic rooms were not soundproof and conversations could be overheard. The service had plans to move to an alternative building next year, where soundproofing was in place.

Patients' care records showed the service sought consent to share information.

Involvement in care

Involvement of patients

Staff involved patients in care planning and risk assessment. Patient records had thorough initial reviews that were individualised and tailored to each patient and their circumstances. Patients received a copy of their assessment so were able to refer to care guidance around sleep patterns, mindfulness and healthy lifestyle choices.

Patients with communication difficulties found reports understandable and the psychiatrist simplified language where necessary.

Not all patients were clear on how to give feedback. However, they all felt confident in raising any concerns with staff in the service or their GP if necessary. We saw feedback forms and a box in the waiting room to gather feedback. Three patients had completed the service's patient feedback survey. They all said they found their experience with the service helpful.

Requires improvement

Community-based mental health services for adults of working age

Involvement of families and carers

Staff informed and involved families and carers appropriately in the care of their loved ones. The service encouraged families and carers to attend appointments and sought their input via self reporting tools at the assessment. The service used friends and family tests to gather feedback.

Carers were provided with information about how to access a carer's assessment via the local authority. Staff said it was important that carers got the support they were entitled to.

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

Access and waiting times

The service held weekly meetings to triage referrals and had clear criteria for which patients would be offered a service. However, patients with a moderate or severe learning difficulty or severe issues with drugs and alcohol could not use the service. This meant that some patients that might need support could not access it via this service.

Patients had long waits to access treatment. The service had an internal target time of three to six months for referral to assessment. The service could not meet these targets due to the financial envelope of the contract. Referral to assessment waits were 18 months. Commissioners confirmed that long waits had built up to avoid overspend on the contract and that demand for the service was increasing. Commissioners did not set key performance indicator targets for the service. The service made some amendments to their service pathway to lessen waiting times. The service had streamlined the process of assessment and removed an appointment with a psychologist before assessment. Managers had also recently been asked by Commissioners to document and explain the continuing increase in the waiting list in terms of capacity and finance so that this could be taken into consideration when the existing contract came to an end.

As of 8 August 2019, there were 313 patients on the ADHD waiting list. The psychiatrist completed seven medicines reviews and two assessments per week over two afternoons per week. The specialist nurse had only recently started having medicines follow up appointments and did not yet have a caseload assigned. Where possible, staff offered patients flexibility in the times of appointments. Staff only cancelled appointments for staff sickness and when they did, staff rearranged their appointments as soon as possible. Appointments usually ran on time and people were kept informed when they did not.

Following assessment there was no clear timeframe when patients would receive treatment. Most patients were issued their medicines via their GP under a shared care agreement. This timeframe was not monitored and there was no follow up process by The Retreat to confirm that medicines had been issued. One patient referred to The Retreat in January 2017 and who was assessed in May 2018, 14 months later in July 2019, had not received any medicines via their GP. The Retreat was not aware of this and had scheduled a follow up medicines review. One member of staff described patients that should have had medicines reviews with The Retreat within one to two weeks of starting medicines that had not been seen in eight months.

There were limited cover arrangements for sickness and leave. Staff described how the psychiatrist would work longer hours prior to and following leave. They explained how leave was planned into the psychiatrist's and specialist nurse's clinical diaries. The sessional psychiatrist was on a term time only contract and so was not always available to cover. We queried how the service would cover staff sickness. For short term sickness, clinicians would pick up the appointments when they returned to work. Where there was longer unplanned sickness staff said they would arrange locum cover. The psychiatrist offered support and guidance to the specialist nurse, therefore when they were absent this had the potential to impact on the care and treatment of patients. If a prescription was required to be issued, then a patient would have to wait until the psychiatrist returned. Additionally, the lack of arranged clinical cover could add an unnecessary pressure on staff returning from leave or sickness.

The service was able to expedite patients that were unable to wait or whose condition had worsened. For example, if their condition put their job at risk. Cases were discussed

on a case by case basis with commissioners. However, if concerns related to mental health and impacted on a patient's ability to receive assessment and treatment then then the patient would be referred back to their GP for support and/or possibly removed from the waiting list.

The team did not respond promptly or adequately when patients telephoned the service. Patients described phoning in, being unable to get through and leaving messages that weren't responded to. One patient received a letter in response to their answerphone message three weeks later. They said that they were only able to discuss their issues at their follow up appointment three months later. The service was aware of the access issues and planned to meet with a telephony supplier for a solution. Where staff were at fault, they were managed via the service's performance management processes.

The service used text reminders to remind patients about upcoming appointments. Patients said they found this helpful. The service had a 'did not attend' policy that resulted in discharge from the service if insufficient notice was given or the patient missed their appointment. The service was not paid for NHS 'did not attend' appointments. Private patients would be charged if they gave less than two days' notice. This fee could be waived if the management team agreed. Although this information was available in the 'what to expect from your assessment' booklet, the policy was not person centred or considerate of the challenges faced by this patient group.

The service had reconfigured the pathway to try to improve patient waits within the existing contract. This had removed an initial psychology assessment and met evidence based best practice for treating patients with ADHD. Commissioners had also asked The Retreat to complete a capacity and demand analysis to explain the limitations of the current contract in relation to finance and waiting times so that they could use it to review the financial envelope when the contract comes to an end in March 2020.

The facilities promote recovery, comfort, dignity and confidentiality

There were enough clinic rooms at the service to see patients however these did not have adequate soundproofing to protect patient's confidentiality. Staff told us they adapted their behaviours to minimise being overheard but we also saw one incident raised due to noise disruption. The service had plans to move to an alternative building next year, where soundproofing was incorporated.Additional clinic rooms were also available and easily accessible at another building three minutes' walk away. The facilities were comfortable and had enough chairs in waiting areas.

Meeting the needs of all people who use the service

The service made adjustments for disabled patients. The referral form asked if patients required reasonable adjustments. The building corridors and entrance were narrow and could not accommodate larger electric wheelchairs. Instead, staff used an alternative building three minutes' walk away. The service complied with the Accessible Information standard. However, staff were not clear what this was. The standard sets out a specific, consistent approach to identifying, recording, flagging, sharing and meeting the information and communication support needs of patients, service users, carers and parents with a disability, impairment or sensory loss.

The service sent a 'what to expect during your ADHD assessment' booklet to patients with their appointment letters. This included information about the appointment format, treatment options, the condition, useful websites, and complaints process. The booklet was clear and easy to understand. It had been redesigned recently in response to patient feedback.

The waiting room had limited information on ADHD and local services or treatments. There were no leaflets in other languages which was reflective of the patient population. Staff said if they needed these they would source them on line.

The service had access to interpreters or signers if needed.

Listening to and learning from concerns and complaints

The service had one complaint in the last six months that was not upheld. We reviewed the complaint and found the service acted appropriately and in line with its complaints policy. Staff understood their responsibilities and would escalate complaints where necessary. Staff were updated on any investigations or outcomes via team meetings and emails.

Some patients were not clear how to raise a complaint. However, all felt comfortable to do so. Feedback boxes were available in the waiting areas and we saw patients filling forms in.

Requires improvement

Community-based mental health services for adults of working age

The service also received seven compliments. We saw copies recorded in patient records.

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

Requires improvement

Leadership

Leaders had a good understanding of the service they managed from a contractual perspective. They could clearly explain how the teams were working to provide high quality care and understood the limitations in the contract. However, there was a lack of skills and knowledge to oversee and implement a systematic process for managing daily operational tasks. For example, booking patients' follow up appointments, ensuring physical tests at the GP had been completed and sending letters. The psychiatrist created the assessment report and letters but there was no clear process for these to be sent or further appointments to be booked by administration staff. The service had identified this gap and the specialist nurse was manually checking all patients using the service. Staff could not confirm the number of patients that they were completing these checks on. The service was working on a handbook for business support staff, but at the time of inspection there was a lack of clarity and ownership about the responsibilities of managers, clinical staff and business support staff.

Leaders, including trustees, were visible in the service. Managers and trustees attended team meetings and trustees attended lunches and led task and finish groups.

Vision and strategy

Staff knew and understood the provider's vision and values and how they were applied in the work of their team. These were based on the values of the Quaker religious group who originally established the hospital. Staff had been involved in redesigning the vision and values after the change in the organisation. Staff had the contributed to discussions about the strategy for their service at staff away days.

Staff could explain how they were working to deliver high quality care within the budgets available. Managers were aware that if they were not limited by the contract the service could provide more psychological support. Commissioners confirmed that managers were working with them to review and potentially increase the service's capacity when the contract was due for renewal.

Culture

The culture of the service was positive in terms of service delivery, but some staff did not feel respected, supported and valued by the management team. Not all staff felt comfortable speaking up. The Retreat had been through a major reorganisation and this had impacted on staff morale. The staff team worked well together and supported each other. We saw staff discussing processes around booking appointments and a mutual respect for challenges that the different roles faced. The management team was aware of cultural issues and had improved communication and set clearer boundaries and were optimistic that this would improve with time. The service had recently created a wellbeing strategy and were working towards the creation of a health and wellbeing delivery plan in November 2019. Staff felt positive and proud about the work that they delivered. Staff felt the service supported patients. Staff appraisals included conversations about career development and how it could be supported. Staff had access to additional training.

The average sickness rate between January 2019 to June was 3%. Staff had access to support for their own physical and emotional health needs through an occupational health service. Managers worked with staff that had long term sickness to help them return to work. Managers dealt with poor staff performance when needed.

Governance

Systems and processes needed improvement for the service to operate effectively and deliver the service in a consistent manner.

Systems and processes for the premises and equipment did not meet the standards expected. Fire safety processes were not followed. Staff were not following actions specified in the action plan, fire alarm tests were not conducted, and staff did not know who the fire warden was. The service was unclear where responsibilities lay for testing fire extinguishers and alarms as they had outsourced facilities management.

The service had not fully considered their responsibilities or responded to staff and patients' needs. Staff had no way to raise an alarm in response to an unforeseen incident, clinic

rooms were not soundproof, and all necessary checks or audits had not been completed on equipment used on patients. The telephone system and processes surrounding patient care records were not effective.

The service's lone working protocols and policy were not fully implemented and did not offer support to all staff groups. Patient risk was not managed in line with the service's policy and staff were not clear of their responsibilities.

The service did not have effective processes in place to safely manage a medical emergency. There was no overall assessment of what emergencies may occur onsite or detailed description of how staff should respond.

The service had ineffective systems to monitor mandatory training and induction compliance. The service's quality improvement plan highlighted that the service was not able to ensure that all training packages were up to date, and it was difficult to monitor compliance. Staffing information such as references, Disclosure and Barring Service checks were not updated on the staffing records, and staff inductions didn't meet the needs of all staff working in the service.

Staffing levels were not enough to meet the demands of the service and waitlists continued to grow. There were insufficient cover arrangements for sickness and leave. There were gaps in processes that meant continuity of care was not provided between the provider and GPs. The service could not always identify when a patient had completed physical checks or initiated treatment. The service could not expedite patients whose mental health was deteriorating and the did not attend policy was not considerate of the challenges faced by the patient group.

The assessment process was well implemented and reviewed. Patients received thorough assessments that were personalised, holistic and recovery orientated with clear patient input. The service's quality improvement plan recognised that there were issues that needed to be addressed in the service. Actions were regularly reviewed by the management team. The plan identified that all outstanding actions would be completed by 31 December 2019 at the latest.

There was a clear framework of what must be discussed in team meetings and supervision to ensure that essential information, such as learning from incidents and complaints, was shared and discussed. This linked into the services governance structure which allowed for two-way communication.

The service had arrangements for working with other teams such as local safeguarding teams, mental health providers and some GPs to meet the needs of the patients.

Staff participated in clinical audits and were encouraged to consider opportunities for improvements and development.

Management of risk, issues and performance

Staff could escalate concerns to the risk register when required from a team level. We saw staff raising concerns via the incident reporting system and these were updated in the risk register. Prior to the inspection the provider told us that the three highest risks were General Data Protection Regulation (GDPR), failure to implement their new three-year strategy and the extent of staff wellbeing and happiness at work due to the significant changes. GDPR was introduced in May 2018 by law regulating how companies protect EU citizens' personal data. We reviewed the service's GDPR action plan. This included multiple high-risk items that had completion dates up to and including December 2019 however the June risk register did not list GDPR compliance as a risk even though compliance with the regulation was not fully resolved. Following the inspection, the registered manager confirmed that GDPR was included on the organisation's most recent risk register. All patients had consented to the use of their data under GDPR.

The service had a plan for emergencies. For example, adverse weather, IT virus, fire and loss of power. We reviewed a copy on inspection. However, all the controls identified on the business continuity plan were not established. For fire, these included evacuation drills and fire wardens which were not in place. For IT viruses, staff were to contact the IT contractors listed, but there were no details populated.

Information management

Although staff had access to equipment and information technology, these did not fully support staff to deliver the service. The telephone system was not suitable. It was difficult to contact the service and staff were not always responding to patients when they left messages. The service had upgraded its electronic records system in

Requires improvement

Community-based mental health services for adults of working age

December 2018, but all patient information was not yet uploaded onto the system. This prevented staff from accessing patient information in a timely way. However, staff had enough computers to allow them to do their work.

Patient records were securely accessed or stored and protected the confidentiality of patients. However, the service had not recognised patients' paper files as information assets on the information asset register. An information asset register helps a service understand and manage the organisation's information assets and the risks to them. It is important to know and fully understand what information is held to protect it.

Team managers did not have easy access to all information needed to support them with their management role. Although they were able to access performance data such as referrals, waiting lists and finance team managers were unable to provide information on staff training and related human resource information at a team level. Information was not always in an accessible format, timely or accurate.

Managers had identified areas for improvement. These were identified on the service's quality improvement plan.

Staff made notifications to external bodies as needed. Expectations surrounding notifications were clearly recorded in the service's incident management policy.

Engagement

Staff had access to up-to-date information about the work of the provider and their services through team meetings and email bulletins.

Patients and carers had opportunities to give feedback on the service they received in a manner that reflected their individual needs. Staff would accept feedback verbally, via email and via feedback cards. Managers and staff had access to the feedback from patients, carers and staff and used it to make improvements. The service had recently updated their 'what to expect from your assessment' booklet in response to patient feedback.

Staff were able to meet with members of the provider's senior leadership team and trustees to give feedback.

Managers and trustees attended team meetings and trustees attended lunches and led task and finish groups relating to organisational changes. For example, one group was identifying recommendations for the Board on staff career progression routes, competency bandings and a new performance appraisal process to be implemented in the summer 2020.

Managers engaged with external stakeholders such as commissioners and Healthwatch. Commissioners fed back that they were positive about the quality of treatment that the service delivered within the limits of the finances available. The only concerns that were raised with them by patients related to waiting times and prescribing of medicines in the York area. The clinical commissioning groups, local mental health provider and The Retreat were participating in a quality improvement event in September 2019 to undertake a fundamental review of the pathway to identify how the pathway could be redesigned and address the challenges.

Learning, continuous improvement and innovation

Staff were encouraged to consider opportunities for improvements and innovation. Attendance at conferences was encouraged and staff developed their knowledge via discussion at the weekly journal club. The psychiatrist attended ADHD special interest groups and the team manager worked with the local authority as an external adviser.

Staff had opportunities to participate in clinical research. There were close links with local universities and students participated in data collection.

The service had registered for the Accreditation Programme for Psychological Therapies Services (APPTS). APPTS is a service development, quality improvement and accreditation network for services providing psychological therapy to adults in the UK.

The service had a quality improvement plan that aligned to its organisational strategy.

Outstanding practice and areas for improvement

Areas for improvement

Action the provider MUST take to improve

- The provider must ensure waiting lists to access assessments are significantly reduced.
- The provider must ensure that patients can access the service by telephone and staff must respond to patients that contact the service.
- The provider must ensure that patient risk is managed appropriately, and that staff adhere to, and are clear on, the organisational expectations.
- The provider must have effective processes in place to safely manage a medical emergency.
- The provider must ensure that contractual work delegated to third party suppliers, including human resources and property management, is well defined, managed and completed.
- The provider must ensure a fully integrated system between themselves and primary care to ensure patients receive all care and treatment identified at the assessment.
- The provider must complete checks on medical equipment used by staff to assess patients in the service.
- The provider must ensure premises are safe and fit for purpose. They must meet fire safety expectations, maintain confidentiality and keep staff and patients safe.
- The provider must ensure staff can access all patient information in a timely way and maintain an accurate, complete and contemporaneous record for each patient.
- The provider must ensure that systems and processes, such as audits assess, monitor and improve the quality and safety of the service.
- The provider must ensure that systems and processes operate effectively and enable the management of daily activities. They must ensure that all staff are clear about their roles and responsibilities.
- The provider must ensure they assess, monitor and mitigate risks relating to the health and safety of staff who may be at risk while working in the service.
- The provider must ensure staff have completed mandatory training and that systems record compliance accurately.
- The provider must ensure that all staff complete an induction that prepares them for all aspects of their role.

Action the provider SHOULD take to improve

Action the provider SHOULD take to improve

- The provider should ensure that referral criteria, policies for non-attendance and processes to expedite patients do not exclude patients that could benefit from care.
- The provider should continue to review staff understanding and compliance with the incident reporting processes.
- The provider should consider the introduction of a policy to support staff in the application of the Mental Capacity Act and how it could apply to patients using the service.

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 9 HSCA (RA) Regulations 2014 Person-centred care **How the regulation was not being met:** • The provider did not do everything reasonably practicable to make sure that people who used the service received person-centred care and treatment that was appropriate and met their needs. Waiting times from referral to assessment were 18 months. • The provider did not ensure that patients could contact the service by telephone or respond to messages left by patients. **This was a breach of regulation 9(1)**

Regulated activity	Regulation
Treatment of disease, disorder or injury	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment **How the regulation was not being met:** • The provider did not ensure staff followed organisational policies in relation to risk assessment and management. Staff did not complete correct paperwork or review risks every three months. • The provider did not have arrangements to take appropriate action if there was a clinical or medical emergency. • The provider did not ensure that fire equipment checks delegated to a third-party supplier were managed or completed. • The provider did not complete checks on medical equipment used by staff to assess patients in the service.

This section is primarily information for the provider

Requirement notices

- The provider did not have a fully integrated system in place with external organisations to ensure patients received all care and treatment identified at the assessment.

This was a breach of regulations 12(2)(a)(b)(d)(e)(i)

Regulated activity	Regulation
Treatment of disease, disorder or injury	Regulation 15 HSCA (RA) Regulations 2014 Premises and equipment How the regulation was not being met: • The provider did not ensure that patients' confidentiality was not compromised. • The provider did not make sure that they met the requirements for fire safety so that premises and equipment were properly used and maintained. This was a breach of regulation 15(1)(c)(e)

Regulated activity	Regulation
Treatment of disease, disorder or injury	Regulation 17 HSCA (RA) Regulations 2014 Good governance How the regulation was not being met: • The provider did not ensure that systems and processes operated effectively in the service. Effective processes were not in place to monitor compliance with Regulations 4 to 20A of Part 3 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 (as amended). • The provider did not ensure that systems and processes such as regular audits of the service assessed, monitored and improved the quality and safety of the service in compliance with Regulations 4 to 20A of Part 3 of the Health and Social Care Act 2008 (Regulated

This section is primarily information for the provider

Requirement notices

Activities) Regulations 2014 (as amended). Information was not always up to date, accurate or properly analysed and reviewed by people with the appropriate skills and competence to understand its significance.
- The provider did not ensure they assessed, monitored and mitigated risks relating to the health and safety of staff who may be at risk while working in the service.
- The provider did not ensure they maintained an accurate, complete and contemporaneous record for each patient. Patient information was not always accessible, legible or up to date.

This was a breach of regulations 17(2)(a)(b)(c)

Regulated activity	Regulation
Treatment of disease, disorder or injury	Regulation 18 HSCA (RA) Regulations 2014 Staffing **How the regulation was not being met:** • The provider did not ensure there were sufficient numbers of staff to meet the care and treatment needs of patients using the service. • The provider did not ensure that all staff had an induction that prepared staff to complete their role. • The provider did not ensure that all staff had completed mandatory training. This was a breach of regulations 18 (1)(2)