Good

Sheffield Health and Social Care 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)
TAHCC	Fulwood House	Memory Service	S5 7JT
TAHXK	Fulwood House	Functional Intensive Community Service	S2 4EA
TAHXK	Fulwood House	Community Mental Health Team (North)	S2 4EA

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

Summary of findings

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 Sheffield Health and Social Care NHS Foundation Trust and these are brought together to inform our overall judgement of Sheffield Health and Social Care 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?	Requires improvement
Are services effective?	Good
Are services caring?	Outstanding
Are services responsive?	Good
Are services well-led?	Good

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

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

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

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

Summary of findings

Contents

Summary of findings

Overall summary

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

- The multidisciplinary approach to care was consistent and positive. Staff across the services managed risk effectively and reviewed patients' risk regularly. They provided safe care and supported patients well.
- Staff undertook a comprehensive assessment of the needs of patients and carers.They provided care and treatment that was effective, recovery focussed and met the needs of patients. Staff used best practice guidelines to deliver effective care and treatment.
- Staff inspired confidence in patients and carers. Staff treated patients with kindness, dignity and compassion. Relationships were built on a mutual respect for each other.
- The service had a co-ordinated approach to managing referrals and care pathways were clear and responsive to the needs of patients.
- Complaints about the community based mental health service for older people were exceptionally low and compliments were high.
- The needs of carers were consistently addressed by the service and this was supported by the role of carer liaison practitioner.

However:

Compliance with mandatory training was low.

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:

- The service at Edmund Road did not ensure clinical room stock was routinely checked for expiry dates. Records for these clinical checks were not maintained, accurate or up to date.
- Staff left keys in external locks of doors within the memory service, and could not give an explanation for why they did this. This was a potential risk to staff and patients.
- There were inconsistencies in the numbering of rooms in relation to the fire panel and personal alarm activation. This meant responses were slow.
- Not all staff had completed or were current with their mandatory training. This included key training in basic life support and managing violence and aggression.

However:

- Staff completed risk assessments and management plans on every patient and reviewed them regularly.
- Care plans were in place to ensure patients and carers knew how to access support in a crisis.
- The majority of community based teams shared a common location.This enhanced teamwork, communication and support.
- There was a good multidisciplinary approach that supported ongoing monitoring and management of caseloads
- Effective systems were in place to manage risk on a day to day basis.
- The services had a good track record on safety.

Are services effective?

Good

We rated effective as good because:

- All patients received a comprehensive assessment of their needs.
- The use of recognised assessment and rating tools strengthened patient outcomes.
- Staff had a clear understanding of best practice and this underpinned the multidisciplinary approach.
- Staff received specialist training, supervision and appraisal. Staff were supported to engage in professional development.
- Multidisciplinary work was central to service success. Communication within the teams was positive and effective.

However:

Summary of findings

- The quality of care plans across the service was inconsistent. Thirteen of the 34 care plans that we looked at did not reflect a person centred approach.

Are services caring?

Outstanding 

We rated caring as outstanding because:

- All staff genuinely respected and valued patients and carers who used the service.
- Interactions between staff and patients were warm, compassionate and caring.
- Staff had a detailed knowledge of their patients, this inspired confidence in patients and carers.
- Feedback about the service and staff was exceptional.
- The needs of carers were important to the service and these were effectively assessed .
- Patients and carers felt involved in decisions about their care.
- The development of the new collaborative care plan reflects the trusts commitment to improving patient involvement.

The service actively sought feedback from patients and carers.

Are services responsive to people's needs?

Good 

We rated responsive as good because:

- The service had inclusion criteria for each team and there were clear pathways between teams that supported the delivery of safe care.
- A single point of access provided a co-ordinated approach to managing referrals.
- The service was responsive to patients' needs and provided care and treatment seven days each week.
- Targets from assessment through to referral were achieved.
- The promotion of assistive technology within the service supported patient independence and a recovery focus.
- Patients and carers were highly satisfied with the care they received.
- Complaints within the service were exceptionally low and compliments high.

Are services well-led?

Good 

We rated well-led as good because:

- Staff were passionate and had pride in their work.
- The service was proactive in gaining feedback from patients and carers.

Summary of findings

- Good governance arrangements were in place and this supported the flow of information across the service and organisation.

The service was committed to improving quality and supported innovative practice.

Summary of findings

Information about the service

The community based mental health services for older people were based at Edmund Road and the Longley Centre.

The Memory Service

Based at the Longley Centre, the service aim was to increase the number of people who receive early assessment and diagnosis of dementia. The service also provided pharmacological treatments for people with dementia and provided a cognitive enhancer (medication) follow up clinic. The service operated Monday to Friday 08.30-17.00.

Functional Intensive Care Service

Based at Edmund Road, the service provided short term, intensive home treatment to older adults with functional mental health problems. Functional mental health issues include problems such as depression, anxiety and schizophrenia. The aim of the service was to prevent hospital admission to the older adult mental health wards and to support people to remain in their own homes. The second element of the service was to provide post discharge support. Interventions by the team were for up to ten weeks. The service operated Monday to Sunday 08.00–18.00.

Community Mental Health Teams

Based at Edmund Road, the service provided prompt assessment, treatment and ongoing support for people over the age of 65 with long term or severe and enduring mental ill health. The service provided four teams to cover the city of Sheffield. The service operated Monday to Friday 09.00-17.00.

Our inspection team

The team was led by:

Chair: Beatrice Fraenkel

Head of Hospital Inspection: Jenny Wilkes, Head of Hospital Inspection (North East), Care Quality Commission

Team leader: Jennifer Jones, Inspection Manager, Care Quality Commission

The team that inspected the community based mental health services for older adults consisted of an inspector, two nurses and an occupational therapist.

Why we carried out this inspection

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

How we carried out this inspection

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

Is it safe?

Is it effective?

Is it caring?

Is it responsive to people's needs?

Is it well-led?

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

During the inspection visit, the inspection team:

Summary of findings

- visited three of the seven community based mental health teams for older people and looked at the quality of the environments where outpatient appointments were held
- attended and observed three visits to patients in their own homes
- observed one appointment held at the memory service
- spoke with 12 patients who were using the service
- spoke with eight relatives or carers of patients using the service
- spoke with the managers for each of the teams
- spoke with 38 other staff members; including consultants, doctors, nurses, administrative staff and other allied mental health professionals
- attended and observed four hand-over meetings and multi-disciplinary meetings
- observed two patient activity groups
- collected feedback from patients using ten comment cards
- looked at 34 patient care records
- reviewed the medication management
- looked at policies, procedures and other documents relating to the running of the service.

What people who use the provider's services say

We spoke to 20 patients, relatives and carers using the service and their feedback about their experiences was exceptional. They felt they were treated with respect and dignity. They described staff as very caring, compassionate and professional. Patients and carers welcomed the support they received outside of their appointments with the service. Relatives and carers complimented the service consistently.

Good practice

The community based mental health service for older people were committed to innovation and research. Staff within the memory service were involved in research locally and nationally. The service achieved accreditation by the Memory Service National Accreditation Programme (MSNAP) and were working towards maintaining this in 2017.

Areas for improvement

Action the provider MUST take to improve

Action the provider MUST take to improve

- The provider must ensure that all staff have received up to date mandatory training.

Action the provider SHOULD take to improve

Action the provider SHOULD take to improve

- The provider should ensure a responsive system is in place for when alarms are activated in the memory service.
- The provider should ensure clinical room stock is routinely checked for expiry dates and records are maintained, accurate and up to date.
- The provider should ensure keys are not kept in external locks of doors within the memory service.

The provider should ensure care plans are person centred.

Sheffield Health and Social Care 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
Memory Service	Fulwood House
Functional Intensive Community Service	Fulwood House
Community Mental Health Team (North)	Fulwood House

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.

There were no patients cared for by the teams on community treatment orders.

Mental Health Act training was mandatory for selected services within the trust. Staff within community based mental health services for older people did not have to undertake this training.

Mental Capacity Act and Deprivation of Liberty Safeguards

Mental Capacity Act 2005 and Deprivation of Liberty Safeguards training was mandatory for staff. Compliance was variable across the service; nevertheless staff had a good understanding of the guiding principles for assessing capacity. We saw evidence that staff considered consent to care and treatment in care records.

Requires improvement

Are services safe?

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

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

Our findings

Safe and clean environment

The community based mental health services for older people provided care and treatment within patients' homes. However, the community mental health team and the memory service also had clinic and treatment rooms available at their base which patients could access.

The community mental health team and the functional intensive community support service were located at Edmund Road. This building was shared with other community based mental health services for older people. The building was modern and well equipped.

Teams were based in their own open plan offices and the office space was adequate. This meant communication within teams and between the different services was more effective.

All patient interview rooms were fitted with alarms. The layout of each room meant that alarms were easy to access by staff. Admin staff told us when the alarms were activated, they sounded in reception and they would investigate. A red light would also light up outside the room when the alarm was pressed. This provided an additional visual prompt to staff that assistance was required.

We tested one alarm in the doctors' office. The response by staff was slow. We discussed this with staff and the service manager. The delayed response was due to confusion with the room number. Staff explained that when the alarm was activated, the alarm panel identified the room by the allocated fire door number. Staff told us they were more familiar with the interview room numbers displayed on the actual doors. These two numbers were different. A delay in responding to an alarm could increase the risk presented by patients to other users of the service and staff.

There was one clinic room and this was available for use by all the community based mental health teams based at Edmund Road. The clinic room had basic physical health monitoring equipment such as weighing scales and a blood pressure monitor. We saw that equipment was maintained and these were regularly electrically tested. Other equipment such as surgical masks, blood glucose testing strips and hand hygiene kits were stored in cupboards and bags. We saw that this equipment was out of date. We checked how the service had monitored its stock and found staff had completed checks on this equipment. However, staff had failed to identify and record they were out of date and had only completed and documented checks up until July 2015. Patient safety could be at risk through ineffective monitoring by staff and the use of out of date equipment. The manager confirmed to us that all out of date stock was removed from the clinic room that same day and disposed of. This was not replaced as the equipment was no longer needed.

The clinic room was very clean and organised. We checked the cleaning schedules and all were current and accurately completed. We saw a schedule for six weekly collection of sharps bins. We observed a small number of sharps bins in the clinic room waiting to be collected. The record of opening and closure dates were clearly documented on each bin. This process meant the risk of a needle stick injury to staff was reduced.

The environment was welcoming and inviting. It was clean, well maintained and met the needs of patients attending the service. We saw a reminiscence display in the reception area and this featured old short stories about Sheffield. Waiting areas were adequately furnished and had facilities for people to make a drink.

We observed keys were left in the external lock of a number of doors. We discussed this with the service manager and there was no rationale for this practice. This meant it was possible for people to be locked in rooms and this was an increased risk to their safety. The trust subsequently told us all of the doors in the memory service have a lock toggle on the inside so people can open the doors from the inside. These are known as 'keyless exit locks' and it is impossible to be locked in.

The memory service had two clinic rooms; a research nurse used one of these predominantly. The clinic rooms were well equipped with weighing scales, blood pressure monitor and an electrocardiogram monitor. Equipment was adequately maintained and nurses had completed the required monthly clinic room checks. We reviewed

documentation from April 2016 and all records were complete. One clinic room had an examination couch and this meant that patients could be examined in an appropriate clinical room.

We observed staff adhering to infection control principles at both locations. Hand washing signs were located at sinks throughout the buildings. Hand gel dispensers were located throughout buildings and were easily accessible.

Safe staffing

Staffing levels varied across the community based mental health service for older people; we found overall that staffing levels were sufficient to meet the service needs. Vacancies across the service were minimal; the functional intensive community service had 0.5 whole time equivalent vacancy for a nurse and 0.75 whole time equivalent vacancy for a nursing assistant. The community mental health team were above their establishment level for qualified nurses and nursing assistants and the memory service had no vacancies.

Sickness levels for the memory service (8%) and the functional intensive community service (14%) were above the trust average of 7%. Both services had experienced long-term absences within their teams over the last 12 months.

The memory service had had three members of staff absent on a long-term basis. At the time of inspection, this had improved and only one member of staff remained absent.

The functional intensive community service team was very small and having two members of the team absent did impact the service. Plus the service had to reduce the size of the staff team further due to non-recurrent funding coming to an end. This loss equated to almost a 1.5 whole time equivalent nurse, which meant that weekend cover may not be sustained and uncertainty remained regarding this provision. In spite of the service being stretched, staff told us the workload was managed effectively through strong teamwork, good communication and by prioritising patient need. The functional intensive community service also had a nurse co-ordinator on duty each day. A senior nurse undertook this role. They had oversight of the daily demands of the service, which enabled effective planning and provided immediate support to team members.

The use of bank and agency staff was not common practice within the older adult community mental health service. The functional intensive community service used a regular bank nursing assistant for 15 hours each week to cover their only vacancy. The memory service had used one bank nurse regularly for the last 12 months. They were both familiar with the respective services and the role. The community mental health team did not use bank or agency staff.

Within the last twelve months, the service had introduced a rotational nursing post within the service. This opportunity meant that a newly qualified nurse spent a dedicated period of time in each team and gained experience across the care pathway for the community mental health services for older adults. This role covered inpatient care, memory service, the functional intensive community service, rapid response and the community mental health team. This approach had helped the service with recruitment, retention of nursing staff and the future planning of the service.

The community based mental health service for older people had effective systems in place to manage caseloads. Staff within the community mental health team had caseloads of 20-30 patients and at the time of inspection. Two patients were awaiting allocation of a care co-ordinator. Staff told us caseloads were allocated based on the need of the patient and not caseload numbers. The senior practitioners in the community mental health team reviewed referrals into the service regularly each week. This gave them oversight of activity within their service and informed decisions regarding which health care professional was best placed to support patients. The role of the nurse co-ordinator within functional intensive community service undertook a similar role with regard to caseload management. All the community services for older people benefitted from a multi-disciplinary approach that supported the ongoing monitoring and management of caseloads.

Each team had access to a psychiatrist that met the needs of the service. There were dedicated psychiatrists based at Edmund Road and patients had rapid access to appointments if required. We observed a good example of this during a multi-disciplinary meeting. A patient was identified as requiring an urgent medical review and the team were able to accommodate this the next day. The memory service had similar access; the service provided emergency appointment slots for patients throughout the week.

Requires improvement

Are services safe?

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

The current compliance rate for mandatory training in the older adults community mental health services as of 13 October 2016 was 70%. Of 23 mandatory courses for the trust, only seven were above the trust target of 75%. These varied across the three services inspected. Clinical risk assessment, equality, diversity and human rights, fire safety and slips trips and falls were above the trust target across all three services.

There was low compliance with some of the trust's identified mandatory training courses, including key training in basic life support, Mental Capacity Act, respect level 1(Training to produce the safest solutions to effectively manage challenging behaviour) and medicines management. We were particularly concerned that data for basic life-support training for both the community mental health team and the functional intensive community service was below the trusts' compliance rate. This training is essential for ensuring that patients are safe, particularly for the community-based services. There was confusion if training in the Mental Health Act was not mandatory and no team had recorded any compliance against this in the data provided by the trust. Following our inspection, the trust advised us that Mental Health Act training was not mandatory for community based mental health services for older people.

Assessing and managing risk to patients and staff

A telephone triage system staffed by nurses was the single point of access for the service. Although it was based at Edmund Road, referrals for the memory service were also taken. The community based mental health service for older people used the community detailed risk assessment and management plan. Assessment of risk commenced at the point of referral into the service and staff gathered information from the patient, carer and referrer. The triage system enabled staff to identify the service that could best meet the needs of the patient. We observed the telephone triage service in operation. Staff confidently completed the detailed risk assessment and management plan and we were told if a patient was high risk, the referral would be acted upon immediately with the relevant team. Having a shared base at Edmund Road supported this process. Following triage the completed detailed risk assessment and management plan would be accessible by the team the patient had been referred to.

Staff told us the detailed risk assessment and management plan was reviewed at every patient contact and would be updated as required. We looked at 29 patient records; all the records we reviewed had a completed risk assessment, management plan and were up to date. Staff recorded the risk history and current mental state. This meant reviews of risk enabled staff to accurately assess the risk to the patient, themselves and others. We observed individual staff and teams consistently discussing risk during multi-disciplinary meetings, handover and patient consultations.

Crisis planning for patients was evident across the service. Patient care plans included information on who they could contact in a crisis and when. The memory service provided a nurse telephone helpline. Patients told us they were aware of the out of hours services and whom they could contact, details could be found on the crisis cards. We observed on two occasions of staff working with patients in their own homes. During these visits, staff discussed care plans in detail and checked out with the patients their understanding of what to do in a crisis.

Staff had received training in safeguarding vulnerable adults and children. Staff we spoke with had a good understanding of what constituted abuse, and how to recognise and report this. Staff told us they were confident in raising an alert to the local safeguarding authority and were aware of the trust's safeguard lead. We observed flow charts for safeguarding procedures within the staff office and these supported staff in the decision making process. Policies and procedures were also available on the staff intranet. During one home visit, we observed a member of staff sensitively discussing with a patient a safeguarding alert that had been made the previous week.

Systems were in place to maintain staff safety. The service followed the trusts lone working policy and the teams effectively used the buddy system. This meant that staff informed another member of the team of their planned schedule for the day and they checked in with each other at the end of the day. Staff at the Edmund Road base would make telephone contact if staff failed to ring in. Staff also told us the use of their electronic diaries supported this process. In addition to this, teams used an 'in and out' board, this indicated if they were in the building or not.

The management of medicines was adequate. We reviewed nine records in relation to medicines. Collaborative care plans included information on the monitoring of side effects of medication. We saw evidence of effective communication with GPs regarding prescribing and changes to medication for patients. The clinic room at

Requires improvement

Are services safe?

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

Edmund Road had a medicine cabinet and different teams at used this. Access to the cabinet was through nursing staff only. We checked the contents of the cabinet and we found individual patient medication appropriately labelled and logged. The functional intensive community service team had access to prescriptions. These were securely stored in a locked drawer and access was limited to qualified nurses. We saw an accurate log of all prescriptions; this detailed the prescription number, date, issued by, patient name and staff signature. On a weekly basis, the team manager audited this process to ensure the safe management of prescriptions. We examined the audit and it had been completed accurately since July 2016. Patients being discharged from hospital to the functional intensive community service were discharged with one week's supply of medication, providing sufficient time for the service to liaise with the patients GP to continue prescribing.

Track record on safety

The trust recorded 18 serious incidents between 1 April 2015 and 31 March 2016. Community mental health services for older people recorded one serious incident during this time. We examined the details of this incident with an operational service manager. The service responded promptly in supporting staff and investigating the incident. No immediate learning was identified; however, the service produced an action plan in response to the subsequent Coroner's inquest. This action related to improving communication with family members. The action was completed.

Reporting incidents and learning from when things go wrong

The trust used an electronic system to record incidents. Memory service staff told us they used a paper-based system for reporting incidents and this was in the managers' office. All staff across the multi-disciplinary teams were confident in what to report and how to report incidents. Staff told us they were encouraged to report incidents. Staff gave us examples of issues reported, such as patient behaviour and accidents, such as slips, trips and falls. All team managers told us that the number of incidents in the services were low and no themes or trends were evident.

Staff received debriefs following incidents, this could be on an individual level or as a group. Psychologists within the service also told us they offered post incident support. During a focus group for staff, staff told us they could directly access the risk department within the trust for additional advice and support.

Staff told us they received feedback from investigation of incidents specific to their service and from the wider trust. Staff received feedback through email and a trust newsletter called 'risk matters.' The trust had governance structures in place to facilitate learning from incidents, ranging from ward to board level governance meetings. We saw evidence of this in the services' business and governance meeting minutes. There was a standardised agenda based on the Care Quality Commission domains and incident reporting was discussed under the safe domain.

We discussed with a service manager a recent incident in relation to medication. We examined the incident report and noted that immediate learning had been identified and actioned within the service. This incident led to changes in the admin process regarding GP letters. Learning was shared with staff through email and we saw documented discussion within the services' business and governance team meeting minutes.

The trust had a Duty of Candour and Being Open Policy and Procedure. Staff understood their responsibilities under the Duty of Candour and they demonstrated an open and transparent culture during interviews.

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

Following triage and allocation to an appropriate team, all patients received a common pathway of assessment. This included but not exclusively an update of the detailed risk assessment and management plan, commenced clustering (a tool to assess patient need over time) and develop a care plan. Patients requiring the memory service then undertook a specialised assessment and the community mental health team and functional intensive community service completed a scheduled care pathway initial assessment.

All teams used a multidisciplinary assessment process, which included a thorough structured assessment of the patient and carer. This comprehensive process captured a wide range of information about the patient, including physical health, mental wellbeing, social networks, education, employment, capacity and consent.

The memory service assessment included the use of recognised tools such as Addenbrookes Cognitive Examination, General health Questionnaire and the Bristol Activities of Daily Living Scale. Carers also received assessment of their needs, again using a number of recognised tools. We observed one initial assessment within the memory service. Each assessment can take up to two hours to complete, this was due to the thoroughness of the process and consideration of the needs of the patients attending. Throughout the assessment we observed staff being caring, compassionate and responsive to the needs of both the patient and carer.

The community mental health team used recognised tools to underpin the scheduled care pathway initial assessment. These included the Health of the Nation Outcome Scale and the Neuropsychiatric Inventory Questionnaire; this provided an assessment of patient symptoms.

Due to the specialist nature of the functional intensive community service, the majority of the referrals were from the community mental health team. In addition to the scheduled care pathway initial assessment, the community mental health team would also complete a crisis assessment tool as required by the functional intensive community service for admission avoidance. This provided up to date information on the nature of the crisis, risk to self or others and the nature of intervention required. Interventions included medication management and/or maintenance, complex case management or cognitive behavioural approaches.

For the discharge support element of the functional intensive community service, assessment began prior to a patients discharge from hospital. The team visited patients in the hospital to discuss how best to support them when they went home. Common interventions provided were medication management, anxiety management, goal setting, social activities and confidence building.

All 34 care records reviewed contained an up to date comprehensive assessment of need. However, the quality of care plans across the service was inconsistent.

We reviewed 15 care records in the memory service, care plans were in place and up to date. Physical healthcare screening and ongoing monitoring was evident. Informed consent was documented in all 15 care records, we saw evidence that this was revisited at each appointment. However, 13 records did not reflect the person-centred approach which we observed within the service. In addition, the service were not using the collaborative care plan. This is to be implemented in January 2017.

We case tracked one care record from referral to discharge. The record was complete, provided detailed evidence of a holistic approach to patient care, including assessment of capacity in relation to residence. Both patient and carer views were documented. We saw evidence of a care plan review and communication with the patients GP.

We reviewed six care records in the functional intensive community service. All records were comprehensive, holistic and current. The records reflected how effectively and consistently the service reviewed and managed risk. In one record, we saw evidence of positive crisis management. Working with the patient and their family, staff successfully arranged a placement within a crisis house. This provided support for the patient for up to seven days, in addition to that provided by the functional intensive community service.

We reviewed 13 care records in the community mental health team. All records were comprehensive, holistic and current. We saw evidence that the team were using the new collaborative care plan and the level of patient involvement was easy to see. We case tracked one record; it detailed a clear referral process, including joint visits between the

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referring team and the community mental health team. We saw evidence of multidisciplinary discussion and allocation within the team. Staff reviewed the care plan regularly and risk updated.

All community based mental health teams for older people used secure electronic records for clinical data. Some staff had access to other electronic systems external to the trust such as the local authority and acute hospital trust, but this was dependent on the function of the community team. Staff access to records was good; data was up to date and readily available to the different teams. This was strengthened by the use of a single comprehensive risk assessment template by the trust.

Best practice in treatment and care

Staff told us when prescribing medication, National Institute for Clinical and Healthcare Excellence guidance were followed, along with recommendations from the Royal College of Psychiatrists and trust policy. The monitoring of medication was consistent for antipsychotics, lithium and cognitive enhancers (anti dementia drugs).

Psychological therapies recognised by National Institute for Clinical and Healthcare excellence such as cognitive behavioural therapy and systemic therapies were available. Staff used recognised rating scales to assess and record severity and outcomes for patients. This included the Health of the Nation Outcome Scale for Older Adults, the Mental Health Clustering Tool, the Generalised Anxiety Disorder (GAD7) Tool and the Patient Health Questionnaire (PHQ9) for depression. The service also assessed carers' needs against the Zarit Burden Interview, a questionnaire that examines the impact of being a carer.

Allied health professionals delivered group work such as cognitive stimulation therapy, living life to the full and caring and coping with loss and dementia. Allied health professionals also used a number of recognised assessment tools including the Model of Human Occupation Screening Tool (MOHOST) and the Pool Activity level instrument (PAL). Staff told us they ran the cognitive stimulation therapy group and carers' group concurrently; this enabled both patient and carer to attend their respective groups.

When we spoke with both allied health professionals and clinical staff, they were able to show a clear understanding of best practice. Service managers also gave detailed evidence demonstrating care was underpinned by appropriate guidelines.

We observed the occupational therapy team facilitate living life to the full group. Patients told us they enjoyed the group, they were able to learn new things from others. One patient told us that they had been motivated to complete major tasks in their life that they were previously unwilling to do. This group provided patients with meaningful activities to engage in. This was in accordance with NICE guidance Lifestyle Matters (2008), which recommends activities, interests and lifestyle to maintain health and wellbeing.

Skilled staff to deliver care

Each team had access to a comprehensive multidisciplinary team. This included psychiatrists, occupational therapists, psychologists, nurses, support workers and admin. The service also had access to a pharmacist.

Staff were experienced and qualified in their various roles. Specialist training was available and staff told us the trust was supportive in their development. Staff had accessed the following training: recovery and value based practice, cognitive behavioural therapy, dual diagnosis and recognising and assessing medical problems in psychiatric settings (RAMPPS). Staff told us they had recently attended Maastricht Interview training. The focus of the training was about hearing voices and was delivered by people with a lived experience. Feedback from staff was very positive. We spoke to one member of staff that who had several research papers published, all of which had an older adult focus. This demonstrated the specialist interest and experience that staff had within the service.

All staff were expected to complete an induction programme, including corporate and local induction. The memory service had developed a structured induction for staff. We saw a comprehensive document that collated key policies, relevant clinical standards and service specific information for new staff. This meant new staff had access to up to date information about the service and had clearly defined guidance about their role.

The trust compliance rate for annual appraisal for staff was 86%. The range for appraisals completed within the

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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.

community based mental health services for older people was between 73% and 89% across the three teams that we visited. The trust target for clinical supervision was 80%. The average clinical supervision rate for community based mental health services for older people was 62% as of 31 July 2016. Senior staff supervised staff nurses and staff nurses supervised support workers. We saw paper records of staff supervision that showed supervision occurred regularly across the service.

Staff told us they attended formulation meetings with a psychologist and received informal supervision through peers. Each team held team meetings. We observed a 'Schwartz round' during the inspection. Schwartz round is an internationally recognised meeting that examines the emotional impact of work people do. The meeting has been running for 12 months within the trust and was delivered approximately ten times each year. We observed three members of staff share examples of their clinical practice with the group. The theme was working with risk. Twenty four members of staff attended from across the trust, covering many different disciplines. The discussion was open and honest and staff were comfortable exploring their thoughts in this forum. Staff told us they were left with a positive message of hope and validation of their feelings.

Staff who do not regularly access clinical supervision will not have the opportunity to talk about their clinical practice and development constructively. We did not see any impact of the service not meeting the trust target for clinical supervision.

We found that the trust dealt with poor staff performance appropriately. There was one ongoing investigation of staff at the time our inspection.

Multi-disciplinary and inter-agency team work

The teams operated within a multidisciplinary framework. Teams consisted of the following professionals: psychiatrist, psychologist, occupational therapist, clinical staff, speciality doctors and administration staff. A pharmacist attended the weekly multidisciplinary team meeting within the functional intensive community service. Multidisciplinary meetings were held once each week across the different teams. Staff told us they were essential for good teamwork and meeting the needs of patients. We observed one multidisciplinary meeting. The structure of the meeting focussed on new referrals, internal referrals and update on previous referrals. Staff also had the opportunity to discuss emerging concerns about current patients. We saw the effective use of the trust's information technology system throughout the meeting. This provided accurate and up to date information about patients. We saw new referrals displayed visually on a screen and read out aloud. This approach provided a greater depth of information and promoted comprehensive discussion within the meeting. The live appointment system was also accessible, this meant the team could make and amend appointments dependent on patient need.

We observed one handover within functional intensive community service, a range of health care professionals attended. The handover was effective. Information regarding patients' needs, risk and safeguarding were some of the issues addressed. We noted that the general approach within the handover was person-centred and recovery orientated. Staff demonstrated a good knowledge of their patients. The handover was timely, focussed and well attended by staff.

Teams within the community based mental health services for older people had a clear care pathway that supported safe patient transitions into the community. Each service had specific objectives and purpose. We tracked two patient journeys through the service and both were good examples of how patients had accessed the service, were allocated to an appropriate team and care was successfully co-ordinated. Both care records demonstrated how patients were handed over between the community mental health team, functional intensive community service and the memory service. Staff consistently told us that the location of the majority of teams at Edmund Road had significantly helped with multidisciplinary teamwork. Staff told us bureaucracy was reduced and teams could talk to each other in person, seek advice and gain support.

The service had good working links with GPs within primary care and the local acute hospital. This was strengthened by having access to the respective clinical data systems. We saw effective communication with patients' GPs in relation to treatment and physical health monitoring. Staff could access information from the acute hospital regarding scans and results from other investigations.

All teams had positive relationships with the local safeguarding authority and confident in accessing them. However, service managers told us that additional work was underway to improve pathways with the local authority.

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.

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

Mental Health Act training was part of the trust mandatory training programme. None of the teams had recorded any compliance rate against this training. We discussed this with a manager; they stated that the training was not mandatory. Staff had a working knowledge of the Act although felt it was not often used in their day to day work with patients. Staff were aware that they could access guidance and advice from the Mental Health Act administrator within the trust. There were no patients cared for by the service on community treatment orders

Good practice in applying the Mental Capacity Act

Mental Capacity Act (MCA) level one and level two was part of the trust's mandatory training programme. Compliance for MCA level one ranged from 0% to 82%. MCA level two ranged from 10% to 81%. When we spoke with staff, we found most had a good understanding of the MCA, especially the guiding principles. Staff told us they could access further information on the trust's intranet.

In the care records we reviewed there was evidence of informed consent being obtained regarding care and treatment with patients. We also observed informed consent being obtained during an initial assessment within the memory service.

Outstanding ☆

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 to 12 patients and eight carers, attended three patient home visits, observed one initial assessment, two groups and three multidisciplinary team meeting. Patients and carers spoke very highly about staff and the service provided. They described staff as caring, understanding, supportive, empathetic and having a genuine interest in patients. One patient told us that the level of respect they received from staff during group work enhanced their feelings of being an equal and knowing they were not alone. Another patient told us staff were "utterly brilliant and treated patients with upmost respect and dignity."

We observed staff delivering two different group work sessions. Staff were welcoming and patients were encouraged to participate at a level with which they were comfortable. In one group, we observed staff provide a patient who had significant sight impairment with a magnifying glass and information sheets in very large print. This meant that all patients could participate in the group and that individual needs and preferences were considered.

We observed one initial assessment within the memory service. Throughout the assessment both patient and carer's needs were addressed. The patient's consent and understanding of the process was checked consistently throughout the assessment. Both patient and carer were encouraged to ask questions and clarify details. We observed a heartening interaction between a member of staff and a patient following their appointment with the doctor. Their carer had gone to collect their car and a member of staff sat in the waiting area, gently holding the patient's hand, providing support and comfort to the patient.

We observed staff visiting patients in their own homes. We saw staff provide support and advice. Staff actively listened to the views of patients and carers. Staff were sensitive to patient need and adapted their responses accordingly. We observed an excellent balance of caring, empathy and professional behaviour. Staff had detailed knowledge of their patients and this inspired confidence in patients and carers.

During one home visit with the functional intensive community service, we observed how staff effectively supported a patient with complex mental health needs and family pressures. The nurse was very knowledgeable about the patient's symptoms, medication and treatment plan. The nurse provided practical and emotional support to the patient by engaging them in an anxiety management intervention. Increased family issues had exacerbated the patient's anxiety and the nurse appropriately discussed a referral to the local safeguarding unit. In addition, the nurse agreed with the patient to increase the support provided during their difficult time. This person centred approach was reflected throughout all three of the community mental health services we inspected. Relationships between staff, patients and carers were strong, caring and supportive.

The involvement of people in the care that they receive

Patients told us they were actively involved in planning their care and could have a copy of their care plan if they chose to. We reviewed the new collaborative care plan used within the teams. This recorded the level of patient involvement in the development of their care plan. The extent of their involvement was colour coded, and staff choose from six options. The level of involvement ranged from 'I do not want to be involved in this goal at the moment' to 'I feel like I am taking a lead on my goal. I have written my goal and practice the steps with very little input and support from staff.' This was extremely beneficial for monitoring the involvement of people in the care they receive. One patient told us they had requested to come off their medication and the service supported them to do this, they contributed to their care plan and received a copy.

Carers were continually positive about how they were involved with and supported by the community based mental health services for older people. Carers told us they were consulted with and involved in discussions about care. One carer told us that staff helped them to understand and this made a big difference to them, stating, "they have been my lifeline." Another carer told us "they seem to care about me as much as my wife." Consistently carers told us they felt supported by the services being so accessible outside of appointment times, particularly by phone. In addition, having a crisis care plan incorporating contact phone numbers for out of hours services provided patients and carers with an additional level of support. One carer told us "Staff have gone above and beyond their duties."

Outstanding ☆

Are services caring?

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

Patients had access to local advocacy services. Staff provided patients with information and information was available in the reception area of each location.

The community based mental health services for older people have developed a service user/carer group that meets on a monthly basis. Named 'Helping One Another', the group empowers people to be informed and have an active voice in their services. Activity within the group includes Trust business, guest speakers and networking opportunities. Service managers attend and staff are encouraged to attend. Within Sheffield, carers and patients also have the opportunity to attend SHINDIG (Sheffield Dementia Involvement Group). The group is organised by the Trust in partnership with Sheffield Alzheimer's Society. Meeting four times each year, the city wide forum aims to provide opportunities for people living with dementia in Sheffield (and their family carers) to share ideas, views and opinions on local services and developments.

We found the community based mental health services for older people actively sought feedback from patients and carers. Staff discussed complaints and comments about the service with both patients and carers. All reception areas displayed information on how to give feedback on the service.

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 provided support for people aged 65 and over with a mental illness and people under the age of 65 whose diagnosis or needs are best met by older peoples services'. The service had clear inclusion criteria for access into the different teams. This covered organic and functional disorders and based on the needs, risks and the Mental Health Act status of patients.

The community mental health team provided a single point of access via a nurse triage telephone system. This provided a co-ordinated approach to managing referrals for the community based mental health services for older people. The service accepted referrals from GPs and specialist services within the trust. An internal target to complete triage from the time of referral was four hours. Staff told us this allowed for information gathering to inform their clinical decision regarding the outcome of triage. Staff told us this target was routinely met.

The community mental health team operated Monday to Friday 09.00 – 17.00. All referrals to the community mental health team were discussed regularly at multidisciplinary team meetings. A key performance indicator for the team was to assess all patients within 28 days of referral. At the time of our inspection, no patients had waited in excess of 28 days. Following multidisciplinary discussion patients were assessed by the most suitable healthcare professional. Determined by the identified needs of the patient, assessment is undertaken by one or a combination of a nurse, doctor, psychologist or occupational therapist. If urgent assessment was required before the next multidisciplinary meeting, the community mental health team could facilitate this. Support outside of the teams operating hours was available and we saw evidence of crisis plans in patient care records.

The team manager told us they regularly monitored the allocation of patients to the staff team, taking into consideration the capacity of the team, risk and complexity of care. This ensured that the manager had good oversight of the team caseload. This was further strengthened by regular supervision where caseloads were discussed and staff supported to retain a recovery focus for patient care. This had reduced the length of stay within the team to an average of five months, compared to a national average of 14 months.

Patients could access support outside of their planned appointments. Patients could contact the admin team directly for general issues; this information would then be passed onto the allocated clinician. However, if the patient was in crisis they could speak to a clinician via the nurse triage telephone system for immediate support.

The team took a proactive approach to engaging with their patients. For those patients that were reluctant to engage, the multidisciplinary team would discuss the bests ways to make and maintain contact. Staff told us they always considered the history of patients' engagement and risk. Staff gave examples of meeting patients in cafes or other meeting places in the community in which they felt comfortable to meet. In addition, the team provided flexibility in appointments. Psychiatrists provide outreach into GP clinics on a weekly basis, providing care closer to home.

The functional intensive community service operated Monday to Sunday 08.00 - 18.00.

The functional intensive community service had two distinct functions, admission avoidance and discharge support. The admission avoidance element of functional intensive community service provided treatment in patients' homes that kept them out of hospital. Discharge support provided additional help to patients when they left hospital to return home. Support included rehabilitation and education. The service is a short-term intervention available for up to ten weeks. Key performance indicators for the team were based on patient and carer contacts for both elements of the service. The operational service manager told us the service was on target to reach these.

The functional intensive community service also monitored the response time from referral to assessment for admission avoidance; at the time of our inspection this was one day. We discussed this with the service manager in relation to risk. We were assured that the referrer (usually the community mental health team) would maintain the care and safety of patients until the functional intensive community service could provide input. For discharge support, referral to assessment was two days. Staff told us they worked closely with inpatient wards to develop discharge plans before patients left hospital. This meant the involvement of the functional intensive community service was clearly defined and patients' expectations were managed.

Are services responsive to people's needs?

Good

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

A senior nurse co-ordinated the team on a daily basis, this provided the team with support and leadership. This role was office based and enabled an immediate point of contact for patients over the telephone. The team held a daily handover and this allowed the opportunity to discuss caseloads within the team, risk and new referrals. We attended one handover meeting and saw how staff were flexible in meeting the needs of patients. Staff discussed one patient in relation to needing consistency in staff supporting them. Staff discussed and planned how potential gaps in service would be addressed to successfully meet the patients' needs.

The team took a proactive approach to engaging with their patients. For those reluctant to engage, staff told us they would persevere with visits or try alternative means of contact by phone. One staff member told us they would negotiate with patients to achieve a safe plan of care. They gave the example of a patient that did not want daily visits but agreed to alternate days. This ensured that the patient got the support they needed when they wanted it.

The memory service operated Monday to Friday 08.30 – 17.00. Referral, assessment and diagnosis timescales were the basis for the key performance indicators for the team. At the time of our inspection, waiting time for assessment from referral was two weeks. The team manager told us patients could be seen earlier if patients cancelled other appointments. Patients waited approximately five weeks from referral to receive a diagnosis and treatment if required.

The memory service provided a nurse advice line 09.15 – 16.00 Monday to Friday. This provided patients and carers with direct support. Staff signpost carers to other organisations, made referrals to other services and offered appointments if required.

Staff took positive steps with patients who were reluctant to engage with the service. At the time of inspection, only 5% of patients had not attended their appointments. Staff told us they would telephone patients to establish why they had not attended and offer a further appointment. If the patient was not ready to engage with the service, the patient's GP would be informed.

Outside of the usual operating hours of the community based mental health service for older adults, patients had access to the crisis team and out of hours' service. We observed this being discussed with patients during home visits and crisis plans were incorporated in patients care plans.

The facilities promote recovery, comfort, dignity and confidentiality

The memory service was based in a dedicated building at the Longley Centre. Patients had access to a variety of clinic, interview and group rooms. Rooms were well maintained and had appropriate equipment to support treatment. We saw staff setting up the group room in preparation for the cognitive stimulation group. Staff explained that they were mindful of the layout of the room, especially in relation to accessibility and comfort. Interview rooms were inviting, although they were not soundproofed.

The memory service had an excellent resource of an onsite assistive technology room. The room was developed in partnership with a local provider of adaptations for the home and individuals. We saw products such as personal alarms, plugs to prevent flooding, grips, chair raisers and medication dispensers. Some products were linked 'live' to the provider, this allowed staff to give practical demonstrations to patients. The service embraced assistive technology as it safely maintained a patient's independence within their home.

The service had two separate waiting areas, each were adequately furnished and comfortable. We saw that the service provided a number of activities in these areas such as knitting, colouring and jigsaws. Refreshments were also available for patients and carers. On display in the main waiting area, we observed several notice boards providing information for both patients and carers. Information about the Alzheimer's Society, Age UK and dementia cafes was prominent.

Edmund Road was the central base for the majority of community mental health services for older people. The majority of visits occurred in patients' own homes but some were seen by the multidisciplinary team at Edmund Road. There was a wide range of interview rooms; their use was well managed by the admin team. We saw offices for consultant psychiatrists, members of the multi-disciplinary team and rooms where patients could be interviewed privately. The interview rooms were not soundproofed.

Are services responsive to people's needs?

Good

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

Meeting the needs of all people who use the service

Both the locations we visited were accessible to all. The entrance to the Edmund Road building had disabled access and there was a stair lift to the first floor. Staff were trained in its use. This meant patients and carers could access both floors within the building. We saw the maintenance certificate; the lift was serviced in April 2016. Disabled toilet facilities were available on both floors. Dementia friendly signs were a prominent feature at both locations.

The Longley Centre provided a dedicated base for the memory service. The building was accessible for all and provided a drop off point immediately outside the door for patients. In addition, the service provided free daily parking permit for patients to use. This meant that parking was easier and access to the service less stressful. There was access to disabled toilet facilities and we observed dementia friendly signs.

The availability of information for patients and carers was considerable. The memory service displayed a welcome poster in the reception area. It translated the word 'welcome' into eight different languages that were most representative of the local community. The poster also included a picture of a person using sign language to say welcome. Edmund Road produced a visitor's file; this could be accessed whilst patients were in the waiting area. The file included information on local groups and services within the area.

Both locations provided extensive information on health and wellbeing. Information that is more specific was available for carers, patients, research initiatives and partner agencies and organisations. Advocacy and interpretation services were available to patients. Two members of staff based within the memory service could use sign language.

Listening to and learning from concerns and complaints

From the 1 September 2015 to 25 August 2016, community based mental health services for older people received no complaints.

All services had information prominently displayed so patients knew how to complain. This included a complaints leaflet and a fast track complaint form. The teams displayed posters detailing a contact name, address, telephone number and email. This meant patients had a number of alternative methods to complain. Comments boxes were also available at each location.

In addition to this, the service has recently developed a 'grumbles log'. The log captures comments made directly to staff from patients and carers regarding any concerns. Action taken is recorded and any learning is shared in the teams' monthly governance meeting. This proactive approach provides an immediate opportunity for people who use the service to express a concern before it becomes a complaint. We reviewed the grumbles log in the community mental health team (North) and issues noted included font size on letters, patient diagnosis and referral process. Each had been successfully actioned. Managers disseminated learning through emails, meetings and in staff supervision.

Services also received and recorded the compliments they received. In the 12 months prior to our inspection, the community based mental health services for older adults received 190 compliments.

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

Sheffield Health and Social Care NHS Foundation Trust state their vision is to be recognised nationally as a leading provider of high quality health and social care services and to be recognised as world class in terms of co-production, safety, improved outcomes, experience and social inclusion. Their aim is to be the first choice for service users, their families and commissioners.

The trusts values included:

- Respect
- Compassion
- Partnership
- Accountability
- Fairness
- Ambition

Staff we spoke with knew the values of the trust and felt they were relevant to their role. Staff would also discuss the values of the trust in supervision and this ensures staff can link these to their practice. Service managers told us that staff appraisals reflected the values of the trust. Staff also received a monthly newsletter from the Chief Executive of the trust; this was based on the trusts values and vision.

All staff knew who their senior managers were within the trust. Contact with the senior management team was consistently good across the service. Staff told us service managers and specialist service operational managers were accessible and frequently visited the teams. The Chief Executive of the trust had spent time working with the community based mental health service for older adults; staff told us this was a positive experience for the team.

Good governance

The trust had adequate governance structures in place to monitor and assess performance and this strengthened the quality of patient care. The trust used key performance indicators (KPI) to gauge the performance of each different team. Service managers could access the trust dashboard to monitor team performance against the KPI. These include but not exclusively:

- Admission avoidance and discharge support contacts
- Face to face contacts with patients
- Referral to assessment and diagnosis rates
- Clustering targets

Service managers produced evidence that supported the achievement of these targets within their services. However, despite service managers' ability to monitor performance, staff training and supervision rates remained below the trust's benchmark. Services had developed localised databases that captured this information, however this did not reflect the data provided to us by the trust.

Services took a proactive approach in gaining feedback from those that used the service and carers. Senior staff attended the service user and carer group on a monthly basis. Despite low numbers for complaints and incidents within the service, we saw evidence of learning and improved practice. For example, following a concern raised by a patient, the font size used in letters was changed. Also, administrative processes were reviewed and changed following the one serious incident in the service this year. Staff received a newsletter that captured incidents and any associated learning within the wider trust.

The service demonstrated governance arrangements from front line staff to the trust board. This process included an annual service review, quarterly performance review, monthly directorate meeting and monthly team business and governance meetings. Operational service managers were central to the success of this approach. In addition to this, teams also held routine team meetings and dedicated professionals' meetings. This arrangement supported the flow of information across the service and the organisation.

Service managers told us they had autonomy and sufficient authority to run their teams. Admin support was good across the service, providing support to the service managers and the wider clinical teams.

All teams had risk registers and this information fed into the trust risk register. Service managers were responsible for the risk register. The service had no items on the risk register at the time of our inspection.

Leadership, morale and staff engagement

Data provided by the trust showed sickness levels for the memory service (7.8%) and the functional intensive

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.

community service (14%) were above the trust average of 7%. However, at the time of the inspection these rates had reduced significantly. There was one case of bullying and harassment under investigation within the service.

Despite these challenges to the service, we observed that staff had an overwhelming pride in the work they undertook. Staff told us that morale had dipped when the teams were stretched; the service managers echoed this. Staff reported a cohesive working relationship with the multidisciplinary team. Teamwork underpinned this and was a positive support for joint decision making. We saw extensive mutual support within the different teams and this made a positive difference to staff. Staff spoke highly about their teams and the service managers.

Lines of communication were open and honest within the service and staff generally felt listened to.

Staff had an awareness of the trust's whistle-blowing process and how to access information. Staff told us they were confident in speaking to their immediate team and service manager to raise concerns without fear of victimisation.

There were opportunities for leadership development. Service managers told us they had successfully completed leadership and management courses at various levels. One manager told us they had recently participated in coaching as part of a leadership development forum. The Chief Executive of the trust facilitated this initiative on a quarterly basis. Staff told us they had opportunities for their own development and the trust encouraged staff to develop their skills.

Staff consistently told us they had the opportunity to feedback about services and service development. Information obtained was via supervision, appraisal and team meetings.

The service promoted an open and honest culture; managers encouraged staff to report incidents to enable service development. The trust had a duty of candour policy and staff were clear in their responsibilities towards patients and carers.

Commitment to quality improvement and innovation

The community based mental health service for older adults demonstrated a clear commitment to quality improvement and innovation.

The Memory Service National Accreditation Programme (MSNAP) rated the memory service as excellent in 2016. This status assures staff, patients, carers and commissioners of the quality of the service provided. We observed an invitation for patients and carers to contribute to service accreditation for 2017.

The memory service had a dedicated research nurse within the team. Working closely with doctors and the pharmaceutical industry, research was ongoing to develop treatment for dementia. Occupational therapists working in both the memory service and community mental health teams were participating in a research project. The valuing active life in dementia (VALID) is a research study funded by the national institute for health research's programme grants for applied research. At the time of our inspection, 58 patients were involved in the research.

Recovery and value based training was being rolled out across the service. Staff we spoke to were positive about their learning and the impact for patient care.

The trust employed a carer liaison practitioner that worked across the community based mental health service for older people. The role was innovative and demonstrated the trust's commitment to supporting carers.

This section is primarily information for the provider

Requirement notices

Action we have told the provider to take

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

Regulated activity	Regulation
Treatment of disease, disorder or injury	Regulation 18 HSCA (RA) Regulations 2014 Staffing How the regulation was not being met Not all staff within the service were current with necessary mandatory training as required by the trust. A number of key training courses had compliance rates of less than 75%. This included Respect training, basic life support, Mental Capacity Act and medicine management. This was a breach of regulation 18 (2) (a)

This section is primarily information for the provider

Enforcement actions

Action we have told the provider to take

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