North Staffordshire Combined Healthcare NHS Trust

Inspection report

Trust Headquarters
Bellringer Road, Trentham Lakes South
Stoke On Trent
Staffordshire
ST4 8HH
Tel: 01782273510
www.combined.nhs.uk

Date of inspection visit: 04 Dec 2018 to 23 Jan 2019
Date of publication: 28/03/2019

We plan our next inspections based on everything we know about services, including whether they appear to be getting better or worse. Each report explains the reason for the inspection.

This report describes our judgement of the quality of care provided by this trust. We based it on a combination of what we found when we inspected and other information available to us. It included information given to us from people who use the service, the public and other organisations.

This report is a summary of our inspection findings. You can find more detailed information about the service and what we found during our inspection in the related Evidence appendix.

Ratings

Overall rating for this trust	Outstanding ☆
Are services safe?	**Good** ●
Are services effective?	**Good** ●
Are services caring?	**Outstanding** ☆
Are services responsive?	**Outstanding** ☆
Are services well-led?	**Good** ●

We rated well-led (leadership) from our inspection of trust management, taking into account what we found about leadership in individual services. We rated other key questions by combining the service ratings and using our professional judgement.

Summary of findings

Background to the trust

North Staffordshire Combined Healthcare NHS Trust was established in 1994. The trust provides services across North Staffordshire and the city of Stoke on Trent to a population of 464,000 people. The trust provides a range of inpatient and community mental health services to adults, older people and children.

The trust provides the following core services:

•Acute wards for adults of working age and psychiatric intensive care units

•Wards for older people with mental health problems

•Wards for people with learning disabilities

•Long stay/rehabilitation mental health wards for working age adults

•Children and adolescent mental health wards

•Mental health crisis services and health based places of safety

•Community-based mental health services for older people

•Specialist community mental health services for children and young people

•Community-based mental health services for adults of working age

•Community mental health services for people with learning disabilities.

The trust also provides the following specialist services:

•Substance misuse treatment services.

From the 1 December 2018, the trust integrated two primary care (GP Surgery) locations into its portfolio. The trust took over responsibility for the staff and assets of the two practices. The GPs maintained responsibility for General Medical Services contracts.

This development reflected the trust's ambition to be an integrator of local services in line with plans of the Sustainability and Transformation Partnership to create an integrated care system

The trust operates from nine registered locations including one hospital site (Harplands Hospital). The trust has 190 inpatient beds across 12 wards, 15 of which are children's mental health beds. All corporate staff are based at Lawton House, the current trust headquarters.

The trust employs approximately 1,277 staff serving a population of approximately 470,000 people from a variety of diverse communities across northern Staffordshire. The trust's closing income for 2017-18was £85m. It currently does not have foundation trust status.

The trust's main NHS partners are the two clinical commissioning groups (CCGs) – North Staffordshire CCG and Stoke-on-Trent CCG.

The trust also works closely with agencies which support people with mental health problems, such as the North Staffs Users' Group, Approach, ASIST, Brighter Futures, Changes, EngAGE, North Staffs Huntington's Disease Association, Mind, North Staffs Carers Association, Reach and the Beth Johnson Association.

The trust has been inspected 4 times since registration. We last inspected this trust in October 2017 and we rated the provider as 'good' overall. At the time of our last inspection, we identified 37 areas of improvement. There were four breaches across the following three core services;

Summary of findings

•Acute wards for adults of working age and psychiatric intensive care units.

•Community-based mental health services for adults of working age.

•Wards for older people with mental health problems.

These breaches related to Regulation 12 – safe care and treatment of the Health and Social Care Act (Regulated Activities)

Overall summary

Our rating of this trust improved since our last inspection. We rated it as Outstanding

What this trust does

North Staffordshire Combined Healthcare NHS Trust provides mental health and primary medical services across 32 locations throughout Staffordshire. This includes a range of inpatient and community mental health and learning disability services to adults, older people and children and primary care to all ages at two GP surgeries.

Key questions and ratings

We inspect and regulate healthcare service providers in England.

To get to the heart of patients' experiences of care and treatment, we ask the same five questions of all services: are they safe, effective, caring, responsive to people's needs, and well-led?

Where we have a legal duty to do so, we rate the quality of services against each key question as outstanding, good, requires improvement or inadequate.

Where necessary, we take action against service providers that break the regulations and help them to improve the quality of their services.

What we inspected and why

We plan our inspections based on everything we know about services, including whether they appear to be getting better or worse.

We inspected three services as part of our ongoing checks on the safety and quality of healthcare services:

- Wards for older people with mental health problems
- Mental health crisis services and health based places of safety, and
- Community-based mental health services for adults of working age.

Our comprehensive inspections of NHS trusts have shown a strong link between the quality of overall management of a trust and the quality of its services. For that reason, all trust inspections now include inspection of the well-led key question at the trust level. Our findings are in the section headed Is this organisation well-led?

What we found

Overall trust

Our rating of the trust improved. We rated it as outstanding because:

Summary of findings

- We rated safe, effective, and well led as good, caring and responsive as outstanding. Following this inspection, one of the trust's 11 services are rated as requires improvement, seven are rated good and three as outstanding. In rating the trust, we took into account the previous ratings of the eight services not inspected this time.
- The trust had met the requirement notices we set out in our previous report. Medicines safety had improved on the wards for older adults and the community teams. Staff in the community teams now inspected emergency equipment as a matter of routine.
- There was good leadership across the trust from the board to front line managers. Managers had the right skills to undertake their roles. The board had good understanding of performance.
- The trust ensured that risk assessments were completed and updated regularly. Staff updated risk assessments for each patient to understand how to best support them. Staff had good access to patient records and stored them safely. Staff knew how to keep patients safe and reported incidents, including abuse, when necessary. Staff learnt lessons from incidents.
- A range of care and treatment interventions was delivered in line with guidance from the National Institute for Health and Care Excellence (NICE).
- The majority of staff had good knowledge of the Mental Health Act, the Mental Capacity Act and the Deprivation of Liberty Safeguards. Staff were up to date with training in the Mental Health Act and Mental Capacity Act.
- Staff treated patients with compassion and kindness. They respected patients' privacy and dignity, and supported their individual needs.
- Staff involved patients and those close to them in decisions about their care, treatment and changes to the service. Throughout their recent management of change project, the trust had listened and acted on the feedback of patients, their families and carers.

However:

- The trust had not met its responsibility to make all required notifications to the CQC. There had been no notices made of the outcomes of applications to authorise Deprivation of Liberty Safeguards. We had reminded the trust of this obligation in our last report.
- The stability of the senior leadership of the trust was at risk with changes in the executive team. The new chief executive, chairperson and remaining board members recognised an opportunity to reflect on their structures, processes and external relationships.
- Enhanced reporting on clinical activity in community teams had recently been introduced, which provided assurance to the Board and service managers, but required development to fully establish its reliability and usability
- The trust's pharmacy team was still developing its strategic plan. The team had made some progress in the last year through development of the team's capacity and skill base.
- Some community service's environmental risk management plans lacked detailed mitigation of identified risks.
- There were some omissions in community and crisis services patient care plans related to crisis plans, physical care plans.

Are services safe?

Our rating of safe improved. We took into account the previous ratings of services not inspected this time. We rated it as good because:

Summary of findings

- The trust had addressed staffing issues in medicine, nursing and the allied health professionals by developing robust strategies that addressed recruitment and career development. Overall there had been positive movement in the recruitment of clinical staff, retention rates and reduced sickness absence.
- The trust had maintained its focus on reducing restrictive practices. We saw significant reductions in the number of physical restraints used on the wards for older adults with mental health problems. Highly personalised care plans around the management of behaviours that challenge allowed staff to find alternatives to restraint and it was only used as a last resort.
- In the community mental health teams there was a good system to monitor and manage caseloads; it used information technology to monitor demand and capacity. The caseload management system would alert mangers to any unsafe of unexpected increases in demand and capacity could be flexibly managed to target those patients most at risk.
- The level and detail of information contained in the initial assessments of need and risk demonstrated a clear holistic approach to care and treatment. This was consistent across the three cores services we visited on this occasion.

However:

- Some community services environmental risk management plans lacked detailed mitigation of identified risks.
- There were some omissions in community and crisis services patient care plans related to crisis plans, physical health care plans.

Are services effective?

Our rating of effective stayed the same. We took into account the previous ratings of services not inspected this time. We rated it as good because:

- Staff provided a range of treatment and care for patients based on national guidance and best practice. Staff supported patients with their physical health and encouraged them to live healthier lives. The trust had continued to expand the range of training available to help staff to identify and mange physical health problems. Having consolidated training in recording physical observation and supporting immediate physical health needs, health promotion training was being rolled out across the clinical services. The early focuses were on smoking and alcohol misuse.
- Managers made sure they had staff with a range of skills need to provide high quality care. They supported staff with appraisals, supervision, opportunities to update and further develop their skills.
- Staff from different disciplines worked together as a team to benefit patients. They supported each other to make sure patients had no gaps in their care.
- Staff understood their roles and responsibilities under the Mental Health Act 1983 and the Mental Health Act Code of Practice. Administration of the Mental Health Act was of a high standard across the three services inspected.
- Staff supported patients to make decisions on their care for themselves. They understood the trust policy on the Mental Capacity Act 2005 and assessed and recorded capacity clearly. The community mental teams needed to improve their recording of capacity assessments. The practice within the crisis team was good and there was close adherence to the Mental Capacity Act Code of Practice on the older adult wards for best interests decisions.

However:

- Although care planning was improving, we found errors and omissions within care plans in each of the core services we visited.

Summary of findings

Are services caring?

Our rating of caring improved. We took into account the previous ratings of services not inspected this time. We rated it as outstanding because:

- Staff treated patients with compassion and kindness. They respected patients' privacy and dignity, and supported their individual needs.
- Staff involved patients and those close to them in decisions about their care, treatment and changes to the service. Throughout their recent management of change project the trust had kept briefed and listened to the feedback of patients, their families and carers.
- Staff on Ward 4 had developed very positive initiatives around the involvement of families in the care of their relatives. Some family members now volunteers on the wards to support others. In crisis and community services

Are services responsive?

Our rating of responsive improved. We took into account the previous ratings of services not inspected this time. We rated it as outstanding because:

- The trust had taken the lead in developing a system wide response to the CQC's local systems review of the care pathways for older adults between health and social care. This had led to a system wide improvement in reducing delays to transfers of care.
- In the community mental health teams for adults, access and crisis teams there were systems in place to offer urgent appointments and access to treatment.
- The high-volume service user service team (part of the crisis service) was judged as being highly responsive and had been successful in reducing the number of visits of mental health patients to emergency departments.
- Staff in all services proactively engaged with partnership agencies to ensure holistic treatment responses to patients with substance misuse problems. This meant that patients received a holistic service that recognised the impact their mental health had on their substance use.
- The crisis services had worked closely with the local police to provide responsive support to those patients without a home that were the most vulnerable and difficult to engage.
- Dedicated staff on the mental health wards for older adults were responsible for ensuring that timely discharges were effectively planned. They did this in collaboration with the patients and their families.
- All service treated concerns and complaints seriously, investigated them and learned lessons from the results, and shared these with all staff. Any complaint and concerns across the trust were reviewed alongside clinical incidents in the safety improvement group. New learning from complaints could therefore share across directorates.

However:

- One ward for older adults had shared sleeping arrangements whereby patients had to share bedrooms. The arrangement did not promote the privacy and dignity of patients using them.

Are services well-led?

Our rating of well-led stayed the same. We took into account the previous ratings of services not inspected this time. We rated it as good because:

- The trust had an experienced leadership team with the skills, abilities, and commitment to provide high-quality services. The trust executive leadership team had a comprehensive knowledge of current priorities and challenges.

Summary of findings

- The board and senior leadership team had a clear vision and set of values that were at the heart of the work within the organisation. They wanted to continue their journey from an assurance led organisation to a more improvement led organisation. They aimed to achieve this through the empowerment of staff at all levels within the organisation. Collaboration with stakeholders, partners and regulators within the system at all levels was another key objective.
- The trust was actively engaged in leading, influencing and shaping local sustainability and transformation plans. The board recognised that partnership was essential to the achievement of the trust's vision for future services within the local system. Great strides forward had been made with the majority of stakeholders.
- Senior leaders visited all parts of the trust and fed back to the board to discuss challenges staff and the services faced. The trust included and communicated effectively with patients, staff, the public, and local stakeholders.
- Overall the trust had been able to successfully recruit staff in a challenging recruitment environment, improve the retention of existing staff and reduce sickness rates.
- The trust had developed a lot of initiatives around the Workforce Race Equality Standards since our last inspection. The trust acknowledged, this work was in development and the impact not yet demonstrable within the lived experience of staff.
- Since the last inspection the trust had completed implementation of a new electronic patient record system. This has improved the quality of clinical data available to support managers in the form of dashboards and reports in most core services.
- There had been a large organisational change project which affected the majority of staff in the trust within the last year. Managers had listened to the concerns of some staff and changes had been made to the original plans and timetable for change. Staff's positive view of manager's approach to the project was not universal, but was supported by the vast majority of staff we met.
- There were positive examples of individuals and teams developing new ways of working in the core services we visited. The trust was at an early stage of developing and embedding a continuous improvement approach through raising the awareness and training of all staff. The recent establishment and appointment of quality leads in each of the new directorates were seen as pivotal to the delivery of the quality strategy of the trust.

However:

- The trust had failed to notify the CQC that they had made a standard authorisation for the Deprivation of Liberty Safeguards (DoLS) when they knew the outcome.
- The Board Assurance Framework (strategic risk register) was comprehensive however some items were over inclusive in the detail of assurance offered which blunted the effectiveness of reporting the current priorities for action.
- The Freedom to Speak Up Guardian was a senior manager working closely with the executive team, this had caused some staff to be concerned whether confidentiality would be maintained. This is a challenge within a smaller organisation and opportunities to work in collaboration with Guardians within the wider system would give greater independence to the role.
- Further work was needed to improve both the validity and reliability of the community safety matrix. This was a dashboard for mangers to monitor the clinical performance of community services. Managers were still refining the number of care records sampled and the frequency of review to make this an effective tool.
- Senior manager's engagement with psychology professionals within the organisation had deteriorated since our last inspection. The trust had plans to address and develop the engagement and contribution of this professional group.
- The board needed to review both the capacity and skills of the executive team to balance the internal priorities and those external objectives within the wider healthcare system and integrated care system.

Summary of findings

- There was an opportunity to review the involvement of the non-executive directors in the performance review process for executives.
- Managers had failed to inform some community teams of changes to emergency equipment and related procedure

Ratings tables

The ratings tables show the ratings overall and for each key question, for each service, hospital and service type, and for the whole trust. They also show the current ratings for services or parts of them not inspected this time. We took all ratings into account in deciding overall ratings. Our decisions on overall ratings also took into account factors including the relative size of services and we used our professional judgement to reach fair and balanced ratings.

Outstanding practice

We found examples of outstanding practice in the wards for older adults with mental health problems, community-based mental health services for adults of working age and mental health crisis services and health based places of safety.

Areas for improvement

We found areas for improvement including two breaches of legal requirements that the trust must put right. We found twelve things that the trust should improve to comply with a minor breach that did not justify regulatory action, to prevent breaching a legal requirement, or to improve service quality.

For more information see the Areas for improvement section of this report.

Action we have taken

Full information about our regulatory response to the concerns we have described will be added to a final version of this report, which we will publish in due course.

What happens next

We will check that the trust takes the necessary action to improve its services. We will continue to monitor the safety and quality of services through our continuing relationship with the trust and our regular inspections.

Outstanding practice

We found the following outstanding practice:

Wards for older people with mental health problems

- There had been a significant reduction in the number of restraints used across the wards. Detailed and personalised care plans around the management of behaviours that challenge allowed staff to find alternatives to restraint and it was only used as a last resort.

Community-based mental health services for adults of working age

- There was a good response to any sudden deterioration whereby patients could just walk in to any location or call the duty person that was allocated for the day to respond to any urgent cases.
- There was a good system to monitor and manage caseloads; it used information technology to monitor demand and capacity. Staff told us that caseloads were manageable and if it’s too much the caseload management system would flag it up.

Summary of findings

- The level and detail of information contained in the comprehensive assessments on admission demonstrated a clear holistic approach to care and treatment.

Mental health crisis services and health-based places of safety

- Professionals and patients regarded the high-volume service user service team as being highly responsive and successful in reducing the number of visits to emergency departments. We saw evidence of this when reviewing feedback from partnership agencies and talking to service staff within the mental health liaison team who worked closely with accident and emergency department staff.
- The access and crisis team's call centre was highly responsive and exceptionally well organised. Patients did not have to wait long to speak directly to a clinician and the interventions provided by staff were of an excellent quality and range. This quality of service was maintained through supervision provided at the point of patient contact.
- Staff in all services proactively engaged with partnership agencies to ensure holistic treatment responses to patients with substance misuse problems. This meant that patients received a holistic service that recognised the impact their mental health had on their substance use.

Areas for improvement

Action the trust MUST take is necessary to comply with its legal obligations. Action a trust SHOULD take is to comply with a minor breach that did not justify regulatory action, to prevent it failing to comply with legal requirements in future, or to improve services.

Action the trust MUST take to improve

We told the trust that it must take action to bring services into line with two legal requirements. This action related to one service.

Wards for older people with mental health problems

- The trust must ensure applications made for authorisation of Deprivation of Liberty Safeguards and their outcomes are notified to the CQC. CQC Registration Regulation 18 (4).
- The trust must ensure that all care plans are comprehensive and personalised to the patient. Regulation 9 (3).

Action the trust SHOULD take to improve

Trust wide

- The trust should consider developing the role of the non-executive directors in informing the performance review process for executives.
- The trust should review the balance of detail in the Board Assurance Framework to gain maximum effectiveness.
- The trust should consider the further development of assurances around the independence of the Freedom to Speak Up Guardian team from the executive.
- The trust should undertake further work to improve both the validity and reliability of the community safety matrix.
- The trust should consider reviewing the balance the extent of external commitments with the capacity, skills and support of the new senior leadership team required to continue the deliver on the trust's internal goals.

Wards for older people with mental health problems

- The trust should consider plans to eliminate the use of dormitories.

Summary of findings

Community-based mental health services for adults of working age

- The trust should ensure that the ligature risk assessment is followed by a detailed management plan that clearly outlines what actions are taken to mitigate the risks identified. Regulation 12 (2a)
- The trust should ensure that there are cleaning schedules for all clinic rooms in place for all locations. Regulation 15 (1a,e)
- The trust should ensure that staff complete crisis plans for all patients where required. Regulation 12 (2a)
- The trust should ensure that all records demonstrate how the mental capacity was assessed where patients are deemed to lack capacity for their treatment. Regulation 11 (1)
- The trust should consider how staff consistently complete the Glasgow side effects monitoring forms and the drug indication on drug charts.

Mental health crisis services and health-based places of safety

- The service should ensure that its intervention record care planning tool includes a prompt to document the interventions required for the maintenance of patient's physical health. Regulation 9 (1 a,b,c).

Is this organisation well-led?

- Our rating of well-led stayed the same. We took into account the previous ratings of services not inspected this time. We rated it as good because:
- The trust had an experienced leadership team with the skills, abilities, and commitment to provide high-quality services. The trust executive leadership team had a comprehensive knowledge of current priorities and challenges.
- The board and senior leadership team had a clear vision and set of values that were at the heart of the work within the organisation. They wanted to continue their journey from an assurance led organisation to a more improvement led organisation. They aimed to achieve this through the empowerment of staff at all levels within the organisation. Collaboration with stakeholders, partners and regulators within the system at all levels was another key objective.
- The trust was actively engaged in leading, influencing and shaping local sustainability and transformation plans. The board recognised that partnership was essential to the achievement of the trust's vision for future services within the local system. Great strides forward had been made with the majority of stakeholders.
- Senior leaders visited all parts of the trust and fed back to the board to discuss challenges staff and the services faced. The trust included and communicated effectively with patients, staff, the public, and local stakeholders.
- Overall the trust had been able to successfully recruit staff in a challenging recruitment environment, improve the retention of existing staff and reduce sickness rates.
- The trust had developed a lot of initiatives around the Workforce Race Equality Standards since our last inspection. The trust acknowledged, this work was in development and the impact not yet demonstrable within the lived experience of staff.
- Since the last inspection the trust had completed implementation of a new electronic patient record system. This has improved the quality of clinical data available to support managers in the form of dashboards and reports in most core services.

- There had been a large organisational change project which affected the majority of staff in the trust within the last year. Managers had listened to the concerns of some staff and changes had been made to the original plans and timetable for change. Staff's positive view of manager's approach to the project was not universal, but was supported by the vast majority of staff we met.
- There were positive examples of individuals and teams developing new ways of working in the core services we visited. The trust was at an early stage of developing and embedding a continuous improvement approach through raising the awareness and training of all staff. The recent establishment and appointment of quality leads in each of the new directorates were seen as pivotal to the delivery of the quality strategy of the trust.

However:

- The trust had failed to notify the CQC that they had made a standard authorisation for the Deprivation of Liberty Safeguards (DoLS) when they knew the outcome.
- The Board Assurance Framework (strategic risk register) was comprehensive however some items were over inclusive in the detail of assurance offered which blunted the effectiveness of reporting the current priorities for action.
- The Freedom to Speak Up Guardian was a senior manager working closely with the executive team, this had caused some staff to be concerned whether confidentiality would be maintained. This is a challenge within a smaller organisation and opportunities to work in collaboration with Guardians within the wider system would give greater independence to the role.
- Further work was needed to improve both the validity and reliability of the community safety matrix. This was a dashboard for mangers to monitor the clinical performance of community services. Managers were still refining the number of care records sampled and the frequency of review to make this an effective tool.
- Senior manager's engagement with psychology professionals within the organisation had deteriorated since our last inspection. The trust had plans to address and develop the engagement and contribution of this professional group.
- The board needed to review both the capacity and skills of the executive team to balance the internal priorities and those external objectives within the wider healthcare system and integrated care system.
- There was an opportunity to review the involvement of the non-executive directors in the performance review process for executives.
- Managers had failed to inform some community teams of changes to emergency equipment and related procedure

Ratings tables

Key to tables					
Ratings	Not rated	Inadequate	Requires improvement	Good	Outstanding
Rating change since last inspection	Same	Up one rating	Up two ratings	Down one rating	Down two ratings
Symbol *	➔🡐	🡑	🡑🡑	🡓	🡓🡓
Month Year = Date last rating published					

* Where there is no symbol showing how a rating has changed, it means either that:

- we have not inspected this aspect of the service before or
- we have not inspected it this time or
- changes to how we inspect make comparisons with a previous inspection unreliable.

Ratings for the whole trust

Safe	Effective	Caring	Responsive	Well-led	Overall
Good 🡑	Good ➔🡐	Outstanding 🡑	Outstanding 🡑	Good ➔🡐	Outstanding 🡑

The rating for well-led is based on our inspection at trust level, taking into account what we found in individual services. Ratings for other key questions are from combining ratings for services and using our professional judgement.

Ratings for mental health services

	Safe	Effective	Caring	Responsive	Well-led	Overall
Acute wards for adults of working age and psychiatric intensive care units	Requires improvement Feb 2018	Good Feb 2018	Good Feb 2018	Good Feb 2018	Good Feb 2018	Good Feb 2018
Long-stay or rehabilitation mental health wards for working age adults	Good Feb 2018	Good Feb 2018	Outstanding Feb 2018	Outstanding Feb 2018	Good Feb 2018	Outstanding Feb 2018
Child and adolescent mental health wards	Good Sept 2016	Good Sept 2016	Good Sept 2016	Good Sept 2016	Good Sept 2016	Good Sept 2016
Wards for older people with mental health problems	Good ↑	Requires improvement ↓	Good →←	Good →←	Requires improvement ↓	Requires improvement ↓
Wards for people with a learning disability or autism	Good Feb 2018	Good Feb 2018	Good Feb 2018	Good →← Feb 2018	Good Feb 2018	Good Feb 2018
Community-based mental health services for adults of working age	Good ↑	Good →←	Good →←	Good →←	Good →←	Good →←
Mental health crisis services and health-based places of safety	Good →←	Good →←	Outstanding ↑	Outstanding ↑	Good →←	Outstanding ↑
Specialist community mental health services for children and young people	Good Feb 2018	Good Feb 2018	Good Feb 2018	Good Feb 2018	Good Feb 2018	Good Feb 2018
Community-based mental health services for older people	Good Sept 2016	Good Sept 2016	Outstanding Sept 2016	Outstanding Sept 2016	Good Sept 2016	Outstanding Sept 2016
Community mental health services for people with a learning disability or autism	Good Sept 2016	Good Sept 2016	Good Sept 2016	Good Sept 2016	Good Sept 2016	Good Sept 2016
Substance misuse services	Good Sept 2016	Good Sept 2016	Good Sept 2016	Good Sept 2016	Good Sept 2016	Good Sept 2016
Overall	Good ↑	Good →←	Outstanding ↑	Outstanding ↑	Good →←	Outstanding ↑

Overall ratings for mental health services are from combining ratings for services. Our decisions on overall ratings take into account the relative size of services. We use our professional judgement to reach fair and balanced ratings.

Community-based mental health services of adults of working age

Good

Key facts and figures

The community mental health teams for adults of working age are part of the trust's services that provide mental health services to adults across North Staffordshire. The service is for adults of working age (16-65) with mental health-related difficulties. The services provided are based upon a recovery orientated model which enables adults with mental health related issues and their families, friends and significant others to live and maintain their optimum social roles. Assessment, treatment and care is provided through a process known as Care Coordination and each person using services will be appointed a Care Coordinator. The services are based at Greenfield Centre in Stoke-on-Trent, Sutherland Centre in Stoke-on-Trent, Lyme Brook Centre in Newcastle under Lyme and Ashcombe Centre in Leek.

In the previous year there had been two significant management of change processes affecting these services. The first was an internal reorganisation of services into locality based directorates aligned to the local Sustainability and Transformation plan. This had led to the creation of two new directorates for community services. One was based in the north Staffordshire area the other was based on the city of Stoke. In addition, from the first of October 2018 an existing joint agreement with Staffordshire county council came to an end and social work staff employed by the county were no longer co-located within combined community mental health team. This change had impacted on the services at the Lyme Brook and Ashcombe centres.

We inspected three teams based on these three locations:

Lyme Brook Centre

Talke Road
Newcastle
Staffordshire
ST5 7TL

Ashcombe Centre

Wall Lane Terrace
Cheddleton
Leek
Staffordshire
ST13 7ED

Sutherland Centre

Belgrave Road
Stoke-on-Trent
ST3 4PN

At the last inspection, the teams had safe rated as requires improvement and effective, caring, responsive and well-led rated as good. We re-inspected all of the key questions to see if they had made improvements.

Our inspection took place between 4 and 6 December 2018 and the trust was only given short notice to enable us to observe routine activity.

Community-based mental health services of adults of working age

Before the inspection visit we reviewed information that we held about this service and information requested from the trust.

During the inspection visit, the inspection team:

- took a tour of the environment,
- spoke with 14 patients who were using the service,
- spoke with two relatives of patients who were using the service,
- interviewed 32 members of staff including nurses, health care assistants, psychologists, occupational therapists, social workers and doctors,
- spoke to staff members of the Early Intervention Team and charity organisations,
- observed care and treatment,
- attended two multidisciplinary team meetings, two clinical reviews and two therapy groups,
- observed one handover meeting,
- looked at 21 care records and 24 patients' medicine prescription charts,
- interviewed key members of staff including the unit managers, service managers and clinical leads.

Summary of this service

Our overall rating of this service stayed the same. We rated it as good because:

- Clinical premises where patients were seen were clean. The number of patients on the caseload of the teams, and of individual members of staff, was not too high and staff managed waiting lists well to ensure that people who required urgent care were seen promptly. Staff assessed and managed risk well and followed good practice with respect to safeguarding.
- Staff developed holistic, recovery-oriented care plans informed by a comprehensive assessment. They provided a range of treatments suitable to the needs of the patients and staff engaged in clinical audit to evaluate the quality of care they provided.
- The teams included or had access to the full range of specialists required to meet the needs of the patients. Managers ensured that these staff received training, supervision and appraisal. Staff worked well together as a multi-disciplinary team and with relevant services outside the organisation.
- Staff understood and discharged their roles and responsibilities under the Mental Health Act 1983 and the Mental Capacity Act 2005.
- Staff treated patients with compassion and kindness and understood the individual needs of patients. They actively involved patients and families and carers in care decisions.
- The service was easy to access. Staff assessed and treated people who required urgent care promptly and those who did not require urgent care did not wait too long to start treatment. The service did not exclude people who would have benefitted from care.
- The service was well led and the governance processes ensured that procedures relating to the work of the service ran smoothly.

Community-based mental health services of adults of working age

However:

- The management plan on how to reduce the risk of identified potential ligature risks was not detailed enough to identify how all the risks were to be mitigated.

Is the service safe?

Our rating of safe improved. We rated it as good because:

- All clinical premises where patients received care were clean, well furnished, well maintained and fit for purpose.
- The service had staff, who knew the patients and received basic training to keep people safe from avoidable harm. The number of patients on the caseload of the teams, and of individual members of staff, was not too high.
- Staff assessed and managed risks to patients and themselves. They responded promptly to sudden deterioration in a patient's health and monitored patients on waiting lists to detect and respond to increases in level of risk. Staff followed good personal safety protocols.
- Staff understood how to protect patients from abuse and the service worked well with other agencies to do so. Staff had training on how to recognise and report abuse and they knew how to apply it.
- Staff kept detailed records of patients' care and treatment. Records were clear, up-to-date and easily available to all staff providing care.
- Staff followed best practice when storing, dispensing, and recording the use of medicines. Staff regularly reviewed the effects of medications on each patient's physical health.
- The teams had a good track record on safety.
- The service managed patient safety incidents well. Staff recognised incidents and reported them appropriately. Managers investigated incidents and shared lessons learned with the whole team and the wider service. When things went wrong, staff apologised and gave patients honest information and suitable support.

However:

- The management plan on how to reduce the risk of identified potential ligature risks was not detailed enough to identify how all the risks were to be mitigated.
- Staff did not consistently complete the Glasgow side effects monitoring forms and the drug indication on drug charts.
- There were no cleaning schedules for clinic rooms in place for all locations.
- Not all patients had crisis plans completed at Sutherland Centre and Lyme Brook Centre

Is the service effective?

Good

Our rating of effective stayed the same. We rated it as good because:

Community-based mental health services of adults of working age

- Staff assessed the mental health needs of all patients. They developed individual care plans and updated them when needed. Care plans reflected the assessed needs, were personalised, holistic and recovery-oriented and staff updated them when appropriate.
- Staff provided a range of care and treatment interventions suitable for the patient group. They ensured that patients had good access to physical healthcare and supported patients to live healthier lives.
- Staff used recognised rating scales to assess and record severity and outcomes. They also participated in clinical audit, benchmarking and quality improvement initiatives. However, the dashboard summary of clinical audits recently introduced was not robust enough to effectively monitor the quality of clinical standards.
- The teams included or had access to the full range of specialists required to meet the needs of patients under their care. Managers made sure they had staff with a range of skills need to provide high quality care. They supported staff with appraisals, supervision, opportunities to update and further develop their skill. Managers provided an induction programme for new staff.
- Staff from different disciplines worked together as a team to benefit patients. They supported each other to make sure that patients had no gaps in their care. The teams had effective working relationships with other relevant teams within the organisation and with relevant services outside the organisation.
- Staff understood their roles and responsibilities under the Mental Health Act 1983 and the Mental Health Act Code of Practice.
- Staff supported patients to make decisions on their care for themselves. They understood the trust policy on the Mental Capacity Act 2005.

However:

- Staff had failed to record how mental capacity was assessed for three out of 10 patients on community treatment orders.

Is the service caring?

Good

Our rating of caring stayed the same. We rated it as good because:

- Staff treated patients with compassion and kindness. They understood the individual needs of patients and supported patients to understand and manage their care, treatment or condition.
- Staff involved patients in care planning and risk assessment and actively sought their feedback on the quality of care provided. They ensured that patients had easy access to advocates when needed.
- Staff informed and involved families and carers appropriately.

Is the service responsive?

Good

Our rating of responsive stayed the same. We rated it as good because:

Community-based mental health services of adults of working age

- The service was easy to access. Its referral criteria did not exclude people who would have benefitted from care. Staff assessed and treated people who required urgent care promptly and people who did not require urgent care did not wait too long to start treatment. Staff followed up people who missed appointments.
- The teams met the needs of all people who use the service – including those with a protected characteristic. Staff helped patients with communication, advocacy and cultural support.
- The service treated concerns and complaints seriously, investigated them and learned lessons from the results, and shared these with all staff.

Is the service well-led?

Good

Our rating of well-led stayed the same. We rated it as good because:

- Leaders had the skills, knowledge and experience to perform their roles, had a good understanding of the services they managed and were visible in the service and approachable for patients and staff.
- Staff knew and understood the provider's vision and values and how they were applied in the work of their team. Managers had maintained a focus on the trust's visions and values through the new management of change processes in the previous year.
- Staff felt respected, supported and valued. They reported that the provider promoted equality and diversity in its day to day work and in providing opportunities for career progression. They felt able to raise concerns without fear of retribution.
- Local and senior managers had effectively engaged with staff through the two management of change processes affecting the services. Staff and patient feedback had been used to guide the shape and speed of change.
- Our findings from the other key questions demonstrated that governance processes operated effectively at team level and that performance and risk were managed well.
- Teams had access to the information they needed to provide safe and effective care and used that information to good effect.
- Staff engaged actively in local and national quality improvement activities.

However:

- Staff found the electronic system used for patients' records to be very slow and frustrating at times.
- The managers had not clearly communicated to staff the changes taken to remove the emergency equipment from all locations.

Outstanding practice

We found three examples of outstanding practice in this service. See the outstanding practice section above.

Areas for improvement

We found six areas for improvement in this service. See the Areas for Improvement section above.

Wards for older people with mental health problems

Requires improvement

Key facts and figures

The trust's wards for older people with mental health problems care for people with both organic and functional mental health disorders. Organic mental illness is usually caused by disease affecting the brain, such as Alzheimer's. Functional mental illness has predominantly a psychological cause. It may include conditions such as depression, schizophrenia, mood disorders or anxiety.

The three wards all based at Harplands Hospital:

- Ward 4 cares for patients with physical and mental illness. It has 19 beds and treats both men and women as part of shared care initiative with the local acute hospital. While commissioned on the basis of 15 shared care beds, the ward can accommodate an additional four beds to support capacity pressures at the acute hospital trust. These were not in use at the time of our inspection.
- Ward 6 cares for patients with organic mental illness, which included dementia. It has 16 beds and treats both men and women.
- Ward 7 cares for patients with functional mental illnesses such as anxiety or depression. It has 20 beds both men and women.

During this inspection, we visited all three wards on the site. At the last inspection, the wards had one key question (safe) rated as requires improvement and the other key questions (effective, caring, responsive and well led) rated as good. We re-inspected all of the key questions to see if they had made improvements. We gave the trust 30 minutes notice of arrival to enable us to observe routine activity during our inspection.

Before the inspection visit, we reviewed information that we held about these services and information requested from the trust and asked other organisations to share what they knew about the trust. This included the Clinical Commissioning Group working with the trust.

During the inspection visit, the inspection team:

- spoke with four patients who were using the service and six carers
- spoke with three ward managers and three deputy ward managers for each of the wards
- spoke with 24 other staff members; including nurses, health care assistants, occupational therapists and housekeeping staff
- observed one handover meeting and one carers group
- reviewed 25 patient records, 42 prescription medication charts, including Mental Health Act paperwork.

Summary of this service

Our rating of this service went down. We rated it as requires improvement because:

- Care plans were not all individualised. On Ward 6, we found three records where partial identical information had been duplicated across three different patient's care plans, including the wrong patient's name. Two records on Ward 4, two did not contain a care plan relating to specifically to factor identified in the risk assessment, for example, fall risk and diabetes.

Wards for older people with mental health problems

- Ward 7 had two multiple occupancy dormitories which restricted the privacy of patients accommodated in those rooms .

However:

- The service provided safe care. Wards were safe and clean. Staff assessed and managed risk well. They minimised the use of restrictive practices, managed medicines safely and followed good practice with respect to safeguarding.
- Wards had access to the full range of specialists required to meet the needs of the patients. Managers ensured that these staff received training, supervision and appraisal. Staff worked well together as a multidisciplinary team and with relevant services outside the organisation.
- Staff understood and discharged their roles and responsibilities under the Mental Health Act 1983 and the Mental Capacity Act 2005.
- Staff treated patients with compassion and kindness and understood the individual needs of patients. They actively involved patients and families and carers in care decisions.
- The service was well led and the governance processes ensured that procedures relating to the work of the service ran smoothly.

Is the service safe?

Our rating of safe stayed the same. We rated it as good because:

- All wards were safe, clean, well equipped, well furnished, well maintained and fit for purpose.
- The service had enough staff, who knew the patients and received basic training to keep people safe from avoidable harm.
- Staff assessed and managed risks to patients and themselves well and followed best practice in anticipating, de-escalating and managing challenging behaviour. Staff only used restraint after attempts at de-escalation had failed. The ward staff participated in the provider's restrictive interventions reduction programme and the number of restraints had fallen significantly since the last inspection.
- Staff understood how to protect patients from abuse and the service worked well with other agencies to do so. Staff had training on how to recognise and report abuse and they knew how to apply it.
- Staff kept detailed records of patients' care and treatment. Records were clear, up-to-date and easily available to all staff providing care.
- Staff followed best practice when storing, dispensing, and recording the use of medicines. Staff regularly reviewed the effects of medications on each patient's physical health.
- The teams had a good track record on safety. Staff had analysed patterns of falls on the wards to better understand the risk factors involved. They had introduced environmental changes in response to their work to limit future risk.
- The service managed patient safety incidents well. Staff recognised incidents and reported them appropriately. Managers investigated incidents and shared lessons learned with the whole team and the wider service. When things went wrong, staff apologised and gave patients honest information and suitable support.

Wards for older people with mental health problems

Is the service effective?

Requires improvement

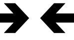
Our rating of effective went down. We rated it as requires improvement because:

- Care plans were not all individualised. On Ward 6, we found three records where identical information had been copied across three different patient's care plans, including the wrong patient's name. Two records on Ward 4, two did not contain a care plan relating to specifically to factor identified in the risk assessment, for example, fall risk and diabetes.

However:

- Staff provided a range of care and treatment interventions suitable for the patient group. They ensured that patients had good access to physical healthcare and supported patients to live healthier lives.
- Staff used recognised rating scales to assess and record severity and outcomes. They also participated in clinical audit, benchmarking and quality improvement initiatives.
- Wards had access to the full range of specialists required to meet the needs of patients under their care. Managers made sure they had staff with a range of skills need to provide high quality care. They supported staff with appraisals, supervision, opportunities to update and further develop their skill. Managers provided an induction programme for new staff.
- Staff from different disciplines worked together as a team to benefit patients. They supported each other to make sure that patients had no gaps in their care. Staff teams had effective working relationships with other relevant teams within the organisation and with relevant services outside the organisation.
- Staff understood their roles and responsibilities under the Mental Health Act 1983 and the Mental Health Act Code of Practice.
- Staff supported patients to make decisions on their care for themselves. They understood the trust policy on the Mental Capacity Act 2005 and assessed and recorded capacity clearly for patients who might have impaired mental capacity.

Is the service caring?

Good 

Our rating of caring stayed the same. We rated it as good because:

- Staff treated patients with compassion and kindness. They understood the individual needs of patients and supported patients to understand and manage their care, treatment or condition.
- Staff involved patients in care planning and risk assessment and actively sought their feedback on the quality of care provided. They ensured that patients had easy access to advocates when needed.
- Staff informed and involved families and carers appropriately. Wards had active and involved carers groups.

Wards for older people with mental health problems

Is the service responsive?

Good

Our rating of responsive stayed the same. We rated it as good because:

- The trust had good arrangements to admit, treat and discharge patients that were in line with good practice. Staff planned for discharge well and showed good liaison with other members of the multidisciplinary team.
- The teams met the needs of all people who use the service – including those with a protected characteristic. Staff helped patients with communication, advocacy and cultural support.
- The design, layout, and furnishings of the ward/service supported patients' treatment, privacy and dignity. Most patients had their own bedrooms and could keep their personal belongings safe. There were quiet areas for privacy.
- The service treated concerns and complaints seriously, investigated them and learned lessons from the results, and shared these with all staff.

However:

- One older adult ward had had shared sleeping arrangements whereby patients had to share bedrooms. This did not promote the privacy and dignity of patients using them.

Is the service well-led?

Requires improvement

Our rating of well-led went down. We rated it as requires improvement because:

- The trust had failed to provide the Care Quality Commission with the required notification of the services application and outcomes for standard authorisations of the Deprivation of Liberty Safeguards.

However:

- Leaders had the skills, knowledge and experience to perform their roles, had a good understanding of the services they managed and were visible in the service and approachable for patients and staff.
- Staff knew and understood the provider's vision and values and how they were applied in the work of their team.
- Staff felt respected, supported and valued. They reported that the provider promoted equality and diversity in its day to day work and in providing opportunities for career progression. They felt able to raise concerns without fear of retribution.
- Our findings from the other key questions demonstrated that governance processes operated effectively at team level and that performance and risk were managed well.
- Teams had access to the information they needed to provide safe and effective care and used that information to good effect. All teams shared performance data through the inpatient safety matrix.
- Staff engaged actively in local and national quality improvement activities.

Wards for older people with mental health problems

Outstanding practice

We found one example of outstanding practice in this service. See the outstanding practice section above.

Areas for improvement

We found three areas for improvement in this service. See the Areas for Improvement section above.

Mental health crisis services and health-based places of safety

Outstanding

Key facts and figures

North Staffordshire Combined Healthcare NHS Trust provides crisis and access, home treatment, a health based place of safety and mental health liaison psychiatric services for adults and children. All services are based at Harplands Hospital in Stoke except for the mental health liaison service which is based at the Royal Stoke University Hospital. Patients can self-refer to the crisis and access team by telephone or by presenting themselves at Harplands Hospital. However, patients are usually seen at home and as an alternative to hospital admission. The health based place of safety provides services for people who require assessment under Section 136 or 135 of the Mental Health Act 1983.

The Care Quality Commission (CQC) last inspected the mental health crisis teams and the health-based place of safety in September 2016 as part of a comprehensive inspection of North Staffordshire Combined Healthcare NHS Trust. We rated the service as Good overall and for each key question.

Our inspection was announced one working day before we visited (staff knew we were coming) to ensure that everyone we needed to talk to was available. The team included three inspectors and two specialist advisers. Specialist advisers are experts in their field who we do not directly employ.

During the inspection visit, the inspection team:

- spoke to the managers of the teams
- spoke with three patients who were using the service
- spoke with one carer
- spoke with 15 other staff members including doctors, nurses, social workers and administration staff
- attended and observed one multi disciplinary team meeting
- attended and observed three home visits
- looked at the environment of the health-based place of safety
- looked at medicine charts of patients in the home treatment team
- looked at 20 patient records within the home treatment team
- looked at a range of policies, procedures and other documents relating to the running of the service

Summary of this service

Our rating of this service improved. We rated it as outstanding because:

- The service provided safe care. Clinical premises where patients were seen were safe and clean and the physical environment of the health-based places of safety met the requirements of the Mental Health Act Code of Practice. The number of patients on the caseload of the mental health crisis teams, and of individual members of staff, was not too high. Staff assessed and managed risk well and followed good practice with respect to safeguarding.

Mental health crisis services and health-based places of safety

- Staff working for the mental health crisis teams developed holistic, recovery-oriented care plans informed by a comprehensive assessment. They provided a range of treatments suitable to the needs of the patients and staff engaged in clinical audit to evaluate the quality of care they provided.
- The mental health crisis teams included or had access to the full range of specialists required to meet the needs of the patients. Managers ensured that staff received training, supervision and appraisal. Staff worked well together as a multi-disciplinary team and with relevant services outside the organisation.
- Staff understood and discharged their roles and responsibilities under the Mental Health Act 1983 and the Mental Capacity Act 2005.
- Staff treated patients with compassion and kindness and understood their individual needs. This care was often exceptional and the level of practical support provided to patients was above and beyond usual expectations. In all cases staff took the time to skilfully help patients fully understand their treatment and its aims, and pro-actively involved them, their families and carers in care decisions.
- The mental health crisis service and the health-based places of safety were easy to access and all teams were meeting their targets. Staff assessed people promptly and were assisted by the access call centre team who used technology and a notably high-quality model of staff supervision to ensure high levels of responsiveness to patient's needs. The inspection team considered the call centre to be a model of excellence and distinctive in the evident level of high quality organisation and effectiveness. Those who required urgent care were taken onto the caseload of the crisis teams immediately. Staff managed the caseloads of the mental health crisis teams well. The services did not exclude people who would have benefitted from care. This included patients with substance misuse problems.
- Services at local level, distinguished by excellent leadership and clinical management, ensured the good governance of clinical and administrative processes and procedures. Local leadership of these services was significantly dynamic in actively promoting the importance of turning the core values of the trust into practice.

Is the service safe?

Good

Our rating of safe stayed the same. We rated it as good because:

- All clinical premises where patients received care were safe, clean, well equipped, well furnished, well maintained and fit for purpose. The physical environment of the health-based places of safety met the requirements of the Mental Health Act Code of Practice.
- The services had enough staff, who received basic training to keep people safe from avoidable harm. The number of patients on the caseload of the mental health crisis teams, and of individual members of staff, was not too high.
- Staff assessed and managed risks to patients and themselves. Staff working for the mental health crisis teams developed crisis plans when this was necessary and responded promptly to sudden deterioration in a patient's health. Staff followed good personal safety protocols.
- Staff understood how to protect patients from abuse and the service worked well with other agencies to do so. Staff had training on how to recognise and report abuse and they knew how to apply it.
- Staff working for the mental health crisis teams kept detailed records of patients' care and treatment. Records were clear, up-to-date and easily available to all staff providing care.
- Staff followed best practice when storing, dispensing, and recording the use of medicines. Staff working for the mental health crisis teams regularly reviewed the effects of medications on each patient's physical health.

Mental health crisis services and health-based places of safety

- The services managed patient safety incidents well. Staff recognised incidents and reported them appropriately. Managers investigated incidents and shared lessons learned with the whole team and the wider service. When things went wrong, staff apologised and gave patients honest information and suitable support.

However:

- In two cases information on physical health risks were not carried through to care plans.
- The care record template did not include a prompt to include a physical health plan in response to identified physical health risks

.

Is the service effective?

Good

Our rating of effective stayed the same. We rated it as good because:

- Staff assessed the mental health needs of all patients. Staff working for the mental health crisis teams developed individual care plans and updated them when needed. Care plans reflected the assessed needs, were personalised, holistic and recovery-oriented and staff updated them when appropriate.
- Staff working for the mental health crisis teams provided a range of care and treatment interventions suitable for the patient group. They ensured that patients had good access to physical healthcare.
- Staff working for the mental health crisis teams used recognised rating scales to assess and record severity and outcomes. Staff working for the crisis teams and in the health-based places of safety participated in community safety matrix, benchmarking and quality improvement initiatives.
- The mental health crisis teams included or had access to the full range of specialists required to meet the needs of patients under their care. Managers made sure they had staff with a range of skills need to provide high quality care. They supported staff with appraisals, supervision, opportunities to update and further develop their skill. Managers provided an induction programme for new staff.
- Staff from different disciplines worked together as a team to benefit patients. They supported each other to make sure that patients had no gaps in their care. The teams had effective working relationships with other relevant teams within the organisation and with relevant services outside the organisation.
- Staff understood their roles and responsibilities under the Mental Health Act 1983 and the Mental Health Act Code of Practice.
- Staff supported patients to make decisions on their care for themselves. They understood the trust policy on the Mental Capacity Act 2005 and assessed and recorded capacity clearly for patients who might have impaired mental capacity.

Is the service caring?

Outstanding

Our rating of caring improved. We rated it as outstanding because:

Mental health crisis services and health-based places of safety

- Staff treated patients with great compassion and kindness and demonstrated skills of empathy and genuineness. We observed patients responding positively to their treatment because of this. Staff also understood the individual needs of patients and supported patients to understand and manage their own care, treatment or condition.
- Staff often went beyond what might be expected of them to deliver care to their patients and took time to offer practical support wherever possible. These acts of kindness, offered within professional boundaries, enhanced the relationships between clinical staff and patients
- Staff in the mental health crisis teams involved patients in care planning and risk assessment and actively sought their feedback on the quality of care provided. Staff we observed with patients delivered holistic care to ensure patients achieved the best overall health and wellbeing. Staff fully understood how imbalances in a patient's life, no matter how small, could negatively affect their overall health. We saw skilled examples of carefully delivered interactions with patients that demonstrated a detailed understanding of individual patients needs and the matters that concerned them in their daily lives.
- Staff nurtured patients by respecting and understanding their physical, mental, emotional, and environmental strengths and challenges. They considered the whole person throughout the patient's journey with them. Staff also reinforced the care they delivered by offering practical help.
- Representatives of both carers and patients told us that they felt the care they received was beyond the usual expectations they had of professionals. We saw that patients benefited from this integrated approach and service user and carers representatives we spoke to placed emphasis on the caring nature of staff. Staff informed and involved families and carers appropriately and ensured they had access to an independent advocate when needed.

Is the service responsive?

Outstanding

Our rating of responsive improved. We rated it as outstanding because:

- The mental health crisis services were available 24-hours a day and was easy to access –through a dedicated crisis telephone line. Staff excelled in responding to the needs of patients through the effective use of technology and by providing high quality responses to patients regardless of the severity of need. The referral criteria for the mental health crisis teams did not exclude people with complex needs and took care to accommodate the needs of the most vulnerable patients including the homeless. Staff assessed and treated people who required urgent care promptly and people who did not require urgent care did not wait too long to start treatment. Staff followed up people who missed appointments to ensure their safety and maintain engagement.
- The teams were constantly reflecting on their practice and how to improve it. Staff and managers had developed innovative practice and excellence in responding to patient needs. This included a new service for those patients frequently attending emergency departments. The High Volume User (HVU) service, a partnership between health services and a charity, offered help and support in directing patients to more appropriate health and social care services. They did this by working in partnership with vulnerable patients, GP surgeries, emergency departments and local ambulance service to develop better options for seeking help. This helped reduce the demand for accident and emergency services.
- The teams' partnerships and liaison with local statutory and voluntary services was key to providing a high-quality service to patients. Staff regularly met with key partners to deliver their services including frequent meetings with the police and social service staff. There was joint project with the police to support those patients who were homeless.

Mental health crisis services and health-based places of safety

- The health-based places of safety were available when needed and there was an effective local arrangement in place to support young people who were detained under Section 136 of the Mental Health Act. Section 12 approved doctors and approved mental health professionals attended promptly when required.
- The services teams met the needs of all people who use the service – including those with a protected characteristic. Staff helped patients with communication, advocacy and cultural support.
- The services treated concerns and complaints seriously, investigated them and learned lessons from the results, and shared these with all staff.
- The access and home treatment services were due to relocate to a new location which was being developed and refurbished specifically for the urgent care needs teams to offer an enhanced service.

Is the service well-led?

Good

Our rating of well-led stayed the same. We rated it as good because:

- Leaders had the skills, knowledge and experience to perform their roles, had a good understanding of the services they managed and were highly visible in the service and approachable for patients and staff.
- Staff knew and understood the provider's vision and values and how they were applied in the work of their team.
- Good local leadership had a direct impact on the quality of the services delivered to patients. Staff felt motivated and the culture within all the teams was enthusiastic, professionally hopeful and focused on delivering the best service possible. Staff felt respected, supported and valued. They reported that the provider promoted equality and diversity in its day to day work and in providing opportunities for career progression. They felt able to raise concerns without fear of retribution.
- Our findings from the other key questions demonstrated that governance processes encouraged innovation and improved services for patients. This included collecting regular feedback from patients. At team level performance and risk were models of good practice.
- Teams had access to the information they needed to provide safe and effective care and used that information to good effect.
- Staff engaged actively in local and national quality improvement activities. This included the workforce wellbeing initiative for which staff were highly commended by peers at a national level.
- There were effective, multi-agency arrangements in place to agree and monitor the governance of the mental health crisis service and the health-based places of safety. Staff worked to improve care outcomes and worked systematically with other organisations to achieve this along with regular audit of service delivery.

Outstanding practice

We found three examples of outstanding practice in this service. See the Outstanding practice section above.

Areas for improvement

We found one area for improvement in this service. See the Areas for Improvement section above.

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 the service provider was not meeting. The provider must send CQC a report that says what action it is going to take to meet these requirements.

For more information on things the provider must improve, see the Areas for improvement section above.

Please note: Regulatory action relating to primary medical services and adult social care services we inspected appears in the separate reports on individual services (available on our website www.cqc.org.uk)

This guidance (see goo.gl/Y1dLhz) describes how providers and managers can meet the regulations. These include the fundamental standards – the standards below which care must never fall.

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Treatment of disease, disorder or injury	Regulation 9 HSCA (RA) Regulations 2014 Person-centred care

Our inspection team

Kathryn Mason, CQC Head of Inspection, chaired this inspection and Michael Fenwick, Inspection Manager, led it. An executive reviewer, Samantha Allen, Chief Executive of Sussex Partnership Trust, supported our inspection of well-led for the trust overall.

The team included two further inspectors, a specialist adviser, and the CQC National Professional Advisor for Well Led.

National professional advisers provide advice and leadership on how CQC inspects and regulates. Executive reviewers are senior healthcare managers who support our inspections of the leadership of trusts. Specialist advisers are experts in their field who we do not directly employ.