Good

Sussex Partnership NHS Foundation Trust

Community-based mental health services for older people

Quality Report

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Locations inspected

Location ID	Name of CQC registered location	Name of service (e.g. ward/ unit/team)	Postcode of service (ward/ unit/ team)
RX240	The Harold Kidd Unit	Older Peoples Living Well with Dementia Team Older Peoples Dementia Crisis Service	PO19 6AU
RX219	Trust Headquarters	Specialist Older Adults Mental Health Services	BN2 3EW
RX219	Trust Headquarters	Older Peoples Living Well with Dementia Team Older Peoples Dementia Crisis Service	RH16 4BE

Summary of findings

Memory Assessment team
(Newpark House)

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

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

Where applicable, we have reported on each core service provided by Sussex Partnership NHS Foundation Trust and these are brought together to inform our overall judgement of Sussex Partnership 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	Good
Are services safe?	Good
Are services effective?	Good
Are services caring?	Good
Are services responsive?	Good
Are services well-led?	Good

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

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

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

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

Summary of findings

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Overall summary

We rated community-based mental health services for older people as **good** because:

- Staff were providing a safe service. Staff were aware of the risks for individual people who used the service, medication was managed well and staff had a good understanding of safeguarding. Staff were able to see people who used the service in a timely manner and prioritised people who needed urgent support.
- Practice reflected current guidance and there was good access to a wide range of interventions. There was good use of outcome measures to monitor if services were effective. Audits that were specific to the service were carried out to provide assurances of robust care with improvements made where needed.
- Staff were consistently caring and showed warmth, kindness and respect to people who used services and their carers. They provided practical and emotional support. Staff went the extra mile to care for people in a person centred way and involve carers and people who use the service in their care. Groups and accessible information was provided for people and carers. The needs of carers were assessed and support groups were provided.
- Staff morale was good. They were well supported with access to training and other opportunities to reflect and learn. There were opportunities for leadership training and career progression.
- The teams worked well with GPs, the local authorities and other local services and groups.
- People who used the service, carers, staff and external stakeholders were encouraged to give feedback through a range of mechanisms and these were used to make improvements.

Summary of findings

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

Are services safe?

Good

We rated safe as **good** because:

- Interview rooms were fitted with alarms however the alarm in the disabled toilet in one location was not accessible if using the toilet.
- Arrangements for safeguarding were clear with good systems in place to monitor and follow up concerns.
- Caseloads were regularly discussed by staff and managers and caseloads were reviewed and risk assessed.
- Staff learnt lessons from incidents and made improvements where necessary.
- Staff carried out individual risk assessments on patients and put plans in place to address identified risks.
- Staff understood and fulfilled their responsibilities to raise concerns and report incidents.
- People who used the service would be visited by staff in their home on the same day if required.
- Staff were aware of lone working policies and procedures. Staff practices regarding lone working were understood by staff.
- Staff training needs were identified and training was in place however not all staff had completed all mandatory training.

Are services effective?

Good

We rated effective as good because:

- There was good use of evidenced based practice with a wide range of interventions available according to identified need.
- Staff carried out comprehensive assessments however not all care records contained evidence of discussion of consent and capacity issues.

However:

- Staff undertook audits, including clinical audits and reviews of services, however, the planned audits of care records should be undertaken.
- Some staff were supported to deliver effective care and treatment through supervision and appraisal.However progress in improving the frequency of staff supervision and completing staff appraisals should be monitored. Appraisal compliance rates for 18 services in community based mental health services for older people ranged from 6% to 80%.
- Staff generally had an understanding of the Mental Capacity Act. They ensured that people who used the service were involved in decisions and acted in their best interests when

Summary of findings

necessary, however not all staff had completed training in the Mental Capacity Act. The trust stated that their target compliance rate for Mental Capacity Act training was 65% and had a compliance rate of 74%.

- Not all staff had received training in the Mental Health Act . The trust stated that their target compliance rate for Mental Health Act training was 65% and had a compliance rate of 64%.

Are services caring?

Good

We rated caring as good because:

- Staff treated people who used the service and carers with care, kindness and respect.
- Staff offered practical and emotional support. This included access to ongoing support groups for carers.
- People who used the service and carers were involved in all aspects of their care and decisions about their treatment as part of the assessments and care planning.
- People who used the service and carers were positively encouraged to give feedback through about the care they received and staff used this to make improvements to the service.
- Staff offered care that was kind and promoted dignity.
- Relationships between people who used the service, carers and staff were strong, caring and supportive.
- Staff recognised and respected the totality of people who used the service and carers needs for example their culture and relationships.
- Feedback from carers was continually positive about the way staff treated people who used the service. A theme from carers was that they felt staff went the “extra mile” when offering support.

Are services responsive to people's needs?

Good

We rated responsive as **good** because:

- Referrals were prioritised and dealt with in a timely manner. There were good pathways into the community mental health teams for older people and people were promptly allocated to an appropriate staff member.
- All of the services were able to respond to urgent referrals on the same day.
- Information on how to complain was clearly displayed in the services and staff knew how to handle complaints appropriately. Staff learnt lessons from complaints and made improvements where necessary.

Summary of findings

- Feedback from other professionals was that staff were very responsive to all requests for support.

Are services well-led?

Good

We rated well-led as good because:

- Staff demonstrated the trust's values in their work.
- Staff in all of the teams spoke highly of the leadership at a team and more senior level. Staff we spoke with felt senior managers were visible and approachable.
- Staff morale was good and there were good levels of staff satisfaction. Staff were proud of the organisation as a place to work and felt able to raise concerns.
- Staff felt engaged in the work of the trust and able to introduce innovative ideas. Staff felt well supported. They had access to leadership training and career progression. They also had supervision but for some teams the frequency needed to increase.
- The teams had access to good information, which enabled them to monitor trends and make improvements where needed.
- Staff ensured that they continuously obtained the feedback of people who used the service, their families and carers, providing opportunities for them to give their comments and raise their concerns verbally and in writing. These were actively reviewed and changes made in response to the issues raised.

Summary of findings

Information about the service

Sussex Partnership NHS Foundation Trust provides a range of dementia services within the county. The trust's aim is to encourage patients to remain as independent as possible, whilst accessing relevant services and support.

The dementia crisis teams provided a short term service to people who are in a crisis which is related to their dementia. People can be referred to this service through their GP or other health or social care professional. The teams visited people in their own homes, care homes or care homes with nursing and sometimes hospitals. They also provided support to family members and/or carers.

The living well with dementia teams were for patients whose needs have become complex and challenging. Referrals to this service are via the GP services. The teams assessed patients' needs and provided advice and treatment to help manage their condition. This included group work and psychological interventions.

The memory assessment service (MAS) is provided to patients following a GP referral. In Brighton and Hove the MAS service was run by Brighton and Hove Integrated Care Service with Sussex Partnership NHS Foundation Trust as a partner alongside the Carers Centre and the Alzheimer's Society. In other areas the service was run completely by the trust. The service offered a range of interventions/groups, such as memory management, reminiscence and cognitive stimulation. These groups support people diagnosed with mild to moderate dementia.

In Brighton and Hove the dementia and later life services had been realigned into specialist older adult services within the assessment treatment services. This ensured there was one management structure for all community services. In other areas, there were specific management structures for dementia which covered acute and community. The trust managed all their acute services separately from the community services.

The care home in-reach service enabled the service to go into care and nursing homes with the aim of improving the quality of care for people with dementia. They do this by providing training and coaching to care home staff on person-centred care and by reviewing the treatment and medicines of individual patients. The trust has five in-patient units which provide intensive assessment and treatment for people with dementia experience behavioural and/or psychological symptoms which cannot be managed in the community. The community dementia team works closely with the staff team within these units.

CQC last inspected the community-based mental health services for older people as part of the trust comprehensive inspection in January 2015. Following that inspection, we rated community based mental health services for older people as good overall, and good in all the domains of safe, effective, caring, responsive and well-led.

Following the January 2015 inspection, we told the trust that it should take the following actions to improve community based mental health services for older people:

- The trust should ensure that all staff have completed their mandatory training.
- The trust should review the people's records to ensure that people are actively involved in planning their care.
- The trust should ensure that people's risk assessments are up to date.
- The trust should ensure the discharge pathway is identifiable within people's records.

Our inspection team

Our inspection team was led by:

Chair: Dr James Warner, consultant psychiatrist and national professional advisor for old age psychiatry.

Summary of findings

Team Leader: Natasha Sloman, Head of Hospital Inspection (mental health) CQC

Inspection Manager: Louise Phillips, Inspection Manager (mental health) Hospitals CQC

The team that inspected community based mental health services for older people comprised five people: two inspectors, one mental health nurse, one occupational therapist and one psychologist.

Why we carried out this inspection

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

How we carried out this inspection

To fully understand the experience of people who use services, we asked the following five questions of the service:

- 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 three locations for community mental health for older people services and looked at the quality of the environment
- spoke with 12 relatives and carers of people who were using the services
- spoke with 24 staff members; including nurses, psychiatrists, occupational therapists, support workers, clinical psychologists, dementia specialists, social workers and administrators
- spoke with six team managers
- spoke with two service managers and one clinical lead
- spoke with one staff member from the Alzheimer's Society
- spoke with six professionals with knowledge of the service
- looked at 18 care and treatment records of patients
- looked at a range of policies, procedures and other documents relating to the running of the service
- accompanied staff on two home visits to patients and carers and observed how staff were caring for patients and one visit to a residential care home
- attended and observed a multi-disciplinary care review meeting which was also attended by family members
- attended and observed a cognitive stimulation group
- attended and observed one multidisciplinary meeting and one staff handover meeting

What people who use the provider's services say

We did not receive direct feedback back from people who used the service because of the degree of their cognitive impairment. We did observe staff interaction with people in the community. We observed this to be caring and professional.

We observed a cognitive stimulation group attended by seven people who used the service and facilitated by a range of professionals and volunteers. We observed staff to be caring and that staff knew the people in the group well. An example of this was that staff were able to say that some of the people who had spoken at this group

Summary of findings

had not spoken at the previous week's group. Staff sat with people in the group who needed encouragement to talk or listen. We observed each person in the group being given time and attention to speak and that each person in the group participated in discussion.

Carers felt that staff showed care and interest in the wellbeing of all of the family as well as the person who used the service. They also felt that staff were helpful, friendly and listened to people carefully and with empathy.

Carers said that staff were approachable, responsive and provided reassurance at times of difficulty.

The carers spoke very positively about the service they received. They said that they were given information, involved in care planning, medication reviews and that staff were kind and caring.

Carers said that staff were polite, responsive and treated the person who used the service with dignity and respect. They felt that staff offered both practical and emotional support. They expressed their appreciation of the support received from staff and how vital it was.

The carers spoke of the great warmth shown by staff towards them and to people who use the service. They commented that they felt they were treated as equals. Also that they felt staff at times went "above and beyond" and they went the "extra mile".

Good practice

- The trust had participated in a pilot project called the "Golden Ticket". Sussex Partnership NHS Foundation Trust had contributed with other stakeholders to the development of this new model of care which won the Health Foundation's Award for Innovation in 2015.
- The trust contributed to the Intelligence Based Information System **(**IBIS) scheme run in conjunction with the South East Coast Ambulance Service. The aim of the scheme was to prevent unnecessary admission to hospital by providing information to the ambulance service. The IBIS was designed to enable ambulance clinicians to have up to date information about a person's health, their care plans, their needs and wishes. It also allowed the ambulance service to play an integral part in the pro-active management and ongoing care of people in partnership with community teams. Community teams use IBIS to monitor and manage patients' 999 interactions.
- The trust had an award for proactive ideas. The Living Well team at Linwood were recently nominated for this award for their work with dementia alliance on producing "twiddle mitts". These are memory mitts which people can hold and 'twiddle', helping to reduce anxiety and promote calm. Staff told us that this was a whole team effort and that their desire was to promote awareness of dementia in their community and to make it "dementia friendly".

Areas for improvement

Action the provider SHOULD take to improve

- The trust should ensure that progress in improving the frequency of staff supervision and completing all staff appraisals is monitored.
- The trust should ensure that all staff have completed their mandatory training.
- The trust should ensure that all staff complete Mental Health Act and Mental Capacity Act training.
- The trust should review the disabled toilet facilities in one location.
- The trust should ensure that all care records contain evidence of discussion of consent and capacity issues.
- The trust should ensure that planned audits of care records are undertaken.

Sussex Partnership 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
Older Peoples Living Well with Dementia Team Older Peoples Dementia Crisis Service	The Harold Kidd Unit
East Brighton Community MH Centre, Specialist older adults Mental Health Services	Trust Headquarters
Older Peoples Living Well with Dementia Team Older Peoples Dementia Crisis Service Memory Assessment team	Trust Headquarters

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.

Staff were able to access psychiatrists and approved mental health professionals to undertake Mental Health Act assessments if required.

Not all staff had completed training in the Mental Health Act. The trust stated that their target compliance rate for Mental Health Act training was 65% and had an actual compliance rate of 64%. Staff were being supported to set aside time to complete this training.

Detailed findings

Mental Capacity Act and Deprivation of Liberty Safeguards

- The trust stated that their target compliance rate for Mental Capacity Act training was 65% and that bespoke e-learning was launched in the trust in February 2016. The figures provided for compliance for community based mental health services for older people were that of the 213 staff eligible to undertake this training, 135 staff had completed this training. The compliance rate for Mental Capacity Act training was 74% as of August 2016, which was above the trust target compliance rate for this training.
- We found that the compliance rate for training in the Mental Capacity Act (MCA) was 29% in the dementia crisis team (Western). This was being addressed and staff were being encouraged and supported to set aside time to complete eLearning for the MCA.
- In the Brighton and Hove team which is an integrated team, the senior social workers took the lead on the Mental Capacity Act and all social workers in this team were approved mental health professionals and best interest assessors. Staff told us that this team was managing 26 Deprivation of Liberty safeguard objections. An application for a Deprivation of liberty safeguard would be made if a person lacks capacity to decide for themselves about the restrictions which are proposed so they can receive necessary care and treatment. These restrictions would deprive the person of their liberty and would be in the person's best interests. If this application is authorised a person or their representative then has the right to request a review of the authorisation if they have objections.
- A new social worker had been appointed to help with this work. The social worker's reviewed the objection applications and liaised with the community team leader. We received feedback from the legal team who received instruction from the community team. They described the team as client focussed, very good at working in partnership, aware, well informed and proactive.

Good

Are services safe?

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

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

Our findings

Safe and clean environment

- Interview rooms in all of the teams we visited were fitted with alarms so that staff could summon assistance if needed, however one room at Brighton and Hove which had been an office and was now a consulting room required an alarm. The alarm in the disabled toilet in Brighton and Hove was located by the door and not accessible if using the toilet. The light in this room also automatically went out after a few minutes. This could put people at risk of falling.
- The waiting areas were clean and but the rooms at Brighton and Hove would benefit from some redecoration. There was hand cleaning gel available in reception areas.
- The clinic rooms we visited were clean, well equipped and maintained to a satisfactory standard. There was no record of daily fridge temperature checks of the fridge in the clinic room at Linwood.
- The community teams at Linwood were based in a building where other community teams and services were located. They could access a range of rooms on the ground floor and team offices shared with other teams were on the first floor. Staff had to "hot desk" when they visited the location and it could be difficult to find space. The environment at Linwood required some refurbishment and there were some issues regarding lack of space and accessibility. These issues had been raised previously and the Chief Executive had visited the location and was aware of them. Staff told us that some improvements had been made to the building with further improvements planned.

Safe staffing

- The team sizes, composition and staff management arrangements varied between the different teams based on commissioning arrangements and agreements with local authorities for the provision of social workers.
- The trust provided data as of May 2016 which stated that the proactive care north team had the highest nurse vacancy of 25%. This was a small team of four staff with one vacancy for a qualified nurse.
- Overall, the staff vacancy rate across the teams we visited was low and the services were actively recruiting to vacant posts. In the Brighton and Hove team a new post had been created for a psychologist which would improve the access to psychology for people who used the service. They had also agreed additional posts for a social worker and a hospital social worker. The memory assessment service (Newpark House) had no staff vacancies. The Living well team at Linwood had one nurse vacancy and the dementia crisis team at Linwood had just appointed a nurse to fill the post of a recently retired nurse.
- The dementia crisis teams had a sickness rate of between 9% to 15% due to some long term sick leave. All teams had permanent team leaders at the time of this inspection except the dementia crisis team in Linwood where the team leader was on long term sick leave and the position was being covered by an existing staff member who had acted up for the past two months. This team received additional support from the service manager.
- In the Brighton and Hove team one staff member was on long term sick leave and another was returning from sick leave. Staff told us that the volume and complexity of cases was high but that the work was manageable. Staff felt well supported by managers but could sometimes feel pressurised. The service manager was based at the location to provide additional support.
- In the specialist older adults mental health services team covering Brighton and Hove some staff had caseloads of up to 100. A high proportion of the people on these caseloads required medication reviews only. The number of people currently held by the memory service was 1200. The team had a good relationship with the local clinical commissioning group (CCG) and staff told us that they were currently reviewing caseloads in conjunction with the CCG. Staff told us that managing high caseloads and completing all paperwork was sometimes a challenge.

Good

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- Caseloads in one of the Living well teams ranged from 35 to 60 and in another team there were much higher caseloads of over 100. In this team a case load weighting tool was used to manage these caseloads which had clear criteria for managing and assessing risk. Staff told us that within this team there were 811 open cases and that of these 319 people were on long term anti-dementia medication and many were in long term placements in a care home with nursing. These people required an annual medication review. The team were moving towards discharging these people from caseloads and referring back to GPs to undertake these medication reviews. This would significantly reduce case load numbers.
- The dementia crisis teams caseloads were between eight and ten people per team. Staff described the teams as busy but with manageable caseloads. The teams covered a large geographical area and travel time was significant.
- The number of people held on the memory assessment service (Newpark House) was 1800 to 2000. Staff described very clear protocols and pathways into this service and that this had helped with meeting targets. The target time for this service was for a person to be seen within 28 days of referral. When this target was not met it was highlighted in monthly audit reports.
- Staff were able to access a psychiatrist quickly when they needed to and staff described the psychiatric support as very good. Staff identified the difficulty on occasions of accessing a psychiatrist at weekends in West Sussex if the psychiatrist was on call in for example, Brighton.
- All teams had good, well established duty systems with staff who understood this role. Staff on duty for the Living well with dementia and dementia crisis teams based at Linwood explained the duty system and that they could respond to crisis and urgent referrals promptly.
- The August 2016 audit undertaken by the dementia crisis teams showed that for the month of August, 43 referrals in total were accepted across the four teams and that all of these referrals received a response within four hours of receipt of the referral. The dementia crisis teams were available from 8am to 8pm on weekdays and from 9am to 5pm on weekends. In Brighton and Hove they had an enhanced duty system which operated from 9am to 7pm every day. During office hours, four staff were available and two staff were available outside of office hours to respond to urgent referrals and internal requests for rapid response and support.
- The trust had a compliance target of 75% for eight of the 12 mandatory training courses and a compliance target of 65% for training in fire procedures at in patient and non in-patient services, Mental Capacity Act, and Deprivation of Liberty Safeguards and the Mental Health Act.
- The trust provided compliance rates for mandatory training data for 22 community services for older people teams as of August 2016. This data showed that in eleven of these teams that the compliance rate of 65% had not been achieved for staff to be trained in the Mental Health Act. The overall compliance rate as of August 2016, was 64%. The data provided also showed that in eight of these teams that the compliance rate of 65% had not been achieved for staff to be trained in the Mental Capacity Act & Deprivation of Liberty safeguards. The overall compliance rate as of August 2016, was 74%.
- Staff in the Brighton and Hove team met trust training targets for equality and diversity, adult safeguarding and child protection level 1 training, risk assessment, information governance and infection control training, but not for fire safety, medicines management for nurses,prevention of management and aggression and resuscitation training. They also did not meet targets for the Mental Capacity Act (53%) and the Mental Health Act (40%). The service manager had been in post for 7 months and the team leader for 6 weeks at the time of this inspection. During that time the overall training compliance rate had increased from 41% in April to 63% in September 2016. The plan was to enable and encourage staff to set aside time for one to two elearning sessions per month.
- The staff in the dementia crisis team at Linwood were that the team met trust training targets for equality and diversity, medicines management for nurses, information governance, infection control, health and safety, risk assessment, fire safety, moving and handling,

Good

Are services safe?

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adult safeguarding and child protection, Mental Capacity Act and the Mental Health Act. The team had not met targets for prevention of management and aggression and resuscitation training.

- The staff in the dementia crisis team at Harold Kidd met trust targets for training in equality and diversity, medicines management for nurses, information governance, health and safety, risk assessment, fire safety, moving and handling, and MHA. The team had not met targets for prevention of management and aggression, resuscitation, child protection and MCA training.
- Staff training needs were identified and training was in place to meet these learning needs, however not all staff had completed all mandatory training.

Assessing and managing risk to patients and staff

- Records and care notes seen contained up to date risk assessments. Some teams had identified the need for improvements in record keeping through audits. One team undertook an audit of records in May 2016 and identified the completion of risk assessments as an issue. Another team had undertaken an audit of six files in September 2016 and identified no gaps in any of the files audited. Staff told us that compliance with completion of risk assessments and recording of care plans was sometimes difficult with high case load numbers. Managers were addressing both the issues of high caseloads linked to ensuring that staff had sufficient time to complete all required record keeping.
- Staff reviewed risk assessments reviewed daily in the dementia crisis teams.Staff in other teams also reviewed the risks affecting patients on their caseloads regularly. Staff discussed high risk patients in daily handovers and weekly multidisciplinary meetings. The dementia crisis teams used a colour zoning system to assess risk. A red assessment indicated a high risk phase, an amber assessment was termed the progress phase and a green assessment was termed the predischarge phase. They used a risk indicators list for all zoning criteria.Staff told us they used the five “P’s” of risk formation which were “presenting, predisposing, precipitating, perpetuating and protective factors” when assessing risk.
- Senior clinicians attended risk panels.Staff told us of one case taken to the risk panel. They said that the panel reviewed all of the clinical notes, the case was discussed and advice and recommendations made. Staff described it as a very supportive experience.
- Staff were aware of the lone working policy. Staff had code words and sentences to use to alert colleagues if they needed assistance in a patient’s home. These were accessible to staff. Staff took precautions to ensure that home visits were safe. Staff identified that mobile phone signals can sometimes be problematic dependent on the area staff visited.
- The trust submitted their safeguarding referrals data for the period between 1 April 2015 to 31 March 2016. During this time, the trust submitted no safeguarding referrals for community based mental health services for older people. Staff had received training in safeguarding adults and children and discussed safeguarding referrals in multidisciplinary meetings.
- In the Brighton and Hove team safeguarding was managed within the service. There was a social work team comprised of a senior social worker and three social workers. The senior social worker took the lead on safeguarding issues. A lead enquiry officer was on duty every day to respond to any safeguarding issues. Fortnightly safeguarding meetings chaired by the safeguarding lead were held. All safeguarding cases were reviewed at these meetings and a progress spread sheet maintained of all referrals. Staff told us that audits took place every three months and the outcome of these audits were fedback to the local authority.
- The care of people who were prescribed medicines for dementia was shared between the consultant for the community team and the persons GP, with evidence of communication relating to reviews of peoples medicines. Staff told us there was a lead GP for dementia care for the coastal and northern Sussex areas. Nurses undertook medicines training via e-learning when they joined the trust and then every three years. Depot injections were transported on an individual patient basis, were appropriately labelled and portable sharps bin were used. However, some staff told us that they occasionally transported medication and

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that there was no designated medication storage but had been advised by the pharmacy that medication could be stored in car boots as long as it was out of sight.

Track record on safety

- The trust submitted data regarding incidents for community based mental health services for older people for the period between 1 June 2015 and 31 May 2016. There were 11 reported incidents for nine teams within this core service. The category of apparent, actual or suspected self-inflicted harm had nine incidents.

Reporting incidents and learning from when things go wrong

- Staff in the Brighton and Hove team recorded six serious incidents in the past 12 months. There were no serious incidents reported over the last 12 months in the dementia crisis teams. There was one serious incident reported over the last 12 months in the living well teams.
- Staff knew how to report an incident and the type of incidents they should report. Staff discussed incidents and lessons learned from them at team meetings. The service manager told us that all incidents are discussed at monthly multi disciplinary meetings leadership meetings. Examples of learning from one of these incidents was that if an appointment with a person who used the service needed to be cancelled then this must be communicated to the person. It also highlighted that if a person made multiple telephone calls to the service that all calls must be recorded, including any follow up action to the issues raised. Staff were offered a de-brief after any serious incident occurred.
- Senior staff were aware of their duties in relation to the duty of candour.

Are services effective?

Good

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

Our findings

Assessment of needs and planning of care

- Staff had carried out comprehensive assessments of peoples needs. Where particular needs had been identified there were care plans in place to address these. The physical as well as mental health needs of people were addressed however, there was limited information on physical care assessments on some files. This was being addressed through the introduction of a new format for recording physical health checks piloted in August 2016. The new format was to be rolled out across the service with the aim of improving recording of physical health care checks in all teams.
- Care notes were detailed, person centred and holistic. Care records were updated at regular intervals and contained up to date information about patients but some files did not show that people had been given a copy of their care plan.
- We looked at three files in the dementia crisis team and these had all relevant information. This included signed consent to share information forms and capacity assessments, risk assessments including an environmental risk assessment and initial 72 hour care plans. Also present were signed care plans, GP summaries, crisis plans and mini mental state examination forms. Social care support was requested if required.
- The dementia crisis teams used a screening referral document which asked if a person had had a physical health screening in the last 24 hours, which was comprehensive. It asked who did the physical health screen and the outcome, the reason for referral, summary of current risks, safeguarding concerns, existing support and current medication.
- Staff considered and discussed the holistic needs of people who used the services and carers, including their social and housing needs. Staff supported people to address issues related to social isolation, budgeting and shopping.
- In the Brighton and Hove team, the service manager described how a pharmacist worked with the community teams to provide support and training. This was a relatively new role and the pharmacist did not see patients directly, but was involved in multi-disciplinary team meetings.

Best practice in treatment and care

- Staff considered National Institute for Health and Care Excellence (NICE) guidelines when making treatment decisions. The memory clinics provided cognitive stimulation therapy groups for people diagnosed with dementia in line with NICE guidance. Staff also offered a range of evidence based therapeutic interventions including cognitive behavioural therapy.
- Staff used a range of tools to measure outcomes for people using the services. For example, staff used the health of the nation outcome scales and quality of life in dementia outcome measures.
- All of the services ran a number of groups for people who used services and carers. including cognitive stimulation therapy (CST) groups, anxiety management groups and relaxation sessions. We observed one CST group. People were accompanied to the group by staff. The group was modelled on recommended NICE guidelines called 'making a difference'. The group was well planned, welcoming and staff partnered those who might need encouragement to participate. A copy of the group plan was given to all who attended.
- Staff participated in audits. Staff were involved in team audits, including medication, infection control, safeguarding, record keeping and risk assessments. The results of local and central audits were shared at team meetings to aid learning, development and improvement.
- Psychiatrists ensured their prescribing was in line with guidance and only prescribed anti-psychotic medication where all other options had been tried. Psychological therapies such as cognitive behavioural therapy were offered.
- Clinical staff actively participated in clinical audits and staff told us were actively encouraged to engage with clinical academic groups such as the psychological interventions in psychosis in dementia group
- The teams also carried out some local service specific audits. For example, the dementia care teams had completed an audit on recording of physical health care.

Are services effective?

Good

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

A new format for recording physical health checks undertaken was piloted in August 2016 and the new format was to be rolled out across the service with the aim of improving recording of physical health care checks in all teams.

- The Brighton and Hove team had identified a staff member as a physical health champion to take a lead role in improving the physical health of people with serious mental illness. This was action agreed as part of their involvement in the Commissioning for Quality and Innovation (CQUIN) scheme.

Skilled staff to deliver care

- All the teams had a full range of mental health professionals including nurses, social workers, occupational therapists, clinical psychologists and psychiatrists.
- Teams had a wealth of experience. For example, in one team all five nurses had completed the five day mentorship training course. The team leader was very proud of this and the impact was demonstrated in the very positive feedback received from student nurses. They described this team as cohesive, knowledgeable, and proactive and that the team provided a good learning environment.
- New staff underwent an induction period before they started working independently. This introduced them to trust policies and procedures. In one team we saw the local induction pack for new staff to the building. This was a detailed document and provided staff with information on fire evacuation protocols and the use of panic alarms. We saw another local induction programme which was also very comprehensive.
- The figures provided for the average clinical supervision rate across core services was 73%. We found that some staff had access to access to clinical supervision. For example occupational therapists received clinical supervision from an occupational therapy lead. The team leader of the memory assessment service told us that regular clinical supervision was provided to all staff in the team. Staff told us that weekly clinical supervision was provided to nurses by a psychiatrist for the Living well with dementia team at Linwood.
- Staff said they had received regular management supervision in line with trust expectations. In other teams which had been without team leaders for a period of months the teams had identified that the frequency of supervision required improvement and this was being addressed. Managers for these teams had set aside time to improve supervision targets and recognised it as a priority.
- The services provided opportunities for peer supervision and monthly forums to share issues of good practice and develop operational policy.
- The trust had produced a document called "Your time to shine". This provided staff with an opportunity to reflect on areas they were proud of in their work and improvements they were making. We saw three completed forms. In one form staff identified the importance of regular supervision and in another form staff said "I find supervision useful and I have recognised this is essential for my practice".
- The trust stated that their compliance target for staff appraisals was 80%. Information provided by the trust for community based mental health services for older people as at July 2016 was that there were two services where all staff had appraisals over the past year (100%). These were the Hastings and Rother dementia team comprising of 11 staff and a one person team based at Neville Hospital. The trust provided appraisal compliance rates for 18 other services in community based mental health services for older people and the compliance rates ranged from 6% to 80%.
- We found that there had been progress with compliance rates for appraisal in the teams that we visited. For the dementia crisis team at Linwood the compliance rate at July 2016 was 60%. The team leader told us that the service manager had now completed all staff appraisals for this team.
- The compliance rate at July 2016 for the dementia crisis team at Harold Kidd was 33%. The team leader told us that 6 staff appraisals had been completed and for the remaining two staff an appraisal date was scheduled.
- The compliance rate at July 2016 for the Brighton and Hove team was 30%. The service manager told us that this was now 100% and all staff appraisals had been completed.
- Staff undertook further training in order to develop their knowledge and skills. For example, the trust had

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supported staff to undertake training in cognitive behavioural therapy, Masters in dementia studies and a diploma in family therapy. Staff told us they had opportunities to attend training on sexuality and intimacy issues for people with dementia and end of life care. The trust also ran a six month developmental programme for managers.

Multi-disciplinary and inter-agency team work

- Staff in all the teams described very good multidisciplinary team working. Teams met every day at handovers and on a weekly basis to discuss patient care and treatment. The integration of different professions into the multidisciplinary teams was positive and enabled a range of perspectives to be considered when providing care and treatment options. Staff made clear decisions made about who was responsible for actions after the discussions were concluded. We observed interactions between all professionals which was respectful and inclusive.
- The teams worked closely with partners in the voluntary sector. This included staff from the Alzheimer's Society.
- Some staff provided support to care home staff on how to care for people with dementia. We spoke with a range of professionals who work with the teams and their view on the work of the teams was extremely positive. They said staff for example drafted timetables of bespoke activities, provided advice and training on dementia and assisted with "this is me" profiles and medication reviews. They described staff as informative and one care home manager staff said "I can't praise them enough".

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

- The trust stated that their target compliance rate for Mental Health Act training was 65% and that bespoke MHA e-learning was launched in the trust in May 2016. The figures provided for compliance for community based mental health services for older people during the period July 2015 to July 2016 were that of the 188 staff eligible to undertake this training, 79 had completed this training. This was an actual compliance rate of 42% which was below the trust target compliance rate for this training. The overall compliance rate for Mental Health Act training as of August 2016 was 64%.
- We found in the Brighton and Hove team that the compliance rate for training in the Mental Health Act (MHA) was 40%. This was being addressed and staff were being encouraged and supported to set aside time to complete eLearning for the MHA.
- No patients were subject to community treatment orders.
- Staff accessed psychiatrists and approved mental health professionals to undertake MHA assessments if required.
- Administrative support and advice on the Mental Health Act was available for staff from the central Mental Health Act office.

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Good practice in applying the Mental Capacity Act

- We found recording of consent and mental capacity issues in five records. One record noted that a person was not able to make decisions about future care needs and a referral to an Independent Mental Capacity Advocate (IMCA) was made. The role of an IMCA is to find out a person's views, wishes and feelings about a decision and help to communicate these for a person. In three records we saw evidence of capacity and best interest discussions with regard to placements in residential care but a lack of recording in relation to medication. In two records we saw notes on people's increased confusion and difficulties with making decisions but no record of this being explored.
- One team had invited solicitors to come and talk to staff about the Mental Capacity Act and Deprivation of Liberty Safeguards.
- Five staff were not able to describe the five principles of the MCA but staff provided examples of applying good practice under the MCA around issues such as intimate relationships, travel on an airplane, personal care and advocacy.

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

- Staff spoke respectfully to patients and carers, and showed warmth and understanding for them during the two home visits we observed. Staff showed empathy and genuine concern for people who used the service during meeting discussions.
- Staff took the time to explain medicines and other treatment options to people and carers in a way they could understand. They checked the person's understanding of what had been said. They provided advice on health issues, weight loss, pain management and referral to other professionals such as a dietician.
- Staff recognised the importance of the person's relationships with those who were close to them including family and friends. The staff also recognised that the people who used the service and their carers might have other needs that would need to be addressed. This included other practical needs such as help with transport and help with finances. The team would either directly make referrals or provide information on local independent organisations who could help. Examples of this included linking carers to a counselling service which provided up to 36 sessions for carers.
- We heard from carers that they really felt that the care they received went beyond their expectations in terms of the care meeting their individual needs. Carers spoke of the great warmth shown to them by staff and that they felt treated as equals.
- Carers said that they felt staff provided reassurance, were responsive, approachable and went "above and beyond" what was required.
- When staff discussed issues with other members of the team or professionals they maintained a focus throughout of concern for the person and family members and a desire to ensure positive outcomes.

The involvement of people in the care they receive

- The services invited and listened to feedback from people who used the service and carers. Services had 'you said, we did' boards displayed in waiting areas. These highlighted feedback given to the services by patients and carers and the action taken by the staff team in response. Staff had placed suggestions boxes in reception areas where patients and carers could post suggestions for improvements to the service and other feedback.
- We attended a meeting attended by a range of professionals and family members of the person who used the service. Staff demonstrated an excellent knowledge of the person's care needs and risk factors. Family members were involved in the discussion and planning throughout the meeting. Their views were considered during the meeting and their contribution valued. Carers' expressed appreciation of the support received from the team over a long period of time.
- The team also provided a wide range of information for people in the waiting area to look at and take away. They encouraged people to join local groups and services which promoted recovery. Teams provided information leaflets about the services on offer. Carers groups were run to provide support and advice. Staff recognised carers need for practical and emotional support and feedback from carers confirmed this.
- We looked at written feedback received for the dementia crisis service for the period from January to June 2016. There were 12 responses of which 10 were from carers, one from a person who used the service and one from a friend. Seven questions were asked such as were staff friendly, helpful supportive and did they listen. Results were positive in all areas with respondents agreeing or strongly agreeing to the questions asked except for involvement in making choices about care and treatment. A few respondents felt this could be improved. Examples of comments made were " every person who visited was helpful and caring", "without doubt I always knew that help was only a phone call away" and " really felt they were at the end of the telephone to help".
- We looked at a further 12 feedback forms for the period July and August 2016 from carers and relatives. Comments made were that staff were helpful, polite, efficient, open and friendly. Staff were also described as compassionate, excellent and sensible. Carers described the support provided as amazing, that staff responded quickly and this enabled carers not to feel so alone at difficult times.

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- We also looked at a feedback summary from carers covering the period October 2015 to March 2016 which showed that the teams received forty one responses. The results showed that 93% strongly agreed that staff were friendly and approachable and 7% agreed. In response to the question on involvement with choices about care and treatment, two respondents did not answer and 29 (74%) strongly agreed and nine (23%) agreed that they felt involved and one respondent disagreed. In response to the question on whether carers felt they were given time to talk and felt listened to, 80% of respondents strongly agreed, 17% agreed and one disagreed. Overall the experience of the service was described as “excellent” by many respondents.

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 trust provided information that they do not have a target for 'assessment to treatment', but have a local 18 week target for 'referral to treatment' overall. The local targets varied by service for referral to assessment of between 24 and 42 days and assessment to treatment of 2 to 19 days.
- The information provided for the overall times from referral to treatment at the memory assessment services was given as between 26 to 49 days (4 to 7 weeks). The information provided for the overall times from referral to treatment at the living well with dementia teams was given as between 16 to 21 days (2 to 3 weeks). The times given for both services fall well within the trust target time of 18 weeks.
- Most referrals came from GPs. Patients who were identified as being a high risk had their assessment prioritised.
- All of the services were able to respond to urgent referrals. Referrals to the services were reviewed each day at by a senior staff member. Where the referral was urgent, action was taken to see the person as soon as possible. The person could be seen the same day in all services.
- Staff told us that when people did not attend an appointment they called them to find out why they did not attend and offered a second and third appointment. The teams were flexible and carried out the majority of assessments in patients' homes if this was easier for people and carers. They also organised transport if required.
- The dementia crisis service had clear criteria for access and guidelines with regards to what constituted a crisis. Their target was to make contact within four hours of referral. If a referral was not accepted they signposted patients and carers to other services.
- The dementia crisis service audit report for August 2016 covered the number of referrals received, assessments completed, referrals taken on by the dementia crisis service and caseloads in each of the four dementia crisis service teams. For the month of August 2016 figures showed that 43 referrals in total were accepted across the four teams and all of these referrals received a response within four hours of receipt of the referral.
- Managers participated in a daily phone call to review the admissions and discharges from inpatient units within the last 24 hours. This enabled them to assess the bed availability within the service, manage their caseloads and facilitate discharge.

The facilities promote recovery, comfort, dignity and confidentiality

- Information leaflets on a range of relevant topics for people who used the service and carers were displayed in waiting areas. These supported people to make decisions about their care and treatment. An example of this was a carer's support information leaflet providing information on workshops, meetings, access to complementary therapies and free counselling sessions.
- There were interview rooms available at two of the team premises. Waiting areas were equipped with a water dispenser so that people waiting could have a drink. People had access to toilet facilities while waiting for appointments.
- The community team based at Brighton and Hove was based in a building where other community teams and services were also located. They could access a range of rooms throughout the building.
- The community teams based at the Harold Kidd Unit were located in the same premises as the in-patient ward which promoted good links and communication. People did not visit staff at this location. Staff undertook home visits and clinics were held elsewhere.

Meeting the needs of all people who use the service

- All interview rooms were on the ground floor. If people had difficulty attending for appointments for any reason, staff would visit them at home and the majority of visits took place in peoples homes.
- Staff were proactive in linking people who use the services and carers with local community groups who could offer support to people from diverse backgrounds, if required. Staff told us that they had arranged for a sign language interpreter to be present when meeting with a person who was partially deaf.

Are services responsive to people's needs?

Good

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

- Information leaflets were available and would be provided to meet different needs if necessary. An example was a leaflet providing information on confidentiality and keeping information safe. This leaflet stated that it could be offered in easy read, large text, audio, braille or a community language.

Listening to and learning from concerns and complaints

- The trust provided information that between 1 June 2015 to 31 May 2016 community based mental health services for older people received 23 complaints, with 13 either fully or partially upheld. The category of 'poor communication' received the highest number of complaints with five.
- The trust provided information that between 1 June 2015 to 31 May 2016 community based mental health services for older people received 44 compliments. The dementia crisis team (southern) received the highest number of compliments with 18. The highest number of compliments received were categorised as the provision of a 'valuable service' with 18 of the 44 compliments received coming into this category.
- Information about how to make a complaint was on display in waiting areas in the services we visited. The teams that we visited had very few complaints.
- Complaints and incidents were discussed in team business meetings and also at multi-disciplinary team meetings. Managers provided examples of learning from complaints. In July 2016 a complaint was made by a carer who had received incorrect advice about benefit entitlements. An apology was given to the complainant and a social worker with up to date knowledge of the changing benefit system was invited to a team meeting to update staff.
- Another example was a complaint that a patient and carer had waited in the waiting room for a long time to see a staff member. An advocate was involved to provide assistance to the complainant, an apology and explanation offered and systems put in place to avoid a repetition.

Are services well-led?

Good

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

Our findings

Vision and values

- Staff knew and understood the values of the organisation. They knew who the senior managers in the trust were. The service managers regularly spent time in the services and their support was valued by staff.
- Staff described working closely with commissioners and other professionals to review and improve the services, especially the review of caseloads numbers. There was also close working with other providers such as the Alzheimer's Society to meet the needs of people who use the service and their carers.

Good governance

- The standard of care plans, risk assessment and risk management was very good and some teams had identified the need for some improvements and had planned audits of care records to achieve this.
- All of the services, at different locations, provided high quality care and this was provided in accordance with national guidance and best practice. There was a continuous focus on the safety of the person who used the service. Systems were in place to ensure that the safety of people was regularly discussed.
- All of the services were able to respond quickly if required. The services were all actively using feedback from incidents and complaints to make improvements where needed. Staff undertook a range of local audits, for example audits of the use of anti-psychotic medicines and using the outcomes from audits to improve services. Risk assessment monitoring systems were in place in all teams and risk factors were discussed daily and at weekly multidisciplinary meetings and this information was shared with the trust board.
- Some staff had completed mandatory training and had received other training to support them to carry out their roles. There were plans to improve compliance rates for some mandatory training including the Mental Capacity Act and the Mental Health Act and these were being addressed in individual teams. There were also plans in place to ensure that the regularity of staff supervision improved across all teams, now that all teams had a team leader in post. Managers were supportive of flexible working and monitored caseloads carefully to ensure staff did not become overworked and were actively looking at ways to reduce caseloads.
- Managers had access to key information on the performance of their teams via a system called a heat map. Heat maps covered areas such as clinical delivery services, waiting times, staff vacancies, staff sickness, complaints performance and monitoring of training rates. People's experience of the service and staff supervision were categories to be added to the heat map.
- Team managers used this information to monitor performance and make improvements where needed.
- There were good staff retention levels, sickness levels were being managed and staff vacancies across the teams being recruited to.

Leadership, morale and staff engagement

- Staff morale was good and staff described being proud of working in good, supportive and knowledgeable teams.
- Staff were positive about the trust as an employer and of the leadership from their directorate. Examples of this were that the medical director visited one team recently and the Chief Executive had been to another team we visited. Also that the Clinical Delivery service (CDS) leads for one area had responded to staff requests for them to visit and a visit from the CDS leads was scheduled for October 2016. They described the culture of the trust as open and said that incidents and mistakes were used as opportunities to improve. Staff felt that positive changes had been made in terms of communication from senior managers.
- Staff were aware of how to use the whistleblowing process. Staff were confident they could raise concerns and would be listened to by senior managers.
- Staff felt supported by line managers and colleagues.There were forums where staff could obtain peer support. Staff said they could obtain support when they needed it. Staff told us they felt valued and supported to undertake further training and development.

Are services well-led?

Good

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- There were opportunities for staff development. Examples of this were the support and encouragement given to staff to access training such as family therapy, cognitive behavioural therapy, Masters in dementia studies and opportunities for reflection time. Protected time was available in teams to improve training compliance rates and the frequency of staff supervision across the board.
- Staff also had access to leadership training provided by the trust and staff were using these skills to improve their work and where appropriate look for promotions. Staff described the leadership course as a good developmental experience and that it provided opportunities to meet and engage with more senior managers.

Commitment to quality improvement and innovation

- The living well with dementia team completed an audit on dementia and antipsychotic prescribing within the team in June 2016. The aim was to include the whole team, improve practice and raise awareness of the use of antipsychotic medication and current guidelines. They produced recommendations and the team planned to conduct a follow up audit in six months' time.
- The team manager of one of the memory assessment services told us that the service had been audited for accreditation with the Memory Service National Accreditation Programme (MSNAP) during this inspection. and was awaiting a decision on accreditation.
- An occupational therapist was researching alternative ways of working with people through animal-assisted therapy.
- A staff member developed a work based learning project presentation entitled "developing a safe, effective and caring pathway for dementia patients in the community on Acetycholinestease inhibitors" as part of the leadership development course.
- Staff told us that patients and carers were invited to be part of interview panels for new staff.