

Outstanding



South Staffordshire and Shropshire Healthcare NHS
Foundation Trust

Community-based mental health services for older people

Quality Report

Date of inspection visit: 21-24 March 2016

Date of publication: 12/07/2016

Locations inspected

Location ID	Name of CQC registered location	Name of service (e.g. ward/unit/team)	Postcode of service (ward/unit/team)
RRE11	St George's Hospital	25 Corve Street, Ludlow, Shropshire. - CDEM Home Treatment South Shropshire	SY8 1DA
RRE11	St George's Hospital	Castle View, Oswestry, Shropshire - CDEM (Community Dementia) Home Treatment North and Central Shropshire	SY11 1LH
RRE11	St George's Hospital	Diamond Jubilee House, Dawley, Telford. - CDEM Home Treatment Telford & Wrekin	TF4 3AL
RRE11	St George's Hospital	Park House Cannock, Staffordshire - CDEM Memory South Staffs	WS11 1JN

Summary of findings

This report describes our judgement of the quality of care provided within this core service by South Staffordshire and Shropshire Healthcare 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 South Staffordshire and Shropshire Healthcare NHS Foundation Trust and these are brought together to inform our overall judgement of Community based mental health services for older people.

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

Outstanding 

Are services safe?

Good 

Are services effective?

Good 

Are services caring?

Good 

Are services responsive?

Outstanding 

Are services well-led?

Outstanding 

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 community based mental health services for older people as outstanding because:

- The services were committed to research and innovation. Staff were involved in research projects to improve the efficiency of the services. Staff were innovative in their approach and had invested in developing learning material. They used technology to share their knowledge to help people learn about working with older people in mental health services.
- The services were responsive to the needs of its staff. Staff routinely received supervision and annual performance reviews. Staff had mandatory training, which managers monitored to ensure compliance. Managers supported staff to develop their skills by funding external and specialist training courses. Staff worked together to develop specialist internal training programmes. There was a culture of leadership at all levels. As a result, staff morale was good.
- All of the service locations were comfortable, safe, and had suitable facilities for patients including those with mobility concerns. There were secure door entry systems and staff complied with lone working policies and local procedures. There was a firm commitment by all staff to work with patients in their homes or at the nearest possible location if there was a requirement to be seen outside their home.
- Staff provided high quality treatment and care. Different professionals worked well together to assess and plan for the needs of patients. Patients had up-to-date, individualised care plans. These focussed on helping patients in gaining independence and confidence, avoiding the need for hospital or other residential care.

- Staff from all disciplines were caring and compassionate. Staff routinely encouraged meaningful engagement with patients and their carers. Service users and carers were also involved in service improvements, for example, staff interviews.
- Staff used specialist tools to assess and monitor patients who used the services. To aid their recovery, patients had access to specialist psychological therapies, for example, psychological improved access to psychological therapies (APT).
- All services had a good track record on safety and staff managed risk well. Staff undertook risk assessments for each patient. They had been trained in safeguarding and there was cohesive joint working with social services. Staff knew how to report incidents. Managers investigated the incidents and then shared lessons learned with staff.
- The services had good relationships with their commissioners and made adaptations to service provision when agreed.
- Each service was well led and managers were approachable and accessible to their staff. They had the skills, experience and motivation needed to drive forward the services. Managers and staff were continually looking for ways to improve outcomes for their patients. The CDEMhome treatment Telford and Wrekin service received accreditation by the Memory Services National Accreditation Programme (MSNAP)

However:

- Some specialist services had high caseloads; for example, the memory clinic at CDEM Home Treatment Telford & Wrekin.

Summary of findings

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

Are services safe?

We rated safe as good because:

- All areas we visited were clean and well maintained. All patients and carers we spoke with told us that they found the services to be clean and well maintained.
- Staff managed risk to self and others appropriately by using safety measures, for example use of personal alarms and individually assessed all patients who were deemed to pose a risk to themselves or others.
- Staff had access to necessary equipment and the skills? to assess patient physical health. This reduced the need for patients wait for GP appointments and prescribed medications could be started quickly.
- There was very much a culture of working with people in their own homes where possible, however, each site was accessible for patients with mobility problems and wheelchair users.
- The service was going through a remodelling programme to improve the quality, efficiency and productivity of patient care they provided. As a result some staff vacancies were not recruited to. There were staffing vacancies across teams. However some were temporarily covered by part time staff who increased their hours. Staff told us they felt supported. Caseloads and duties were managed and reassessed regularly.
- Staff consistently assessed and reviewed risk to patients. Staff were trained in safeguarding. Each team worked closely with safeguarding teams and followed safeguarding policies and procedures.
- Staff we spoke to knew how to recognise and report incidents of harm or risk of harm. They were confident they could report incidents. Each site had clear incident reporting policies and they were easy for staff to access.

Good



Are services effective?

We rated effective as good because:

- Assessment of needs and planning of care were person specific, holistic in approach and involved a number of people involved in the patients' care.
- Staff were committed to following National Institute for Health and Care and Excellence (NICE) guidance when working with patients.
- Services were multidisciplinary and holistic in their approach.

Good



Summary of findings

- Each service had access to a wide range of disciplines and were able to offer psychological therapies recommended by NICE.
- Staff used a number of nationally recognised rating tools to demonstrate outcomes for patients.
- There was a culture of encouraging staff to develop their skills. There were clear progression pathways for staff to advance in their career.
- Staff had a good understanding of the Mental Health Act (MHA), and Mental Capacity Act (MCA). They had mandatory training and updates on the code of practice and its guiding principles.

Are services caring?

We rated caring as good because:

- All interactions between staff, patients and carers were responsive, kind, compassionate, respectful and provided appropriate practical and emotional support.
- Staff we spoke to were compassionate and considerate in the way they spoke about patients. Care given was patient centred and involved all relevant people.
- Where possible, patients were involved in their care plans. We saw involvement of patients, carers, families, and other professionals in care plans.
- Feedback was encouraged from people who used the service. Stakeholder feedback given to us at inspection was consistently positive about care, treatment and the way that staff treated people.
- We saw that there was a focus on maintaining independence where possible. Staff worked to enable older people to remain living at home. Staff told us about tangible benefits in promoting well-being and other aspects of maximising independent living.
- Staff told us that carers were integral to care and treatment for patients. We saw this in care records and interactions we observed. All carers we spoke with told us they were happy with the service they received. They said staff were kind, compassionate and polite. Carers we spoke with unanimously told us that there was an open line to staff when required.

Good



Are services responsive to people's needs?

We rated responsive as outstanding because:

- Patients were seen rapidly for assessment following referral. Skilled staff were available to assess patients immediately if patients were in crisis.

Outstanding



Summary of findings

- There was a clear criterion for people who were offered a service. This did not unnecessarily exclude people who needed or would benefit from treatment.
- Discharges from the service were explored as a multidisciplinary team to make sure joint decisions were made and support packages were in place in advance.
- The services were sensitive to engage with people who found it difficult or were reluctant to engage with mental health services. Staff went over and above what might be expected of them engage those who were hard to encourage in to services.
- Services worked with commissioners in providing a flexible approach to patient care and treatment.
- Services were innovative in their approach.They introduced new technology to improve communication between patients and staff.
- All carers and patients spoken with told us that they knew how to complain but never had reason to.We held focus groups with carers and services users about the services and all were complimentary about the service they received.
- Staff received feedback on the outcome of investigation of complaints and acted on the findings.Staff used the feedback for discussion in group sessions to learn and to improve practice.

Are services well-led?

We rated well-led as outstanding because:

- Staff knew and understood the values and visions of the service. We saw this in the work that staff did with service users, their carers, partnership agencies and each other.
- At services we visited, we saw well established and effective relationships with partner agencies, including social services, GP's and commissioners..
- All staff we spoke with expressed pride in their services and in working for the trust. Patients, carers and external agencies spoke highly of standard and quality of all four services.
- There was a culture of leadership and development across all levels.Overall compliance for mandatory training was above the trust target and training development opportunities were rolled out across the teams and staff were encouraged to support the development of each other.
- Services were innovative and staff were encouraged to be innovative and contribute to services developments. The services were research orientated and we saw additional professional staff were employed to carry out research.

Outstanding



Summary of findings

- The CDEM home treatment Telford and Wrekin service received accreditation by The Memory Services National Accreditation Programme (MSNAP).

Summary of findings

Information about the service

South Staffordshire and Shropshire Healthcare NHS Foundation Trust provide community mental health services for older people across South Staffordshire and Shropshire, Telford and Wrekin, Oswestry. As part of this inspection, we visited four locations, Oswestry, Ludlow, Telford and Wrekin. Staff are employed from multiple healthcare disciplines, including mental health nurses, support staff, occupational therapists, psychologists and psychiatrists. The four locations offer the same service across the geographical areas. The services provide community based secondary mental health services to the patients. They serve the local population of older adults over the age of 65 who experience memory loss

and dementia. However, the service as a whole is needs led regardless of age. Where desired by individual patients, the services welcome the input and involvement of the Carers Association South Staffordshire (CASS) to ensure a supportive service for carers. The services actively support service user involvement in the development of the service. Where appropriate, joint working did occur with other internal and external services to achieve positive outcomes. There had been no recent inspections of the community mental health services for older people in South Staffordshire and Shropshire.

Our inspection team

The team was comprised of: three Care Quality Commission inspectors, one inspection manager, one specialist advisor who was a registered nurse and one specialist advisor who was a social worker.

Why we carried out this inspection

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

How we carried out this inspection

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

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

Before the inspection visit, we reviewed information that we held about these services, asked a range of other organisations for information and sought feedback from patients at focus groups.

During the inspection visit, the inspection team:

- visited four separate locations and looked at the quality of the environment and observed how staff were caring for patients
- spoke with 6 patients and their carers who were using the services
- visited 6 patients and carers in their homes
- spoke with the 3 operational managers and 2 clinical managers for each of the locations
- spoke with 13 qualified nurses and support workers, other staff members; including doctors, associate practitioners, psychologists, assistant psychologists and psychiatrists
- attended and observed three multidisciplinary meetings.

Summary of findings

We also:

- collected feedback from patients using comment cards.
- looked at nineteen treatment records of patients.
- looked at a range of policies, procedures and other documents relating to the running of the services

What people who use the provider's services say

We spoke with 6 carers of patients who were using the services, visited 6 patients and carers in their homes, and

visited two patients in care homes. The feedback we received about the services was all positive. Patients and carers felt well supported and reported that staff were available when needed.

Good practice

- The service was engaged in a research programme around the use of neuropsychological assessment to reduce the number of brain scan referrals. It was a cost efficiency analysis and anecdotally there had been a slight reduction in the number of scans and cost savings identified.
- Telford and Wrekin services were accredited by the Memory Services National Accreditation Programme (MSNAP). The services were assessed as excellent in improving the quality of memory services for people with memory problems / dementia and their carers. Staff were engaged in a comprehensive process of review, through which good practice and high quality care were recognised. Accreditation assured staff, service users and carers of the quality of the service being provided.
- Services used a range of assisted technology. This was for example, a hearing tool to improve communication between patients and others.
- Services worked closely with commissioners to agree practical ways of working with the resources available. For example, working outside NICE guidance, “supporting people with dementia in carrying out assessments and reviews” when there was less of a need to review those within the specified timeframes who were being looked after by other professionals in care homes.

Areas for improvement

Action the provider SHOULD take to improve

- Ensure safe and sufficient staffing levels to make sure they can meet people’s care and treatment needs.

South Staffordshire and Shropshire Healthcare 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
CDEM Home Treatment South Shropshire	25 Corve Street Ludlow, Shropshire
CDEM Home treatment North and Central Shropshire'	Castle View Oswestry, Shropshire
CDEM Home Treatment Telford & Wrekin	Diamond Jubilee House Dawley, Telford
CDEM Memory South Staffs	Park House Cannock, Staffordshire

Mental Health Act responsibilities

We do not rate responsibilities under the Mental Health Act 1983 (MHA). We use our findings as a determiner in reaching an overall judgement about the Provider.

- The trust had a MHA office with an administrator for guidance and support and staff knew how to access this.
- Staff were trained and the training updated annually in the Mental Health Act (MHA).
- There were regular trust audits to ensure that the MHA was being applied correctly and there was evidence of learning from these audits.

Mental Capacity Act and Deprivation of Liberty Safeguards

- All staff received mandatory Mental Capacity Act (MCA) training and updates. Staff we spoke with were

Detailed findings

knowledgeable and understood the principles of MCA and Deprivation of Liberty Safeguards (DoLs). The policy on MCA was on the intranet, staff knew where to find this.

- We saw examples of DoLs applications having been made and best interest meetings arranged. The MCA states that if a person lacks mental capacity to make a particular decision then whoever is making that decision or taking any action on that person's behalf must do this in the person's best interest.
- In the casenotes looked at, we saw documentation relating to capacity for assessment and diagnosis. There were also recorded best interests decisions and timely reviews.
- For patients who had impaired capacity, their capacity to consent was assessed and the information recorded appropriately.

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

- In relation to cleanliness, the 2015 Patient-led Assessments of the Care Environment (**PLACE**) score for South Staffordshire and Shropshire NHS Foundation Healthcare Trust was 97%. This figure was just 0.6% below the national average. Patients and carers we spoke with told us that they found the services to be clean and well maintained. Cleaners were based at each site; however, we did not look at cleaning records. Each site we visited was visibly clean and well maintained and compliant with the control of substances hazardous to health (COSHH) regulations. These regulations required employers to control exposure to hazardous substances to avoidable harm. We saw that cleaning materials were stored safely in cupboards separate from patient areas.
- Staff adhered to infection control principles, including handwashing. We saw there was an infection control lead. Staff had access to infection control resources, including hand cleaning equipment they kept on their person. Each member of staff had completed annual infection control training. We saw in the business meeting minutes that staff had been provided with guidance and resources to ensure infection control processes were followed. For example, staff were given cleaning wipes to clean medical devices.
- Staff had personal alarms and in some rooms there were integrated alarm systems. Closed circuit television had been installed in the interview rooms at CDEM Home Treatment South Shropshire and CDEM (Community Dementia) Home Treatment North and Central Shropshire.
- Interview rooms were available at each site. They were not well equipped to carry out physical examinations, for example, there were no examination beds. None of the service locations held emergency bags to respond to emergencies. Patients had their physical health needs met by their GP's. Staff told us that they would call emergency services if needed. There were no recent events that required emergency service intervention.

- Staff had access to blood pressure monitors and other necessary equipment to assess patient's physical health. All staff had access to portable electrocardiogram (ECG) machines to take to patients for use in their own homes. This meant that patients did not have to wait for GP appointments and that prescribing could start if required following ECG screening.
- Equipment had stickers to indicate when calibration was required. Calibration There were also calibration audits to ensure compliance. We also observed evidence that PAT testing was taking place on equipment.

Safe staffing

- The service manager told us that demands on the services were increasing however the resources were not. This meant that they were going through a restructuring programme to combine the services and make better use of their resources. As a result there was flexible use of staff across all services while they were transitioning. Managers reviewed staffing periodically to ensure patient and staff safety.

CDEM Home Treatment

Team: N. & Cent. Shrops; S. Shrops; Telford & W.; Memory S. Staffs

Est levels : 41.59 ; 22.8
; 37.64 ; 66.46

Vacancies : 11.6 ; 19.7 ; 14.6 ; 11.2

Sickness rate: 6.2 ; 5.1 ; 4.5 ; 5.1

Number of leavers: 4 ; 4 ; 2 ; 2

- The services had not used bank staff in the past; however, to ensure sufficient staffing, they could access the resource if needed.
- Each service had a number of part time staff. They had no agency staff but extended the hours of part time staff to cover any gaps in service. Managers funded extended hours through savings from maternity leave and vacancies that were put on hold.

Are services safe?

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

- All managers across the four services told us that they sometimes used staff from other teams to support them if needed. Staff we spoke with told us they were coping with support from each other.
 - We looked at data in advance of the inspection that told us the service had an average sickness rate of 4.5 %, compared to 4.8 % trust wide.
 - Across all four services there were over 1300 people on the caseload. Around 600 of those were patients in the memory clinics and managed by three nurses with support from assistant practitioners and support workers. We were told that it was difficult to manage the high caseload at the memory clinic and that it was being regularly reviewed. To mitigate any risks, staff told us they were very well supported and received ad hoc support and formal, regular supervision. These patients were also living in care homes and supported day to day by other professionals. The service had agreed with commissioners a more flexible way of working to manage the caseload safely and effectively.
 - Staff in the home treatment teams had caseloads of around 15-23 patients. There were no service users awaiting allocation of a care co-ordinator. Caseloads were well managed; we looked at 19 patient records and saw patients were being reviewed regularly.
 - The teams had access to a psychiatrist and an associate specialist. We were told by staff, patients and carers that they were very responsive and approachable. The psychiatrist was accessible outside normal working hours on their mobile phone.
- Assessing and managing risk to patients and staff**
- We looked at 19 care records across all services, all of which had an up to date risk assessment which had been reviewed. Staff used the risk information to inform where they saw patients and if they needed more than one person to attend with them.
 - Each care note we reviewed had evidence of informed consent and mental capacity being assessed. Advanced decisions, (which are decisions you can make now to refuse a specific type of treatment at some time in the future) were supported and recorded on the electronic case management system.
 - Staff told us they assessed risks at every opportunity. One nurse gave us an example of a safeguarding issue with a nursing home. It was raised with the safeguarding team and dealt with effectively.
 - Staff were trained in safeguarding and this training was updated annually and was monitored on an electronic recording system and overseen by managers. There were safeguarding alerts, assessments and records on the electronic case notes system. Safeguarding alerts were automatically sent to the trust safeguarding team, reviewed by the clinical lead and the trust had a safeguarding lead who reviewed the information and made a decision about whether to involve the local authority.
 - All records we reviewed had a crisis and contingency plan so staff knew how to respond in a crisis. We saw good care plans with linked narratives in the progress notes. Staff monitored and reviewed risks regularly, using information from partner agencies to inform their risk management plans.
 - At Castle View, the team were based in the same office as the local authority safeguarding team and worked together jointly raising concerns. They sent out joint letters to patients and carers and worked together to manage risks. Staff gave us an example of when a carer raised concerns about a patient on a residential unit which was very understaffed. The team, along with safeguarding, investigated, liaised with the provider and carer. They wrote a letter jointly to the provider requesting more staff and informed them they would be monitoring it. This gave the carer confidence that that matter was taken seriously and that the situation was being monitored by agencies involved in the patient's care.
 - Staff demonstrated a good understanding of how to recognise and report safeguarding concerns. Two staff gave good examples of how their intervention had reduced safeguarding risks.
 - Staff told us that other agencies were likely to flag up deterioration in patients, for example, staff at care homes or GP's. Staff responded to raised risks as soon as possible; the same day if possible.
 - Managers told us that there were rarely waiting lists, however, when there were waiting lists, it might be as a result of cancelled and rescheduled appointments or another example might be when younger people were referred. People under the age of 65 were automatically referred for brain scans to rule out any physical causes

Are services safe?

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

for memory dysfunction and this sometimes meant they will wait longer than the target 20 days. Staff told us that they were looking at ways to counter this, for example, support workers may make contact during this period of waiting for their appointment.

- All teams had effective protocols on personal safety and they followed the lone working policy. The locations of their visits were written down, they had a signing in and out system, and all staff had a trust mobile phone. They had to ring in to a central number when finished at each visit. All visits were risk assessed; joint visits were used with social services when appropriate.
- At Diamond Jubilee House, staff demonstrated a clear understanding of the lone working policy and could give examples of how it worked within their teams.
- There were a number of non-medical prescribers, for example, at Castle View the clinical lead and operational manager were both qualified nurse prescribers. The clinical manager at Diamond Jubilee House was also being supported by the trust to complete the nurse prescribing training. This meant that prescribing for patients didn't rely exclusively on doctors.

Track record on safety

- In a 12 month period the services had reported two serious incidents. Both incidents were investigated and learning shared with staff.

Reporting incidents and learning from when things go wrong

- Staff we spoke to knew how to recognise and report incidents. Each site had clear incident reporting policies and they were easy for staff to access.
- Managers told us they promoted an open and transparent culture. One manager gave an example where they had used their duty of candour to share information with a patient and family,
- Staff attended team meetings monthly and the agenda highlighted incidents in the trust and locally. Staff discussed incidents, lessons learned and changes to practice at these meetings. Staff also used handovers and team meetings to share information about risks and incidents. The minutes of these discussions were kept for other staff to read. Managers offered staff and patients de-brief meetings following incidents, we saw this happen during a multidisciplinary meeting.
- We saw an example of where an incident had changed practice. The incident prompted changes to the prescribing system and processes. A checking system was introduced overseen by a doctor. All trust services had adopted this new system which had introduced an effective pathway for safe prescribing.

Are services effective?

Good 

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

Our findings

Assessment of needs and planning of care

- We looked at 19 electronic care records and saw formal comprehensive assessments for all patients; 17 of the 19 records viewed contained robust, person specific and easy to follow care plans. The care plans were holistic; recovery orientated and contained information and an individualised approach to each patient's physical, psychological and social care needs. Two of the records did not have care plans in place but the progress notes specified reviews, assessments and that care plans were to be completed. The care plans were generally holistic in their approach and described the involvement of a number of people involved in the patients care such as carers, social services and Age UK.
- Staff carried out joint assessments with colleagues in social services. A nurse gave us an example of when a capacity assessment for medication was undertaken while social services completed an accommodation needs assessment. The professionals met for a best interest meeting and developed a joint plan of care for the patient.
- Patients were not always given a copy of their care plan; this was usually because the person said they did not want it. We saw this documented in electronic progress notes.
- The trust had a secure electronic records system that all staff could access either from the office or when they were working offsite. Staff were encouraged to work remotely and from home when possible. This meant that staff could access the information they needed and remain efficient with their time.

Best practice in treatment and care

- All staff spoken with told us they were committed to following National Institute for Health and Care and Excellence (NICE) guidance: Supporting people with dementia in carrying out assessments and reviews.
- Each service had access to a wide range of disciplines and were able to offer psychological therapies recommended by NICE such as cognitive behavioural therapies and improved access to psychological therapies (IAPT).

- Staff used Health of the Nation Outcome Scales (HoNOS) as a way to measure individual treatment and care. This meant that staff could assess a patient's HoNOS score when they were first assessed, at regular intervals to check changes and again when they were discharged. By comparing the records, the outcome of the care and treatment provided for an individual patient could be measured.
- Staff worked in partnership with a number of relevant agencies that enabled support for employment, housing and benefits. We saw this described in care plans; advertised on leaflets; posters and in welcome packs given to patients and carers.
- The multi-disciplinary teams used a wide range of recommended assessment and outcome tools. For example, the clinical psychologist used the 'R assessment tool for diagnosis Addenbrookes Cognitive Assessment' was commonly used as a screening test for dementia; all of which were practical best practice options for clinical services diagnoses.
- Staff considered physical healthcare needs and worked closely with local primary care services. One support worker told us they referred to a GP if there were any changes in presentation that required physical intervention. CDEM (Community Dementia) Home Treatment South Shropshire worked in partnership with their local medical centre and patients' receiving additional specialist support.
- Staff actively participated in clinical audits including those of case files and medication audits at trust level. Operational managers carried out local audits and fed back to the team to outline good practice and areas for improvement.
- There were a number of non-medical prescribers, for example, at CDEM North and Central Shropshire the clinical lead and operational manager were both qualified nurse prescribers. The clinical manager at CDEM Home Treatment South Shropshire was also being supported by the trust to complete the nurse prescribing training. This meant that prescribing for patients didn't rely exclusively on doctors.

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.

Skilled staff to deliver care

- Each service was multi-disciplinary in their approach and had access to a number of appropriate disciplines for the patient group including psychiatrists, occupational therapists, psychologists, social workers, nurses and support workers.
- There was a culture of encouraging staff to develop their skills and progress in their career. There were clear pathways for example for staff to progress from support worker to qualified nurse. We saw examples of career progression throughout each service. The trust had supported learning and development packages for these progression opportunities.
- At CDEM Home Treatment South Shropshire; staff had access to a schedule of in-house training opportunities. Each training session was led by a member of the team and the schedule was updated when the team identified further learning. For example, we saw that doctors and staff on the team had a team away day and observed a member of staff carry out a role play based around breaking bad news. With support from the trust leadership team, the staff were creating a training DVD in order to share learning with other staff around this key area of working with older people and their families
- Staff identified and recorded additional training needs in supervision and business team meetings. For example, emotional resilience training had been identified as a training need during a team meeting and a doctor had taken responsibility to support the learning.
- We saw that there were a range of supervision and reflective groups; this included peer support groups for specific disciplines such as occupational therapists.
- The percentage of staff that had an appraisal in the last 12 months was 100%. We saw one staff appraisal document which included a behaviour review and a maximising performance review. It also included a section from 'living our values' which evaluated progress.
- All staff were inducted to the trust and each service had local inductions.

- One manager gave us examples of performance issues being identified and managed, following policy, and with support and challenge as a focus.
- Across services, compliance with mandatory training was 85%. Staff on maternity leave who had missed mandatory were due to attend the training as soon as possible. Two support workers at CDEM Home Treatment Telford & Wrekin were highlighted on records as not having completed a mandatory level three safeguarding children course. Managers told us this had been an error on the system that they were trying to rectify because this training was not indicated as mandatory for junior staff.

Multi-disciplinary and inter-agency team work

- We attended multi-disciplinary team meetings across all services. Attendance was good and included psychology, consultant psychiatrists, registrars, student nurses, memory nurses, occupational therapists, management and clinical leads. Robust discussions took place regarding medications, physical health and psychological therapies. We saw lots of learning from each discipline and patients were at the forefront of all of their decisions. Each discipline focused on how they could support patients and who else they should involve. There were references to other services throughout the meeting such as fire service and police.
- All services had well established and effective relationships with partner agencies, including commissioners. Commissioners spoke highly of the services when we held focus groups.
- We saw examples of good working relationships with partner agencies, for example, at nursing homes and GP's. At CDEM (Community Dementia) Home Treatment North and Central Shropshire, social services were based in the same office and we saw routine joint working to improve patient care.

Adherence to the MHA and the MHA Code of Practice

- Staff had a good understanding of the Mental Health Act (MHA), the code of practice and its guiding principles. At the time of our inspection, completion rates for MHA training was around 98%.

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.

- Staff told us the trust had a MHA office with an administrator who they could liaise with if they needed guidance and support.
 - Staff understood the role of Independent Mental Health Advocacy (IMHA) and patients had access to an IMHA if needed. We saw IMHA and Independent Mental Capacity Advocacy IMCA resources in information packs for patients, advertised on notice boards and on leaflets in waiting rooms.
 - We observed that consent to treatment and capacity requirements were adhered to and recorded on their care record system.
 - There were regular trust audits to ensure that the MHA was being applied correctly and there was evidence of learning from these audits. Any learning was shared with the team as a whole and then individual feedback given around good practice.
- Good practice in applying the Mental Capacity Act**
- All staff received mandatory Mental Capacity Act (MCA) training and updates. Staff were knowledgeable and understood the principles of MCA and Deprivation of Liberty Safeguards (DoLS). At a multi-disciplinary meeting we attended, a DoLS application was discussed. A doctor who is a DoLS assessor is based with CDEM Home Treatment North and Central Shropshire team could be called upon for advice and guidance. The policy on MCA and DoLS was available on the intranet. MCA and DoLS were audited across services.
 - We saw examples where DoLS applications had been made and best interest meetings arranged. For example, we attended a care home visit with a member of staff for one patient who had a DoLS application in place. A best interests meeting took place to determine if another placement should be sought for this patient with a more comprehensive package of support.
 - In the casenotes we looked at, we saw documentation relating to capacity, best interests decisions and reviews. Staff we spoke with could give examples of consent and capacity to have treatment. Staff told us and we saw in case notes, that capacity assessments were reviewed regularly with patient's best interests in mind.
 - Each casenote we reviewed had evidence of informed consent and mental capacity being assessed. Advanced decisions, (which are decisions you can make now to refuse a specific type of treatment at some time in the future) were supported and recorded on the electronic case management system.
 - For patients who might have impaired capacity, their capacity to consent was assessed and the information recorded appropriately. This was done on a decision-specific basis with regards to significant decisions and people were given every possible assistance to make specific decisions for themselves before they were assumed to lack mental capacity.

Are services caring?

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

Our findings

Kindness, dignity, respect and support

- In all interactions with patients and carers, we saw that staff were responsive, kind, compassionate and respectful. They made every effort to provide appropriate practical and emotional support. During the home and care home visits we attended; staff demonstrated a positive approach and some staff were inspiring. For example, we attended an emergency home visit and saw that the nurse who led the process was kind and respectful, and treated both the patient and carer with dignity. Despite pressure on her time, the nurse listened carefully to both the patient and carer without any sense of rush, which put them both at their ease. The carer expressed their gratitude at the end of the visit.
- We spoke with five carers and one patient about the care they received; they said the service provided was very good. We looked at feedback about the service, including through the patient advice and liaison service (PALS). All of the responses were very complimentary; thanking the service for the good care that they provided.
- Staff we spoke to were very compassionate and considerate in the way they spoke about their patients. We saw that all the care they provided was centred on the patient's needs. Staff took care to involve all relevant people involved in caring for patients. It was clear throughout our inspection that the staff within the teams were very passionate and proud of the work that they did with patients and their carers.
- Patient identifiable material was securely managed and confidentiality maintained. The information management system was password protected and we saw staff lock their computers when they were not at their desk.
- Based on the evidence in patient records; discussions with staff; feedback from patients and carers; There was a clear focus on maintaining patients independence where possible. All staff worked to enable older people to remain living at home if practically possible. Staff were able to explain the tangible benefits in promoting well-being and other aspects of maximising independent living.
- Each service also worked jointly with Age UK to provide support for all service users. We were given an example of a patient without family who was supported in taking first steps to go to a day centre. The staff member arranged the visit, went with the patient and stayed with them to encourage them to attend and return in future. Patients also had access to advocacy services.
- Staff told us that carers were integral to care and treatment for patients and we saw this in care records and interactions we observed. Carers also told us this when we spoke with them. All carers told us they were happy with the service they received; that staff were kind, compassionate and polite. They could access information and resources they needed including a psychiatrist.
- One carer told us that their family member had been engaged with the service for around 5 years. The carer told us that the nurse had recognised they were low in mood and they were referred to carers' support services. The carer was involved in conferences facilitated by the trust and they sat on panels for staff interviews.
- One carer told us they were treated as an individual and felt valued. They involved their family member in all decisions and gave examples of using a power of attorney. A nurse explained power of attorney to them in an effective manner.
- Carers told us that they had been invited to reviews and updated when there were changes. They said they had been given an information folder with all relevant information. Any information sent to family member were also sent to the carer where indicated.
- A manager and other staff across teams told us that there was a lot of carers support. All carers spoken with told us that this was the case. Carers unanimously told us that there was an open line to staff when required.

The involvement of people in the care they receive

- Where possible, patients were involved in the planning of their care. Patients were offered a copy of their care plan; if a patient declined a copy, this decision was recorded clearly in the care records. There was evidence that carers, families and other professionals were involved in the care planning process.

Are services responsive to people's needs?

Outstanding 

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

Our findings

Access and discharge

- All services focused on assisting people to remain in the community and reducing admission into hospital where possible. The trust set target times for referral to triage/assessment of 20 days and all four teams were meeting this target. The only delays in starting treatment following assessment were those who were awaiting brain scans to rule out physical health factors.
- The single point of access received and triaged all referrals. Where necessary, a patient would be seen as an emergency as soon as possible if they were acutely unwell or at risk. The community mental health services responded to urgent referrals the same day. The teams operated a duty system and the allocated staff member on duty that day would respond to the emergency and urgent referrals.
- Services had an agreement with the commissioners that patients could be discharged when living in a care home and could be readmitted if they have a relapse within a 6 month period.
- Skilled staff were available to assess patients immediately if patients were in crisis during normal working hours. If patients were in crisis out of hours, crisis teams would follow care plans accessible on shared electronic records.
- Staff responded promptly and adequately when patients phoned in to the services; this applied to both crisis and routine care. We saw this in practice during our inspection.
- The services were sensitive to engage with people who found it difficult or were reluctant to engage with mental health services. We saw staff encourage engagement with patients, for example, one nurse, who very compassionately and patiently worked with a patient at a care home who was not engaging well with services and was not happy with their diagnosis.

The facilities promote recovery, comfort, dignity and confidentiality

- All staff encouraged patients to engage in a range of activities. Staff told us they were keen to help patients' increase their confidence and enjoyment of life;

improving their health and wellbeing. We saw evidence in records of discussions with staff and people who used the services that there were a range of useful community groups they could attend locally and that they were supported in attending. Staff would collect patients' from home and take them to groups so that they could increase their support network.

- Interview rooms across all services promoted safety, comfort and confidentiality. Staff told us that rooms were not always sound proofed. Where this was the case; they took steps to improve things by playing low volume easy listening music to absorb sound.
- All patients were given an information folder to introduce them to the service; it included information on treatments, local services, patients' rights and how to complain.

Meeting the needs of all people who use the service

- Each service prioritised seeing people in their own home where possible. The service locations had disabled access or adjustments were made for people requiring disabled access.
- Information leaflets were made available in languages spoken by people who used the services when needed. Managers and staff spoke with us about the changing demographic of their patient group in Oswestry where there was an increasing number of Polish patients accessing the service. All services could access interpreters and signers if necessary.
- All patients were given an induction pack which included all of the information that they would need to know and understand about the service; including how to give feedback and make complaints.
- Staff spoke to us about assistive technology to support patients to maintain or improve their independence wellbeing; for example, the introduction of hearing boxes for hearing impaired patients. The hearing box came with headphones and amplified sound which helped to improve communication between patients and staff.

Are services responsive to people's needs?

Outstanding



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

Listening to and learning from concerns and complaints

- At CDEM Home Treatment South Shropshire there was one complaint in the last 12 months. There were no complaints referred to the Ombudsman. We spoke with managers from all four services about complaints and were assured that any concerns identified by patients and their carers were dealt with and the low numbers of complaints were as a result of positive, communicative relationships with all people involved in patient care. This included patients, their families and carers and partner organisations; including commissioners.
- Patients knew how to complain and received feedback in the event that they had to. There were service user groups and events that provided people with support and an opportunity to contribute to improvements. All carers and patients spoken with told us that they knew how to complain but never had reason to. We held focus groups with carers and services users about the services and all were complimentary about the service they received.
- Staff knew how to handle complaints appropriately. They would discuss any complaints with management and the multi-disciplinary team and where necessary an investigation would take place. Staff gave us examples of when this happened. Staff received feedback on the outcome of investigation of complaints and acted on the findings. Staff used the feedback for discussion in group sessions to learn to improve practice.
- Staff gave feedback forms and people were encouraged people to feedback on their experiences of the services.
- Staff were very flexible in their work with patients. Patients were predominantly seen at their homes at a time that was convenient to them. Appointments were only cancelled when absolutely necessary. Patients received an explanation and were given a further appointment as soon as possible.

Are services well-led?

Outstanding



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

Our findings

Vision and values

- Staff told us about the values and visions of the service. The trust's values were to be respectful, honest and trustworthy, caring and compassionate, taking time to talk and listen, working together and leading by example. We observed these values in the work that staff did with service users, their carers, partnership agencies and each other.
- The trust told us that they valued their staff. We saw this demonstrated at every service we visited. Staff were provided with appraisals, which identified areas for development, career progression and they were supported in achieving their objectives.

Good governance

- Staff received mandatory training; we saw that overall compliance for the services was at 85%.
- Staff were regularly appraised and supervised. We were told that supervision could be increased if staff or managers felt there was an issue that warranted more frequent meetings.
- Each service used key performance indicators and other outcome measures to gauge the performance of the teams. The measures were in an accessible format and used by the staff team to develop action plans when there were issues. Operational managers told us that the trust had recently appointed a business support officer who identified any performance issues. They would notify staff for example, if they had not carried out a care plan review in a timely manner. This meant that performance could be improved as a result.
- There was a low volume of incident reporting. There was evidence of learning from incidents, complaints and service user feedback.
- Safeguarding, Mental Health Act and Mental Capacity Act procedures were followed and we saw that staff had a good understanding of each of these areas of practice.
- There was a culture of leadership and development at all levels. The team were shown several examples of staff who were being supported to further develop advanced

clinical or leadership roles. Career progression pathways were in place for staff at all levels. There was two year accredited training course to take a support worker to assistant practitioner level.

- Leadership was evident throughout; morale was good across all services and staff were engaged in their work. Staff told us they were valued and invested in by the trust. One registrar told us there was good staff morale and that there were opportunities for leadership development.
- There were no formal bullying or harassment issues at the time of our inspection; however when it was identified, it was managed in timely and supportive manner.
- The management teams consisted of a clinical lead, an operational lead and a consultant psychiatrist to encourage good joint working and leadership. We saw this worked well at CDEM Home Treatment Telford & Wrekin, where each lead told us that they had improved service delivery as a result.

Leadership, morale and staff engagement

- Staff morale was high across all four teams. Staff felt supported by their managers, at both a team and service level and felt they operated an open door policy. Staff told us they were proud of the work they did with older people in the community.
- Managers actively sought feedback from staff on what could be improved and where possible action was taken. We saw this in supervision and appraisal documentation. Staff also gave us examples of where they were encouraged to contribute to service developments. For example, one member of staff made a learning video for all staff to access on the trust intranet.
- Staff knew how to raise concerns and one member of staff gave us an example of where they had raised a concern and the changes that were made to support them as a result.
- All managers from all four services told us they had sufficient authority and support from senior managers.

Are services well-led?

Outstanding



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.

Commitment to quality improvement and innovation

- An assistant psychologist was employed on a 6 month fixed term contract to support a research programme around the use of neuropsychological assessment to reduce the number of brain scan referrals. It was a cost efficiency analysis and anecdotally there had been a slight reduction in the number of scans and the financial saving to date had off-set the cost of employing the assistant psychologist. The service were hoping to extend the contract to engage further in the research.
- The services had received accreditation by
- There was evidence of innovation at the services. For example, CDEM Home Treatment Telford & Wrekin used assisted technology that helped to ensure safety in the home for those at risk of harm. The tool alerted family and carers if the front door opened; this helped to prevent service users from coming to harm if they wandered from the safety of their home.
- Staff at CDEM (Community Dementia) Home Treatment North and Central Shropshire and CDEM Home Treatment Telford & Wrekin used a hearing box to communicate with patients who were hard of hearing. This was a tool that staff could use to communicate clearly with hearing impaired service users that amplified sound without the need to raise voices.