Good

Hertfordshire Partnership University NHS Foundation Trust

Community-based mental health services for older people

Quality Report

Trust Headquarters
99 Waverley Road
St Albans
AL3 5TL
Tel:01727 804700
Website: www.hpft.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)
RWR99	Trust Head Office	North West Community Mental Health Service (OP), The Orchards, Hemel Hempstead	HP3 8EH
RWR99	Trust Head Office	East Community Mental Health Service (OP), Rosanne House, Welwyn Garden City	AL8 6JE
RWR99	Trust Head Office	North Community Mental Health Service (OP), Saffron Ground, Stevenage	SG1 3LJ

Summary of findings

RWR99	Trust Head Office	South West Community Mental Health Service (OP), Colne House, Watford	WD18 0JP

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

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

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

Summary of findings

Ratings

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

Overall rating for the service	Good
Are services safe?	Good
Are services effective?	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-based mental health services for older people as **good** because:

- The service operated safely, with sufficient numbers of well-trained staff who were aware of, and used, safe practice such as the lone worker policy and procedures.
- The needs of people using the service were assessed and responded to promptly and monitored effectively.
- The teams had a good mix of professionals, nurses, support workers, psychologists, pharmacists, social workers, psychiatrists, occupational therapists, speech and language therapists, who worked together well.
- People using the service were treated with respect and dignity and their individual needs responded to. They were very complimentary about the service and the staff they came into contact with.
- There was a low turnover of staff throughout the services. This offered people using the service consistency and experience.
- Staff were highly motivated, caring and enthusiastic about their work. This was reflected in their contact with people who used the service.
- Changes to the service had been managed effectively, whereby three out of the four areas had relocated services to central 'hubs'. Staff working in these hubs had responded positively. One area, the North West, was still to move to a hub.

We also noted:

- The environments of some memory clinics were not very welcoming for people using them, and there were delays for some people between being referred and receiving an assessment.
- It was not always clear if people using the service had had mental capacity assessments, which is needed to ensure people are not given treatment they are unable to consent to.

Summary of findings

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

Are services safe?

Good

We rated safe as **good** because:

- The service had a good safety record, with few incidents. The service learned from incidents and improved practice as a result of them. The crisis team at Saffron ground gave an example of a carer giving their partner an overdose of liquid medication. The team had learned from this and now ensured carers were given far more explicit detail regarding such medications and their understanding tested out more robustly. This incident was referred to by all staff we spoke with in this team, showing that awareness and learning had been shared with all the team.
- There were sufficient trained staff to provide a safe service. Good safety protocols were in place and practiced by staff. Staff had personal alarms that monitored where they were. Not all staff had received these yet, but staff that did not were aware of the protocol of ringing in the office to alert them of their whereabouts.
- The needs of people using the service were assessed and safety risks responded to promptly. One carer at Saffron ground told us that a psychiatrist was able to see them promptly when they requested help Staff were clear on what to do in the event of safeguarding alerts.

Are services effective?

Good

We rated effective as **good** because:

- Assessments were completed in a timely manner. People were seen at home promptly. There was good team working, with different disciplines all contributing and working together effectively in the best interests of people using the service.
- Physical and mental health needs were effectively monitored and there was access to psychiatrists and psychologists when required. There was a good mix of well-trained staff to meet the needs of people using the service.

We also noted:

- There is no clear distinction as to what triggers a mental capacity assessment within the service.

Are services caring?

Good

We rated caring as **good** because:

Summary of findings

- Staff showed a good understanding of the needs of people using the service and how to respond to them.
- People using the service were very positive in their responses about the service. They used phrases such as “brilliant.”
- Carers and people directly using the service told us they were kept fully informed and involved in care decisions. Care plans we looked at included the views of people using the service. One carer told us how they had formulated care and crisis plans with the team. They said they were given information about medication and possible side effects. They said they were fully involved in discussions and were offered advice throughout which they saw as helpful and informative.

Are services responsive to people's needs?

Good

We rated responsive as **good** because:

- Crisis and outreach teams were able to respond quickly to referrals. Targets for crisis response were four hours with a visit within twenty four hours. Urgent referrals were prioritised. We accompanied staff on visits that were in responses to urgent requests made earlier in the day.
- The new Single Point of Access referral point made it easier to access to services for people needing to use the service and for GPs referring them.
- The service responded to complaints and learned from them. We discussed examples with staff and managers and saw how they had responded to them. We saw how learning had taken place in one instance of staff responding to a carer who was under stress. There were carer and user groups where people could raise issues and get additional advice and support.

We also noted:

- Access to the Memory Clinics was delayed on occasions because of waiting lists and, on some occasions, staffing pressures..
- Memory clinics, particularly the reception area at Saffron and the entrance to Colne House, were not very ‘user friendly’. Saffron ground had doors that were not easy to open, while Colne House did not have clear signage to lead people to reception.

Are services well-led?

Good

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

Summary of findings

- Staff were very positive and well-motivated. There was high morale and expressions of job satisfaction amongst staff who said that they felt supported by the trust. Staff comments and training records showed that staff received suitable training and supervision. Staff felt confident to raise issues and have these responded to.
- There had been major changes within the service, involving services being moved to central hubs, where staff all worked together in one open plan office. This had been managed in a positive manner within the service. Staff in the new hubs were positive about working in them.
- Senior managers were known to staff and visited locations regularly.
- Initiatives such as Dementia First Aid were helping carers to better support people using the service. The Dementia First Aid course had been set up to help equip carers to care for partners or relatives with dementia. This involved a short course for carers giving them practical advice and knowledge to help better equip them for caring. Initial feedback from carers and professionals for this recently introduced initiative showed positive results with carers feeling more confident, supported and better able to continue caring.

Summary of findings

Information about the service

Community-based mental health services for older people provide support to older people with mental illness living in the community throughout Hertfordshire. Services are made up of outreach teams and diagnostic services.

The services were going through a period of extensive change at the time of our visit. There were three hub-based services, at Watford (Colne House), Stevenage (Saffron), and Welwyn (Roseanne House). These had all been established in their current configuration within the past year. The service at Hemel Hempstead (The Orchards) was awaiting the move to an integrated 'hub'.

Each service comprised of diagnostic centres, or memory clinics, community teams, and intensive outreach, or 'crisis' teams.

We have not previously inspected this service.

Our inspection team

The team that inspected community-based mental health services for older people consisted of

Five people: an inspector, a Mental Health Act reviewer, a psychiatrist, a nurse and a manager of community mental health services.

Why we carried out this inspection

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

How we carried out this inspection

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

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

During the inspection visit, the inspection team:

- Visited the three main hubs where community-based mental health services for older people were based and a fourth geographical area which had not yet moved to a hub location.
- Spoke with 18 carers and people directly using the service
- Spoke with 6 managers and deputy managers in the service
- Spoke with 21 other staff members; including doctors, nurses and social workers
- Spoke with the overall manager for this service
- attended and observed three hand-over meetings and a multi-disciplinary meeting
- Observed two assessments of people using the service
- Observed four home visits to people using the service
- Attended and observed a carer's group and a newly established user's group.

We also:

- Looked at 12 care and treatment records of people using the service
- Carried out a check of the medication management at Stevenage.
- Looked at a range of policies, procedures and other documents relating to the management of the service.

Summary of findings

What people who use the provider's services say

People we spoke with, either by phone, during visits or in carer and users' groups, were overwhelmingly positive about the service. They were full of praise for the caring, understanding and helpful nature of all staff they came into contact with. They also commented favourably on the responsiveness and effectiveness of the service.

The only negative comments came from people using the service in Stevenage, who were not happy with the recent closure of the local day service and inpatient ward there. They felt this closure had created a gap in the service.

Good practice

The service had set up a Dementia First Aid programme, supporting carers to care more effectively for loved ones with dementia.

The 'bottom up' approach we saw in operation, by which support workers were given more responsibility and autonomy in day-to-day practice, helped support workers gain confidence and skills. We saw this in the confident and valued contributions support workers made to team meetings

Areas for improvement

Action the provider SHOULD take to improve

- The provider should ensure that, whenever people's mental capacity may be an issue, their ability to consent to treatment is documented.
- The provider should ensure that reception areas for memory clinics are more 'user friendly', with better signage at Colne House and more suitable seating and waiting areas at Saffron.
- The provider should ensure that waiting times from referral to appointment at memory clinics meet agreed target times

Hertfordshire Partnership University NHS Foundation Trust

Community-based mental health services for older people

Detailed findings

Locations inspected

Name of service (e.g. ward/unit/team)	Name of CQC registered location
North West Community Mental Health Service (OP), The Orchards, Hemel Hempstead	Trust Head Office
East Community Mental Health Service (OP), Rosanne House, Welwyn Garden City	Trust Head Office
North Community Mental Health Service (OP), Saffron Ground, Stevenage	Trust Head Office
South West Community Mental Health Service (OP), Colne House, Watford	Trust Head Office

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.

- As part of mandatory training, all staff received training via 'e-learning' in the Mental Health Act.
- We observed good discussions about assessments under the Mental Health Act in a team handover at Roseanne House. This showed a good awareness of the Act and access to an Approved Mental Health Professional when required.
- Community Treatment Orders (CTOs), although rarely used in the service, were completed properly when they

were required. One member of staff at Orchards gave an example of a CTO from the previous year which had been removed once the prescribed medication had improved the patient's mental health. A clinician at Roseanne knew of only one CTO in the team since 2007. There were no CTOs currently at Saffron, which had an AMHP duty desk. Staff told us they could get advice on implementation of the MHA and its Code of Practice from within the trust if required.

- People had their rights explained to them appropriately. This was evident on visits to people's homes and in discussions with carers and people directly using the service.
- Patients had access to advocates and an Independent Mental Health Advocate. There was a specific organisation used by the trust to provide advocacy services.

Mental Capacity Act and Deprivation of Liberty Safeguards

- As part of mandatory training, all staff received regular training via 'e-learning' in the Mental Capacity Act.
- Where patients did not have capacity to make a decision, this was clearly assessed and recorded. These capacity assessments were decision based, rather than 'blanket' assessments. This showed that they were person-centred and in line with the mental capacity act. However, there was no record when a patient was deemed to have capacity. This meant it was unclear whether patients in these cases had capacity, or had just not had an assessment. We were told consistently by staff and managers that consent was assumed, unless there was evidence or concerns to the contrary. Of the 12 care records we looked at, only one had evidence of consent and/or a capacity assessment. In two records looked at in Roseanne House, for example, a capacity assessment and best interest decision was recorded, in respect of financial abuse. There was no record of a capacity assessment, however brief, for medication or treatment consent. The implication was that the patient had capacity to give consent for treatment and medicines, but this was not explicitly stated. One health professional we spoke with who was not directly involved in capacity assessments acknowledged that capacity was rarely documented. They were aware that it was decision specific and that there was a presumption of capacity unless evidence indicated otherwise.
- A nurse at Colne House stated they always asked for consent prior to assessment and conducted a capacity assessment proportional to need. We witnessed on visits staff checking for consent where appropriate. This indicated that consent was sought and capacity assessed, but that this was not always recorded.
- Staff at Orchards gave an example of where a mental capacity assessment had been made to establish lack of capacity in a safeguarding where police had been involved where financial abuse was alleged.
- Staff told us they advised homes regarding the use of Deprivation of Liberty Safeguards (DoLS) when issues arose regarding patients in this respect.
- Best interest decisions were made and people were supported to make decisions. We saw these were recorded. At the intensive outreach team handover at Roseanne DoLS, mental capacity and safeguarding issues were discussed and actioned.
- We saw updates on the Mental Capacity Act were available. At Orchards, for example, a 'user friendly' update was in a prominent position on an office door. Staff told us there was a Mental Capacity advisor available within the trust if they had queries regarding mental capacity issues. One staff at Colne House told us they were unaware of identified person within the trust from whom they could get advice about the Mental Capacity Act. This person also said they received training on the Mental Capacity Act and The Mental Health Act, but as it was 'e-learning' they found they did not retain the information as effectively as they did face-to- face training.

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

Summary of findings

- The service had a good safety record, with few incidents. The service learned from incidents and improved practice as a result of them. The crisis team at Saffron gave an example of a carer giving their partner an overdose of liquid medication. The team had learned from this and now ensured carers were given far more explicit detail regarding such medications and their understanding tested out more robustly. This incident was referred to by all staff we spoke with in this team, showing that awareness and learning had been shared with all the team.
- There were sufficient trained staff to provide a safe service. Good safety protocols were in place and practiced by staff. Staff had personal alarms that monitored where they were. Not all staff had received these yet, but staff that did not were aware of the protocol of ringing in the office to alert them of their whereabouts.
- The needs of people using the service were assessed and safety risks responded to promptly. One carer at Saffron told us that a psychiatrist was able to see them promptly when they requested help Staff were clear on what to do in the event of safeguarding alerts.

Our findings

Safe and clean environment

- People who used the service were normally visited at home. The exception to this was where people used the memory service for a possible diagnosis of dementia. Hubs were equipped with generic rooms for appointments. We visited the clinic rooms at Roseanne House(Welwyn Garden City), Saffron (Stevenage) and Colne House (Watford)
- Interview rooms were fitted with alarms. In addition, staff using clinical rooms had personal alarms to further ensure their safety.
- Clinic rooms at Roseanne House and Colne House had a couch, blood pressure monitoring equipment and a weighing machine. At Saffron, equipment was borrowed from other areas to the booked room as required.
- Clinic areas were clean and well maintained.

Safe staffing

- Staff turnover throughout the service was generally low. In 2014, the percentage of leavers in this service had been 9%. Many staff we spoke with had worked for the trust for many years. At the Orchards, in particular, the majority of staff had worked for the service for over ten years. Teams had a balance of qualified nurses, support workers and psychology and psychiatric input.
- Reorganisation had produced some staff changes at the hubs. At Saffron, for example, some staff had left to join other teams. This was seen as a positive move for the staff concerned, enabling them to gain new experience, and develop their career, but it had left a temporary shortfall filled by agency staff and managers. At Colne House there were two temporary staff vacancies which were being covered by existing staff and management until two staff were recruited.
- All teams had clear lists of staffing numbers required to meet user needs and were clear where there were vacancies and where agency staff were used. At Colne House, for example, the crisis team the crisis team staffing was for 5 nurses and 3 support workers, the memory service was made up of 4 nurses and the Community mental health team (Planning and Prevention) was made up of 7 nurses and two support workers. These involved a small number of regular agency staff. At Saffron, for example, there were two agency staff employed long term. Managers told us they were budgeted to provide sufficient numbers of staff to meet the needs of people using the service. At Roseanne House the community team was made up of eight qualified nurses and eight support workers. There were no vacancies and no long term sickness. The intensive outreach, or 'crisis' team had three qualified nurses and three support workers. There were two vacancies for band 5 nurses. These were being recruited to and an agency nurse was due to start. The early memory diagnosis and assessment service at Roseanne House

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was made up of six nurse and three Alzheimer's society support workers. At Saffron House there was one current vacancy which had just been recruited to. Two long term agency staff were employed at Saffron. At Colne House there were two nurse vacancies in the crisis team which were currently filled by existing staff and management cover whilst the posts were being recruited to.

- There was access to a psychiatrist when required. All hubs had a psychiatrist working directly with them or available when required. At Orchards, for example, there was access to four psychiatrists. Carers we spoke with told us they had good access to clinicians. One carer at Saffron told us that a psychiatrist was able to see them promptly when they needed such help.
- Staff training records showed up to date training on mandatory areas. A 'traffic light' system showed less than 10% of training needs not met on all local records we looked at.
- A typical caseload for a Community Psychiatric Nurses at Roseanne House was 25-30. Staff told us they felt this was manageable and enabled them to respond to needs. Observations at team meetings and from visits and discussions with staff and people who used the service showed that the service was able to respond to and monitor patient safety.
- Agency staff were used to provide cover in teams where there were vacancies. Agency staff who were used were employed on a regular basis and were familiar with the service and the needs of people using it. We spoke with an agency nurse who had been working for the service for almost a year. They had received full induction, training and were initially able to 'shadow' more experienced staff until they were confident and able to work on their own.

Assessing and managing risk to patients and staff

- We looked at a total of 12 care records over the four teams we visited. These showed risk assessments taking place at initial screening and being reviewed and updated as required.
- Crisis plans and advance decisions were in place in care records we sampled. One carer told how a plan had been formulated and agreed in advance of them not being able to care for their partner. They were impressed at the support worker's empathy and advance planning which brought them 'peace of mind.'
- Services responded promptly to deteriorations in people's health. We witnessed team meetings assessing needs and responding with proportionate, prompt and informed actions.
- Staff were clear on what to do in the event of safeguarding alerts. They gave examples of where safeguarding concerns had been raised in respect of suspected financial abuse and the actions that had been taken. An example at Saffron ground showed how a senior support worker had noted incorrect medication being administered by a care agency and had promptly reported this. It was rectified within hours and the agency involved was required to investigate. We attended a multi-disciplinary team meeting at Colne House where safeguarding issues were discussed and referrals made where needed.
- There were good safety protocols in place. Staff had personal alarms that monitored where they were. Not all staff had received these yet, but staff that did not were aware of the protocol of ringing in the office to alert them of their whereabouts.
- We looked at medicines management and storage at hubs. Medicines were stored safely and securely and appropriate records kept. We spoke with the pharmacist who supports the service. They provided additional support to patients as well as monitoring the safety and effectiveness of the medicines administration and management.

Track record on safety

- Managers at individual services told us they had no serious incidents directly involving staff in the past twelve months. Nevertheless, the service had been pro-active in introducing ways to improve personal safety. For example, initial assessment visits to people's homes took place in pairs and telephone contact was made first.
- At The Orchards, the last adverse event had occurred three years ago, and the service had made improvements in contacts and inter-agency communications following this. At Rosanne House, staff

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told us there had been no adverse events in the past year. We saw no evidence of adverse incidents. At the Colne house service there had been two suicides in the past year, from which there had been some learning in respect of risk assessment recording.

Reporting incidents and learning from when things go wrong

- Staff were clear on what to report and how to report incidents. They were able to explain the process for recording incidents into the trust's Datix information system.
- The crisis team at Saffron ground gave an example of a carer giving their partner an overdose of liquid medication. The team had learned from this and now ensured carers were given far more explicit detail regarding such medications and their understanding tested out more robustly. This incident was referred to by all staff we spoke with in this team, showing that awareness and learning had been shared with all the team.
- People using the service told us staff were open with them. One person told us, "They would let us know if something was wrong."
- Staff told us they received feedback from investigations, and were debriefed following incidents. One member of staff at The Orchards told us "the trust doesn't sweep things under the carpet." One nurse at Colne House detailed the debriefing and feedback and lessons learned following a serious incident the previous year. They noted there had been more training on managing risk and functional mental illness since this serious incident. The manager at Colne House told us how they had improved the recording of risk assessments following an incident.

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.

Summary of findings

- Assessments were completed in a timely manner. People were seen at home promptly. There was good team working, with different disciplines all contributing and working together effectively in the best interests of people using the service.
- Physical and mental health needs were effectively monitored and there was access to psychiatrists and psychologists when required. There was a good mix of well-trained staff to meet the needs of people using the service.

We also noted:

- There is no clear distinction as to what triggers a mental capacity assessment within the service.

Our findings

Assessment of needs and planning of care

- We looked at 12 care records over the four sites we visited. Comprehensive assessments were completed in a timely manner and contained suitable information to assist in the support and recovery of a person's well-being.
- We saw where capacity assessments had resulted in some lack of capacity being noted in specific areas and where subsequent best interest decisions had been made. Unless there was a lack of capacity, nothing was recorded. Staff told us consistently that capacity was assumed until evidence or concerns indicated otherwise. Because in such cases (the majority) there was no recording, it was unclear whether someone had capacity or whether they had just not had an assessment.
- Staff we spoke with were able to give a thorough account of how full assessments were done. Memory service assessments involved presentation, support needs, risks, spiritual and cultural perspectives and past history as part of a person-centred assessment and treatment. These took place at clinics unless there were specific reasons a person could not attend the clinic.
- Community mental health assessments took place at a person's home. They contained up to date recovery-orientated care plans. We saw, during home visits, records and risk assessments being updated in light of new information and observations.
- Information was stored securely in hubs and was accessible. Records were stored electronically. Paper records were made available if information was needed by other agencies.
- We observed a crisis team handover meeting. This demonstrated excellent multi-disciplinary team working, with support workers, nurses and clinicians all sharing their experience knowledge and expertise to ensure the best outcome for the patients concerned. The team showed a good understanding of individual patients with at least one member of the team being able to provide sufficient information on a patient to ensure a person-centred response

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Best practice in treatment and care

- Discussions led by consultant psychiatrists in team meetings and handovers showed that medicines were being prescribed and monitored by appropriate professionals with the experience and knowledge to ensure people were getting optimum benefits from medication.
- Psychological therapies were offered by occupational therapists employed within teams. For example, at Roseanne house, we saw that anxiety management was offered as a resource to patients as an effective way in enhancing their well-being.
- Staff supporting people in the community were able to offer support on social matters such as benefits and employment. We saw how a carers' group at Saffron ground provided an opportunity to give benefits advice and answer queries on such topics. We observed a visit where the worker was giving support in respect of benefits.
- Physical health care needs were monitored during home visits. Community Psychiatric Nurses had access to GP notes and would do 'baseline' assessments if appropriate. Many patients would already be known to

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District Nurses who shared information with the community mental health teams. This information sharing allowed patient physical well-being to be monitored with minimal duplication.

- Anti-psychotic medication was used on isolated occasions to alleviate distress. Health professionals were consistent in telling us these were only used as little as possible. The use of these was monitored by consultants. We observed discussions in meetings where consultants were advising on and monitoring the well-being of patients on particular medications.
- Risk assessments and treatment and care plans used outcome measures such as the Bristol Activities of Daily Living Scale to rate severity of need.
- We saw examples of clinical audits, including medical audits. For example, at Saffron a medical audit had resulted in the provision of a clinical room. A records audit had showed the need to shred paper copies of some records once they had been updated, to prevent old information being referred to.

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Skilled staff to deliver care

- There was a full range of mental health disciplines available in all teams. We saw evidence (at handovers, multi-disciplinary meetings, care records and in discussions with staff and users of the service), of input from psychologists, pharmacists, social workers, psychiatrists, occupational therapists, speech and language therapists.
- There was a good mix of qualified staff and support workers and of experienced and relatively new staff. We saw handover meetings, such as the intensive outreach handover at Roseanne, also being used as information and learning for the team with clinicians advising. It was good to see support workers taking an active role in team meetings and their views being given full attention.
- New staff we spoke with were able to give full details their induction. This included agency workers.
- All staff told us they received regular supervision and yearly appraisals. Records we looked at confirmed this. Staff told us they attended regular team meetings. Where hubs had recently been set up, such as at Colne House, team meetings had just been started up with the newly organised teams.
- Staff were able to access relevant specialist training. Support workers were able to access training on areas such as physical health monitoring and welfare benefits for older people. Saffron crisis team had received training on pain management, suicide prevention as well as dementia.
- We asked managers about issues of poor performance and how they were addressed. The manager at Orchards told us performance issues were rare and not acute and were dealt with supportively in supervisions. The manager at Colne House discussed how a performance issues had resulted in a member of staff leaving. This issue had resulted in complaints regarding inaccurate assessments and prolonged waiting times, which had alerted management to the problem.

Multi-disciplinary and inter-agency team work

- There were daily handover meetings where teams worked shifts. We saw effective handover meetings taking place between early and late teams.
- A handover in the intensive outreach team at Roseanne demonstrated good interactions, communications and teamwork in providing viable options to hospital admissions.
- We saw effective multi-disciplinary team meetings take place. These were attended by relevant specialists and clinicians. Meetings were minuted and made available as information for staff who were unable to attend. Staff who had been re-organised into 'hubs' were generally positive about it. One comment from a nurse at Roseanne was that "we no longer worked in silos". We saw teams working together, sharing information and benefitting from being in the same office.
- A memory clinic team meeting at Colne House showed a wide variety of professionals working together in a decisive, caring, supportive and professional manner. Diagnoses were made and referrals arranged to appropriate services. A wide range of post-diagnostic

Are services effective?

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support was available, including psychologists, speech and language therapists, dementia advisors, and a mild cognitive impairment group. Safeguarding issues were discussed and referrals made where needed.

- There were good links with other agencies, particularly voluntary agencies such as the Alzheimer's Society, whose staff worked closely with and within teams. The Single Point of Access meant that GPs could refer effectively to services. The managers of memory services were working to involve GPs more closely post-diagnosis so they could take on more of the monitoring role of patients diagnosed with dementia.

Adherence to the MHA and the MHA Code of Practice

- As part of mandatory training, all staff received training via 'e-learning' in the Mental Health Act.
- We observed good discussions about assessments under the Mental Health Act in a team handover at Roseanne. This showed a good awareness of the Act and access to an Approved Mental Health Professional when required.
- Community Treatment Orders (CTOs) are used to ensure that people in the community who might otherwise be detained in hospital have the treatment that is necessary to keep them safe. These were used extremely rarely within this service. They were documented properly. One member of staff at Orchards gave an example of a CTO from the previous year which had been removed once the prescribed medication had improved the patient's mental health. A clinician at Roseanne knew of only one CTO in the team since 2007. There were no CTOs currently at Saffron, which had an AMHP duty desk. Staff told us they could get advice the MHA and its Code of Practice from the trust if required.
- People had their rights explained to them appropriately. This was evident on visits to people's homes and in discussions with carers and people directly using the service.
- Patients had access to advocates and an Independent Mental Health Act assessor. There was a specific organisation, POhWER, used by the trust to provide advocacy services.

Good practice in applying the MCA

- As part of mandatory training, all staff received training via 'e-learning' in the Mental Capacity Act.
- Where patients did not have mental capacity to make a decision in any area this was clearly assessed and recorded. These capacity assessments were decision based, rather than 'blanket' assessments. This showed they were person-centred. However, there was no record when a patient was deemed to have capacity. This meant it was unclear whether patients in these cases had capacity, or had just not had an assessment. We were told consistently by staff and managers that consent was assumed, unless there was evidence or concerns to the contrary. Of the 12 care records we looked at, only one had evidence of consent and/or a capacity assessment. In two records looked at in Roseanne, for example, a capacity assessment and best interest decision was recorded, in respect of financial abuse. There was no record of a capacity assessment, however brief, for medication or treatment consent. The implication was that the patient had capacity to give consent for treatment and medicines, but this was not explicitly stated. One health professional we spoke with who was not directly involved in capacity assessments acknowledged that capacity was rarely documented. They were aware that it was decision-specific and that there was a presumption of capacity unless evidence indicated otherwise.
- A nurse at Colne House stated they always asked for consent prior to assessment and conducted a capacity assessment proportional to need. We witnessed on visits staff checking for consent where appropriate. This indicated that consent was sought and capacity assessed, but that this was not always recorded.
- Staff at Orchards gave an example of where a mental capacity assessment had been used in order to establish the capacity of a service user in relation to a safeguarding referral that police had been involved where financial abuse was alleged.
- Staff told us they advised homes regarding the use of Deprivation of Liberty Safeguards (DoLS) when issues arose regarding patients in this respect.

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.

- Best interest decisions were made and people were supported to make decisions. We saw these were recorded. At the intensive outreach team handover at Roseanne DoLS, mental capacity and safeguarding issues were discussed and actioned.
- We saw updates on the Mental Capacity Act were available. At Orchards, for example, a 'user friendly' update was in a prominent position on an office door. Staff told us there was a Mental Capacity advisor available within the trust whom they could contact if they had queries regarding mental capacity issues. One staff at Colne House told us they were unaware of identified person within the trust from whom they could get advice about the Mental Capacity Act. This person also said they received training ion the Mental Capacity Act and The Mental Health Act, but as it was 'e-learning' they found they did not retain the information as effectively as they did face-to-face training.

Good

Are services caring?

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

Summary of findings

- Staff showed a good understanding of the needs of people using the service and how to respond to them.
- People using the service were very positive in their responses about the service. They used phrases such as "brilliant."
- Carers and people directly using the service told us they were kept fully informed and involved in care decisions. Care plans we looked at included the views of people using the service. One carer told us how they had formulated care and crisis plans with the team. They said they were given information about medication and possible side effects. They said they were fully involved in discussions and were offered advice throughout which they saw as helpful and informative.

Our findings

Kindness, dignity, respect and support

- Staff we observed on visits and in appointments were respectful, responsive and provided appropriate support. We accompanied staff on visits from all hubs and found the support and treatment offered to people to be of a consistent high quality.
- People using the service consistently told us that staff were good. Two carers we contacted by phone from the Orchards were extremely positive, saying the staff were "brilliant". They said they understood problems, sorted out problems and that they "couldn't fault them". One carer said the support worker was very good and helped alleviate pressure by their understanding and defusing of stressful situations.
- Staff showed a good understanding of people's needs and of the support users and carers required. Staff were sensitive to people's needs and feelings in producing care plans. For example, one nurse was sensitive about not upsetting a person by not including the term 'dementia' in their copy of their care plan.
- Carers told us how staff had organised day care by directing them towards established or recently introduced drop-in services and support groups. One person using the service at Roseanne House was very appreciative of the support provided by the team, with their only negative being that the service was sometimes too intensive and 'over-worried' about the person's short absences from home.
- Confidentiality was maintained and information was stored securely, whether on paper or electronically. Paper copies of care plans were given to patients and electronic copies were stored securely and password protected in the trust electronic system.

The involvement of people in the care they receive

- People who used the service told us they were involved in care planning. Care plans we looked at included the views of people using the service. One carer told us how they had formulated care and crisis plans with the team. They said they were given information about medication and possible side effects. They said they were fully involved in discussions and were offered advice throughout which they saw as helpful and informative. One carer who was very happy with the service said they had not received a copy of the care plan. They did not consider this an issue, as the care plan had been discussed and agreed at length with them. Their partner was in a care home. They were very positive about the swift response of the service.
- Another person using the service told us when we visited that they were very happy with the responsiveness and quality of the staff. They told us they consistently saw the same nurse, who had always been caring and interested in them. We saw information leaflets in the person's home, and evidence in their care plan of the involvement of their family.
- A carer we spoke with at Saffron told us they received an information pack with details of helplines and patients' rights and information on mental health problems, which they said was very useful.
- There was access to advocacy. The Independent Mental Health Advocate service was available, as was a more local advocacy service, in supporting people where abuse was suspected. They were also available where people needed support in making decisions about medications, for example, anti-psychotic medication. At

Good

Are services caring?

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Saffron we were made aware of an example of the advocacy service supporting a patient where family members expressed different views. An interpreter was also used in this case to ensure all views were heard.

- At Roseanne House, we were told how the trust had recently recruited service users to sit on staff recruitment panels. This showed good involvement by people using the service.
- We saw copies of leaflets given out to carers and people using the service giving them the opportunity to feedback on services. Staff and managers at all services consistently told us that although they offered surveys, they had very few returned. They said people generally passed on compliments verbally. Users of the service were happy to give us verbal compliments about the service. We attended a carers' group and a service users' group, where people were able to get support and raise issues. The one area of concern voiced by the carers' group at Saffron concerned the recent closure of the local day service as part of the restructuring of the service.

Are services responsive to people's needs?

Good

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

Summary of findings

- Crisis and outreach teams were able to respond quickly to referrals. Targets for crisis response were four hours with a visit within twenty four hours. Urgent referrals were prioritised. We accompanied staff on visits that were in responses to urgent requests made earlier in the day.
- The new Single Point of Access referral point made it easier to access to services for people needing to use the service and for GPs referring them.
- The service responded to complaints and learned from them. We discussed examples with staff and managers and saw how they had responded to them. We saw how learning had taken place in one instance of staff responding to a carer who was under stress. There were carer and user groups where people could raise issues and get additional advice and support.

We also noted:

- Access to the Memory Clinics was delayed on occasions because of waiting lists and, on some occasions, staffing pressures..
- Memory clinics, particularly the reception area at Saffron and the entrance to Colne House, were not very 'user friendly'. Saffron had doors that were not easy to open, while Colne House did not have clear signage to lead people to reception.

Our findings

Access and discharge

- Referrals came from the central triage team, the Single Point of Access (SPA). We heard a variety of views on this recently introduced system. Staff at Orchards said it worked, but they did not always get full histories or risks so local team had to do fuller assessment, which some felt was a duplication of effort. However, staff acknowledged that GPs liked the system because it made referrals straight forward, and patients liked it because they could self-refer if they wished.
- In crisis and outreach teams, we saw throughout that responsiveness was prompt. This was reflected in positive feedback from all patients we spoke with. Urgent referrals were prioritised. We accompanied staff on visits that were in responses to urgent requests made earlier in the day. Nurses in crisis teams made contact and saw patients within 24 hours. A recent case at Saffron showed how a person contacting the team because they felt suicidal was assessed that evening.
- Crisis teams had same day responses. Carers told us they were able to contact care co-ordinators or support workers and get a prompt response. We accompanied a home visit that was a response to a call that morning requesting hospital admission. This demonstrated the service responding to urgent calls. The approach was very person-centred. The health professional worked with the patient and carer exploring possible actions and options and both expressed appreciation of the support offered.
- The only concerns about waiting times were in respect of the memory clinics. There were target times in place for the memory clinics of six weeks from referral to initial assessment. These were not always met. This was because of a combination of high levels of referrals, some temporary staff shortages in relatively small services, and staff continuing to monitor patients they had assessed. At Orchards there were waiting lists of over six weeks for the memory clinic. The manager said this was because of the high level of referrals and this was being resolved by moving the role of monitoring to GPs. At Saffron they had not met waiting time targets for the previous month. The manager said this was because they were one staff down for a period, but also because of the high number of referrals. At Saffron people who had been diagnosed as having memory problems stayed in the service, as there was no shared protocol with GPs to take over prescribing of memory enhancement medicines. The manager told us the trust was seeking to resolve this by negotiation with GPs.
- When a person's condition changed to the extent they needed extra support, they were then referred to the relevant team, for example the crisis, or outreach team. Where people needed additional visits, these would be discussed at multi-disciplinary meetings, and the crisis teams would then provide additional support.

Are services responsive to people's needs?

Good

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

- The team engaged with people who found it difficult to engage with the service. Two people would visit where risk assessments showed this was beneficial. Visits were able to be arranged outside the home, if a person wished this.
- There were flexible appointments to meet the needs of people using the service. Staff were able to make home visits to suit people's needs. We discussed an example where one person missed an appointment and how the manager went out to visit them to ensure they had their assessment.

The facilities promote recovery, comfort, dignity and confidentiality

- There were clinical rooms for people attending the memory clinics but these were generic, being used by all services. This meant elderly people, who were either on their own or with supporters, were required to attend clinics at a hub with other, younger, users of mental health services with differing needs. At Saffron, furniture was too low for some elderly people to sit comfortably in it. The reception area was not very welcoming. There was a lack of pictures and colour. There was poor disability access with the main doors being heavy and not easy to open for an older person. There was a more 'user friendly' reception area at Colne, with staff readily available to assist and answer queries and good disabled access. However, it was on the second floor and signage was not very clear. Parking restrictions did not make the facility very accessible for older people. The difficulty of parking near to services was an issue raised by staff and users at all hubs.
- There were leaflets available about mental health issues, advocacy details and how to complain. These were more prominent in some hub reception areas than in others, such as at Saffron where they were on a stand in a position with poorer visibility.
- An occupational therapist we spoke with acknowledged their role had changed with the closure of day centres. This meant that people using the service were now seen in their own home, rather than being seen and assessed at a service they attended. As a result, they were seeing fewer people in a day, but the advantage was that they were seeing people in their own homes. This meant the service was more person–centred, as it was taking into account people's home environment more than was the case previously. Clinicians commented on clinical rooms at Saffron being unsuitable, saying they were "unsettling for memory patients with noise, distance from reception area and the proximity of younger patients often with serious mental health issues and behaviours. As a result, they were now carrying out most testing and assessments at home.

Meeting the needs of all people who use the service

- There was disabled access, but this was not good in some hubs where doors were heavy and not automatic. Parking was a problem for people attending memory clinics at all the hubs, with parking being difficult to find, or some way from the memory clinics people were attending. This was commented on staff and by users of the service. One patient we spoke with at Saffron told us they couldn't find parking and had to walk some distance in the rain, while his wife had to remain in the car.
- Leaflets were predominantly in English with further information available in a variety of languages.
- We were told interpreters and signers were available and accessible, and we discussed examples which illustrated their availability when required. These included where an interpreter supported an advocate where two family members had differing views on a person's needs.
- Home visits were available where people were unable to attend clinics. The crisis and outreach teams would always do home visits, unless there was a specific reason why someone did not want a home visit.
- There was disabled access for people attending memory clinics, but as noted elsewhere in the report; clinics such as Saffron had doors that were not easy to open, while Colne House did not have clear signage to lead people to reception.

Listening to and learning from concerns and complaints

- People using the service told us they knew how to make complaints. The overwhelming majority also told us they did not feel they had any need to complain. One person who had complained told us their complaint "had been resolved very quickly". There were leaflets giving guidance on making comments, compliments and complaints.

Are services responsive to people's needs?

Good

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

- Staff were aware of complaints and their outcome. There were few complaints. At Saffron ground there was one current complaint that had resulted in a response from the service. This was a complex complaint and involved the reactions of a carer to what they saw as an insufficient response by a number of agencies to differing needs. The learning from this had been shared amongst the staff team. This learning principally involved the clarity of responses from teams to relatives under stress.
- All teams told us of the 'having your say' leaflets which were given to patients along with pre-paid envelopes. Staff consistently told us they had a low rate of return, around 10%. This was echoed by clinicians and other staff who said telephone responses were being trialled and these were getting a higher rate of feedback.
- At Orchards, we heard details of one complaint regarding the availability of a particular type of service for one person. This involved a user of the service complaining that the appropriate type of counselling service had not been available at the right time. The service had responded by accessing counselling services from the adult service.
- Many complaints were resolved locally. These included minor misunderstandings between users of the service and staff, and expectations of GPs. Staff discussed examples of difficult situations, such as when faced with carers who were stressed and confrontational. They said such instances were discussed in team meetings and had resulted in actions such as staff doing such visits in pairs so that alleged actions were witnessed.
- At Saffron ground, the manager advised that the majority of complaints concerned waiting times for the memory clinic. They said measures were being taken to alleviate this, such as having GPs take responsibility for prescribing medicines to alleviate medications and reviewing the needs of people whose condition was stable. This involved negotiation with GPs to take up this responsibility, so that the service had more time to see new referrals. These negotiations were still ongoing, but felt they would have a successful outcome as GPs did this in most other parts of the country
- We attended a carers' meeting at Saffron ground. This was a regular event facilitated by two workers. It was attended by six carers, who were appreciative of the opportunities afforded by the group to air issues. It enabled carers to get together and have a voice.
- At Colne House there had been two complaints regarding lack of availability of disabled parking. In response the trust had employed a private parking firm to prevent illegal parking on dedicated disabled bays, helping to ensure these were kept free for people with disabilities who needed to use them when visiting the memory clinic.

Are services well-led?

Good

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

Summary of findings

- Staff were very positive and well-motivated. There was high morale and expressions of job satisfaction amongst staff who said that they felt supported by the trust. Staff comments and training records showed that staff received suitable training and supervision. Staff felt confident to raise issues and have these responded to.
- There had been major changes within the service, involving services being moved to central hubs, where staff all worked together in one open plan office. This had been managed in a positive manner within the service. Staff in the new hubs were positive about working in them.
- Senior managers were known to staff and visited locations regularly.
- Initiatives such as Dementia First Aid were helping carers to better support people using the service. The Dementia First Aid course had been set up to help equip carers to care for partners or relatives with dementia. This involved a short course for carers giving them practical advice and knowledge to help better equip them for caring. Initial feedback from carers and professionals for this recently introduced initiative showed positive results with carers feeling more confident, supported and better able to continue caring.

Our findings

Vision and values

- Throughout the core service, in all areas and all grades, staff we spoke with were consistently positive and supportive of the trust's values. The team at the Saffron hub, in particular, had a number of awards on display for high team performance within the trust.
- Staff were aware of senior managers within the organisation. Staff at hubs told us that managers visited and were visible.

Good governance

- Staff received mandatory training, were supervised and appraised and were able to prioritise direct care activities. Incidents were reported and learnt from and staff took part in clinical audits. There were mixed views from staff on e-learning, which compromised the majority of mandatory training. Some staff felt that e-learning was not suited to their learning style and felt that information was difficult to retain.
- Staff told us they received regular supervision and appraisal. Where reorganisation had only recently been completed, such as the hub at Colne House, appraisals and supervisions had only just restarted, but we saw schedules in place, and staff told us that managers were always available to advise and support.
- Staff were able to maximise shift time on direct care activities. We saw staff had full diaries, with work scheduled effectively, and were able to respond to needs where required.
- Incidents were reported; staff learnt from incidents, feedback from users of the service, and complaints.
- The manager at The Orchards gave us example of how medication audits had resulted in safer storage and temperature monitoring. A consultant at Roseanne house told us they conducted clinical audits to improve patient care. At Saffron ground a medical audit had resulted in the provision of a clinical room. A records audit had showed the need to shred paper copies of some records once they had been updated, to prevent old information being referred to.
- Safeguarding procedures were followed. Staff recognised safeguarding concerns and knew how to raise alerts. They gave examples of where safeguarding concerns had been raised in respect of suspected financial abuse and the actions that had been taken. An example at Saffron showed how a senior support worker had noted incorrect medication being administered by a care agency and had promptly reported this. It was rectified within hours and the agency involved was required to investigate. We attended a multi-disciplinary team meeting at Colne House where safeguarding issues were discussed and referrals made where needed.
- It was not always clear that mental capacity assessments were done, as these tended only to be

Are services well-led?

Good

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recorded if a health worker considered someone did not have the mental capacity to make a decision about their lives; for example, whether they should agree to treatment.

- Key performance indicators helped gauge the performance of the team. We saw how these highlighted visits and helped ensure people were seen between agreed times. One example we discussed with staff showed how a person was flagged as red as they were currently an inpatient. This prompted the community team to contact the hospital and be prepared to offer support when the person was discharged.
- The manager at Saffron felt that one big advantage of the new hubs was that teams were all together and that the manager was available and visible to all the teams. This helped teams work together more effectively and enabled managers to be more responsive to issues across teams.
- Staff were able to raise items at team meetings and have them submitted to the trust risk register as appropriate.

Leadership, morale and staff engagement

- There was a high level of morale and job satisfaction in all the teams. Staff throughout this service were extremely positive about the trust, their work and their local management. A nurse at Saffron told us it was "the best team I've ever been involved in". Figures given to us by the trust showed sickness levels were below the national average. Trust figures for 2014 also showed that 17% of staff in older people's community teams felt pressure to be at work when unwell. This was not reflected in discussions with the twenty staff we spoke with. They were very positive about their work. Except where re-structuring had provided opportunities for staff changes, turnover was low. Many staff had worked for the trust for over ten years.
- Staff in the three 'hubs' we visited had adapted to major changes in a positive way. One nurse said that the "transformation agenda had been managed well". The only negatives in this respect came from the staff at Hemel Hempstead, who were concerned about moving to a hub. Some staff felt the move would make the service less accessible with decreased parking space.
- Staff told us they were aware of the whistleblowing policy, knew how to use it and were comfortable in doing so.
- Staff acknowledged that the nature of the work and the amount of work could be stressful, but felt that was to be expected. The only concern at workload was expressed by some staff at Colne, where two vacant posts were being covered as two staff had moved to another team during the restructuring. These posts were to be recruited to.
- Staff told us leadership programmes that were available within the trust and were available to all staff who showed an interest in such development. One member of staff we spoke with had recently been on such a course.

Commitment to quality improvement and innovation

- There were innovative practices in place aimed at improving services. The Dementia First Aid course had been set up to help equip carers to care for partners or relatives with dementia. This involved a short course for carers giving them practical advice and knowledge to help better equip them for caring. Initial feedback from carers and professionals for this recently introduced initiative showed positive results with carers feeling more confident, supported and better able to continue caring. 'Bottom up' practice was in place, giving support workers key roles in caring and treatment. We saw the positive effects of this in the way in which support workers felt empowered and valued in discussions, in team settings and in their practice.
- Memory services were all applying for accreditation with the Memory Services National Accreditation Programme established by the Royal College of Psychiatrists. They were aware they would have to make improvement in particular areas, such as signage and user-friendliness of rooms, in order for their applications to be successful. The manager at Colne House was in the process of having signage improved, and the manager at Saffron had ordered new furniture for the reception area there.
- We saw that informal carers and user groups had been set up, providing valuable resources for advice and support for carers and other users of the service. We

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attended 'Terry and Sandra's group' at Stevenage, where carers benefitted from being able to raise concerns and get advice. This is a monthly group for carers in North Herts facilitated by two staff members.

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.