Requires improvement

Gateshead Health NHS Foundation Trust

# Community-based mental health services for older people

## Quality Report

Trust Headquarters
Queen Elizabeth Hospital
Queen Elizabeth Avenue
Sheriff Hill
Gateshead
NE9 6SX
Tel: 0191 482 0000
Website: http://www.qegateshead.nhs.uk/

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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) |
|---|---|---|---|
| RR7EN | Queen Elizabeth Hospital | Community Mental Health Nurses – Central Gateshead | NE8 4YL |
| RR7EN | Queen Elizabeth Hospital | Community Mental Health Nurses – East Gateshead | NE8 4YL |

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

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

# Summary of findings

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

# Summary of findings

## Ratings

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

| | |
|---|---|
| Overall rating for the service | Requires improvement  |
| Are services safe? | **Requires improvement**  |
| Are services effective? | **Requires improvement**  |
| Are services caring? | **Requires improvement**  |
| Are services responsive? | **Good**  |
| Are services well-led? | **Requires improvement**  |

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

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

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

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

# Summary of findings

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# Summary of findings

## Overall summary

We rated community mental health services for older people as requires improvement because:

- Both the Central Gateshead and East Gateshead community mental health nurses teams were using an electronic patient record system which was not fit for purpose
- Neither team maintained a record of attendance for supervision. This meant that the service was not monitoring whether staff received supervision in line with the trust's policy.
- Staff did not review and update Risk assessments routinely in ether the Central Gateshead and East Gateshead community mental health nurses team.
- Risk assessments did not include evidence of how staff planned to mitigate identified risks.
- Care plans were not always personalised, holistic or recovery focussed. There was little evidence of personalisation or active involvement of patients in care planning. Patients were not given copies of their care plans.

However:

- The service had no staff vacancies.
- All staff had undertaken the training deemed by the trust to be mandatory.
- Feedback from patients about the service was entirely positive. Staff had a good understanding of the individual patient needs and a detailed knowledge of their previous history.
- The trust was aware of some of the areas of concern in the service and had started a project which aimed to make improvements.

# Summary of findings

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

**Are services safe?**

**Requires improvement**

We rated safe as requires improvement because:

- Risk assessments were not routinely reviewed and updated in either the Central Gateshead and East Gateshead community mental health nurses team.
- The electronic system used by the service did not capture how the staff mitigated identified patient risks in both the Central Gateshead and East Gateshead community mental health nurses team.

However:

- The service had no vacancies for qualified nurses and nursing assistants. There was no use of bank or agency staff in the service. Mandatory training compliance in the service was 100%.
- Staff knew how to report incidents and we saw evidence of staff receiving feedback from incidents. Staff knew the duty of candour.
- Staff in the service used an electronic device to ensure personal safety when lone working in the community.

**Are services effective?**

**Requires improvement**

We rated effective as requires improvement because:

- Care plans were not always personalised, holistic or recovery focussed. One care plan was reviewed by staff without any amendment or update for five years.
- The electronic patient record system did not support staff to deliver effective care.

However:

- All staff had received an appraisal in the twelve months prior to inspection. All seven consultant psychiatrists had undertaken and completed their revalidation.
- Staff described good working relationships with local primary care services. We saw evidence of staff working in partnership with the trust's inpatient mental health services for older people.

**Are services caring?**

**Requires improvement**

We rated caring as requires improvement because:

# Summary of findings

- We saw limited evidence of personalisation or active involvement of patients in care planning. Patients were not given copies of their care plans.
- The service did not have additional routes for people to be involved in the service such as in recruitment of staff.

However:

- Feedback from patients about the service was entirely positive. Feedback from carers was mostly positive about the service.
- We observed kind, caring and friendly interactions between staff, patients and carers. Staff had a good understanding of the individual patient needs and a detailed knowledge of their previous history.

**Are services responsive to people's needs?**

**Good**

We rated responsive as good because:

- The service had clear criteria for accepting referrals. The service was ahead of its target for the percentage of patients completing a treatment pathway within 18 weeks.
- Patients told us that staff were flexible with appointment times and always arrived on time for visits.
- In the twelve months prior to inspection neither team had received any complaints from patients or carers.

However:

- The service had an internal referral system, which the trust had identified prior to the inspection to be outdated and cumbersome. The trust was in the early stages of improving this system.

**Are services well-led?**

**Requires improvement**

We rated well-led as requires improvement because:

- Both the Central Gateshead and East Gateshead community mental health nurses teams were using an electronic patient record system which was not fit for purpose
- Neither team maintained a record of attendance for supervision which meant that the service was not monitoring whether staff received supervision in line with the trust's policy.
- The service did not maintain a team-level or service-level risk register or alternative method of monitoring risks to the service.

However:

# Summary of findings

- The trust was aware of some of the areas of concern in the service and had started a project which aimed to make improvements.
- Staff morale was high in the service. Staff were positive about their teams about their teams and their manager.
- Staff knew and understood the vision and values of the trust.

# Summary of findings

## Information about the service

Gateshead Health NHS Foundation Trust provides community mental health services for older people living in West, East and Central Gateshead. The community mental health nurses team are based at Bensham General Hospital. The teams provide mental health nursing care for elderly people in their own homes.

The service is split into three teams, East, West and far West, and central Gateshead.

We last undertook a comprehensive inspection of Gateshead Health NHS Foundation Trust in September 2015. The community mental health services for older people were not included as part of this inspection. This is the first comprehensive inspection of the community mental health services for older people provided by this trust.

## Our inspection team

**Team Leaders:** Chris Storton, Inspector (Mental Health) Care Quality Commission

The team inspecting the community mental health services for older people comprised three inspectors, one inspection manager, and one assistant inspector.

## Why we carried out this inspection

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

## 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.

During the inspection visit, the inspection team:

- visited the Central Gateshead community mental health nurses team based at Bensham Hospital
- visited the East Gateshead community mental health nurses team based at Bensham Hospital
- interviewed the manager Central Gateshead community mental health nurses
- interviewed the acting-manager of the East Gateshead community mental health nurses
- interviewed nine staff including doctors, nurses, and nursing assistants.
- spoke with seven patients who were using the service
- spoke with four carers of patients who were using the service
- reviewed eight care records of patients who were using the service
- accompanied staff from Central Gateshead community mental health nurses team for two visits to patients.
- accompanied staff from East Gateshead community mental health nurses team for one visit to a patients.
- looked at policies, procedures and other documents relating to the running of the service

# Summary of findings

## What people who use the provider's services say

We spoke with seven patients using the service. All seven patients provided positive feedback about the service. Patients also highlighted to us individual staff members who they wanted to praise. One patient told us that staff were 'pleasant and nice and warm' and that 'never act like it's just a job'. Three patients told us that the staff were friendly and always available if needed.

We spoke with four carers of patients using the service. Whilst the carers gave us mixed feedback about how involved they felt in the care being provided by the service, all were positive about the staff.

## Areas for improvement

### Action the provider MUST take to improve

- The trust must ensure that the electronic patient record system used by the community mental health nurses teams supports effective patient care.
- The trust must ensure that the community mental health nurses teams maintain an accurate, complete and contemporaneous record in respect of each service user, including a record of the care and treatment provided to the service user and of decisions taken in relation to the care and treatment provided.
- The trust must ensure that care records are personalised, holistic and reflective of patient preferences.
- The trust must ensure that risk assessments are regularly reviewed and updated and include how staff mitigate risks.
- The trust must ensure that all staff receive regular supervision and that this is monitored in line with the trust's supervision policy.
- The trust must ensure that effective governance systems are in place to share information in a timely manner.

### Action the provider SHOULD take to improve

- The trust should ensure that staff have a procedure in place which routinely monitors the physical healthcare of patients in the service.
- The trust should ensure that all staff have a good understanding of the Mental Health Act and Mental Capacity Act.
- The trust should ensure that all patients receive an assessment of their capacity by the community mental health nurses teams prior to commencing treatment.
- The trust should ensure that all patients have the option to have a copy of their care plans.
- The trust should ensure that all patients and carers are aware of the procedure for making complaints.

Gateshead Health NHS Foundation Trust

# Community-based mental health services for older people

**Detailed findings**

## Locations inspected

| Name of service (e.g. ward/unit/team) | Name of CQC registered location |
|---|---|
| Community Mental Health Nurses – Central Gateshead | Queen Elizabeth Hospital |
| Community Mental Health Nurses – East Gateshead | Queen Elizabeth Hospital |

## 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.

Training in the Mental Health Act was mandatory for all staff working in the community mental health nurses teams. All eligible staff had been trained in the Mental Health Act.

Staff told us it was rare for them to have any interaction with the Mental Health Act. Staff displayed limited understanding of the Mental Health Act, the Code of Practice and the guiding principles.

Patients conditionally discharged under guardianship or a supervised community treatment order could access an independent mental health advocacy service.

## Mental Capacity Act and Deprivation of Liberty Safeguards

Mental Capacity Act training was mandatory for all staff working in the community mental health nurses teams. All staff were trained in the Mental Capacity Act as part of the trust's training in safeguarding.

We saw one example of staff assessing mental capacity and making a decision for a patient in their best interest.

# Detailed findings

However, we did not see that staff had sought and documented the views of carers, family members or other professionals involved in the patient's care as recommended in the Mental Capacity Act Code of Practice.

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 staffing

We requested staffing establishment levels for the service. The service had a budgeted establishment level of 9.4 whole time equivalent qualified nurses and had an actual establishment level of 12 whole time equivalent nurses. The service had no vacancies for qualified nurses and was in fact over-established by 2.6 whole time equivalent qualified nurses. The service had an establishment level of 5 whole time equivalent band four support staff and had no vacancies. There was no use of bank or agency staff in the community mental health services for older people.

The service had a sickness rate which was slightly higher than the NHS national average. The sickness rate for the service was 5.5% whereas the national average is 4%. The turnover rate was low at 6.6% which related to only one member of staff leaving in the twelve months prior to the inspection.

The average caseload per worker was 28 patients. At the time of inspection the central Gateshead community mental health nurses had a total caseload of 106 patients and the East Gateshead community mental health nurses had a total caseload of 79 patients. The service did not use a caseload management tool. However, staff did undertake a weekly caseload meeting to discuss and allocate patients who were new to the service.

The service operated from 9am to 5pm Monday to Friday and was not commissioned to provide services outside of these hours. The trust had an on-call rota for consultant psychiatrists which operated from 5pm to 9am Monday to Friday and from 5pm on Fridays to 9am Mondays to cover every weekend. The on-call rota allowed the trust to provide cover for assessments under the Mental Health Act.

Mandatory training compliance in the service was 100%. Staff were required to undertake modules of mandatory training which were all completed via e-learning. Modules included training in safeguarding adults and safeguarding children.

### Assessing and managing risk to patients and staff

We reviewed eight care records. The service used an adapted version of the functional analysis of the care environment risk assessment which was embedded into the service's electronic patient record system. Staff undertook a risk assessment of every patient on admission to the service. The risk assessment required staff to identify the severity of risks but did not allow staff to record what action was required to mitigate the identified risks. We saw one record for a patient admitted to the service in January 2015 and we saw that the risk assessment was not reviewed until May 2016. In another record we saw that a patient had been identified as having a risk of self-neglect but similarly neither the record nor the care plan documented any action for staff to mitigate the risk.

When a patient entered the service, staff would always undertake an initial assessment supported by another staff member. Staff described how it was routine for risks to be discussed between members of the team prior to appointments. If a patient presented a risk to staff then they would avoid lone working with the patient and work in pairs. Staff told us how the electronic patient record system was unreliable and that it was not unusual for information to be lost in the system. Staff were candid about the limitations of the system and told us how it did not capture all the details including the planned mitigating actions for identified risks. Staff used various work-arounds to overcome the limitations of the system with some documenting additional information for risk assessments in case note entries in the system and others relying on paper records to support the electronic system. Staff used these solutions according to their individual preference which meant that there was not a systemic approach in the service to assessing, recording and reviewing patient risks.

Staff told us it was not routine for patients to have a crisis plan. Two of the eight records had a plan of action for patients entering a state of mental crisis.

All staff were trained in safeguarding adults and safeguarding children. Staff were able to describe the process for raising safeguarding concerns and the different types of abuse. In the twelve months prior to inspection the service had made two referrals to the local safeguarding authority.

The service had introduced an electronic device to ensure personal safety when lone working in the community. The

Requires improvement

# Are services safe?

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

device allowed staff to record their location prior to and following an appointment. In an emergency the device could be used to signal that a staff member needed assistance.

### Track record on safety

In the period May 2016 to November 2016 the service reported 11 incidents using the trust's electronic incident reporting system. The majority of incidents were reported as safeguarding concerns. Safeguarding concerns were reviewed by the trust's safeguarding team which would decide whether to refer to the local authority. The service made two referrals to the local safeguarding authority in the twelve months prior to inspection. There were no serious incidents requiring investigation or incidents classes as reportable to the national Strategic Executive Information System in the twelve months prior to inspection.

### Reporting incidents and learning from when things go wrong

Staff were aware of the types incidents which needed to be reported and how to use the trust's electronic incident reporting system. Staff told us that all incidents were investigated and a root cause analysis was completed. Staff received feedback from incidents in team meetings. We reviewed team meeting minutes for meetings from January 2016 to November 2016. The team received feedback from root cause analysis reports in three meetings. A recurring theme in the root cause analysis feedback was the difficulties faced by the service in retrieving information from the electronic patient record system.

Most staff had knowledge of the duty of candour and described it as the duty to be open and honest following an incident. Two staff members were aware that the trust had a policy for the duty of candour.

# 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

We reviewed four records of patients receiving care from the central Gateshead community mental health nurses team and four records of patients receiving care from the East Gateshead community mental nurses team. On the day of inspection, staff faced significant difficulties using the electronic patient record system. The system frequently froze and had to be restarted in order to access patient information. During a twenty-minute period we documented that the system froze six times meaning that staff were unable to access patient records.

The trust explained that the system issues on the day of inspection were caused by a compatibility issue with other systems used in the trust. We concluded that the electronic patient record system was neither reliable nor fit for purpose and that the experience of system failures on the day of inspection was not an uncommon incident. Staff from both the central Gateshead and East Gateshead community mental health nurses teams told us that the system was the most significant concern in the service. Staff described how updates to patient records following appointments, which were entered as 'contacts', could be lost or deleted by the system and could not be retrieved. The trust clarified that there was a procedure in place to retrieve lost information. The service had six team meetings in 2016. In all six meetings the electronic patient record system was covered as an item in the meeting minutes. Two meetings described the system as 'not fit for purpose', and additional meeting minutes noted that the using the system had created 'dangers in practice'.

Seven of the eight records we reviewed included a comprehensive assessment which was completed in most cases within a month of the patient's admission to the service. One record included a comprehensive assessment which had been started within a month of the patient's admission to the service but was not completed. In care records that we reviewed, care plans were not always personalised, holistic or recovery orientated. In one record, a patient's care plan was 'to maintain a level of functioning by means of prescribed depot injection'. The patient had entered the service in 2011. Staff reviewed the patient's care plan without changes every year from 2012 to 2016. We did not see any indication that the service had considered how or if the patient might be discharged in the future. We did not see evidence that care plans were written in way that was person-centred and captured the patient voice.

### Best practice in treatment and care

The managers of both teams told us that the service was able to refer patients to the trust's psychology department. Staff told us that the teams used an approach which was based on cognitive behavioural therapy. One staff member was able to describe a current patient who was being supported with anxiety management using a psychological approach, including being supported to attend a peer support group, rather than with medication.

The service worked closely with the trust's Ellison Unit. The Ellison Unit was a day hospital which provided assessment, treatment and rehabilitation to older people with mental health problems. Patients could be referred to the service by the community mental health nurses. The Ellison Unit allowed patients to access psychology and peer support.

The service had a system to check patients' most recent physical healthcare results at the point of admission. The service did not routinely monitor physical healthcare or undertake checks such as height, weight or blood pressure nor did they check, as a matter of routine, that the GP had done this. The team managers told us that staff could refer patients to the trust's community matrons or to other departments in the trust if a patient had a known physical healthcare need. Without undertaking regular monitoring of physical healthcare or having policies and procedures in place underpinned by agreements with primary care to ensure care co-ordinators routinely liaised with the GP regarding all patients' physical health, it was not clear how staff would identify a physical healthcare need. The service referred patients to either the acute hospital or their local GP service for blood tests and electrocardiogram tests to monitor for potential side-effects of antipsychotic medication.

### Skilled staff to deliver care

Both teams comprised qualified nurses, nursing assistants and support workers. The teams worked closely with the trust's team of consultant psychiatrists who provided care for people both in the community and in the trust's wards for older people with mental health problems. Staff told us that the service could refer patients to other departments in the trust including occupational therapy and psychology.

# 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 appraisal rate for the service was 100% which meant that all staff had received an appraisal in the twelve months prior to inspection. All seven consultant psychiatrists had undertaken and completed their revalidation.

Neither team provided compliance figures for supervision and we found that the teams were not routinely monitoring supervision. The trust's supervision policy stated that 'managers will ensure that protected time is given for formal clinical supervision for a minimum of 1 hour every 3 months'. However, the service was not monitoring whether staff received supervision in line with the trust's policy.

### Multi-disciplinary and inter-agency team work

Both teams had a weekly caseload meeting which was attended by both the community mental health nurses teams and the consultant psychiatrists. The meeting allowed staff to allocate new referrals, discuss current patients on the caseload and undertake group supervision. The service operated from 9am to 5pm Monday to Friday and was not commissioned to provide care outside of these hours. The service did not have separate shifts within these operating hours, which meant that staff were not required to have regular handover meetings.

We observed a visit to a patient in the community who had recently been discharged from one of the trust's wards for older people with mental health problems. Staff from the community mental health nurses teams had visited the patient whilst they were an inpatient on the ward and had established a relationship with the patient. Staff had worked to support the patient's discharge into the community and were working with the patient to prevent future readmissions to hospital.

Staff in both teams described good working relationships with local GP services. We were told that the majority of referrals received by the service came from local GP services. The teams formerly shared office space with the local authority's older person's social worker team. By the time of inspection the local authority had reorganised and relocated its social workers. Staff told us this move had made it more difficult for the service to access social workers.

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

Training in the Mental Health Act was mandatory for all staff working in the community mental health nurses teams. All eligible staff had been trained in the Mental Health Act. Staff told us it was rare for them to have any interaction with the Mental Health Act. Staff displayed limited understanding of the Mental Health Act, the Code of Practice and the guiding principles.

One patient in the service was under a community treatment order. The trust's consultant psychiatrists had all undertaken Section 12 Practitioner and Approved Clinician training.

Patients in the service had access to an independent mental health advocate service. Within the community mental health services for older people the relevant criteria for referral to the independent mental health advocacy service was patients detained under the Mental Health Act, patients conditionally discharged under guardianship or supervised community treatment, patients being considered for surgery for a mental disorder.

### Good practice in applying the Mental Capacity Act

Mental Capacity Act training was mandatory for all staff working in the community mental health nurses teams. All staff were trained as part of the trust's mandatory training module for safeguarding.

The trust had a policy on the Mental Capacity Act for staff to refer to. During the inspection, we reviewed a record of a mental capacity assessment and a best interest decision. Staff had assessed capacity in line with the Mental Capacity Act. Following the assessment of capacity a decision had been made in the patient's best interest. However, we did not see that staff had sought and documented the views of carers, family members or other professionals involved in the patient's care. This is recommended in the Mental Capacity Act Code of Practice which states that staff should try to 'consult other people for their views about the person's best interests and to see if they have any information about the person's wishes and feelings, beliefs and values'.

Requires improvement

# 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

We spoke with seven patients who were receiving care from the service and observed three visits to patients in the community. We saw that staff were kind and caring and showed a genuine interest in the patients. Staff were friendly, approachable and appeared to have a good rapport with both the patients and with the patient's family members. We saw that staff had a good understanding of their patients and a detailed knowledge of their history.

All seven patients provided positive feedback about the service and highlighted to us individual staff members who they wanted to praise. One patient told us that staff were 'pleasant and nice and warm' and that 'never act like it's just a job'. Three patients told us that the staff were friendly and always available if needed.

### The involvement of people in the care that they receive

We did not see evidence of active involvement in care planning in the care records we reviewed. Patients did not receive a copy of their care plan and staff told us that the electronic patient record system did not have an option for staff to print copies of care plans. Care records showed limited evidence of personalisation. We saw that care plans used the patient's first name.

Carers gave mixed feedback on how involved they felt in the care being delivered by the service. Two carers told us that they felt involved and felt that the service supported and updated them appropriately. Two carers told us that they felt the service did not communicate with them as often as they would like and that it was difficult to get updates from the service. Four care records included a record of carer's opinions expressed during visits in the community or from care programme approach meetings.

The service did not have additional routes for people to be involved in the service such as in recruitment of staff. We did not see evidence that people who used the service were engaged and involved in service development or in the trust's ongoing plan to improve mental health services.

# Are services responsive to people's needs?

Good

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

## Our findings

### Access and discharge

The service accepted referrals from GPs, the trust's mental health liaison team and the trust's wards for older people with mental health problems. Any person over the age of 65 years old who had a mental health problem could be referred to the service. The trust had commissioned a review of the community mental health services for older people in July 2016. The October 2016 update report of this review recognised that the referral pathway for the service was not sustainable. Referrals could be directed either to the community mental health nurses teams or to the trust's consultant psychiatrists' team. The report noted that the consultant psychiatrists were the point of access for 1100 referrals per year and the community mental health nurses were the point of access for 240 referrals per year. The consultant psychiatrists had become, in effect, the main point of access for community mental health services in the absence of a single point of access to both services.

The service had an internal referral system. The professional team which received a referral undertook the initial assessment of a patient. This meant that the majority of referrals were initially assessed by the consultants. If a patient's care was more appropriately led by the community mental health nurses team then the consultant would make an internal referral to the team covering the relevant area of Gateshead. Trust data noted that 55% of referrals to the community mental health nurses teams came from the consultant psychiatrist teams. The October 2016 update report noted that the internal referral system was outdated and added unnecessary delays to patient care. At the time of inspection the trust had established a workstream led by a project nurse who was tasked with establishing a single point of access to the community mental health teams, as well as a triage procedure for referrals.

Routine referrals had a target time of six weeks from referral to initial appointment for both the community mental health nurses teams and the consultant psychiatrist team. Urgent referrals were risk assessed on a case by case basis with target for the service to see the patient on the same working day. From January to September 2016, 88% of patients had commenced treatment within 12 weeks of initial referral. The trust did not provide a compliance target for the percentage of patients commencing treatment within 12 weeks of initial referral. Trust data stated that 97% of patients completed a treatment pathway within 18 weeks which was above the target of 92%.

Patients told us that staff were flexible with appointment times and always arrived on time. The trust had a 'patient access (waiting list / waiting times) policy' which detailed how staff should respond in cases where patients did not attend appointments. The policy stated that both the patient and the patient's GP would be sent an explanatory letter which gave the GP the option of re-referring the patient to the service.

### Meeting the needs of all people who use the service

Patients were seen in the community, usually in their own homes. If a patient preferred then it was possible for staff to make appointments to see patients in local GP surgeries. Staff in the service could refer patients to the trust's occupational therapy department if it was felt that that patient would benefit from equipment or environmental adaptations to their homes. Information leaflets for the service were available. We did not see leaflets available in a language other than English. The team managers told us that the service could access interpreters for other languages including sign language for deaf patients if required.

### Listening to and learning from concerns and complaints

In the period November 2015 to November 2016 the service received no complaints. Only one of the seven patients we interviewed told us that they knew how to make a complaint and that staff had explained the complaints procedure to them. None of the carers told us that they knew how to make a complaint. The trust had a patient advice and liaison service which patients could access if they wanted to make a complaint. Staff told us that complaints were rare but if a patient was unhappy then they would direct them to the patient advice and liaison service. Staff told us that it had been too long since they had last had a complaint to recall a complaint that had led to an improvement in the service.

# 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

Both teams were part of the community mental health services for older people provided by Gateshead Health NHS Foundation Trust. The trust had adopted a vision and values.

The vision and values of the trust were presented as an image with five different concentric circles. In the outermost circle the trust identified eleven values which were:

- Creativity and innovation
- Honesty
- Equality
- Respect
- Trust
- Partnership
- Reform
- Dignity
- Engagement
- Transparency
- Openness

The trust also had a five supporting statements which explained the different tiers of each circle.

- We believe in the patient being at the heart of everything we do.
- We also want to work well with our partners to give you the best experience possible
- We want to be the best employer, creating the right conditions for our staff to excel
- We want to spend our money wisely, that means being held accountable to you by a board of non-executive directors and governors
- Living our values every day including honesty, equality, respect, trust, openness, dignity and reform

During the inspection three members of staff were asked to identify one or more of the trust's values. Two staff members could identify one or more of the values.

Staff knew and were positive about their managers. The team managers were positive about their immediate line manager. Staff identified the service manager responsible for all three community mental health nurses teams as the most senior manager who regularly visited the service.

### Good governance

The trust's clinical supervision policy stated that supervisors were responsible for 'a written record of attendance and supervision for audit purposes'. The team managers told us that individual staff members maintained their own notes of supervision; neither team maintained a record of attendance. The service did not have a process that provided assurance that all staff in the service received the minimum of one hour of clinical supervision every three months as stated in the trust's clinical supervision policy.

Almost every member of staff expressed concerns to us about the electronic patient record system used by the service. We heard from staff that the system was 'not fit for purpose' and 'difficult to navigate'. The system was only used by the three community mental health nurses teams and did not have the functionality to be able to send or receive information from the other systems used by the trust. Staff told us that information put on the system was sometimes lost and could not be retrieved, although the trust clarified that there was a procedure in place to retrieve lost information. Whilst we were told that addressing the issues in the system was one of the key areas for the community mental health workstream, we noted that staff had routinely raised concerns about the system in every team meeting since January 2016. We saw how root cause analysis reports following incidents routinely flagged the system as an issue.

The trust risk register identified that the trust faced a risk caused by the 'lack of [a] fit for purpose IT solution for mental health patient records'. This risk was added to the risk register in July 2011. In November 2016, the trust produced a gap analysis report, which noted that 'IT system [are] not fit for purpose for a contemporary mental health service'. The report indicated that the trust's redesign of community mental health services intended to achieve compliance by 2020/21. The slow pace of change in solving this issue meant that the trust was not ensuring staff could maximise their time on direct care activities rather than dealing with the electronic system.

The service had adequate systems and processes to assess performance and make timely improvements in other areas. Both teams achieved 100% compliance with mandatory training targets and with appraisal targets. The service had no vacancies for qualified nurses or nursing assistants. Staff knew how to report incidents and what

# 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.

constituted a reportable incident. Staff were able to describe how incidents were investigated and team meeting minutes showed evidence that staff received feedback from incident investigations. Staff were able to describe the procedure for raising safeguarding concerns.

The service monitored key performance indicators including number of referrals received, number of discharges, sickness rates, mandatory training rates and appraisal rates. Neither team had a local risk register and the service did not maintain a service-level risk register. The trust risk register had two risks identified which were specific to the community mental health nurses teams.

### Leadership, morale and staff engagement

There were no reported incidents of bullying or harassment during the twelve months prior to inspection. The service had no vacancies. The sickness rate was slightly higher than the national average for the NHS. Staff knew and understood the concept of whistleblowing and how to raise concerns. Staff told us that they felt confident they would be able to raise concerns without fear of victimisation.

We found that morale was high in the service. Staff expressed frustration with the electronic patient record system but were otherwise positive about their work. The trust had appointed a project nurse to lead transformation in the service. The key areas highlighted for improvement were how patients access the service, how referrals should be triaged, how assessments should be undertaken and how the service would carry out follow-ups on patients.

Staff were positive about their teams about their teams and their manager. Most staff had knowledge of the duty of candour and described it as the duty to be open and honest following an incident.

### Commitment to quality improvement and innovation

The community mental health nurses teams were included in the trust's review of its older person's mental health services. This review and subsequent delivery plan established a new methodology in the trust and a new governance framework to improve quality in the trust's mental health services. The trust established seven workstreams to improve mental health services, with one workstream allocated to the community mental health services. The workstreams had an identified lead and were monitored by a newly established mental health review steering group. At the time of inspection the project lead for community mental health services had just started secondment and was three weeks in post. The project lead had a good understanding both of the areas of development in the service and what the aims of the role were within the timescale of the ten-month secondment.

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 |
|---|---|
| Diagnostic and screening procedures<br>Treatment of disease, disorder or injury | Regulation 9 HSCA (RA) Regulations 2014 Person-centred care<br>**How the regulation was not being met:**<br>Care plans used by the Central Gateshead and East Gateshead community mental health nurses teams were not personalised, holistic or reflective of patient preferences.<br>This was a breach of Regulation 9(1)(a)(b)(c) |

| Regulated activity | Regulation |
|---|---|
| Diagnostic and screening procedures<br>Treatment of disease, disorder or injury | Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment<br>**How the regulation was not being met:**<br>Risk assessments used by the Central Gateshead and East Gateshead community mental health nurses teams were not consistently reviewed or updated. Care plans did not reflect risk assessments.<br>This was a breach of Regulation 12(1)(2)(a)(b) |

| Regulated activity | Regulation |
|---|---|
| Diagnostic and screening procedures<br>Treatment of disease, disorder or injury | Regulation 17 HSCA (RA) Regulations 2014 Good governance<br>**How the regulation was not being met:**<br>Both the Central Gateshead and East Gateshead community mental health nurses teams were using an electronic patient record system which was not fit for purpose. |

This section is primarily information for the provider

# Requirement notices

Neither the Central Gateshead nor East Gateshead community mental health nurses teams maintained a record of attendance for supervision which meant that the service was not monitoring whether staff received supervision in line with the trust's policy.

This was a breach of Regulation 17(1)(2)(c)(d)(i)(ii)