Requires improvement

North Staffordshire Combined Healthcare NHS Trust

Community-based mental health services for adults of working age

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)
RLY	North Staffordshire Combined Healthcare NHS Trust	Recovery and resettlement service: Hillcrest Street	ST1 2AA
RLY	North Staffordshire Combined Healthcare NHS Trust	City ICMHT: Greenfields centre	ST6 5UD
RLY	North Staffordshire Combined Healthcare NHS Trust	City ICMHT: Sutherland centre	ST3 4LR
RLY	North Staffordshire Combined Healthcare NHS Trust	Moorlands County ICMHT: Ashcombe centre	ST13 7ED

Summary of findings

RLY	North Staffordshire Combined Healthcare NHS Trust	AMHP/Best Interest team, Hillcrest, 23 Hillcrest Street, Stoke-on-Trent	ST12BX
RLY	North Staffordshire Combined Healthcare NHS Trust	Early Intervention Service, The Hope Centre, Upper Huntbach Street, Stoke-on-Trent	ST12BX
RLY	North Staffordshire Combined Healthcare NHS Trust	Resettlement & Review team, The Hope Centre, Upper Huntbach Street, Stoke-on-Trent	ST12BX
RLY	North Staffordshire Combined Healthcare NHS Trust	Growthpoint & Kniveden, The Hope Centre, Upper Huntbach Street, Stoke-on-Trent	ST12DA

This report describes our judgement of the quality of care provided within this core service by North Staffordshire Combined Healthcare 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.

Where applicable, we have reported on each core service provided by North Staffordshire Combined Healthcare NHS Trust and these are brought together to inform our overall judgement of North Staffordshire Combined Healthcare 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	Requires improvement 
Are services safe?	**Requires improvement** 
Are services effective?	**Requires improvement** 
Are services caring?	**Good** 
Are services responsive?	**Requires improvement** 
Are services well-led?	**Requires improvement** 

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

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

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

Summary of findings

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Overall summary

We rated community based mental health services for adults of working age as requires improvement because:

- Staff were able to show how they provided care and treatment to both patients and carers in line with the National Institute for Health and Clinical Excellence (NICE) guidelines. However, the records read did not identify the involvement of patients in partnership with their health and social care professionals. For example; out of 27 records within the access team we found that 18 did not identify the patient's relative or carer's involvement in the care planning/management plan process. We found no evidence of a review of patient's care/management plans within 18 of the records read.
- Of the care records reviewed, 29% had no risk assessment evident.A further 46% had some evidence of risk assessment having taken place but there were errors present with inconsistent data regarding suicide risk of one patient. Historical risks had been identified in some risk assessments but lacked detail of antecedents, static or dynamic risks and crisis plan.
- We found inconsistencies in the care planning and risk assessment documents. Some risks identified in the trusts 3 point risk assessment tool which was to be updated on a six month basis were not transferred to a more comprehensive modular risk assessment tool.
- Of the care plans we reviewed, 44% had no evidence of being recovery oriented. Patients strengths and goals were not identified.
- Of the care records we reviewed, 58% had no evidence of informed consent.
- Staff told us that the integration of the trusts community rehabilitation and Assertive Outreach function had taken place in June as part of the trusts cost improvement programme. However, they felt there was a lack of a management of change programme to accompany this.
- Staff told us that they felt unable to always deliver quality care due to increased pressure of workloads in the community teams.
- Annual personal development review (PDR) compliance within the ICMHT's was below the trust standard of 95% and had an average score of 70%. The trust reported that having confirmed the results with the team managers, more PDR's had taken place, but had not been recorded appropriately.
- Most community staff confirmed their caseloads were manageable. Staff said they could effectively monitor the people on their cases and there were both daily and weekly team meetings to review these. However the city ICMHT staff reported having higher caseloads. Within the city ICMHT the average caseload sizes were 37 at the Sutherland centre and 35 at the Greenfields centre. Staff within the city ICMHT's told us that they felt unable to always deliver quality of care due to increased pressure of workloads in the community teams. The trust currently have no policy for the effective and safe management of caseloads.
- The highest combined caseload of a non medic member of staff was at Greenfields ICMHT which was 76. This was a combination of people on the care programme approach (CPA) and standard care. Staff reported having placed their team on the trust risk register due to high clinician case loads and low staffing levels.
- Staff in the city ICMHT's reported that there had been increased pressures due to vacant posts and increased caseloads. Staff within the services told us there had been further workload pressures due to staff being absent due to long term illness.
- Carers and services users told us that there can be lengthy waits for appointments with community teams.
- Staff told us that combined paper and electronic notes meant that duty staff working weekends at the Greenfields site were not able to view progress notes of patients not under the care of that team as they were at a separate location. This meant that all information was not in an accessible form or readily available.
- No evidence of adherence to NICE Guidance regarding offering discharged service users the opportunities to pursue advocacy or moratorial services.
- Standard operating procedures within the Access team stated that should people need to wait before an

Summary of findings

assessment this is for no longer than 20 minutes after the agreed appointment time. The manager we spoke with said the team did not monitor or measure the outcome of whether they were meeting this.

- The teams we inspected had a lone working policy but not all staff were aware of how to use this correctly. Two staff were unaware of the trust wide safety word for alerting others should there be an issue whilst on community visits. One staff member described the teams approach to the lone working policy as "ad hoc and loose".
- Two staff we spoke to told us that they were aware of the requirement to check the patients electronic notes on the Corporate Health Information Programme (CHIP's) prior to home visits to be aware of changes to risk, but this did not always happen.
- Two of the three clinic rooms we visited within the ICMHT's had temperatures of 25 degrees centigrade during our inspection.
- Managers were not able to use the trust based governance tool to provide an overview of their team compliance with statutory and mandatory training on a regular basis. Managers were provided with a weekly spread sheet from the trust data management system but this included the training details of all staff including those in unrelated clinical teams.
- Staff were not up to date with statutory and mandatory training with an average of 93% compliance in training across the three integrated community mental health teams and the recovery and resettlement team. The trust standard for staff to be fully compliant is 95%
- The paper records seen across the services showed that consent to care and treatment and information sharing was inconsistently recorded.

However:

- Patients told us that there was access to a psychiatrist when required.
- We saw evidence within the Moorlands ICMHT of learning from the outcomes of serious untoward incidents and the team were able to describe and demonstrate changes in practice as a result of this.
- All areas were clean and well maintained, there were well equipped clinic rooms with equipment regularly checked.

Summary of findings

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

Are services safe?

Requires improvement

- Of the 70 care records reviewed, 29% had no risk assessment evident, a further 46% had evidence of risk assessment having taken place, however, we found errors present with inconsistent data within them. Historical risks had been identified in some risk assessments but lacked detail of antecedents, static or dynamic risks and crisis plans.
- We saw that risk assessments were not always regularly updated. We found risk assessments that had inconsistent information, had not been updated following changes in risk and lacked signatures of the care co-ordinator or patient.
- Staff reporting having high case loads in the city integrated community mental health teams (ICMHT's). The highest combined caseload of a non medic member of staff was at Greenfields ICMHT which was 76. This was a combination of people on the care programme approach (CPA) and standard care.
- Staff at the Sutherland centre reported having placed their team on the trust risk register due to increasing case loads sizes and low staffing levels.
- The teams we inspected had a lone working policy but not all staff were aware of how to use this correctly.
- High clinic room temperatures at the Greenfields and Sutherland ICMHT's, 25 degree's centigrade on the day we visited in September.
- Not all staff were up to date with statutory and mandatory training with an average of 93% compliance across the three ICMHT's and the recovery and resettlement team.

However:

- All areas were clean and well maintained, there were well equipped clinic rooms with equipment regularly checked and calibrated according to manufacturers instructions.

Are services effective?

Requires improvement

We rated these services as requires improvement for effective because:

- During the inspection process we reviewed 70 care records across the community services visited of which 44% had no evidence of care/management plans being recovery oriented with the patients strengths and goals identified.

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- Staff told us that combined paper and electronic notes meant that duty staff working weekends at the Greenfields site were not able to view progress notes of patients not under the care of that team as they were at a separate location. This meant that all information was not in an accessible form or readily available.
- The trust had failed to deliver the 2014/15 Commissioning for Quality and Innovation (CQUIN) regarding physical health checks. Management at the Early Intervention team had recognised the shortfall and were creating a health passport and physical health clinics to encourage staff to discuss health issues with patients. They confirmed this was a work in progress and the areas identified included healthy eating and staying active.
- The trust participated in the Commissioning for Quality and Innovation (CQUINs) framework which encourages care providers to share and continually improve how care is delivered and to achieve transparency and overall improvement in healthcare. The CQUIN for quality improvement framework was identified in the trust quality priorities for 2015/16 which recognised the 5W (who, what, when where and why) methodology as a focus on measuring outcome and recovery for people who used the services within the community teams. However, we did not see any measuring outcomes within the service to monitor the recovery of people who used the service.
- The paper records seen across the services showed that consent to care and treatment and information sharing was inconsistently recorded.
- Discharge planning was inconsistent across the teams.
- Annual personal development review (PDR) compliance within the ICMHT's was below the trust standard of 95% and had an average score of 70%. The trust reported that having confirmed the results with the team managers it was reported that more PDR's had taken place but had not been recorded in the appropriate place.
- We reviewed the training records for the community teams which showed that the mandatory training compliance rates averaged 93% which was below the trust's target of 95%. The training records showed that most staff had completed their mandatory training.

However:

- There was evidence of regular structured team meetings within the community teams. We observed comprehensive shift

Summary of findings

handovers taking place within the recovery and resettlement team at Hillcrest and we participated in multi disciplinary team (MDT) and governance meetings at the Moorlands ICMHT. These meetings promoted team working and learning from lessons.
- The records read showed that the Resettlement and Review team had maintained 100% of patients receiving a 6 month review of their care plan approach (CPA).
- Staff in the community teams told us that multi-disciplinary working was good. Staff felt able to consult with their colleagues and well supported by them.

Are services caring?

Good

- In the community teams we observed staff to be kind, caring and compassionate. This was demonstrated by all staff that we observed and shadowed.
- When we spoke with people they were positive about the care they felt they received. With one exception all people we spoke to and their carers reported that they were treated with respect and found staff to be supportive and helpful towards them.
- Staff demonstrated a good knowledge and understanding of people using the service. we observed staff on home visits to interact with patients in a positive, warm and empathetic manner.
- Patients were offered a variety of therapies and were encouraged to participate in meeting new people, learning new skills and getting support in a safe, welcoming environment. Examples included the “Clubhouse Network” which enabled patients to call in for a drink or lunch with friends, sit quietly with a book or participate in activities which included quiz sessions, computer skills and music sessions.
- We read comments left by patients for the AMHP and best interest assessors. One patient said that “assessment staff have been very helpful and very explanatory” and another said “staff took time to get to know my relative and made it easy to build up a relationship.”
- Friends and Family Test (FFT) were displayed within the community services. We saw the trust’s audit which showed that 89% of patients said they had been involved in what was important to them.

However:

- No evidence of adherence to NICE Guidance regarding offering discharged service users the opportunities to pursue advocacy or moratorial services.

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Are services responsive to people's needs?

Requires improvement 

- Within Growthpoint we found there were no systems in place for throughput. Patients did not exit the service within any specific period. There were currently 40 patients waiting for a placement. We found that one patient had been at Growthpoint for over 15 years.
- The Early Intervention team were aware they did not routinely capture the duration of untreated psychosis (DUP). The DUP refers to the time elapsing between psychosis onset and treatment initiation. However, the manager informed us that an audit had recently been completed by one of the junior doctors to evaluate the DUP. The results were not available on the day of our inspection.
- Staff reported that the Sutherland building can get hot during summer. On the day we carried out our inspection the temperature in the clinic room at the Sutherland centre was 25 degrees centigrade and staff were using a fan to cool the room down.
- We did not see good signage for people who may have difficulty communicating for example, pictures and symbols.
- There were some inconsistencies in the range of easily accessible information for people who used the services we inspected. We saw a range of leaflets available in the waiting areas of the ICMHT's. Information available included local support group information, the trust complaint process and information for carers. We did not see information available in languages other than English, this was brought to the attention of staff during the inspection process. Many of these leaflets have been provided by third sector and other organisations so are not Trust leaflets. Staff would however explain that a leaflet can either be provided in the format needed or an interpreter can be accessed to help with this.

However:

- Weekend and bank Holiday ICMHT cover was staffed from 9am to 5pm by one qualified clinician from each team and operated from the Greenfields centre with support from support time recovery (STR) workers.
- The Early Intervention team were working towards the new access and waiting time standards for mental health services in 2015/16. This was in accordance with NICE guidelines for psychosis and schizophrenia in children and young people (CG155 (2013) or adults CG178 (2014). The standard requires that by 01 April 2016 more than 50% of people experiencing a

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first episode of psychosis will be treated with a NICE approved care package within two weeks of referral. The records showed that the Early Intervention team had achieved a target of 28% from February 2015 to April 2015.

Are services well-led?

Requires improvement

- Staff said they did not always feel able to maximise time spent on direct care activities or always deliver the quality of care they would like to due to increasing referrals into the Community Mental Health Teams. Staff also described increased caseload sizes and information governance difficulties caused by the trust having joint paper and electronic care records.
- Management at the Growthpoint centre said they did not report their performance to the trust. They did not have key performance indicators (KPI) to assess the effectiveness of the service. This meant the trust had no knowledge of how this service was progressing.
- There was no monitoring of compliance to the Section 75 agreement from the trust or the local authorities. This was partly due to appropriate technology not being in place. The three information technology (IT) systems being used were not compatible. There was a risk of information not being recorded accurately when it was duplicated. However, neither the trust nor the local authorities were aware of any incidents that had occurred as a result of this.
- Annual personal development review (PDR) compliance within the ICMHT's was below the trust standard of 95% and had an average score of 70%.
- Staff said that morale was being impacted upon by increasing caseload sizes within the city ICMHT's. This was leading to increased pressure on staff due to sickness rates within the teams and pressures placed upon them as a result of the trust having combined paper and electronic records.

Summary of findings

Information about the service

- The Integrated Community Mental Health Teams (ICMHTs) provide services throughout the whole county. They are made up of consultant psychiatrists, psychiatric nurses, occupational therapists, psychologists providing a range of treatments, interventions and assistance to adults aged 16-65. Integration of the trusts community rehabilitation and assertive outreach function to the ICMHT's had taken place in June 2015 as part of the trusts cost improvement programme
- The Recovery and Resettlement team which is delivered by a team of support, time and recovery (STR) Workers. Tenancy support is provided by Brighter Futures who are the social care landlords. Accommodation consists of shared supported tenancies offering 40 bed spaces in 7 different locations within the City of Stoke-on-Trent. The service is able to provide a variety of accommodation and support options depending upon individuals assessed needs. A 24 hour service over 7 days is provided and a short break service is also available.
- The Early Intervention Team (EIT) provided assistance to young adults aged between 14 and 35 experiencing the early signs of psychosis. The EIT provided support which included coping with worries and stress, how to manage and recognise distressing symptoms and how to maintain social activities, education and returning to work. The EIT provided support and advice to family members with discussion and negotiation around the need for medicines.
- The Resettlement and Review team were responsible for the care management of people who use the service in funded placements.
- The Growthpoint and Kniveden scheme provided a therapeutic approach through creating training programmes which included horticulture, pottery, woodwork and jewellery and alternative therapies. The project is aimed for adults aged 18 to 65 by providing a structured approach to practical skills which could be used to encourage development, the encouragement of social inclusion and boost patient's well-being.

Our inspection team

Our inspection team was led by:

Chair: Dr Paul Lelliot; Deputy chief inspector for hospitals. (mental health, CQC

Team Leader: James Mullins; Head of Hospital Inspection (mental health) CQC

Inspection Manager: Kenrick Jackson

The team that inspected the community-based mental health teams consisted of three CQC inspectors, a psychiatrist, two nurses and a social worker all of whom had recent mental health service experience and an expert by experience who had experience of using mental health services.

The team would like to thank all those who met and spoke to inspectors during the inspection and were open and balanced with the sharing of their experiences and their perceptions of the quality of care and treatment at the trust. They had prepared for our visit by gathering relevant information and requesting availability of staff and service users to meet or speak with us.

Why we carried out this inspection

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

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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, and asked a range of other organisations for information.

We carried out an announced visit from 7-11 September 2015.

- During the inspection visit, the inspection team:

• Visited 9 community mental health services and looked at the quality of the care provided and how staff were caring for people.

• Spoke with 26 people who were using the service.

- Spoke with 6 carers of people using services.

• Spoke with the managers for each of the services.

• Spoke with 57 other staff members; including nurses, social workers, STR's and psychiatrists.

• Attended and observed 2 hand over meetings, 2 multi-disciplinary team (MDT) meetings, visited two people who used the services in the community. We also attended the North Staffs User Group (NSUG).

We also:

• Looked at 70 care records.

• Looked at a range of policies, procedures and other documents relating to the running of the service.

What people who use the provider's services say

- We spoke with 26 people and 6 carers of people using the service. People who used the service told us that they were very happy with the care they received. One person we spoke to told us that staff "go above and beyond" and the service provided was very respectful.Another carer that we spoke to told us that "staff are wonderful, absolutely fantastic".

Good practice

- The Early Intervention team were involved in the "Early Intervention Dual Diagnosis Engagement and Recovery (EIDDER) project. This is an 18 month project that aims to improve engagement and recovery outcomes for people who use the service experiencing psychosis and co-existing substance use. The outcomes of the project is due June 2016.

Areas for improvement

Action the provider MUST take to improve

- The provider must ensure that all relevant care records contain a risk assessment and that this risk assessment contains detailed and consistent information about historical risks of the people that use their services.
- The provider must ensure that the care plans completed for the people who use their services are recovery oriented with the persons strengths and goals evident within them.

Summary of findings

- The provider must ensure that a persons relative or carer's involvement in the care planning/management plan process is evident within care records where appropriate.
- The provider must ensure that consent to care and treatment and information sharing is consistently recorded within the care records of people using services.
- The provider must ensure that individual caseloads within the ICMHT's remain within the guidance of the mental health policy implementation guide for community mental health teams and that teams have adequate staffing provision.
- The provider must ensure that where people rights under the mental health act are explained to them, this is recorded consistently within care records.
- The provider must ensure that statutory and mandatory training compliance is monitored regularly and that outstanding areas of non-compliance are addressed.
- The provider must ensure that where clinical supervision takes place it is consistent with the guidance of the providers generic clinical supervision policy and is recorded accurately.
- The provider must ensure that where refrigerator equipment for medication is available within community teams, that equipment must be fit for purpose.

Action the provider SHOULD take to improve

The provider should ensure that all staff who undertake home visits to people in the community are aware of their responsibility to check the electronic records systems prior to doing so as stated in the providers lone worker policy procedure.

North Staffordshire Combined Healthcare NHS Trust

Community-based mental health services for adults of working age

Detailed findings

Locations inspected

Name of service (e.g. ward/unit/team)	Name of CQC registered location
Recovery and resettlement service: Hillcrest Street	North Staffordshire Combined Healthcare NHS Trust
City CMHT: Greenfields centre	North Staffordshire Combined Healthcare NHS Trust
City CMHT: Sutherland centre	North Staffordshire Combined Healthcare NHS Trust
County CMHT: Moorlands	North Staffordshire Combined Healthcare NHS Trust
AMHP/Best Interest team, Hillcrest,	North Staffordshire Combined Healthcare NHS Trust
Early Intervention Service,	North Staffordshire Combined Healthcare NHS Trust
Resettlement & Review team	North Staffordshire Combined Healthcare NHS Trust
Growthpoint & Kniveden,	North Staffordshire Combined Healthcare NHS Trust

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 a provider.

- 93% of staff had been trained in the Mental health act code of practice across the ICMHT's we visited.
- Staff we spoke to told us that they could seek support from the trusts mental health act office based at the Harplands hospital if they needed support with this.

Detailed findings

- The documentation in respect of the Mental health Act 1983 (MHA) were of an acceptable standard and completed appropriately. Patients were able to receive prompt mental health assessments.
- The training records showed that staff had received training on the Mental Health Act 1983/2007.
- We reviewed the records of 6 people subject to a community treatment order (CTO) 92% of the CTO records we reviewed were filled in correctly, up to date and stored appropriately.

Mental Capacity Act and Deprivation of Liberty Safeguards

- Staff had a good understanding of the Mental Capacity Act 2005 (MCA) and knowledge of Deprivation of Liberty Safeguards (DoLS).
- 94% of staff across the ICMHT's had been trained in MCA and DoLs.
- We were informed that patients had access to an independent mental capacity advocate (IMCA) when required. However, there was no literature available supporting this. An IMCA could speak to patients on issues relating to for example; health care and accommodation.
- Most staff had a good understanding of the provisions of the Mental Health Act (MCA) and Code of Practice. The records showed that staff within the community services visited had received their MCA and Deprivation of Liberty Safeguards (DoLS).

Requires improvement

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

- Access to the mental health centres were through staffed reception areas with clean and tidy waiting areas.
- We saw there were well equipped clinic rooms to carry out physical examinations. We saw that equipment was being checked within the clinic rooms on a regular basis including the contents of the emergency bag and defibrillator.
- We saw that clinic fridge temperatures were being checked although in the Greenfields and Sutherland centre the temperatures within the clinic rooms were high and 25 degrees centigrade on the day that we visited. This was brought to the attention of staff who said they had reported this to the trust and had requested air conditioning. Staff were using fans to regulate the clinic room temperature in the interim.
- Call alarms were available to all staff within rooms where staff saw people and staff were aware of how these operated and how to respond to them. We saw that alarms were tested monthly within the access team.
- We saw the health and safety audit for June 2015 which did not identify any issues or concerns.
- Staff said the environment at the Growthpoint centre was peaceful. The centre had a variety of setting which included; allotment/vegetable growing areas, buildings for woodworking and a hot house. There were processes and risk assessments in place to ensure the safety of the environment to people accessing the service.

Safe staffing

- Most community staff confirmed their caseloads were manageable. Staff said they could effectively monitor the people on their cases and there were both daily and weekly team meetings to review these. However the city ICMHT staff reported having higher caseloads. Within the city ICMHT the average caseload sizes were 37 at the Sutherland centre and 35 at the Greenfields centre. Staff within the city ICMHT's told us that they felt unable to always deliver quality of care due to increased pressure of workloads in the community teams. The trust currently have no policy for the effective and safe management of caseloads. The average caseload size at the County CMHT at Moorlands was 24.
- Staff in the city ICMHT's reported that there had been increased pressures due to vacant posts and increased caseloads. Staff within the services told us there had been further workload pressures due to staff being absent due to long term illness. The trust reported that sickness levels within the city CMHT's was an average of 3% over the period August 2014 to August 2015. Due to the two city CMHT's being counted as one team with two locations on the trusts electronic staff records system they were unable to provide this data for the individual teams. The average sickness level within the County ICMHT at moorlands was 7% over the period over the period August 2014 to August 2015 however this was decreasing as a trend from May 2015. 3 of the 4 vacant posts within the Greenfields ICMHT had been recruited to.
- The trust reported low levels of bank and agency staff within the city ICMHT's and the recovery and resettlement service at 0.5 and 12 hours for each respective service, averaged per month over the period August 2014 to July 2015. The trust reported no bank staff usage within the Moorlands ICMHT.
- There are no national tools to calculate staffing requirements within ICMHT's. The trust had reflected upon the daily operations of the community teams and as such levels for community services had been set on population demands.
- The community services' managers said that caseloads were reviewed at weekly meetings and during supervision. Staff confirmed they worked well as a team and supported each other where required.
- We reviewed the current and previous staff rotas and these showed us that there were sufficient staff on duty to meet the needs of the people in these services.
- Staffing skill mix was sufficient to meet need and showed a range of different professions, including nurses, social workers, STR's, occupational therapists and psychiatrists.

Requires improvement

Are services safe?

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

- Staff at Growthpoint said that shortage of staff impacted on their ability to deliver additional training to people who used the service.

Assessing and managing risk to patients and staff

- Of the 70 care records reviewed 29% had no risk assessment evident. A further 46% had some evidence of risk assessment having taken place. However, we found errors present with inconsistent data for example regarding suicide risk of one patient identified within initial 3 point risk assessment but not identified in further modular risk assessment. Historical risks had been identified in some risk assessments but lacked detail of antecedents, static or dynamic risk factors and crisis plans.
- We saw that staff undertake risk assessments of patients on the teams caseload but that these were not always regularly updated. We found risk assessments that had inconsistent information, had not been updated following significant risks occurring and lacking signatures of the care co-ordinator or patient.
- The ICMHT's had a designated duty worker on shift from 8am to 8pm to enable them to respond promptly to a sudden deterioration in patients health in the absence of the patients designated care co-ordinator being able to respond. We saw this system in practice during our inspection.
- Across the community teams we inspected, an average of 96% of required staff were trained in level 1 safeguarding of children and 95% of required staff were trained in level 1 safeguarding of adults. Staff we spoke to were able to identify and discuss the process of raising a safeguarding alert and said they felt able to do this when appropriate.
- Staff were clear about the appropriate procedure to follow if people did not attend their appointments, this included telephone contact, making home visits and sending follow up letters.
- There were nurse prescribers working within the ICMHT's. Medicines were managed safely and staff were able to discuss the process for liaising with pharmacy for people prescribed over British National Formulary (BNF) limits.
- STR's became involved in social support and short term intervention of up to four weeks which included employment, benefit and housing support. The STR's also liaised with resource teams and supported patients whilst awaiting therapies.
- Staff told us they could access the best interest assessors to provide support in the Deprivation of Liberty Safeguard (DoLS) referral procedures.
- The Early Intervention team used the Positive and Negative Syndrome Scale (PNSS) for measuring symptom severity of patients with schizophrenia. They also used the Children At-Risk Mental State (CARMS) to measure prodromal periods characterised by changes in thinking, perception, mood, affect and behaviour.

Track record on safety

- Staff knew how to report any incidents and had access to the electronic system.
- Staff were able to describe the learning from incidents and the sharing of information at team meetings.
- Staff had personal alarms which they could use within interview rooms.
- Staff we spoke to were aware of the trust lone working policy, the use of a buddy system when undertaking visits and described the process of reviewing patients risk and increasing staff to undertake visits if this was felt necessary. There were inconsistencies in how staff adhered to the lone working policy within the teams. Two members of staff told us that they didn't always have time to review a patients records via the trusts electronic corporate health information programme (CHIPS).

Reporting incidents and learning from when things go wrong

- There had been no "never events" reported in the community services between April 2014 and May 2015. A never event is defined as a serious, largely preventable patient safety incident that should not occur if the available preventative measures are implemented.
- There were 61 serious incidents reported from April 2014 to May 2015 of which 33 concerned patient deaths. Twenty of these were attributed to community patients.
- We spoke with staff within the Early Intervention team who were aware of incidents which had attributed to patients death. They told us they had been supported by the trust and had access to counselling when required. Staff said they were aware of the result of the root cause analysis reports which identified no recommendations as all relevant safety measures were in place.

Requires improvement

Are services safe?

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

- Staff said they were aware of the safeguarding incident reporting system used by the trust Feedback from incidents and learning were discussed at team meetings. We saw minutes of meetings where learning had been shared.
- Staff told us that they received feedback from the investigations into serious untoward incidents. Lessons learned were discussed during weekly multi-disciplinary team (MDT) meetings and monthly governance meetings. We observed evidence of this during our attendance at these meetings
- We saw evidence that practice had changed following a trust investigation into a serious untoward incident in the Moorlands ICMHT. Procedures for allocation of new referrals to the team had been reviewed by the team following a local debrief and new systems developed to reduce risk of a reoccurrence.
- Staff told us that they received monthly updates via email from the trust safety lead in a bulletin via the intranet called "learning lessons"
- The locality managers said they acknowledged all Central Alerting System (CAS) notifications. They said they reviewed the alerts and reported back to the risk and safety team, where applicable.

Are services effective?

Requires improvement

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

- During the inspection process we reviewed 70 care records across the community services visited,of which 44% had no evidence of care/management plans being recovery oriented with the patients strengths and goals identified.
- Staff were able to show how they provided care and treatment to both patients and carers in line with the National Institute for Health and Clinical Excellence (NICE) guidelines. However, the records read did not identify the involvement of patients in partnership with their health and social care professionals. For example; out of 27 records within the access team we found that 18 did not identify the patient's, their relative or carer's involvement in the care planning/management plan process. We found no evidence of a review of patient's care/management plans within 18 of the records read.
- All the records were stored securely and were available to staff when they needed it.
- Individual assessments we reviewed took into account the reason for referral, patient's mental health presentation and past psychiatric history.
- The Early Intervention team had a red, amber and green (RAG) board system on display to assess patient risk. This was updated by the care co-ordinator daily and as and when there were changes.
- The trust had failed to deliver the 2014/15 Commissioning for Quality and Innovation (CQUIN) regarding physical health checks. Management at the Early Intervention team had recognised the shortfall and were creating a health passport and physical health clinics to encourage staff to discuss health issues with patients. They confirmed this was a work in progress and the areas identified included healthy eating and staying active.
- Staff within the Early Intervention Team contributed to the "Living with Risk" project. This is a CQUIN based innovation which involved collaboration with a suicide and self-harm group which looked at keeping patients safe.
- The records read showed that the Resettlement and Review team had maintained 100% of patients receiving a 6 month review of their care plan approach (CPA).
- The Resettlement and Review team told us they assessed patient's needs in line with the Care Standards Act 2000 and the National Capabilities Framework 2004. This was evidenced in the records read.
- We saw the DoLS team were working effectively with care providers to improve their understanding of DoLS. This ensured that DoLS referrals were appropriate and contained correct & relevant information.

Best practice in treatment and care

- The trust participated in the Commissioning for Quality and Innovation (CQUINs) framework which encourages care providers to share and continually improve how care is delivered and to achieve transparency and overall improvement in healthcare. The CQUIN for quality improvement framework was identified in the trust quality priorities for 2015/16 which recognised the 5 W's (who, what, when where and why) methodology as a focus on measuring outcome and recovery for people who used the services within the community teams. However, we did not see any measuring outcomes within the service to monitor the recovery of people who used the service.
- The trust had embedded the "Short Warwick and Edinburgh mental wellbeing scale." This is a scale for assessing positive mental health and well-being which includes positive thoughts and feelings.
- The paper records seen across the services showed that consent to care and treatment and information sharing was inconsistently recorded.
- Managers carried out regular audits of care records. However, we found the audit did not provide sufficient information to support what had been audited. We saw actions were identified but we did not find any outcomes to support this. The trust provided us with a copy of the tool used to audit healthcare records which contained tick boxes for whether a care plan or risk assessment was evident. However, it did not contain further audit information of the quality of the two documents.
- The trust used the Health of the Nation Outcome Scales (HoNOS), for working age people. These were completed at the start and end of each episode of care and identified historical and current risks using a cluster tool. We saw the results for the Resettlement and Review team which showed they had achieved an average percentage of 97% against the trust target of 95% in July 2015

Are services effective?

Requires improvement

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.

- The Early Intervention Team were aware of the shortfall in measuring outcomes. They told us they were looking at using the MECCA questionnaire which looked at people's mental and physical health, medicines and activities, CHOICE (a questionnaire used to ask people who had used therapy services in distressing times) and PSYARTS (delusions and voices) which would be used to track change overtime in terms of symptoms, functioning and perception of difficulties within the early intervention services

Skilled staff to deliver care

- We reviewed the training records for the community teams which showed that the mandatory training compliance rates averaged 93% which was below the trust's target of 95%. The training records showed that most staff had completed their mandatory training. However, the records showed that the access team's clinical risk course compliance was low at 34% and fire compliance at 65%.
- Annual personal development review (PDR) compliance within the community mental health teams was below the trust standard of 95% and had an average score of 70%. The trust reported that having confirmed the results with the team managers it was reported that more PDR's had taken place but had not been recorded in the appropriate place.
- The training department provided the locality managers with an update of any training outstanding which could be addressed with the staff concerned.
- Newly qualified social workers we spoke with said they did not have access to the assessed and supported year in employment (ASYE) framework. The ASYE scheme is designed to help newly qualified social workers develop their skills, knowledge and professional confidence. It provides them with access to regular support during their first year of employment.
- STR's worked autonomously but had weekly case supervision with the case manager.
- Most staff said they would like role specific training due to the reconfiguration of the integrated teams.
- New staff received an induction to the service. This included both a corporate and local induction. We saw a copy of the induction programme which staff undertook. Areas covered included; mandatory training and mentoring within the teams.
- Staff said they received monthly supervision and annual appraisals. However, the managers confirmed that this was informal supervision and not formally recorded. They said they were aware of the shortfall and this was a work in progress. Staff described receiving good support from their line managers.
- Staff at the Growthpoint centre encouraged people who used the service to attend training such as woodwork and horticultural. During our visit, we saw that a STR who had knowledge of plumbing had undertaken a course so they could address people who used the services 'request and provide the necessary training.
- All staff at Growthpoint undertook induction followed by four to six week observation in the use of machinery which included woodwork and electrical tools. All staff were certified users of herbicides.
- Staff at Growthpoint said that long term sickness had impacted on the waiting list. This meant that staff were unable to take more people who used the service onto their books.
- Managers within the Early Intervention team were aware of the new Care Act. They said they were in the process of ensuring that all staff were able to describe the patient's eligibility of a needs assessment to manage every day activities such as looking after the
- Staff within the Early Intervention teams said they had received role specific training which included cognitive behavioural therapy (CBT) and psychological interventions (PSI) training. This was in accordance with the NICE (2002) guidance on the treatment of people with psychosis.
- Staff were able to tell us of the duty of candour regulations. They said the trust was committed to being open and transparent in their approach to safe care.
- Staff came from a range of professional backgrounds including nursing, social working and occupational therapy. The teams had input from psychiatric, allied mental health professionals and occupational therapy staff.

Multi-disciplinary and inter-agency team work

- Staff in the community teams told us that multi-disciplinary working was good. Staff felt able to consult with their colleagues.
- Assessments were multidisciplinary in approach. The care/management plans did not include advice and input from different professionals involved in a person's care within the Access team records.
- Staff reported good access and support from the Approved Mental Health Professionals (AMHPs).

Are services effective?

Requires improvement

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.

- Discharge planning was inconsistent across the teams.
- The community services had good access to a psychiatrist. The resettlement and review team said they were able to get appointments within two weeks The psychiatrist who visited the Early Intervention team also attended a weekly multi-disciplinary team meeting.
- The Growthpoint team had good links with the Steps to Change charitable organisation. The aim of the Changes service is to provide an opportunity for those suffering from mental distress to move from isolation, withdrawal and dependency to becoming active and contributing members of their immediate and wider community.
- Staff in the community teams said they had good links with the local Multi Agency Safeguarding Hub (MASH).

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

- 93% of staff across the CMHT's and the recovery and resettlement team had been trained in the Mental Health Act code of practice at the end of August 2015
- Staff we spoke to told us that they could seek support from the trusts mental health act office based at the Harplands hospital if they needed support with this.
- The documentation in respect of the Mental health Act 1983 (MHA) were of an acceptable standard and completed appropriately. Patients were able to receive prompt mental health assessments.
- The training records showed that staff had received training on the Mental Health Act 1983/2007.
- We reviewed the records of 6 people subject to a community treatment order (CTO) 92% of the CTO records we reviewed were filled in correctly, up to date and stored appropriately.

Good practice in applying the Mental Capacity Act

- 94% of staff across the ICMHT's and the recovery and resettlement team had been trained in the Mental Capacity Act and Deprivation of Liberty Safeguards at the end of August 2015.Staff we spoke to during our inspection had a good understanding of the Mental Capacity Act 2005 (MCA) and knowledge of Deprivation of Liberty Safeguards (DoLS).
- We were informed that patients had access to an independent mental capacity advocate (IMCA) when required. However, there was no literature available supporting this. An IMCA could speak to patients on issues relating to for example; health care and accommodation.

Good

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 the community teams we observed staff to be kind, caring and compassionate. This was demonstrated by all staff that we observed and shadowed.
- When we spoke with people they were positive about the care they felt they received. With one exception, all people we spoke to and their carers reported that they were treated with respect and found staff to be supportive and helpful towards them.
- Staff demonstrated a good knowledge and understanding of people using the service. we observed staff on home visits to interact with patients in a positive, warm and empathetic manner.
- When staff spoke with us about patients, they discussed them in a respectful manner and showed a good understanding of their individual needs. However, the records did not show a person-centred approach throughout care and 44% of care plans across the services lacked recovery oriented and person centred information.

The involvement of people in the care that they receive

- During our visit in the community we observed the patient was asked if they would like a copy of their care plans. This was provided to the patient during our visit. However, most of the records read did not identify that patients were offered a copy of their care/management plan.
- There was no evidence of contact with next of kin or clarification of social factors and support networks.
- There was no evidence of the involvement of carers/next of kin's views, where appropriate.
- Carers were offered the opportunity of a carer's assessment. However, this was not identified in the records read.
- Patients were offered a variety of therapies and were encouraged to participate in meeting new people, learning new skills and getting support in a safe, welcoming environment. Examples included the "Clubhouse Network" which enabled patients to call in for a drink or lunch with friends, sit quietly with a book or participate in activities which included quiz sessions, computer skills and music sessions.
- The involvement from people who used the service and family was recorded in some records but not all.
- People who used the service attended monthly meetings at Growthpoint to discuss the running of the project.
- One person who used the service at Growthpoint told us they "enjoyed the courses" and another said the place "felt like a community" and there was "always someone to talk to and help."
- Two people who used the service at Growthpoint had been encouraged and supported through training. This resulted in them being qualified as STR's within the trust. Patients who attended Growthpoint attended first aid courses and were trained First Aiders.
- We saw the best interest assessor's team service evaluation for November 2014. We saw that 89% of patients said they had received enough information about the assessment process and 83% said they had been given legal information regarding the MCA and DoLS.
- We saw comments left by patients for the AMHP and best interest assessors. One patient said that "assessment staff have been very helpful and very explanatory" and another said "staff took time to get to know my relative and made it easy to build up a relationship."
- Friends and Family Test (FFT) were displayed within the community services. We saw the trust's audit which showed that 89% of patients said they had been involved in what was important to them. We saw that only 50% of the patients said they had been provided with information regarding new medicines.
- The records read did not identify that people were involved in their care or that they or their relatives were given a copy of their care plan to comment on and agree or disagree with.
- We did not see leaflets on display in some team bases on advocacy or information on how to access the advocacy services.
- No evidence of adherence to NICE Guidance regarding offering discharged service users the opportunities to pursue advocacy or moratorial services.
- We saw no evidence within access team records of people being offered a preference for a male or female health or social care professional to conduct crisis assessments.

Are services responsive to people's needs?

Requires improvement

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

Our findings

Access and discharge

- Within Growthpoint we found there were no systems in place for throughput. Patients did not exit the service within any specific period. There were currently 40 patients waiting for a placement. We found that one patient had been at Growthpoint for over 15 years.
- There were processes in place for example, informing their care co-ordinator, should a patient become unwell whilst attending Growthpoint. This guidance was agreed with patients during their initial assessment and further discussed at monthly meetings.
- Should patients not turn up for their appointment at Growthpoint, the staff made phone calls to ascertain the reasoning for non-attendance and if applicable refer to their carer, family or care co-ordinator. However, Growthpoint did not monitor the number of people who did not attend. This meant they could not ensure the effectiveness of the service.
- Staff said they made every effort to ensure that patients were admitted locally. However, on occasions some patients were admitted to services located in different parts of the country for example; Middlesborough or Walsall. We saw that staff had made efforts to ensure that family contact was maintained where appropriate. Care co-ordinators said that people located out of the area caused issues with the attendance of reviews and meetings.
- Weekend and bank Holiday ICMHT cover was staffed from 9am to 5pm by one qualified clinician from each team and operated from the Greenfields centre with support from STR's.
- The Early Intervention team were working towards the new access and waiting time standards for mental health services in 2015/16. This was in accordance with NICE guidelines for psychosis and schizophrenia in children and young people (CG155 (2013) or adults CG178 (2014). The standard requires that by 01 April 2016 more than 50% of people experiencing a first episode of psychosis will be treated with a NICE approved care package within two weeks of referral. The records showed that the Early Intervention had achieved a target of 28% from February 2015 to April 2015.
- The Early Intervention team were aware they did not routinely capture the duration of untreated psychosis (DUP). The DUP refers to the time elapsing between psychosis onset and treatment initiation. However, the manager informed us that an audit had recently been completed by one of the junior doctors to evaluate the DUP. The results were not available on the day of our inspection.
- The Occupational Therapists told us they used the mental health recovery star model. The mental health recovery star is designed to capture evidence whilst supporting people who use the service. This enabled staff and therapists to discuss important issues and to assess peoples' skills to live independently. Examples included shopping and cooking skills.
- The DoLS assessment targets were not being met by the best interest team. They were currently 50% above target. However, this is a national problem and the local authority was positive about the trust's performance in this area.

The facilities promote recovery, comfort, dignity and confidentiality

- We saw that within the community teams there were a full range of rooms and equipment to support treatment and care. We saw that clinic rooms were clean and well equipped with regular checks being made of equipment present. We saw that rooms where staff saw people had adequate soundproofing. Within the recovery and resettlement service there was no clinic room due to the nature of the service being provided.
- Staff reported that the Sutherland building can get hot during summer. On the day we carried out our inspection the temperature in the clinic room at Greenfields was 25 degrees centigrade and staff were using a fan to cool the room down.
- We saw reception areas within the ICMHT's that were clean.
- We saw within the recovery and resettlement service at Hillcrest that peoples bedrooms were bright, well furnished and all en-suite.
- There were some inconsistencies in the range of easily accessible information for people who used the services we inspected. We saw a range of leaflets available in the waiting areas of the ICMHT's. Information available included local support group information, the trust complaint process and information for carers. We did not see information available in languages other than English, this was brought to the attention of staff during the inspection process.

Are services responsive to people's needs?

Requires improvement

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

- We did not see good signage for people who may have difficulty communicating for example, pictures and symbols.

Meeting the needs of all people who use the service

- The buildings we visited had disabled access with parking available although general parking at the Sutherland centre was raised as an issue by staff due to low capacity. All sites we visited had disabled toilet facilities.
- Staff told us that if required they could access a "language line" if they required assistance with interpreting or sign language services. This would be paid for by the individual teams budget.
- Staff at the recovery and resettlement service told us that they were currently caring for a person with hearing difficulties and they were learning sign language in order to better support them.

Listening to and learning from concerns and complaints

- Patients did not have access to information on how to report any concerns or complaints There were systems for complaints to be investigated and complainants to be given a response. Staff said they endeavoured to deal with complaints "on the spot" if possible Patients were referred to the Patient Advice and Liaison Service (PALS) if they were unable to resolve the issue locally .The manager at the Access team said they worked closely with the PALS service and were in the process of analysing all complaints received to report directly to PALS.
- Feedback and lessons learnt from complaints were discussed at team meetings. This was confirmed by staff spoken with and in the team meeting minutes seen.
- Staff were able to describe the complaints process

Are services well-led?

Requires improvement

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

- The trusts vision and values were on display across all the sites we visited. Staff were able to discuss these values with us and how they demonstrated them through patient care.
- Staff told us they were aware of who the senior staff in the organisation were and told us that they had visited the teams at their bases. Staff spoke of the trust initiative called "team brief" and told us they had been visited by senior management staff within the trust recently.
- Team managers said they received good support from senior managers.

Good governance

- All staff were not up to date with statutory and mandatory training with an average of 93% compliance in training across the three ICMHT's and the recovery and resettlement team.
- Staff said that they received feedback from the investigations into serious untoward incidents and these were discussed during weekly MDT and governance meetings. We observed MDT meetings and governance meetings being held and reviewed minutes from previous meetings and found this to be the case.
- Staff said they did not always feel able to maximise time spent on direct care activities or always deliver the quality of care they would like to due to increasing referrals into the ICMHT's. Staff also described increased caseload sizes and information governance difficulties caused by the trust having joint paper and electronic care records.
- The community teams held monthly quality meetings regarding service improvement. Support time and recovery staff told us their criteria had been redefined as a result of discussions at these meetings.
- Management at the Growthpoint centre said they did not report their performance to the trust. They did not have key performance indicators (KPI) to assess the effectiveness of the service. This meant the trust had no knowledge of how this service was progressing.
- There was no monitoring of compliance to the Section 75 agreement from the trust or the local authorities. This was partly due to appropriate technology not being in place. The three information technology (IT) systems being used were not compatible. There was a risk of information not being recorded accurately when it was duplicated. However, neither the trust nor the local authorities were aware of any incidents that had occurred as a result of this.
- Most staff had received regular supervision. Management informed there was a shortfall in the recording of supervisions and were implementing guidelines to staff in the recording of formal supervision. Information provided by the trust told us that an average of 93% of staff across the ICMHT's were recorded as receiving supervision. The information provided by the trust did not specify how frequently supervision was taking place or compliance against the generic trust supervision policy which states that "The Trust expects that all staff will receive a minimum of one hour long supervision session per quarter, though this policy recommends that teams and individual staff should strive to establish supervision on a monthly basis as a best practice standard".
- Annual personal development review (PDR) compliance within the ICMHT's was below the trust standard of 95% and had an average score of 70%. The trust reported that having confirmed the results with the team managers, more PDR's had taken place, but had not been recorded appropriately.
- Both the managers and staff told us that where they had concerns, they could raise them. Where appropriate the concerns could be place on the trust's risk register. We found there was not a local risk register in place for community services.
- We saw the Stoke-on-Trent AMHP team annual review for June 2015. This included a summary of findings which included the risk to be considered and other methods for managing risk. Examples included hospitalisation and community treatment orders (CTO).

Leadership, morale and staff engagement

- With the exception of one member of staff, all staff said they felt able to raise concerns without fear of victimisation.
- At the time of our inspection there were no grievance procedures being pursued within the teams, and there were no allegations of bullying or harassment.
- Staff told us they were aware of the trust whistleblowing policy and would feel able to raise concerns using this.

Are services well-led?

Requires improvement

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 discussed the trusts " Dear Caroline" system where they could raise concerns directly with the chief executive. Staff told us they felt this was useful and they were happy to use it if required.

- The managers said they felt supported and enabled to manage poor staff performance and/or competencies
- Staff told us that they felt they were well supported by local management. Staff described good morale and good working relationships within the teams However, staff said that morale was being impacted upon by increasing caseload sizes.
- Staff said they had the opportunity for leadership development. For example, one staff member of staff said they had progressed within the trust to managing the recovery and resettlement service. Another staff member said they had been encouraged to train as a social worker, they said the training was supported by the trust.

Commitment to quality improvement and innovation

- The trust had introduced the “Dear Caroline” scheme whereby staff could raise concerns anonymously about quality or any other related issue within the trust. The website was accessible anywhere that had an internet access.
- Staff were aware of the “Listening into Action” events which the trust ran to gain feedback from staff on how to improve services.
- The Early Intervention team were involved in the development of a recovery academy. We saw the paperwork which was a work in progress.
- The Early Intervention team were involved in the “Early Intervention Dual Diagnosis Engagement and Recovery (EIDDER) project. This is an 18 month project that aims to improve engagement and recovery outcomes for people who use the service experiencing psychosis and co-existing substance use. The outcomes of the project is due June 2016.

This section is primarily information for the provider

Requirement notices

Action we have told the provider to take

The table below shows the legal requirements that were not being met. The provider must send CQC a report that says what action they are going to take to meet these requirements.

Regulated activity	Regulation
Treatment of disease, disorder or injury	Regulation 9 HSCA (RA) Regulations 2014 Person-centred care Patients were not provided with care which was personalised specifically for them. Patients' capacity and ability to consent to be involved in the planning, management and review of their care and treatment was not routinely established. This was a breach of regulation 9 (3) (b,c,d,e,f)

Regulated activity	Regulation
Treatment of disease, disorder or injury	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment The provider did not maintain accurate, complete and detailed records in respect of each person using the service. Risk assessments for people receiving care were absent or did not contain detailed information. This was a breach of regulation 12 (2) (a, b)

Regulated activity	Regulation
Treatment of disease, disorder or injury	Regulation 18 HSCA (RA) Regulations 2014 Staffing Staff did not receive regular appraisal of their performance in their role from an appropriately skilled and experienced person. Staff received supervision but this was completed on an informal basis and a record of the process was not completed. This was a breach of regulation 18 (2) (a)

Regulated activity	Regulation

This section is primarily information for the provider

Requirement notices

Regulated activity	Regulation
Treatment of disease, disorder or injury	Regulation 15 HSCA 2008 (Regulated Activities) Regulations 2010 Safety and suitability of premises Equipment provided in the community for the storage of medication was not working. The provider had been made aware of this and there were not suitable arrangements for the maintenance or replacement of equipment. This was a breach of regulation 15 (1)(e)
Treatment of disease, disorder or injury	Regulation 18 HSCA (RA) Regulations 2014 Staffing One community team was on the trust risk register due to low staffing. Staff and people who used services reported high case loads impacted on the quality of care provided. Providers must deploy sufficient numbers of suitably qualified, competent, skilled and experienced staff to make sure that they can meet people's care and treatment needs This was a breach of regulation 18 (1)

This section is primarily information for the provider

Enforcement actions

Action we have told the provider to take

The table below shows the legal requirements that were not being met. The provider must send CQC a report that says what action they are going to take to meet these requirements.