Care Quality Commission

Good

Rotherham Doncaster and South Humber NHS Foundation Trust

Specialist community mental health services for children and young people

Quality Report

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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)
RXE00	Trust Headquarters - Doncaster	Rotherham CAMHS	S61 1HE
RXE00	Trust Headquarters - Doncaster	Scunthorpe CAMHS	DN15 6NU
RXE00	Trust Headquarters - Doncaster	Doncaster CAMHS	DN4 8DE

This report describes our judgement of the quality of care provided within this core service by Rotherham Doncaster and South Humber 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.

Summary of findings

Where applicable, we have reported on each core service provided by Rotherham Doncaster and South Humber NHS Foundation Trust and these are brought together to inform our overall judgement of Rotherham Doncaster and South Humber 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?	Requires improvement

Mental Health Act responsibilities and Mental Capacity Act / Deprivation of Liberty Safeguards
We include our assessment of the provider's compliance with the Mental Health Act and Mental Capacity Act in our overall inspection of the core service.

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

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

Summary of findings

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Summary of findings

Overall summary

We rated specialist community mental health services for children and young people as Good because:

- Staffing levels had been effectively calculated as part of the restructure and managers had been able to recruit above the previous staffing levels to ensure each care pathway had adequate staff to deliver care.
- Care was provided in line with National Institute for Health and Care Excellence guidelines including offering patients access to a range of psychological therapies.

However:

- Care records, including risk assessments and care plans on the electronic system were found to be incomplete or missing.
- The system did not enable risk assessment updates to retain relevant information from previous assessments which meant that risk information was not readily available on the system. The electronic records system used by the trust contained limited evidence of patients consent to treatment.
- Lone working procedures were inconsistent across the service and there was no formal process in place at St Nicholas house to mitigate the lack of call point in interview rooms.

Summary of findings

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

Are services safe?

We rated safe as good because:

Good

- Staffing levels had been calculated as part of the restructure and managers had been able to recruit above the previous staffing levels to ensure each care pathway had adequate staff to deliver care.
- Staff caseloads were reviewed regularly within supervision and allocation meetings.
- The service maintained good links with external stakeholders and used these to monitor patients' wellbeing outside of the service.
- Incidents were discussed on both a team and individual level.

However:

- Staff did not follow best practice in safe lone working consistently.
- The interview rooms in Scunthorpe did not have access to a call point and there was no formal process in place to ensure staff safety whilst in an appointment.
- One of the two blood pressure monitors at Kimberworth Place was broken and both had labels indicating their calibration was out of date

Are services effective?

We rated effective as good because:

Good

- All new referrals received a comprehensive initial assessment including an assessment of a patients physical health.
- Care was provided in line with National Institute for Health and Care Excellence guidelines including offering patients access to a range of psychological therapies.
- Staff regularly liaised with primary care staff where patients had ongoing physical health needs.

However:

- Care records were missing or poorly completed on the electronic system.

Are services caring?

We did not review caring as part of this inspection

Good

Are services responsive to people's needs?

We did not review responsive as part of this inspection

Good

Summary of findings

Are services well-led?

We rated well led as requires improvement because:

Requires improvement

- The electronic system was difficult to navigate and did not retain information in updated documents therefore, risk assessments on the electronic system were found to be incomplete or missing
- The electronic system was difficult to navigate, containing a wide range of menu options and did not retain information in updated documents therefore; care records were missing or incomplete.
- The electronic system demonstrated limited evidence to consent to treatment.

Summary of findings

Information about the service

The specialist community mental health services for children and young people in Rotherham, Doncaster and South Humber Foundation Trust covered a large geographical area. Services were based in Rotherham, Doncaster and Scunthorpe. Each service comprised of a multidisciplinary team of professionals who work with children, young people and their families or identified carers. Where a child or young person was experiencing mental health issues or emotional difficulties, their GP made a referral to the service based within the specific geographical area.

The community services provided assessment and interventions for young people and their families. The aim was to gain an understanding of their difficulties, and find ways to manage, improve, and reduce the impact of them. Examples of mental health conditions treated were:

- anxiety disorder
- depression/low mood
- bipolar disorder
- obsessive-compulsive disorder
- eating disorders
- self-harm/suicidal thoughts
- neurological-developmental disorders where an assessment is required, for example autism spectrum disorder and attention deficit hyperactivity
- learning disabilities (with mental health presentation).

Each service provided a range of interventions as identified by the National Institute for Health and Care Excellence guidelines to address the identified needs of each child/young person/family. These included individual or group therapies, family work, medication where indicated and inpatient care if required. Joint working and provision of support to other agencies through consultation was also offered.

At the time of the inspection, the service was in a state of transition. The trust was implementing a move to a new locality based model of care.

The child and adolescent mental health community services were in the process of realigning their service delivery model in to a pathway model in line with the recommendations in the Future In Mind report. The Future In Mind report sets out proposals the government wish to see by 2020 to promote, protect and improve children and young people's mental health and wellbeing. This had seen changes to the team structures and roles across all locations. Alongside these changes, the team based in Balby were in the process of transitioning to an agile working pattern; staff would not be office based and have the flexibility to work from a range of community locations. Consequently, they were due to move out of the Balby office base the week after the inspection.

This was a focused follow up inspection following the first comprehensive inspection for this trust in September 2015.

Our inspection team

The team that inspected the services provided by Rotherham, Doncaster and South Humber NHS Foundation Trust was led by Jenny Wilkes, Head of Hospital Inspection (North East), Care Quality Commission.

The team that inspected the specialist community mental health services for children and young people comprised two CQC Inspectors and two nurse specialist advisors.

Summary of findings

Why we carried out this inspection

We undertook this inspection to find out whether Rotherham Doncaster and South Humber NHS Foundation Trust had made improvements to their specialist community mental health services for children and young people since our last comprehensive inspection of the trust on 15 September 2015.

When we last inspected the trust in September 2015, we rated specialist community mental health services for children and young people as requires improvement overall. We rated the core service as requires improvement for Safe, requires improvement for Effective, good for Caring, good for Responsive and good for Well-led.

Following that inspection we told the trust that it must take the following actions to improve specialist community mental health services for children and young people:

- Risk assessments must be completed fully and maintained for people who use the service.
- Care plans must be completed, holistic, up to date, and reflect the treatment for people who use the service.
- Electronic records did not reflect the content of paper records, and had not been updated or scanned into the electronic system, even though scanners were available. Electronic records and paper records must be synchronised to give a full reflection of care, with all paper records scanned or inputted into the electronic records.

We also told the trust that it should take the following actions to improve:

- Mandatory training should improve in areas not reaching compliance, especially quality and diversity and conflict resolution. The trust should ensure that mandatory training is kept current and on-going.
- Appraisals of non-medical staff should be undertaken to improve current figures. The trust should ensure that non-medical staff have appraisals in line with guidelines.

We issued the trust with two requirement notices that affected specialist community mental health services for children and young people. These related to:

Health and Social Care Act (Regulated Activities) Regulations 2014, Regulation 12, Safe care and treatment.

How we carried out this inspection

We asked the following questions of the service:

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

Before the inspection visit, we reviewed information that we held about these services, including previous CQC reports, complaints and the provider's action plan following the last inspection. This information suggested that the ratings of 'good' for caring, responsive and well led, that we made following our September 2015 inspection, were still valid. Therefore, during this inspection, we focused on those issues that had caused us to rate the service as requires improvement for safe and effective.

This inspection was unannounced, which meant the service did not know that we would be visiting. During the inspection visit, the inspection team:

- visited all three of the locations and looked at the quality of the environment and observed staff.
- spoke with four carers of people who were using the service
- spoke with three people who used services
- spoke with the managers for two of the locations

Summary of findings

- spoke with 27 other staff members; including doctors, psychologists and child and adolescent mental health practitioners
- spoke with the divisional director with responsibility for these services
- attended and observed one allocation meeting, one home visit and a play therapy assessment
- looked at 27 treatment records of patients
- reviewed the medication management and prescribing at each location.
- looked at a range of policies, procedures and other documents relating to the running of the service.

What people who use the provider's services say

We spoke with four parent/carers for people who use the service. All were happy with the care they received from the service and felt the service provided the support they needed. The people we spoke to told us staff had completed detailed assessments identifying both the needs and risks of the young people. When asked everyone we spoke to said they felt safe when visiting the service.

Areas for improvement

Action the provider MUST take to improve

- The provider must ensure that risk assessments are easily accessible on the electronic records system and that the system enables staff to easily update and maintain the records.
- The provider must ensure that care plans are easily accessible on the electronic records system and that the system enables staff to easily update and maintain the records.

Action the provider SHOULD take to improve

- The provider should review lone working protocols across the service to ensure risks to staff are effectively managed both in the service locations and in the community.
- The provider should ensure that equipment used for monitoring the physical health of patients are operational and regularly serviced and calibrated.
- The provider should ensure care plans are holistic and represent the full range of the patients' needs

Care Quality Commission

Rotherham Doncaster and South Humber NHS Foundation Trust

Specialist community mental health services for children and young people

Detailed findings

Locations inspected

Name of service (e.g. ward/unit/team)	Name of CQC registered location
Rotherham CAMHS	Trust Headquarters
Scunthorpe CAMHS	Trust Headquarters
Doncaster CAMHS	Trust Headquarters

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.

The staff we spoke to demonstrated an understanding of the principles of the Mental Health Act and their application in the children and young people's community mental health services core service. Staff were aware of the role of the Mental Health Act office and how to seek support from them in relation to the Act. There had been a lot of recruitment in the Rotherham team therefore, at the time of the inspection, compliance with Mental Health Act training was only 43%. However, compliance across the other locations averaged 91%.

Mental Capacity Act and Deprivation of Liberty Safeguards

Specialist community mental health services for children and young people provided treatment with parental consent. Where a young person under 16 was able to provide consent for treatment this would be assessed

Detailed findings

under Gillick competence. Gillick competence is a process used to decide whether a child is able to consent to treatment, without the need for parental permission. Ninety-nine per cent of staff had attended training on the Mental Capacity Act. Staff were able to articulate the principles of the Act and how they would utilise these to support someone in making a choice where they had been assessed as lacking the capacity to do so.

Good

Are services safe?

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

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

Our findings

Safe and clean environment

Kimberworth Place (Rotherham) was located in a shared building alongside other local authority and voluntary sector children's services. Access was through a shared reception area. Staff were based on the first floor with interview rooms available on the ground floor.

St Nicholas House (Scunthorpe) was a single story building shared with other children's services. Access was through a shared open plan reception area. Interview rooms were located at the start of the corridor behind the reception area and the staff offices were towards the back of the building.

At the time of the inspection, Balby Court (Doncaster) was only used as an office base. Staff saw patients at interview rooms in East Laith Gate or in the community. The service was preparing to move out of Balby Court the following week as the trust were introducing a system of agile working, where staff would access office space in various venues within the community. East Laith Gate was based in a city centre building shared with other community services including a sexual health services and a drug and alcohol service. The building provided open access through a shared ground floor entrance. The children and adolescent mental health service was on the third floor of the building, providing an open reception area and access to a range of clinic and interview rooms. The facilities also included access to an admin annexe on the floor below where staff could access a desk space. Access to the third floor was via a lift or a staircase. The staircase was very narrow and had several blind spots. These were mitigated between the third floor and the admin annex using a mirror. The lift was located next to the stairs and the doors opened on to a very small landing next to the stairwell, which could be an issue for disabled visitors, particularly wheelchair users.

The interview rooms at services in Kimberworth Place and East Laith Gate House were fitted with alarm systems to raise an alarm in an emergency. However, the interview facilities at St Nicholas House were not fitted with alarm systems. Where staff were aware of potential risk issues they would attend appointments in pairs.

All the buildings we visited were clean and well maintained. None of the services inspected had specific clinic rooms for the examination of people who used the service. Each service had equipment for measuring the weight and height of people who used the service, as well as access to blood pressure monitoring equipment. External contractors maintained and serviced the equipment at each location. However, one of the two blood pressure monitors at Kimberworth Place was broken and both had labels indicating their calibration was out of date. The service was unable to provide any servicing logs for these pieces of equipment.

Safe staffing

The assistant director took over the service in January 2016. As part of implementing a new locality based structure the post of director of child and adolescent mental health services was due to be implemented in October 2016. The child and adolescent mental health service was in the process of realigning the service delivery model in to a pathway model across all three locations in line with the recommendations in the Future In Mind report. The Future In Mind report sets out proposals the government wish to see by 2020 to promote, protect and improve children and young people's mental health and wellbeing. To achieve this there had been significant recruitment across all three locations. However, Rotherham had seen the biggest recruitment process and had two vacancies remaining, which were covered by agency staff. Interviews for these vacancies were underway during the inspection.

As part of the restructure, the service had estimated staffing levels based on previous caseloads, commissioning needs and referral rates. However, there was an ongoing project to review establishment levels when the restructure was complete. Managers told us they had been able to recruit above previous establishment levels as part of the restructure to ensure each care pathway had the appropriate levels of staff to provide care. Managers could put a business case forward to recruit additional staff for a specific care pathway if there was evidence this was required.

Establishment levels (Whole Time Equivalent) for each team were:

Rotherham

- service manager - 1
- pathway leads – 4.2
- psychiatrist – 0.3
- psychologist – 5.3
- therapy staff – 3.8 including 0.5 family therapist vacancies
- nursing/CAMHS practitioner – 16.5 including 2 vacancies
- peer support worker/support worker – 3.44

Doncaster

- service manager - 1
- pathway leads – 4
- psychiatrist – 0.2
- psychologist – 5
- therapy staff – 3
- nursing/CAMHS practitioner – 27.2 including 2.6 vacancies
- peer support worker/support worker – 2.4

Scunthorpe

- service manager - 1
- clinical lead – 1
- psychiatrist – 0.8
- psychologist – 9.2
- therapy staff – 1
- nursing/CAMHS practitioner – 14.4 including 3 vacancies
- peer support worker– 0.6

Data received from the trust showed the average caseload between September 2015 and August 2016 for each location as:

- Rotherham 973 open cases
- Doncaster 852 open cases
- Scunthorpe 325 open cases

A breakdown of the average caseload by case holder was not available for any of the locations due to the service restructuring. However, the staff we spoke to told us that caseloads were routinely reviewed within supervision and as part of allocation meetings. Staff would hold differing caseloads based on staff experience and the complexity of the patient. We saw evidence of caseload discussions in the allocation meeting we observed.

A consultant psychiatrist was available during office hours and the staff we spoke to said they were able to access them for support when needed. Staff told us emergency appointments were available for patients in a crisis and could be booked each day. The service provided out of hours cover on a rota basis in line with the trust out of hours procedure.

Evidence provided by the trust shows the average mandatory training compliance rate for the service is 87%. Scunthorpe had the lowest compliance rate of 80.7% whilst CAMHS management had the highest of 97%.

Assessing and managing risk to patients and staff

All the staff we spoke to told us that they completed risk assessments for every child during the initial assessment using the Functional Analysis of Care Environments risk tool. Staff told us due to the length of the tool the initial risk screening section would often be used in the first instance and the more detailed risk assessment completed by the child's care manager. The service was aware of this and was in the process of piloting a more concise risk screening tool which staff could use at the point of first contact. Staff demonstrated a culture of being risk aware and staff were able to describe the risk assessment process and articulate the risks for specific patients on their case load. We witnessed discussion of risk in the sessions we observed and, where patients presented with a high risk, the service had a 'high risk' meeting where staff could discuss risk issues and management plans.

Each location was meeting their individual targets set by their commissioners for completing an initial assessment of young people who were referred to the service. Where people were waiting for treatment the service would provide them with a phone number should they require further support.

Staff completed a crisis plan as part of a patient's initial assessment and included details on how to access support in an emergency. Following an initial assessment, any young person and their carer(s) were able to call the service for support should there be an increase in the individual's

needs. The service had good links with school nurses, GP surgeries, accident and emergency departments and out of hour's services. The service utilised these links alongside staffs' contact with the young person and their carer(s) to monitor any deterioration in their health.

The staff we spoke to all demonstrated an understanding of local safeguarding procedures and where to seek advice. Each location had a safeguarding lead who supported staff with difficult cases. Information provided by the trust demonstrates compliance with safeguarding adults level one training and safeguarding children level one were both at 99% and 98% across the service. Compliance with safeguarding children level three training was 74%. However, compliance with the higher level safeguarding adults training was only 46%.

The staff we spoke to were aware of the trust's lone working policy. Home visits were rare and patients were generally seen in the interview rooms at each location, a community hub or in the young person's school. However, we found different approaches to lone working across each location and team:

- Staff in Doncaster had been using a white board and a buddy system but were unsure how the process would work following the move to agile working and had concerns this could make them vulnerable without a set base where a 'buddy' could be contacted.
- Staff in Rotherham used a 'buddy' system however staff informed us due to the changes in staffing over the last year this had become more of an informal arrangement although a new task group had been set up to review the process.
- Scunthorpe also utilised a buddy system and staff informed us personal alarms were available to staff if required. Interview rooms at Scunthorpe were not equipped with call points to raise an alarm if staff members felt at risk. Staff told us if they were aware of any possible risks or if they felt it could be a difficult appointment, two staff members would attend the appointment. However, this process relied upon staff being aware of current risk issues for both the young person and their carer. Staff advised us they were often unaware of any concerns associated with carers. This could potentially place staff at risk.

Staff across the service also took part in an out of hours on call rota. This involved staff working from 5pm – 9am Monday to Friday and covering the weekend on split 12-hour shifts. Staff told us the on call rota was regularly issued late which meant staff already had commitments, which they were unable to cancel. We saw an oncall rota for the current month which was issued the week before the inspection. This meant if staff were called out to complete an assessment overnight; they were often unable to take time back the next day due to the commitments in their diary. The staff we spoke to felt this could affect their judgement and impact on their safety and the safety of patients due to the risk of fatigue if they had been called out the previous night.

Track record on safety

Between 1 September 2015 and 31 August 2016 there have been two serious incidents reported. The most recent incident in August related to an issue which arose out of hours where cover had not been available on the rota. Although the incident remained under investigation, this had been discussed in both the organisational learning forum and a team meeting and staff were able to give us examples of the lessons the service had learned including improving communication processes.

Reporting incidents and learning from when things go wrong

The service used the incident reporting system 1 (IR1) for reporting incidents. All the staff we spoke to were aware of the process for reporting incidents and could access the system via a shortcut on their computer desktop.

Staff were able to describe their duties under the duty of candour and were aware of when they would need to follow the trust's policy following an incident.

Staff told us learning from incidents was discussed on an individual level as part of a debrief or supervision. Incidents were also discussed within team meetings and we saw evidence of this in the minutes of team meetings.

Are services effective?

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

Our findings

Assessment of needs and planning of care

Staff completed a comprehensive initial assessment of all new referrals. We saw evidence of different assessments being used depending on the care pathway the patient had entered. For example, a patient on the psychological therapies pathway may complete several self-assessments alongside the assessment completed by the psychologist.

Staff told us when the service became paper-light, paper records had been scanned on to the electronic system and care plans had been archived. However, these were not always available or easy to find on the system. The care plan section on the system was not easy to navigate due to the drop down menus and did not always reflect the needs of the patient therefore, staff would record the support provided to patients in the progress notes.

We reviewed 27 care records on the trusts electronic system. Of these, we could not find care plans for five records at Rotherham. The remaining 22 records across the service consisted of a few lines of text around the basic treatment the patient received. Care plans were neither holistic nor representative of all the patients' needs. We found records on the electronic system which referred to paper files that were no longer available.

Best practice in treatment and care

The service was in the process of realigning to provide patient care through specific care pathways as recommended in the Future In Mind report. Each care pathway followed the National Institute for Health and Care Excellence guidance specific to the care pathway. For example, the eating disorder pathway followed the eating disorder guidance CG9 and the autism spectrum disorder pathway followed the CG170 guidance on autism in under 19's.

The service provided a range of psychological therapies in line with the National Institute for Health and Care guidance including cognitive behavioural therapy, psychoanalytical therapy and systemic family therapy. The service also had staff qualified in children and young people improving access to psychological therapies who were able to provide psychological interventions as part of their role.

Patients' physical health needs were assessed within the initial assessment. Staff would monitor patients' weight, height and blood pressure as required, staff would liaise with patients GP for any on-going health monitoring including annual health checks. The Scunthorpe team had a diabetic pathway that monitored patients who were diagnosed with diabetes.

Patient outcomes were measured using the routine outcome measures toolkit. However, a range of outcome tools specific to the care each patient received relevant to the care pathway were also utilised. For example the revised child anxiety and depression scale and the social communication questionnaire

Skilled staff to deliver care

Each team comprised of a range of disciplines including consultant psychiatrists, psychologists family therapists, CAMHS workers, nurses and support workers. Staff working hours ranged from 7.5 hours a week to 37.5 hours a week.

Staff working for the trust attended a trust induction and completed a local service induction alongside completing a mandatory training programme. Staff were able to access specialist training, specific to their role and to meet the needs of the service. At the time of the inspection, several staff discussed being trained in children and young people' improving access to psychological therapies training.

Staff informed us they received management, clinical and safeguarding supervisions. We saw evidence the service had implemented a supervision log to record management and clinical supervisions. However, at the time of the inspection, the log had not been completed and we were informed the admin team were waiting for confirmation of completed supervisions from each member of staff before completing the log. The average compliance rate for safeguarding supervisions across the service was 75%.

Information provided by the trust showed an average of 70% of staff had received an annual performance review. This was an improvement on the figure of 24% at the time of the previous inspection though had not met the trusts target of 90% due to the level of recruitment within the service restructure.

Multi-disciplinary and inter-agency team work

The service held a managers meeting every two weeks where the managers from each location met to discuss issues across the service. Each care pathway had a weekly multidisciplinary meeting or allocation meeting to discuss staff caseloads and new referrals. We observed an

allocation meeting and saw positive discussions between team members centred on patient needs. Where patients moved between care pathways, staff would meet to discuss the individual and handover any relevant information.

The staff we spoke to told us they felt the service had effective links with external services including school nurses, GP surgeries and local authorities.

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

Data provided by the trust showed 76% of staff had received training in the Mental Health Act. This was due to the level of recent staff recruitment in Rotherham where only 43% of staff had attended the training although, the service had plans to ensure the remaining 57% of staff received the training. The staff we spoke to were able to demonstrate knowledge of the Mental Health Act. However, staff informed us the majority of the children and young people who accessed the service were not subject to the Act. Staff told us if they had any concerns relating to the Act that support war available through the trust Mental Health Act office.

Good practice in applying the Mental Capacity Act

The trust provided data which showed that 99% of staff had received training in the Mental Capacity Act. The staff we spoke to were able to articulate how they would support a child or young person to make a choice and how they would assess capacity to consent. However, they informed us in most cases children were seen with their carers and treatment would be provided under parental consent. Staff also described the use of Gillick competence to assess if a person under the age of 16 can consent to medical treatment without the permission or knowledge of their parent(s). Staff told us support around the use of the Act was available through the Mental Health Act office.

Staff informed us that consent to treatment was obtained during the initial assessment. However, consent to treatment was only evident in seven of the 27 records we reviewed. We were unable to find any evidence of capacity to consent being considered or recorded in any of the electronic records we reviewed.

Are services caring?

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

Our findings

We did not review caring as part of this inspection.

Are services responsive to people's needs?

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

Our findings

We did not review responsive as part of this inspection.

Are services well-led?

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

Our findings

Good governance

We did not inspect the well led domain during this inspection. However, whilst reviewing the safe and effective domains we found issues relating to the governance of the service.

Of the 27 care records, we reviewed on the trust's electronic recording system, four contained risk assessments that were incomplete and lacked a detailed risk management plan. A further nine records could not be found on the system. The trust's own draft audit report of care records, completed in July 2016, highlighted that only 40 percent of records audited included a risk management plan. Staff told us there was an issue with the system. When a risk assessment was updated, the information was not 'pulled' forward on to the new record; therefore, staff were recording risk issues in the patients' notes rather than on the risk assessment. We saw evidence of staff recording entries in patients' notes relating to risk which were not reflected in the patients risk assessment. This resulted in patients risk assessments not being representative of patients' needs or level of risk and made current risk information difficult to find. The trust was aware the system was not meeting the needs of the service and had plans to move to a new system in 2017. In the interim, the service intended to invest in an update to the current system to ensure information could be carried through to updated risk assessments.

Care plans on the system were difficult to navigate due to the number of menu options available. Therefore, staff completed the electronic records inconsistently, with different staff recording information in different sections of the care plans. Staff told us the complexity of the system made care plans difficult to complete and update.

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 17 HSCA (RA) Regulations 2014 Good governance **How the regulation was not being met** Thirteen of the 27 risk assessments reviewed on the system were incomplete and did not reflect the patients' needs. The current system did not automatically include current information on a new risk assessment when assessments were updated. This is a breach of regulation 17 (2) (a)

Regulated activity	Regulation
Treatment of disease, disorder or injury	Regulation 17 HSCA (RA) Regulations 2014 Good governance **How the regulation was not being met** Care plans on the system were difficult to navigate due to the number of menu options available. This made them difficult for staff to complete. This is a breach of regulation 17 (2) (b)