Good

Mersey Care NHS Trust

Community-based mental health services for older people

Quality Report

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Locations inspected

Location ID	Name of CQC registered location	Name of service (e.g. ward/ unit/team)	Postcode of service (ward/ unit/ team)
RW400	Trust HQ Princes Dock	North Liverpool and Kirkby older people's community mental health team	L9 7AL
RW400	Trust HQ Princes Dock	South Sefton older people's community mental health team	L22 3XR
RW400	Trust HQ Princes Dock	Liverpool Central older people's community mental health team	L18 8BU

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

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

Summary of findings

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

Summary of findings

Ratings

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

Overall rating for the service	Good 
Are services safe?	Good 
Are services effective?	Good 
Are services caring?	Outstanding 
Are services responsive?	Good 
Are services well-led?	Good 

Mental Health Act responsibilities and Mental Capacity Act / Deprivation of Liberty Safeguards

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

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

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

Summary of findings

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Summary of findings

Overall summary

We rated the community based services for older people as 'Good' overall because:

- People had their needs assessed, care planned and delivered in line with best practice.
- Multi-disciplinary teams managed the referral process, assessments, on-going treatment and care. This included care navigators who support people with dementia.
- Common assessments and pathways for post diagnostic support for people with dementia had been agreed across mental health, acute and specialist NHS trusts.
- People who used services had timely access to care and treatment.
- There were systems in place to triage referrals based on the individual needs of people who used the service. Services were planned and delivered to meet people's needs in a person centred way, taking their cultural needs into account.
- Each team was well led by committed managers.
- Each team had team objectives which helped guide staff and teams.
- Two out of three of the memory clinics were accredited as excellent, with the Royal College of Psychiatrists' memory services network accreditation project.

We saw outstanding user involvement initiatives with significant service user involvement and community engagement, including by people with dementia. This was particular apparent in Central Liverpool. This included:

- the work of the service user reference forum.
- service users and staff working as partners to be involved in developing apps to assist their memory, reminiscence and daily functioning and working with businesses to make them 'dementia friendly'
- partnership work with Everton Football Club.

People were exceptionally positive about the care they received.

However, there were vacancies within teams which meant that some staff had to manage caseloads greater than they usually would. Care navigators were managing large numbers of people. We did not see significant impact on patients from these; managers were looking to address these by recruiting staff and working with commissioners.

Some risk assessments for people using the service were over 12 months old. Lone working practices did not always fully ensure staff safety. Staff were not always proactive in following up on updates on safeguarding processes. There were minor issues with equipment in the clinic room at Central Liverpool older people's CMHT

Summary of findings

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

Are services safe?

Good

We rated safe as 'Good' because:

- The team offices provided clean and safe environment to see patients and for staff to work.
- Staff understood their responsibilities in assessing for risk and managing risk.
- Staff had a good understanding of safeguarding thresholds and how to raise an alert.
- Staffing levels were good. Whilst there were vacancies within teams these were actively being recruited to.
- Staff received mandatory training and extra role specific training as required. Staff felt supported in their role.
- There were overall good medicine management arrangements.
- Staff were aware of how to raise safety incidents.
- There was a good track record of safety within the teams.

However;

- There were vacancies within teams which meant that some staff had to manage caseloads greater than they usually would.
- Care navigators were managing large numbers of people. We did not see significant impact on patients and managers were looking to address these by recruiting staff and working with commissioners.
- Some risk assessments for people using the service were over 12 months old.
- Lone working practices in some teams did not always ensure staff safety.
- Following making a safeguarding alert to the local authority; staff were not always proactive about following up on subsequent updates and keeping care files updated in regard to safeguarding.

There were minor issues with equipment in the clinic room at Central Liverpool older people's CMHT

Are services effective?

Good

We rated effective as 'Good' because:

- People had their needs assessed, care planned and delivered in line with best practice.
- Staff had the skills, knowledge and experience to deliver effective care and treatment.
- Arrangements were in place to support staff by means of clinical and management supervision, appraisal, and team meetings.

Summary of findings

- Multi-disciplinary teams managed the referral process, assessments, on-going treatment and care, including care navigators supporting people particularly with dementia.
- Common assessments and pathways for post diagnostic support for people with dementia had been agreed across mental health, acute and specialist NHS trusts.

The Mental Health Act and Mental Capacity Act was being adhered to.

Are services caring?

Outstanding ☆

We rated caring as 'Outstanding' because:

- People were exceptionally positive about the care they received.
- People told us that staff engaged with them in a caring, compassionate and respectful manner.
- There was significant service user involvement and community engagement including by people with dementia, especially in Central Liverpool. This included:

- the work of the service user reference forum,
- service users and staff working as partners in developing apps to assist their memory, reminiscence and daily functioning and working with businesses to make them 'dementia friendly'
- partnership work with Everton Football Club and the 'creating memories' initiative.

- People were supported to manage their own health and independence.
- Care plans included carer support.

Information leaflets were provided to people and carers to explain particular information in more detail.

Are services responsive to people's needs?

Good

We rated responsive as 'Good' because:

- People who used services had timely access to care and treatment.
- There were systems in place to triage referrals based on the individual needs of people who used the service.
- Services were planned and delivered to meet people's needs in a person centred way, taking their cultural needs into account.
- The teams had access to interpretation services.

People who used services knew how to make a complaint if necessary.

Summary of findings

Are services well-led?

Good

We rated well led as 'Good' because;

- Staff understood the trust's vision and values and were committed to trust initiatives such as 'perfect care' and reducing suicide.
- Each team was well-led by committed managers.
- Each team had team objectives which helped guide staff and teams.
- Staff felt respected, valued and supported by their managers and their peers.
- Two out of three of the memory clinics were accredited as excellent with the Royal College of Psychiatrists' memory services network accreditation project.

There was a commitment to improvement and innovation, for example, through a joint partnership called 'Innovate Dementia'.

Summary of findings

Information about the service

Mersey Care NHS Trust has four older people's community mental health teams, which deliver community mental health services across Liverpool, Sefton and Kirkby.

Community mental health teams for older adults deliver age appropriate, needs based person centred care, to people with both organic and functional illnesses. The teams work in partnership with a range of agencies, to aid and maintain recovery and reduce admissions to hospital. They also support people in nursing or residential care, to ensure people are cared for in the least restrictive manner. The teams have memory clinics, which assess, diagnose and treat people with dementia.

Teams consisted of consultant psychiatrists, nurses, occupational therapists/assistants, care navigators and community support workers. Some teams also had psychologists, speech and language therapists and/or physiotherapists.

People are often seen in their own homes and at outpatient clinics where appropriate.

We have not inspected the community older people's mental health services provided by Mersey Care NHS Trust before this inspection.

Our inspection team

Our inspection team was led by:

Chairs: Professor Jonathan Warren, Director of Nursing and Dr Paul Gilluley, Head of Forensic Services; East London NHS Foundation Trust

Head of Hospital Inspection: Natasha Sloman, Care Quality Commission

Team leader: Serena Allen, Inspection Manager, Care Quality Commission

The team that inspected the community based services for older people included a CQC inspection manager, a CQC inspector, a CQC Mental Health Act Reviewer and a variety of specialist advisers: two consultant psychiatrists, a consultant psychologist, two mental health nurse managers, and a mental health 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 get to the heart of 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 visiting, we reviewed a range of information we held about this service and asked other organisations to share what they knew. We carried out announced visits on 2 June through to 4 June 2015.

The inspection took place across a range of the community-based mental health services for older

Summary of findings

people. We sample community mental health services as part of our new inspection process. We therefore visited three out of the four community older people's mental health teams. The teams we visited were;

- North Liverpool and Kirkby older people's community mental health team based at Aintree Hospital.
- South Sefton older people's community mental health team based at the South Sefton Neighbourhood Centre.
- Central Liverpool older people's community mental health team based at Mossley Hill Hospital.

We did not visit Sefton older people's community mental health team based at the Boothroyd unit and no concerns had been highlighted about this service.

During this inspection;

- We spoke with 24 people who used the service and 18 carers.
- We received four comment cards from people who used the service. We also received a written comment by email from a carer which was very positive.
- We met with two groups of patients, attended by twelve people in total. This included the service user reference panel in Liverpool.
- We spoke with 57 members of staff from a range of disciplines and roles. This included 11 staff who attended a focus group, held at the Central Liverpool Older people's CMHT.
- We looked at 20 care records and one Mental Health Act record relating to a community treatment order.
- We attended five multi-disciplinary team meetings.
- We accompanied staff on nine home visits and observed how they provided care and treatment to people.
- We spoke with a GP about how services worked together across mental health and primary care.
- We spoke to three staff members of the Everton Football Club about the partnership work with Everton in the community.
- We observed a cognitive stimulation therapy session. We saw a liveability session take place. This is a physical exercise group for people with dementia and their carers. We also observed a group based session for people with dementia at Everton Football Club.
- We looked at the environments and equipment where the CMHTs were based.
- We looked at the arrangements for the management of medicines.

What people who use the provider's services say

We spoke with 24 people who used the service and 18 carers. We met with two groups of patients, attended by twelve people in total. This included the service user reference panel in Liverpool. We also received a written comment by email from a carer which was very positive

People were exceptionally complimentary about the care they received from the older people's community mental health teams. People told us staff treated them with dignity, respect and compassion. They felt involved in the decisions about their care and treatment. People told us that the care navigators were valued for their support and flexibility in supporting them, following a diagnosis of dementia.

People and their carers told us that access to the service was good and support was given when needed in a crisis situation.

As part of the inspection we left comment cards boxes at various locations across the trust for people to tell us their experiences. We received four comments from the locations where older people's community teams were based. These comments included four positive comments and one negative comment.

Summary of findings

Good practice

There was significant service user involvement and community engagement, including by people with dementia, especially in Central Liverpool. This included;

- the work of the service user reference forum,
- service users and staff working as partners in developing apps to assist their memory, reminiscence and daily functioning and working with businesses to make them 'dementia friendly'
- partnership work with Everton Football Club and the creating memories initiative.

There was an agreed joint care pathway for people who had received a diagnosis of dementia; between Mersey Care, the local acute trust and a specialist neuro-rehabilitation trust. The aim of this was to ensure that referrals, common assessments and treatment across the specialities, were seamless and holistic.

The trust employed care navigators. Care navigators support, guide and signpost people, principally with a diagnosis of dementia to the help them access the resources and services they need. People told us that the care navigators were valued by them for the support and flexibility offered following a diagnosis of dementia.

Areas for improvement

Action the provider SHOULD take to improve

- The trust should ensure that they continue to address identified vacancies within teams, manage caseloads and clarify the arrangements for psychology input in the North Liverpool and Kirkby older people's CMHT.
- The trust should ensure that the lone working policy is reviewed to increase clarity for staff and service user safety.
- The trust should ensure that systems are in place for monitoring equipment used in the clinic room at the Mossley Hill Hospital site
- The trust should ensure that progress on safeguarding investigations is monitored. Staff should ensure that care records fully reflect all safeguarding concerns and incidents.

Mersey Care NHS Trust

Community-based mental health services for older people

Detailed findings

Locations inspected

Name of service (e.g. ward/unit/team)	Name of CQC registered location
North Liverpool and Kirkby older people's community mental health team	Trust HQ Princes Dock
South Sefton older people's community mental health team	Trust HQ Princes Dock
Liverpool Central older people's community mental health team	Trust HQ Princes Dock

Mental Health Act responsibilities

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

Overall we found good systems in place to ensure that the MHA was being adhered to within the community older people's teams. Staff told us about how they could request an assessment under the MHA for people in the community and this would generally be co-ordinated quickly.

We saw the records relating to one community treatment order (CTO) for one patient. Records showed that the CTO paperwork was in place, renewals occurred appropriately and the conditions of the CTO were monitored and met. We found minor issues with patient rights and informing the community patient about the independent mental health advocacy service. The second opinion appointed doctor (SOAD) certificate was not kept with the medication card. These issues were addressed during the inspection.

Detailed findings

Mental Capacity Act and Deprivation of Liberty Safeguards

Overall we found the services were adhering to the requirements of the Mental Capacity Act. There was a record and monitoring of mental capacity and consent, when significant decisions were made. For example, when people needed to be brought into hospital, considered for residential care, or if covert medication was being discussed. Staff contributed to best interest considerations where necessary.

Staff we met with had a clear understanding of their responsibilities in undertaking mental capacity assessments, when they were the principle decision maker. Staff made sure health decisions were made based on mental capacity assessments, or in the best interest of the person.

Good

Are services safe?

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

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

Summary of findings

We rated safe as 'Good' because:

- The team offices provided clean and safe environment to see patients and for staff to work.
- Staff understood their responsibilities in assessing for risk and managing risk.
- Staff had a good understanding of safeguarding thresholds and how to raise an alert.
- Staffing levels were good. Whilst there were vacancies within teams these were actively being recruited to.
- Staff received mandatory training and extra role specific training as required. Staff felt supported in their role.
- There were overall good medicine management arrangements.
- Staff were aware of how to raise safety incidents.
- There was a good track record of safety within the teams.

However;

- There were vacancies within teams which meant that some staff had to manage caseloads greater than they usually would.
- Care navigators were managing large numbers of people. We did not see significant impact on patients and managers were looking to address these by recruiting staff and working with commissioners.
- Some risk assessments for people using the service were over 12 months old.
- Lone working practices in some teams did not always ensure staff safety.
- Following making a safeguarding alert to the local authority; staff were not always proactive about following up on subsequent updates and keeping care files updated in regard to safeguarding.

There were minor issues with equipment in the clinic room at Central Liverpool older people's CMHT.

Our findings

Safe and clean environment

- The teams provided most of the services to people in their own home. People who used services would occasionally attend the locations for various reasons. All three locations had clean environments and interview rooms were equipped with alarms.
- Overall, environments were well maintained. There were some minor concerns regarding the clinic room at the Central Liverpool team
- temperatures within the clinic were recorded as moderately high on a small number of occasions, without any record of action. This could mean that medication is not stored at the correct temperature,
- when checked, single use lancets, cleaning fluid and a spillage kit were found to be just out of date;
- there was no evidence of the weighing scales being calibrated to check that they were measuring the correct weight and
- the equipment for measuring patients' body mass index was not fit for purpose.
- The location of the alarms in the interview rooms at the new offices which the North Liverpool and Kirkby team, were not in an accessible place so that staff could easily raise an alarm without delay. All teams had systems in place for visitors to sign in and out of the building.

Safe staffing

Key Staffing Indicators, North Liverpool and Kirkby Team

- Establishment levels: qualified nurses (whole time equivalent WTE) - 10
- Establishment levels: support workers (WTE) - 3.9
- Number of vacancies: qualified nurses (WTE) - 2
- Number of vacancies: support workers (WTE) - 2
- Staff sickness rate (%) in 12 month period - 6.8
- Staff turnover rate (%) in 12 month period- 0

Key Staffing Indicators, Central Liverpool Team

- Establishment levels: qualified nurses (WTE) - 22.1
- Establishment levels: support workers (WTE) - 14

Good

Are services safe?

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

- Number of vacancies: qualified nurses (WTE) - 2
- Number of vacancies: support workers (WTE) - 1
- Staff sickness rate (%) in 12 month period - 5.6
- Staff turnover rate (%) in 12 month period - 0.1

Key Staffing Indicators, South Sefton Team

- Establishment levels: qualified nurses (WTE) - 9.9
- Establishment levels: support workers (WTE) - 4.5
- Number of vacancies: qualified nurses (WTE) - 1.3
- Number of vacancies: support workers (WTE) - 0.4
- Staff sickness rate (%) in 12 month period - 0
- Staff turnover rate (%) in 12 month period - 0.1

- Actual staffing levels were reduced by vacancy rates and some long–term sickness. This was offset in some teams, by use of overtime and long term agency staff, who were familiar with the team's work. Despite staffing levels which were lower than the established levels in some teams, this did not impact on people waiting to be assessed or allocated to a named worker. Where there were vacancies, managers were working to address these with well-developed plans to recruit staff.
- The Central Liverpool team had higher staffing levels because it covered a wider geographical area. Staffing levels had not been reviewed for some time. However plans were in place for managers to consider demographic need to reflect staffing levels in the future. There were disparities in staff skill mix, the North Liverpool and Kirkby team was the only team not to have a psychologist, speech and language therapist or a physiotherapist.
- Staff received mandatory training and extra role specific training as required. Mandatory training included, conflict resolution, equality and diversity, fire awareness, health and safety, infection control, manual handling and safeguarding. All teams maintained appropriate training compliance rates of above 97%.
- None of the teams used caseload weighting tool to monitor staff caseloads. Some staff reported having higher caseloads due to short staffing and sickness. For example, in one team staff were managing a caseload of 56 people. This meant that some staff had to manage caseloads greater than they usually would.
- Some of the care navigators were managing between 130 and 193 people. Not all of these cases were active at any given time depending on the presentation and health of the patient.
- Caseloads were managed in supervision and reviewed regularly. However, not all staff had received regular supervision; for example one care navigator had not received supervision for two years although the staff member felt supported.

Assessing and managing risk to patients and staff

- Referrals were screened primarily by the consultant psychiatrist who would then assess each person who was accepted into the service. This assessment would inform the needs of the person and the consultant psychiatrist would inform the team leader if any other interventions were required. The team leader would then allocate a named care worker based on the needs of the person and the expertise of staff.
- Staff undertook comprehensive risk assessments at initial referral and updated them when necessary. Most of the risk assessments were kept up-to-date; However, because the older people's community mental health teams were not formally reviewing care at prescribed intervals, some people's risks assessments were not routinely reviewed. This meant that some people's risk assessments were more than 12 months old. We were assured that risk assessments were updated following significant events. People we spoke to confirmed they knew who to contact in a crisis and their care plans were clear and understandable.
- People received regular checks to make sure that the medication they received was not causing adverse effects; especially when people were first put on medication such as Lithium
- Staff were trained in safeguarding matters and had a good understanding of how to raise a safeguarding alert. However, staff informed us that they were not involved in the safeguarding process because this was passed to the local authority to investigate. Staff were often unaware of the progress of safeguarding investigations and any safeguarding plans put in place. Following making a safeguarding alert to the local authority; staff were not always proactive about following up on subsequent updates and keeping care files updated in regard to safeguarding issues.

Good

Are services safe?

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

- Lone working procedures varied between the teams. All members of staff were provided with mobile phones and signed in and out of the buildings. The trust had a lone working policy in place. Staff were following this at each location we visited. However, the policy was unclear on individual responsibilities and did not require staff to report their safety following each visit. Staff at each location signed out and ensured the service had information on their appointments.
- Checks on staff's whereabouts were not carried out until the end of each day and it was unclear who would conduct these checks, as there was no-one allocated as a shift co-ordinator. Therefore if staff had multiple back to back visits, it would not be known if the staff member was safe until the end of their scheduled appointments. Staff did inform us that if there were identified safety risks, or if the person was not known to the service, they would ensure two members of staff attended the appointment. Some staff across the teams were not aware if the teams operated a specific phrase that could be texted or telephoned to alert colleagues if they were in danger.
- There were good systems in place regarding safe medicines management. Medications were stored securely in locked cupboards. Two staff checked and signed documents prior to prescriptions being dispensed.

Track record on safety

- We looked at the incidents database reported by the teams and these generally included many incidents of expected deaths of people receiving services. When we analysed the data about the trust's incidents, there were no adverse events in relation to older people's community teams in the last 12 months. There was no other concerning information highlighted about incidents involving the community older people's services. This was corroborated by managers in the teams who confirmed that that there had not been any significant safety incidents recently.

Reporting incidents and learning from when things go wrong

- Staff were aware of how to raise safety incidents with the management team. Incidents were inputted onto the datix system and themes were discussed and addressed in weekly surveillance meetings with the service manager. Information and any lessons learnt were subsequently discussed in weekly multi-disciplinary team meetings.
- Staff showed an open and transparent culture. Managers discussed how they prefer to say "sorry" if necessary and resolve problems at a local level. There had been no incidents that met the 'duty of candour' regulations within the older peoples' community mental health teams.
- Staff received feedback from incidents within the trust by attending Oxford model events, and information disseminated via quality practice alerts. Oxford model events occur after a serious incident and staff from other teams can attend feedback sessions to learn from the mistakes made. Staff were actively encouraged to attend and feedback to the wider teams. Quality practice alerts were disseminated from team leaders to the weekly MDT's; these alerts consisted of identified safety themes and information regarding best practice

Are services effective?

Good

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

Summary of findings

We rated effective as 'Good' because:

- People had their needs assessed, care planned and delivered in line with best practice.
- Staff had the skills, knowledge and experience to deliver effective care and treatment.
- Arrangements were in place to support staff by means of clinical and management supervision, appraisal, and team meetings.
- Multi-disciplinary teams managed the referral process, assessments, on-going treatment and care, including care navigators supporting people particularly with dementia.
- Common assessments and pathways for post diagnostic support for people with dementia had been agreed across mental health, acute and specialist NHS trusts.

The Mental Health Act and Mental Capacity Act was being adhered to.

Our findings

Assessment of needs and planning of care

- Each referral was discussed and prioritised at the multi-disciplinary team (MDT) meeting.
- Assessments and care plans contained up to date, personalised information to support the treatment pathway.
- Teams worked with GP services as part of the shared care protocols to ensure people received relevant physical health checks.
- Most people on the caseload of the teams had a named worker, a statement of care which outlined the care they would receive and had regular reviews of care. This would not necessarily mean that everyone was receiving care under the framework of the care programme approach (CPA); unless there were particular reasons, such as if they had transferred from adult services or from secure services already on a CPA. Reviews of care were occurring but to no particular deadline, such as at least annually as required under CPA.

Best practice in treatment and care

- The teams ran a range of groups including cognitive stimulation therapy and recovery groups. Talking therapies was also available. The services followed a dementia pathway which was based on National Institute for Health and Care Excellence (NICE) guidance; this included cognitive stimulation therapy as part of the pathway. People received cognitive behavioural therapy and other therapies which were nurse led. The services used a range of outcome measures which included Health of the Nation Outcome Scales.
- Teams had care home liaison nurses and care navigators. Care home liaison nurses worked with care homes and nursing homes to meet the needs of people in residential care. Care navigators supported people to be cared for appropriately, when presenting with severe mental health problems and/or challenging behaviour. This helped to reduce admissions to hospital. Care navigators also supported, guided and signposted people with a diagnosis of dementia to the help and resources they needed. People told us that the care navigators were valued by them for the support and flexibility offered following a diagnosis of dementia.
- The memory service in two teams was accredited as excellent through the Royal College of Psychiatrists' memory services national accreditation programme.

Skilled staff to deliver care

- The services had access to a range of mental health disciplines which included psychiatrist, community psychiatric nursing staff, occupational therapists, and community psychiatric nurses, advanced nurse practitioners, medical secretaries and administration staff. Some teams also had psychologists, speech and language therapists and/or physiotherapists. Staff and managers in the North Liverpool and Kirkby CMHT were unclear about the vacant psychologist posts in their team and were awaiting a definitive decision on the posts.
- The nursing staff were experienced band 6 and 7 staff.
- As well as mandatory training, staff could also access dementia and carer training, cognitive behavioural therapy (CBT) skills, cognitive stimulation therapy and university courses such as a masters degree in dementia care.

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.

- Most staff felt supported and commented favourably on the team approach. However, not all staff had received regular management supervision; for example one care navigator had not received supervision for two years, although the staff member felt supported.

Multi-disciplinary and inter-agency team work

- Services worked together to plan ongoing care and treatment in a timely way through the multi-disciplinary (MDT) meetings. Care was co-ordinated between teams and services from referral through to discharge or transition to another service. MDT meetings were used to collaboratively manage referrals, risks, treatment and appropriate care pathways options. We observed very good multi-disciplinary working in the majority of teams with one team being more medically led.
- The teams operated shared care with GPs and primary care services. The teams linked in with the inpatient services for people who have been admitted to hospital under a section or informally.
- Common referrals, assessments and pathways for post diagnostic support for people with dementia had been agreed across mental health, acute NHS trust and specialist neuro-rehabilitation NHS trust. This supported seamless care to be delivered across different health specialities.

Adherence to the MHA and the MHA Code of Practice

- Overall we found good systems in place to ensure that the MHA was being adhered to.
- Staff told us about how they could request an assessment under the MHA for people in the community and this would generally be co-ordinated quickly by an approved mental health professional.
- In two of the teams we visited, none of the patients were on a community treatment order (CTO). We saw the records relating to one CTO for one patient in the other team we visited. Records showed that the CTO paperwork was in place, renewals occurred appropriately and the conditions of the CTO were monitored and met.
- We found minor issues with patient rights on this file. Whilst it was clear the person had been informed of their rights and had exercised their right to a tribunal, it was not clear that following the renewal of the CTO, that they had their rights re-read.
- It was also not clear that the person had been informed of their legal right to receive support from the independent mental health advocacy services. The community psychiatric nurse agreed to address this.
- The medication for mental disorder for the patient subject to the CTO was appropriately authorised on an appropriate legal certificate. However, the second opinion appointed doctor (SOAD) certificate was not kept with the medication card. This ensures that staff and patients are assured that the medication was legally authorised when the depot was given. This issue was addressed during the inspection.

Good practice in applying the Mental Capacity Act

- Overall we found the services were adhering to the requirements of the Mental Capacity Act. People using the service of the community mental health teams for older adults were living in the community with a high degree of autonomy. There was a record and monitoring of mental capacity and consent, when significant decisions were made. For example, when people needed to go into hospital, or being considered for residential care, or if covert medication was being discussed. Staff contributed to best interest considerations where necessary.
- Staff we met with had a clear understanding of their responsibilities in undertaking mental capacity assessments when they were the principle decision maker. Staff ensured health decisions were made based on mental capacity or in the best interest of the person.
- The care home liaison nurses gave examples of where they had provided professional advice and input when someone on their caseload was being considered for a deprivation of liberty safeguards (DoLS) within care or nursing homes.
- As part of the post diagnosis support for people with dementia, people received comprehensive information

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.

from the trust. This included guidance on making decisions prior to the progressive nature of dementia, such as lasting power of attorney for health, welfare and financial decisions.

Outstanding ☆

Are services caring?

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

Summary of findings

We rated caring as 'Outstanding' because:

- People were exceptionally positive about the care they received.
- People told us that staff engaged with them in a caring, compassionate and respectful manner.
- There was significant service user involvement and community engagement including by people with dementia, especially in Central Liverpool. This included:

- the work of the service user reference forum,
- service users and staff working as partners in developing apps to assist their memory, reminiscence and daily functioning and working with businesses to make them 'dementia friendly'
- partnership work with Everton Football Club and the 'creating memories' initiative.

- People were supported to manage their own health and independence.
- Care plans included carer support.

Information leaflets were provided to people and carers to explain particular information in more detail.

Our findings

Kindness, dignity, respect and support

- Feedback from people who used the service and their carers was extremely positive about the way staff treated them. People told us they were treated with dignity, respect and kindness during all interactions with staff.
- People told us that staff understood their needs and respected their privacy and confidentiality. People felt that staff went the extra mile, such as working above their hours to ensure groups continued.

The involvement of people in the care they receive

- There was significant service user involvement and community engagement, including by people with dementia, especially in South Liverpool. This included:

- The work of the service user reference forum. Service users were involved in commenting on policies and service design for services in Liverpool.

- Service users worked with people who had received a diagnosis of dementia for peer support.

- Service users and staff worked as partners in developing apps, to assist their memory, reminiscence and daily functioning. They also worked with businesses to make them 'dementia friendly' (for example, by working with the local supermarkets; and local transport services to help public transport staff become more aware of the needs of people with dementia).

- There was excellent partnership work between Everton Football Club and Mersey Care NHS Trust. This included a reminiscence session for people with cognitive impairment. We observed a session at the Everton club which involved staff leading a reminiscence group and observed positive interactions. The trust and the football club working in partnership had trained 500 dementia friends, including all the head stewards of the football club.

- There was a creating memories initiative, which involved service users and staff working together to visit local places, to form new friendships and memories.

- People were involved and encouraged to be part of their care and treatment decisions with support when it was needed. Staff helped people and those close to them to cope emotionally with their care and treatment. People were supported to maintain and develop their relationships with those close to them, their social networks and community.
- People were provided with copies of their care plans and it was recorded in the care records when a copy had been declined by the person, with an explanation. People with dementia and their carers were provided with information regarding benefits, advocacy, lasting power of attorney and advanced decisions.

Are services responsive to people's needs?

Good

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

Summary of findings

We rated responsive as 'Good' because:

- People who used services had timely access to care and treatment.
- There were systems in place to triage referrals based on the individual needs of people who used the service.
- Services were planned and delivered to meet people's needs in a person centred way, taking their cultural needs into account.
- The teams had access to interpretation services.

People who used services knew how to make a complaint if necessary.

Our findings

Access, discharge and transfer

- The community mental health teams (CMHTs) accepted referrals from in-patient wards, other trust services and via local GPs. People who used services were seen within six weeks from referral. New referrals which had been triaged could be seen more urgently than the six week target if necessary. One person we saw had only waited four weeks from when he went to the GP to be seen and started to receive treatment from the CMHT. The initial assessment evaluated people's needs and the care and treatment options available to them. People and staff we spoke with confirmed that there was rapid access to a psychiatrist when required.
- Teams could respond promptly if there was a sudden deterioration in a person's physical or mental health. Staff explained that they could be flexible with patient contact times and dates and that accessing a consultant psychiatrist at short notice was possible.
- Staff attempted to engage people who missed appointments, mainly by phone calls and letters and discharged them if they no longer accessed the service.
- All the teams had developed links with the acute wards and bed managers, to make sure that people who used services were admitted to and discharged from hospital when clinically appropriate. Aftercare support was agreed and people were followed up within seven days of discharge from hospital. The trust met national targets on 7 day follow up. People transferred to care and nursing homes continued to receive support from the community mental health teams, through the care home liaison nurses within the teams
- Shared care protocols were in place with primary care services. This ensured that people under the care of the community mental health teams, were properly treated and monitored in the community.
- People with dementia would generally not be transferred back to primary care and would remain open to the team, usually on the caseload of the care navigators. People with functional mental health needs, such as depression or schizophrenia, who had been stable for many years, remained open to the community mental health teams without being transferred back to primary care. This meant that people continued to be seen within the community mental health teams for significant periods of time.
- The impact of this was that staff had larger caseloads but we did not see other impacts such as long waiting times, difficulties accessing the service or missed or cancelled appointments. People who used services told us they had not experienced delays or any cancelled groups or appointments. The managers were liaising with the clinical commissioning groups to improve the resource and recruit more care navigators. They were also working to fill nursing and non-nursing staff vacancies.

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Facilities promote recovery, dignity and confidentiality

- The waiting areas and clinic rooms were welcoming and comfortable in the locations where the community older people's teams were based.
- The information pack that people received contained a good range of literature, including information on community and voluntary groups and how people's data would be maintained confidentially.

Policies and procedures minimise restrictions

- The teams focussed on assisting people to remain within the community and avoid admission to hospital

Are services responsive to people's needs?

Good

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

where possible. The teams also facilitated the early discharge of some people from hospital by offering them support during the move from hospital to the community.

Meeting the needs of all people who use the service

- Staff respected people's diversity and human rights. Attempts were made to meet individual needs including cultural, language and physical needs. Interpreters were available to staff if required.
- The central Liverpool team had developed links with the local Chinese and Somali communities.
- The premises were accessible to people who had physical disabilities, including accessible toilet facilities. Reaching the age of 65 did not lead to automatic transfer to older people's services if their needs could be better met elsewhere in the trust.

Listening to and learning from concerns and complaints

- People who used services told us they knew how to complain if they wanted to. We saw posters in the reception areas about how to offer suggestions or compliments.
- There was information in the information pack that people received, about how to complain and the support available from the patient advice and liaison services in raising complaints informally or formally.
- The teams did not receive many complaints – one team only had two complaints and another team had no complaints in the last 12 months. Where complaints had been raised, we saw that the trust had worked to resolve these complaints.

Are services well-led?

Good

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

Summary of findings

We rated well led as 'Good' because;

- Staff understood the trust's vision and values and were committed to trust initiatives such as 'perfect care' and reducing suicide.
- Each team was well-led by committed managers.
- Each team had team objectives which helped guide staff and teams.
- Staff felt respected, valued and supported by their managers and their peers.
- Two out of three of the memory clinics were accredited as excellent with the Royal College of Psychiatrists' memory services network accreditation project.

There was a commitment to improvement and innovation, for example, through a joint partnership called 'Innovate Dementia'.

Our findings

Vision and values

- The vision of the trust was to be recognised as the leading organisation in the provision of mental health care, addiction services and learning disability care. The vision of the trust was underpinned by the following values:

- Continuous improvement
- Accountability
- Respect
- Enthusiasm.

- The trust's visions and strategies for the services were evident and most staff considered that they understood the vision and direction of the trust. Staff were able to tell us about specific initiatives such as perfect care, which was the trust's strategic commitment to provide high quality care and the zero suicide initiative.
- Each team had objectives which identified how teams would perform and continuously improve. These objectives put the vision and values into practical steps and action at a local level.

Good governance

- There was an effective governance framework in place to support the delivery of the strategy and quality assurance to drive performance improvement.
- The locality meetings covered the management and monitoring of training, waiting time, data quality, ward stay information, clustering and payment by results. If there were any particular areas of improvement identified, the team manager had to produce an action plan. This was monitored at the performance management meeting until improvements have been met.
- Teams held their own risk registers and could raise issues to put forward for the trust's risk register in order to escalate the matter up to the board.
- There was a trust clinical audit programme in place. The quality assurance group managed and monitored the outcomes of the audits. Services were required to provide action plans to meet any recommendations as a result of the audit outcome.
- Datix incidents and complaints were managed and monitored centrally to review lessons learnt and monitor themes.
- Patient experience surveys and results were displayed in the clinic areas at most of the teams. Results of the surveys were discussed at the team meetings. It was acknowledged there were some problems in capturing feedback from people who used the services on their experience.
- South Sefton team reception staffing levels had increased to ensure one person could greet visitors and one staff member could answer the phone to improve people's experiences of contact with the service.
- The local division (where the older people's community mental health team sat within the governance structure) had a transformation improvement plan which prioritised improved community services, teams and accommodation.

Leadership, morale and staff engagement

- We spoke with the managers and band 7 nurse managers, who led the community mental teams for older people. Managers were committed to providing a good quality service and were effective leaders. Staff spoke of feeling valued and supported by effective managers and their peers.

Are services well-led?

Good

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

- Staff spoke of a strong culture of openness and honesty with effective processes in place to share information via team meetings and de-briefings. There was a good governance structure which ensured the right meetings and committees were in place. There was good communication from the board to teams and upwards.
- Morale within teams was good and people were committed to providing high quality and responsive care.

Commitment to quality improvement and innovation

- There were plans to recruit more care navigators across some of the teams to improve patient experience and reduce the caseloads of the care navigator service.
- The trust is the lead agency in a three year project called 'Innovate Dementia' in collaboration with academic partners at a local university. This project aimed to address some of the challenges faced by people living with dementia. It uses collaborative techniques in the areas of lighting, living environments, models of access, nutrition and exercise, all underpinned by the use of technology. This project is based on a partnership with people who use services, who work with the trust to deliver the project.
- Staff used tablet devices to access and input data. These helped with efficiency at team bases but the devices were not as reliable out in the community.
- Two out of three of the memory clinics were accredited as excellent with the Royal College of Psychiatrists' memory services network accreditation project.
- The local division's transformation improvement plan stated that the trust would prioritise improved community services, teams and accommodation as one of the six priorities within the plan. One of the community older people's teams was moving to new improved premises, this was in line with this plan.