healthwatch Richmond upon Thames

Richmond Home Treatment Team Enter and View Report

Queen Mary's Hospital, Roehampton Lane, London, SW15 5PN

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Introduction

Given the continual NHS pledge to move service provision away from inpatient settings and allocate more resources to care in the community, there is a growing and present need to ascertain whether these services are meeting local residents' needs. It was increasingly evident from our work with patient groups and from emerging trends in our patient experience database that a significant number of people were having difficulties accessing mental health care and in some cases experiencing a poor quality of care in community mental health services. Our report on the Richmond Home Treatment Team (HTT) is part of our wider programme of work in adult mental health.

The objective for this project was to capture the views and experiences of patients, carers and staff in order to form a snapshot of the care provided by the Richmond Home Treatment Team.

Background to providing crisis care

Work to improve the help and support people receive during a mental health crisis actually spans several decades and culminated in the Crisis Care Concordat (February 2014), an agreement that challenges commissioners and service providers to ensure people can access effective and specialised support for their mental health at the times they need to.

The Concordat recognises the key roles crisis resolution and home treatment teams (CRHT) play in crisis care. Beyond keeping people safe during a crisis, CRHTs also aim to 'gatekeep' which means preventing unnecessary hospitalisations and reducing the length of inpatient stays. In Richmond this service is delivered through the Richmond Home Treatment Team (HTT) which is run by South West London and St Georges' NHS Trust.

About the Richmond Home Treatment Team

The Richmond HTT is a multidisciplinary team composed of mental health nurses, doctors, an occupational therapist and a consultant psychiatrist. There are typically 30 – 35 people on Richmond HTT's caseload at any one time and people are usually with the team for 6-8 weeks.

The team provides continuous assessment of a person's mental state and intensive support to help in their recovery from an acute mental health crisis. For most people the majority of contact with the team will be with mental health nurses. An occupational therapist can provide more formal cognitive behavioural therapy based interventions where appropriate. Patients can also have medication options reviewed with a team doctor or consultant psychiatrist.

Visits usually take place in the person's own home or, if preferred, at one of the Trust's clinics and can be arranged for every day to up to several times a day

depending on clinical need. Appointments are then scaled back to approximately every other day as the person becomes more stable. Appointments may involve some education on coping strategies but will mainly revolve around staff checking on the person's mental state and that they are keeping themselves safe. More recently, there has been an increased focus by the Trust on signposting patients to relevant organisations in the voluntary sector such as Richmond Mind to facilitate people's ongoing recovery by creating a sustainable social support base.

Given the acute nature of the people's difficulties, the HTT operates on a 24/7 basis with appointments taking place from 9am to 9.30pm. Outside of these hours, patients can call the team mobile to speak to the nurse on call. As an additional source of support, patients should also be signposted to the Trust's mental health support line (previously known as the crisis line) which is open from 5pm to 9am Monday-Friday and 24 hours on weekends and bank holidays. This line is staffed by senior (Band 4) healthcare assistants who offer emotional support and advice to patients and carers.

Referrals into the Home Treatment Team

New referrals should be processed within 4 hours. If accepted, a patient should have their initial assessment in the following 24 hours. While self-referrals are not accepted, referrals to the team can be made through the following pathways:

- Police & Street Triage Team
- Social workers
- GPs via Richmond Assessment Team in hours.
- GPs can refer directly to the team out of hours
- Local recovery cafes via HTT scheduled visits
- Mental Health Support Line
- Recovery Support Teams
- Inpatient wards
- A&E Psych Liaison Team (approximately 20% of referrals are via this route)

There is no upper limit on the number of referrals made to the Richmond HTT. As a result, this can lead to a bottleneck if discharges to the Recovery Support Team are delayed due to capacity issues. This can then create a strain on the HTT's workload as staff must provide intervention to patients active on their caseload. Additionally, a recent gap-analysis conducted by the Trust shows that current commissioning of the HTT is based on figures from 2012 which may have implications on the team's ability to meet rises in demand due to local population growth.

Method

In October 2018, Healthwatch Richmond met with the Trust's Acute Care Lead and service manager for Richmond Home Treatment Team to discuss our project objectives and how these could be best achieved. Through this we gained an

overview of the service, and the current challenges faced by staff and patients which helped inform our survey design.

To collect patient feedback, it was agreed that it would be most appropriate to conduct one to one interviews in the waiting areas of the Maddison Centre in Teddington or Richmond Royal Hospital. Patients attending appointments at outpatient clinics are typically further on in their recovery than those receiving home visits and therefore are more likely to be comfortable to participate and to have more experience of the service to draw on.

We also ran an online survey to pick up experiences from past patients and carers. This was advertised through our internal mental health bulletin and via Richmond Mind's social media channels and mailing lists.

To collect staff feedback, we held a group interview with 10 HTT staff in December 2018 to discuss their general working conditions and the main pressures affecting the team and potential impact on patient care.

By having a regular presence at the Maddison Centre and Richmond Royal throughout November 2018, we were able to speak to 13 current patients which represents approximately 40% of an average caseload. Our online survey picked up the experiences of 5 past patients and 13 carers; 83% of responses were from experiences in the last 18 months. Responses from over 2 years ago were excluded from the final analysis as they may not accurately reflect the quality of care or service provision the HTT now provides as there have been several managerial changes since then.

Limitations

This research project was not designed nor does it claim to provide a representative view of the patients and carers with the Richmond Home Treatment Team. Some of the questions in the patient interview audit pertain to a time when patients were at the most acute stage of their mental health crisis and therefore may not be able to recall their experiences entirely accurately.

Qualitative analysis was solely used in this report which allowed us to identify key themes. However, qualitative analysis is not able to provide an accurate sense of scale to issues raised as the data cannot be robustly quantified.

Analysis

The qualitative data analysis was conducted as follows:

- Survey responses and individual interviews with staff, patients and carers were reviewed and answers were categorised into themes
- A descriptive summary of the themes was prepared, including assigning an overall tone to comments (i.e positive, neutral, negative or no data)

- The themes that emerged were grouped according to survey questions and some have been narrowed into sub-themes.

Findings

How well do assessments meet patients' needs?

Performing initial assessments within the 24 hour Trust target is critical to providing responsive crisis care. It was therefore pleasing to hear that most current patients recalled their assessment taking place soon after being referred, with most estimating that it took the place the day after referral at the latest.

Patients said that the assessment questions were effective at identifying their needs and that staff conducted assessments at a measured pace which gave them time to reflect and properly consider their responses.

"Quick, simple and easy to participate in"
"Very helpful, time and care was taken to understand my needs and how to help me"
"Questions allowed me to really reflect on where things had gone wrong"
"Staff were non-judgemental and gave me the space I needed to consider my answers"
"Assessment helped to put a new perspective on my situation"

One patient we spoke to, however, felt that the follow-up from the assessment was handled poorly. There was a miscommunication over where their medication was being delivered and they were not told about what type or level of support to expect from the service because staff had only shared this information with their mother. Naturally they would have preferred to be told this information directly by staff so none of the information could be missed or misconstrued.

While the patient experience above highlights an area of practice that certainly needs to be learnt from to ensure an effective follow-up for patients and carers, responses to how assessments are actually conducted were uniformly positive and we would therefore suggest the Trust view this as an area of good practice to be shared with other teams where needed.

How easy is to contact the team?

All of the patients we spoke to had been given a direct mobile number for the HTT which is manned 24/7 and consequently patients largely felt it was very easy to access the team when they needed to. One patient described it as a "*godsend*" and made them very reassured they could access support at all times.

This is in stark contrast to when patients had to rely on contacting the team through the Trust's central switchboard. For example, 3 patients who were running late for an appointment and did not have the team's mobile number with

them said it took 15 minutes to get through to a "*human being*" and that the ring tone "*just went on and on*". One of these patients also got cut off when they attempted to get through the first time and said they had to go through several options to reach the Richmond HTT. As they were trying to warn the team they were running late, this experience caused some additional distress. Two other patients believed that the team mobile number was only for arranging visits at home and not in the community and had experienced similar problems. One carer also highlighted that staff should actively point to the numbers highlighted in the HTT patient leaflet as not everyone may think to check and relying solely on leaflets could be problematic for those with language difficulties.

Accessing support through the central switchboard has been acknowledged by the Trust as a significant problem for many patients and carers. Work is underway to investigate and improve this.

Until these known issues with the central switchboard are resolved we recommend that the Trust encourage patients of the HTT to contact the team via the main HTT number for all reasons and not via the switchboard.

What do patients think of the support that's provided?

14 current patients described the overall quality of care as excellent, mainly owing to the empathetic and compassionate approach from staff.

"The team saw me as a real person, not just my diagnosis or set of symptoms. My care felt holistic and personal"
"Every nurse has made me understand how to effectively manage my crisis symptoms and when to reach out for help so my feelings no longer engulf me"
"Staff are very skilled at alleviating any concerns I may have"
"The support got me through my worse period and out the other side"
"All the staff are lovely, I couldn't ask for anything more"

We were pleased to hear from 3 current patients who had used the HTT several times previously that the communication and care from staff were *"better than ever"*. The Richmond Home Treatment Team has undergone managerial changes recently so this may a factor in why patients are seeing an improvement in standards.

Additionally, as people begin to recover, our overall patient narrative indicates that the support and level of interaction with the team is scaled back at appropriate and gradual intervals. One patient commented *"it does not feel like my support is just falling away"*. Reducing support appears to be done mostly in consultation with patients, with the exception of 1 current patient who told us the decision to lower visits to every other day from everyday was made without their input. While they felt the team got the timing right, they would have still

appreciated being informed in advance so they could manage their expectations of the service and plan their work or family obligations.

Three current patients reported some variation in the standards of care amongst individual members of staff. These patients said the level of communication from staff varied significantly where some nurses sit down with them and talk through their feelings, whereas others were described as *"impersonal"* and mainly use the visit to drop off medication or perform basic risk assessments. One patient commented their support from the HTT felt *"very hit and miss. Some staff are good, whereas others are dreadful"*. Notably, one patient highlighted how it was not the use of agency staff that accounted for the negative interactions and described the agency nurses as *"lovely and competent at their role"*. We recommend this group of patient experiences be considered by the team as a caution to ensuring the same standard of intervention is offered across appointments and that staff always offer patients the opportunity to engage.

While it is clear that most current patients were very pleased with the actual care and support they received from staff, the organisation and consistency of care and coordination with other professionals are some of the areas which undermined their overall experience of the service and are further discussed in the sections below.

Consistency of Care

All of the patients we spoke to highlighted that the vast majority of appointments are with a different member of staff, making this by far the most dominant theme to emerge from our feedback. Most people described this as having negative implications to their care including:

- Two patients said seeing different staff meant having to explain their situation and surrounding context repeatedly, effectively shortening the time for the appointment.
- Six patients said it reduced the trust and rapport they built up with the team; a significant component underlying good crisis care.
- One patient said that seeing a smaller group of staff made it difficult for them to monitor his/her progression.

Only one patient said that seeing different staff was positive as it exposed them to a range of therapy techniques which had benefitted their recovery.

As a way of alleviating the issues raised above, all patients were unanimous in their support for a change in the system where their care was managed by 3-4 staff. This would enable some much needed consistency to their care and should be a way of overcoming the limitations imposed by the rota system used for staffing a 24 hour team. It would also retain the benefits of maintaining exposure to different staff members and their individual expertise or approach to managing crisis symptoms.

Access to medication

It was pleasing to hear that all current patients felt they had been consulted on the initial decisions made around their medication. However, one current patient did not feel staff had been responsive afterwards when they expressed concern over some sedative side-effects. Another patient reported not being seen for a follow-up for 2 weeks as the consultant psychiatrist had been on sick leave and questioned why they could not have seen another doctor.

All current patients emphasised the importance they placed on always being able to access their medication and obtain refills easily. Unfortunately, we found several examples where the HTT's procedures around the organisation of medication were not effective, which are summarised below.

One person's GP was not informed by the HTT of the new medication they had been prescribed and was only able to organise a repeat prescription because they happened to have a copy of the drug chart left by the HTT. For another patient new to the HTT, staff did not make it clear that their GP remained responsible for repeat prescriptions of their pain medication. This led to an exacerbation of their physical pain and crisis symptoms as they had to organise an emergency GP appointment when staff did not bring a refill. Unfortunately, staff still did not communicate clearly that her pain medication prescription is the GP's responsibility and so the next time the patient needed a refill, they called twice the day before to remind staff and said their response was to *"tell me off rather than reassure me"* and quoted one staff member as saying *"you should stop ringing here"*.

Another patient who had recently been accepted by the HTT said their medication was incorrectly sent to the Maddison Centre rather than their home, causing some exacerbation of their crisis symptoms. One carer also reported that their daughter's medication was not delivered during the first home visit and therefore her daughter was without medication at the worst stage of their relapse when she needed medication the most. They said errors like this at the beginning made them lose confidence in the service and that it did not set the right foundation for building trust with staff.

Given the importance that patients and carers place on medication we strongly recommend the Trust look at the procedures surrounding this to safeguard against future prescription issues.

Communication with GPs

We saw that a general lack of communication between the HTT and GPs can cause ramifications for patients across a number of areas. One GP had not received any correspondence about the patient's decline in mental state and recent hospital admission, and therefore was not able to provide a retrospective sick note and the patient had to fill out insurance forms. Two patients said their GP had not received any information about their new medication from the HTT and therefore could not

prescribe it without approval from a speciality doctor which subsequently caused delays in them accessing this medication.

The other patients we spoke to had not seen their GP so it is not possible for us to comment on how potentially widespread communication issues are with between the HTT and GP is unknown. However, the feedback above demonstrates the potential for disruption for patients in several areas and we ask that the team are mindful of this in future planning.

Arrangement of appointments

The HTT informed us that patients receiving home visits are given an hour's time-slot for the appointment to take place whereas patients being seen at outpatient clinics are given a fixed time for appointments. This is due to the uncertain nature of home visits where it is not known how much support and time people will need with staff. This information however does not always seem to filter down as 4 current patients commented that their home visits were often 30 minutes to an hour late which caused significant frustration and in some cases distress. In view of this feedback we suggest that this way of working needs to be further explained by staff and reiterated to patients at assessment and at the first appointment.

Some people also told us that the time and location of appointments can be miscommunicated. One patient we interviewed thought his discharge planning meeting was taking place that day. It then transpired he had not been informed that it had been changed to the next day and that staff had mistakenly left the intended voicemail message with the patient's care coordinator in the community mental health team. A mix-up similar to this had also happened to him at a previous appointment. Additionally, another current patient experienced a mix-up with locations at her last appointment where she thought it had been agreed to meet at the Retreat (local crisis house) only for staff to arrive at her home.

Given the chaotic nature of working with people going through a crisis, it is reasonable to expect that staff are usually working in a fast-paced and changeable environment; a factor which may then increase the risk of errors in relation to appointments. In view of the negative impact this can have on patient care, we ask the Trust to reconsider the administration of appointments and implement a more robust system at handover to ensure that the time and location of appointments are correctly recorded.

Quality of therapeutic interventions

The patients we spoke to were generally keen to explore a number of avenues for managing their crisis symptoms, including getting the right medication, using coping techniques to manage stressors and looking at general prevention work. They saw the HTT as a good starting point to developing this and their experiences of how well their care met these expectations are summarised below.

Four patients thought the team's central ethos revolved too strongly around medication management. While they understood this could be key to resolving acute symptoms, they believed a shift towards more behavioural therapies and

looking at preventative strategies would enable people to self-care more sustainably and build resilience. One patient said *"high dose anti-psychotic starts to really inhibit my overall functioning. I'd like practitioners to include more therapeutic interventions to manage my crisis"*.

There was a strong sense from all the patients we spoke to that appointments mostly felt like check-ups which involve monitoring mental state, checking that social supports are in place and that they know how to stay safe. This level and frequency of interactions with the team was a strong contributor towards patients feeling supported. However, one patient commented that the predominant focus on assessment during appointments can come at the expense of learning coping techniques and may be a missed opportunity, especially for patients new to mental health services. Four people also highlighted a variation in interventions offered at appointments where some are mainly used to check their mood and medication, whereas at other times staff cover ground on basic coping mechanisms which they really valued.

Two patients further questioned whether interventions went far enough with prevention work and recognising symptom triggers. One of these patients felt he could easily relapse and said *"I feel like I'm in the same space mentally as I was before I went into hospital"* and would value more knowledge of prevention strategies.

Overall, current patient feedback indicates there is an appetite for more work around recovery techniques to be included in the HTT's care package, and for the teaching around prevention strategies to be developed further.

How supported are Carers?

Our online survey drew responses from 12 carers whose last contact with the team was between July 2017 and November 2018; 75% of responses were within the last 6 months, 100% within the last 18 months. Ten carers were pleased overall with the support they received from HTT staff and felt that staff were accessible to them. Two carers however were dissatisfied with the service they received, which was largely driven by lapses in communication where their calls were not returned, care planning was not done in collaboration with them and an overall feeling of not being listened to by staff. Another carer also felt that support from the HTT had been withdrawn too abruptly despite expressing their reservations.

The Trust is a member of the Triangle of Care framework, which was developed by the Carers' Trust and is a best practice guide that aims to improve carer engagement in acute inpatient and home treatment services. While most feedback denotes a largely positive approach to carers, more could be done to ensure that all carers have been involved or responded to. We therefore encourage service managers to revisit the Triangle of Care and the Trust's internal Carers' Charter to ensure that teams are aware of the service provision that carers are entitled to.

Discharge process

We spoke to 3 current patients who were due to be discharged who, overall, reflected upon the experience positively.

These patients agreed that discussions about discharge had been timed appropriately when they were at a stage of recovery where they were stable enough to no longer need intensive support. One patient who was being discharged back to his GP, said "*nothing has been rushed at all*" and had been told about informal support groups to further help his transition. The two other patients were being discharged either to the early intervention service or community mental health team and both commented that they "*had not been left to fall through the gaps*" while they were waiting to be allocated a care coordinator. Overall, they felt supported and that their transition had been managed well.

However, another patient we spoke to had found a discharge planning sheet in her prescription box, which she took as an *"ominous sign"* as discharge had not been discussed with her yet. This also fitted with her wider experience of staff being *"premature"* when it came to future goal planning and had caused additional anxiety. While this may be an outlier in terms of the overall feedback we received about staff's approach, it is a significant issue which could impact other patients. We therefore ask the Trust to put plans in place to ensure this feedback is learnt from.

Staff perspectives on current service provision

The Trust have struggled to recruit permanent staff over the last 3 years and staff told us that the team has had to continuously rely on agency nurses to cover some shifts. Rolling adverts put out by the Trust every 6-8 weeks over this period have so far not been successful in recruiting permanent staff. The Trust attributes this to Richmond being a high cost area to live in and not being covered by the inner London salary allowance. These have been longstanding deterrents and have made it challenging to recruit to permanent posts in the Richmond HTT and in local recovery and support teams (RST). Problems with using agency staff in the RST can then spill over and increase the HTT's workload from staff having to screen inappropriate referrals from agency staff who are unfamiliar with patients and are more likely to refer to make sure they have safely covered their bases.

While there is generally good morale, with staff being able to provide an effective support network for each other, staff were consistently clear and candid around their main incentive for staying with the HTT, which is the shift pattern or rota the team currently uses, where staff work an average of 3-4 long days and then have 2-3 rest days. Recently, the Trust has suggested changing this system to 5 shorter working days but this has not been received well by HTT staff, many of whom pointed out that most of them have a long commute of approximately 2 hours each way and therefore prefer the current system. Staff said that 2 nurses had left because of this proposed change.

Wider crisis care issues in Richmond

While this project was primarily targeted towards people's views of the HTT, we naturally picked up feedback around other forms of support or services people had used in crisis. This feedback will be collated with other patient experiences we have accumulated in the course of our adult mental health project and general outreach, and summarised in a specific report on the state of crisis care in Richmond.

Out of hours support - The Mental Health Support Line

The mental health support line (formerly known as the crisis line) provides out of hours emotional support to SWLStG patients and is staffed by senior healthcare assistants. It can therefore act as a back up to the HTT out of hours mobile number in the event staff are busy with other patients.

The comments we received from patients about the mental health support line were mixed, with perceptions significantly influenced by the acuity or severity of need.

Three people who had used the support line outside of an acute crisis reported overall positive experiences, commenting that someone is usually available or if not voicemails are responded to quickly; 1 person further described staff as *"lovely"*. Another patient who had not been informed about the mental health support line said they would have valued this added layer of support when he could not get through to the HTT out of hours mobile.

However, two people who had used the mental health support line in an acute crisis had poor experiences. One patient who called when she was feeling suicidal was told *"it's your responsibility if you to decide to die"*. At other times, staff have made inappropriate suggestions of *"have you had a cup of tea"* or *"have you tried having a bath"*. This patient pointed out that as it is promoted as a crisis line, most people will be calling in a distressed state or using it as a last resort. Comments like these were therefore viewed as particularly insensitive or inadequate. Another patient we spoke to said the person who responded to their call generally seemed *"disinterested"* and they came away feeling staff communication skills did not seem to match well to dealing with someone going through an active crisis.

Overall, patient feedback demonstrates that HTT staff need to consistently signpost to the mental health support line to protect against patients not being able to access support out of hours. However, feedback also indicates a need for additional training or refresher sessions for helpline staff on how to support people going through an active crisis.

Conclusion

The overall picture formed by the patient experiences we collected largely suggests that the Richmond Home Treatment Team is providing a good service that fits most patients' needs. The care and compassion shown by most staff resonates

strongly with patients and carers and significantly contributes to their perception of good care. However, this could be strengthened even further by improving the continuity of care within the team by allocating the same 3-4 members of staff to patients throughout their episode as most patients told us that seeing different staff made it harder to build up trust and rapport with the team. More work could also be done to improve the standardisation of interventions offered across appointments where patients are always offered the opportunity to engage in learning recovery techniques.

The main pressure on the team appears to stem from capacity issues in local recovery and support teams. This can result in excess referrals and an excess number of patients active on the HTT's caseload if they are not able to discharge patients safely, thereby pushing it significantly above the number of patients they are commissioned to provide for.

Response from South West London & St Georges' NHS Trust (SWLStG)

Currently there is a lot of work being done internally on crisis care services. Healthwatch Richmond and SWLStG have agreed to meet in 3 months time to discuss the overall progress of this, as well as the actions to our recommendations.

Statement from SWLStG on issues with the Contact Centre

The Contact Centre is the gateway for patients, carers and partners contacting the trust. Over the next 2 years we are looking to make improvements to how the Contact Centre operates including developing the technology and systems, investing in training for staff and working with key stakeholders including staff, patients and carers to map the user journey. We have already delivered a series of workshops to collect feedback on current experiences and improvements that can be made to the Contact Centre

Recommendations

We made a number of recommendations to the Trust which are set out below along with a description of their response.

Our recommendations	Response from South west London &St Georges Mental health Trust
Ensure that patients are told directly by staff about the type and level of support they can expect from the HTT including the appointment system (hours timeslot for home visits and a fixed time for outpatient appointments), and relevant phone numbers.	The Trust agreed that this should be happening and staff will be reminded in their next meetings.
Encourage patients to store the HTT mobile in their phones given the ongoing problems with the Trust's central switchboard	Team manager will remind staff to provide and encourage use of HTT mobile number.
In view of the significantly negative comments on the mental health support line, we ask the Trust to consider training sessions on supporting people with acute mental health crises	The Trust recognises problems with this and is already in the process of improving the Mental Health Support line by: • Improving the links with the HTT • Refreshing staff training • Improving supervision and escalation In addition the Trust is reviewing the "Contact Centre" - essentially the Trust Switch board and seek to improve caller experience.
To consider and implement a team nursing system where patients are allocated to the same 3 -4 member of staff where possible	The Trust recognises this as common feedback about the service and reports that it is a national issue. There are plans to change team structures to accommodate this. The Trust is working to improve consistency through a piece of work called *Fundamental Standards of Care* which will run in 2019.
Review procedures in relation to prescribing and dispensing medication, and compliance with these, to address the problems raised by patients/carers	The Trust told us that medication needs are always discussed in the daily handover meetings, and staff have strict practices on how they prescribe, record and transport medication. It is

	therefore unclear why patients reported problems with this to us.
Review communication with GPs and consider implementing an audit of correspondence to GPs to ensure they are updated when patients are referred to the HTT and when changes to medication are made	The Trust told us that they now use a system for automatically sending letters to a GP. It is unclear whether the feedback relates to failures within this system or whether the system has been more recently introduced and so is expected to resolve these problems
Involve patients in decisions around what they want to get from appointments, including more therapeutic interventions	The Trust is working to improve this through *Fundamental Standards of Care* in 2019 but that they are not currently resourced to provide more therapeutic interventions but will raise this with Commissioners.
To consider a regular group therapy programme on CBT skills for crisis management led by the team's OT	The Trust agrees with this but is not currently resourced to provide CBT Skills for Crisis Management and will raise this with Commissioners.
To avoid mix-ups with appointment times and locations, introduce an administrative log that can be accessed by staff at all times to ensure that times and appointments are recorded correctly and can be reviewed during handover for appointment planning the following day	The Trust told us that they have a system in place that does this. Whilst we recognise that the system should be working there is evidence that mistakes do occur and we encourage the Trust to review this.
Incorporate the views of HTT frontline staff when reviewing possible rota changes	The Trust remains committed to ensuring that staff be involved in any changes.