Good

Cheshire and Wirral Partnership NHS Foundation Trust

Community-based mental health services for older people

Quality Report

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Locations inspected

Location ID	Name of CQC registered location	Name of service (e.g. ward/ unit/team)	Postcode of service (ward/ unit/ team)
RXAX2	Trust Headquarters	Community-based mental health services for older people	CH2 1UL

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

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

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

Summary of findings

Ratings

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

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

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

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

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

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

Summary of findings

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Summary of findings

Overall summary

The facilities for delivering care and treatment were clean and safe.

Managers planned and reviewed the staffing skill mix to ensure patients received safe care and treatment. They allocated referrals among staff based on caseload, complexity of cases and expertise of staff and they monitored caseloads during supervision. Staff understood their roles and responsibilities to raise concerns and report incidents and near misses.

Staff talked about their work in terms of the recovery model. Their focus on supporting people to remain in the community was clear. However, some care plans, while containing elements of a recovery based approach, were mainly generic. There was inconsistency in care pathways and structure for care. We found little evidence of processes and systems being embedded into practice. Some staff were unclear about whether systems were in place or not. Systems to ensure care plans were reviewed regularly were not robust or effective.

We did not find evidence to show how patient's views and experiences were gathered locally so that they could be used to drive improvement or influence service development.

Best practice guidance was not embedded consistently. Outcomes were not being measured and at Vale House, physical health needs were not being assessed routinely.

People who were subject to the Mental Health Act (MHA) 1983 were assessed, cared for and treated in line with the Act and the MHA Code of Practice.

Capacity assessments carried out under the Mental Capacity Act 2005 were not always specific to the decision needing to be made.

We gathered information from a range of sources to gain feedback from patients and their carers. Their feedback was positive, particularly about the way staff treated them. Patients and their family members were treated with kindness and respect. They felt they were involved in decisions about their care. They told us they were listened to and supported during their care and treatment. Staff were sensitive and respectful of patients' wishes and were committed to providing personalised care based upon their needs.

The teams focused on assisting people to remain within the community and avoid admission to hospital where possible. They facilitated early discharge by offering people intensive support during the move from hospital to the community. Patients were enabled to participate in the activities of the local community so that they could exercise their right to be a citizen as independently as they were able to. The teams made efforts to meet people's diverse needs.

Staff felt respected, valued and supported. There was a meeting structure to escalate and cascade information through all levels of staff. This included governance and incidents. We found some good examples of practice designed to improve services. However, there was little evidence of local audits being carried out which could be used to ensure that systems were working and drive improvement, and the strength of local leadership differed significantly in the teams.

Summary of findings

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

Are services safe?

Good 

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

- The environment was clean and safe.
- Staff identified risks and formulated them into a risk management plan.
- There were systems to ensure risks were reviewed regularly.
- Staff had a good understanding of safeguarding people from abuse and they knew how to escalate concerns.
- Staff understood their responsibilities in reporting incidents.

Are services effective?

Requires improvement 

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

- Care pathways and structures for care were inconsistent.
- Care plans were not always person centred, holistic or recovery based.
- Systems to monitor care planning were not robust or effective.
- Best practice guidance was not embedded consistently.
- Outcomes were not being measured.
- Multi-disciplinary working was inconsistent.
- Capacity assessments were not always specific to the decision needing to be made.

However:

- Initial assessments of people's needs were comprehensive and included their social, occupational, cultural and psychological needs and preferences.
- Staff understood their responsibilities in relation to the Mental Health Act 1983.

Are services caring?

Good 

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

- Staff engaged with patients with kindness and respect.
- Patients and their families were involved in planning care and treatment.
- Care plans included evidence of carers' involvement.

Summary of findings

Are services responsive to people's needs?

Good

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

- The teams offered support to facilitate early discharge from hospital.
- Staff helped patients to participate in the activities of the local community.
- The teams had access to interpretation services.
- Patients knew how to make a complaint.

However:

- Embedding of processes and systems into practice was inconsistent.
- Staff were unclear about whether systems were in place or not.

Are services well-led?

Good

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

- Staff felt respected, valued and supported.
- There was a meeting structure to escalate and cascade information through all levels of staff. This included governance and incidents.
- Staff were motivated to ensure service development took place
- There were pockets of practice designed to improve services.

However:

- There was little evidence of local audits being carried out which could be used to ensure that systems were working and drive improvement.
- Patient's views and experiences were not being gathered locally so that they could be used to drive improvement or influence service development.

Summary of findings

Information about the service

Cheshire and Wirral Partnership NHS Foundation Trust provided a range of community based mental health services. During our inspection we visited two of the four community mental health services (CMHS) for older people, at Vale House and Upton Lea. These services have not been inspected by the Care Quality Commission before.

The CMHS were multi-disciplinary teams that provided mental health assessments, treatment, rehabilitation and support for people primarily aged 65 and over who had functional or organic disorders. The teams undertook initial assessments to understand how they could meet people's needs and provided on-going support to patients and their carers or family members. Potential support included further appointments with a psychiatrist, psychologist, community mental health nurses, occupational therapists and arrangements for after care, where this was required.

At Upton Lea, 90% of referrals came from GPs but referrals were accepted from wards, liaison psychiatry and district nurses as well. At Vale House, staff told us that they only accepted referrals from GPs. A duty system also operated in the Upton Lea team for urgent referrals. At Vale House we were told that the duty system had not worked and was no longer used.

The Upton Lea CMHS included a memory service that assessed and diagnosed the nature of people's memory difficulties and advised on further intervention. This was accredited as excellent by the Royal College of Psychiatrists.

The CMHS operated a range of clinics or groups and all the patients were seen in their own homes or other outpatient settings. Post-diagnostic support was offered to people with dementia and their carers.

The CMHS also linked with other trust services, such as psychology, to provide a comprehensive service for people.

All the CMHS operated from Monday to Friday from 8am to 5pm. The Upton Lea service also offered 9am to 5pm weekend support for people with dementia who needed intensive support.

The CMHS monitored people's mental health and interventions were planned to prevent relapse. They promoted independence and rehabilitation of social skills by supporting and encouraging patients to access and be involved with local services. Upton Lea ran groups such as a wellbeing group and a post-diagnosis support group.

The teams worked in line with the principles of the recovery model. This was demonstrated by their focus on supporting patients to remain in the community.

Our inspection team

Our inspection team was led by:

Chair: Bruce Calderwood, Director of Mental Health, Department of Health (retired)

Head of Inspection: Nicholas Smith, Care Quality Commission

Team Leader: Sharon Marston, Inspection Manager (mental health), Care Quality Commission,

Simon Regan, Inspection Manager (community health services), Care Quality Commission.

The team that inspected this service included a CQC inspector and three qualified nurses.

Why we carried out this inspection

We inspected this core service as part of our on-going comprehensive mental health inspection programme.

Summary of findings

How we carried out this inspection

Before visiting, we reviewed a range of information we hold about the trust and asked other organisations to share what they knew.

We also arranged focus groups prior to the inspection where we spoke to staff from the community mental health services (CMHS) and patients.

We carried out announced visits to the service on 23rd and 24th June 2015.

During the visit we:

- met and interviewed 17 members of staff who worked within the service, including; administrative staff, managers, nurses, psychiatrists, social workers and support workers
- met with nine patients
- accompanied staff when they visited patients and observed how they cared for them
- talked with three carers and family members
- reviewed the care or treatment records of 11 patients
- looked at 11 staff records
- looked at a range of records including clinical and management records
- carried out tours of two premises
- observed a wellbeing group.

What people who use the provider's services say

Before and during this inspection, we held a series of focus groups to gain feedback from patients and carers about their experiences of using the services. We reviewed the results of our latest survey which looked at the experiences of patients receiving community mental health services in 2014. Across its community mental health services (CMHS), the trust scored about the same as other similar trusts in most areas but scored better in organising and planning care and crisis care. People's overall views and experiences were better.

During the inspection, we spoke with nine patients and three carers. People described the services as 'supportive' and 'caring'. They told us staff were friendly and treated them with kindness and respect. They felt involved in the decisions being made about their care and treatment. They said they felt their views were listened to and the service was flexible. They said access to the CMHS was good and staff offered them support when they needed it.

Good practice

The CMHS at Upton Lea had arrangements in place for people with a new diagnosis of dementia to undergo a 'safe driving' assessment.

The CMHS at Upton Lea carried out a 'what's next?' clinic, providing post-diagnostic support for people with a recent diagnosis of dementia.

Areas for improvement

Action the provider MUST take to improve

The trust **must** ensure that:

- Staff take proper steps to ensure that each patient is protected against the risks of receiving care or treatment that is inappropriate or does not reflect their personal preference.

Action the provider SHOULD take to improve

The trust **should** ensure that:

- Best practice guidance is embedded consistently.
- Capacity assessments are carried out appropriately.
- Effective systems or processes to assess, monitor and improve the quality and safety of the services provided are established.

Summary of findings

- Staff seek and act on feedback from patients and others for the purposes of evaluating and improving services or to evaluate and improve their practice.

Cheshire and Wirral Partnership NHS Foundation Trust

Community-based mental health services for older people

Detailed findings

Locations inspected

Name of service (e.g. ward/unit/team)	Name of CQC registered location
Community-based mental health services for older people Upton Lea Resource Centre	Trust Headquarters
Community-based mental health services for older people Vale House Resource Centre	Trust Headquarters

Mental Health Act responsibilities

We do not rate responsibilities under the Mental Health Act 1983. We use our findings as a determiner in reaching an overall judgement about the Provider.

Staff we spoke with understood their responsibilities in relation to the Mental Health Act.

Mental Capacity Act and Deprivation of Liberty Safeguards

Take-up of mandatory MCA training was 85% across the teams against the trust's target for compliance of 85%. Staff we spoke with understood that capacity fluctuated and that people may have capacity to consent to some things but not others. They were able to explain their responsibilities in undertaking capacity assessments and continuous monitoring to ensure people were able to understand and agree to decisions being made or if not

that they were made in the best interest of the person. They understood the circumstances when an independent mental capacity advocate (IMCA) would be accessed. The 11 care records we looked at showed that capacity assessments were carried out where they were necessary but at Vale House, four out of six assessments were not specific to the decision needing to be made. This meant that people may not always receive appropriate support to help them make specific decisions.

Good

Are services safe?

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

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

Summary of findings

Our findings

Safe and clean environment

Both teams had facilities for people to attend clinics and groups. They had clean, safe environments which were suitable for delivering care to older people. All fixtures, fittings and equipment were in a good state of repair. There was space for interviewing and meeting individual patients and carers, which had comfortable seating. However, the layout of some rooms meant that staff did not have easy access to the door and could be trapped in an emergency. Some rooms did not have alarms. There was a personal alarm system for staff to use to maintain their personal safety. Staff were aware of the system; however, they did not use it consistently.

All medical equipment was available and checked routinely. We saw up to date records of these checks.

There were effective systems to ensure security and safety. On the days we inspected we were asked to show identification and to sign into and out of the building.

There was a lone worker policy. Staff understood the policy. They explained what they would do if they were concerned about their safety while on a visit or if someone did not return when they were expected to.

Safe staffing

Managers planned and reviewed the staffing skill mix to ensure patients received safe care and treatment.

Staff had caseloads of approximately 35 cases per full time equivalent. Managers allocated referrals based on caseload, complexity of cases and expertise of staff and they monitored caseloads during supervision. This was confirmed by the records we reviewed.

Managers monitored compliance with mandatory training via the computer system. The trust had set a target for compliance of 85%. Across the teams, staff compliance with mandatory training requirements was 91%.

Assessing and managing risk to patients and staff

Staff carried out risk assessments either before or at the start of people's involvement with the CMHS as part of a comprehensive assessment. However, at Vale House we also found that there was a reliance on GPs to identify risk at the point of referral.

The electronic recording system incorporated alerts to ensure that staff were aware of incidents and risks relating to patients. However, the monitoring system managers used had identified that staff at Vale House were not always documenting these.

There was an audit process to monitor and review risk. Managers carried out this audit every two months and we looked at the most recent one from June 2015. At Vale House, the completed audit document we saw had identified gaps in recording risk in three of the five records audited. In one care plan in which clinical risk had been identified, that risk was not formulated in a risk management plan or flagged as an alert on the clinical system. Two others did not contain a crisis and contingency plan and did not contain information about risk or how it should be managed. Two did not document any assessment of risk or action plan when the patient had failed to attend a follow up appointment. There was no timescale for completing the records. However, we reviewed six care records at Vale House and five at Upton Lea. We found in all 11 records that staff had assessed and recorded risk appropriately and all the records were up to date.

This meant staff and managers carried out assessment, identification and monitoring of risk in an effective manner.

The multi-disciplinary team at both locations met every morning to discuss the team's caseload. This meant that they monitored patients so that changes in level of risk could be detected early.

Clinical staff all had a clear understanding of their responsibilities regarding safeguarding people from abuse and they were able to explain the process for reporting safeguarding concerns.

Good

Are services safe?

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

There were appropriate systems for the storage and administration of medicines. However, at Vale House we found that patients' clozaril records were stored in a cabinet that had a broken lock. This meant confidentiality may be compromised.

Track record on safety

No serious incidents had been recorded or reported in the last 12 months. At Upton Lea, staff were encouraged to record all lower rated incidents so that trends could be identified and addressed before a serious incident occurred.

Reporting incidents and learning from when things go wrong

Staff knew what constituted an incident and how to report it.

Information from incidents across the trust was shared with the staff by email and briefings. We saw minutes that showed these were discussed in monthly business meetings. Staff told us they felt supported and would take responsibility for incidents.

There was a process for de-briefing and investigating incidents should they occur.

Are services effective?

Requires improvement

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

Summary of findings

Our findings

Assessment of needs and planning of care

People were seen by a nurse within one to two weeks of referral. The community mental health services (CMHS) completed an initial comprehensive assessment that evaluated people's needs and the care and treatment options available to them. Staff used standard assessment tools such as the mini mental state examination and Addenbrooke's cognitive examination. Assessment included people's social, occupational, cultural and psychological needs and preferences. However, at Vale House staff did not always make a comprehensive assessment of people's physical health needs. Staff made plans for people's continuing support from the start of their treatment.

Care plans were not always personalised or holistic. The quality varied within the teams. Some care plans were comprehensive and clear. Others lacked detail in relation to a holistic approach and were not always recovery-based. Recovery-based means staff are focused on helping patients to be in control of their lives and build their resilience so that they can stay in the community and avoid admission to hospital wherever possible.

Overall, there was a holistic approach to assessing, planning and delivering care and treatment but at Vale House we saw little evidence of using best practice guidance. Some care plans were not comprehensive. This meant people's care needs were not being reflected accurately and may not be being met.

Managers carried out a safety metrics audit of care plans every two months. 'Metrics' is a tool that services can use to measure how well their processes are being implemented and where they could improve. However, the most recent audit document we saw at Vale House, completed in June 2015, was not consistent. It scored the quality of care plans, crisis and contingency plans and risk assessments as 'high quality' but also found that none of the five care plans audited contained goal-based outcomes.

Of the 11 care and treatment records we reviewed, eight contained information that was not complete. None of the six records we saw at Vale House contained a comprehensive assessment of physical health; for example, staff had not recorded smoking status, medication and other illnesses. Staff told us that physical health care was the responsibility of the G.P. At Upton Lea, two of the five records we reviewed were not holistic or recovery-based and they did not reflect the patient's involvement in planning their care. One contained no information in three of five domains for care planning. In one, a physical need was evident but staff had not addressed it. This meant staff did not have a clear and accurate understanding of the person's needs thus may not always be providing appropriate care. The systems to monitor care planning were not robust or effective.

Current information was stored on the trust's database system. Social work staff also used a second system alongside this. They told us the two systems were not synchronised and this led to duplication of work.

Best practice in treatment and care

Both teams had access to psychological interventions provided within the trust.

At Vale House, none of the six records we reviewed contained a comprehensive assessment of people's physical health needs. At Upton Lea, one care plan did not address a physical need that was evident in the record. However, we found some good examples of how teams ensured they were meeting patients' physical health care needs. The team at Upton Lea included an assistant practitioner who provided support around physical health care. Physical health care at this service was generally well planned and documented. There were lithium and clozaril clinics for initiation onto medication and monitoring.

At Upton Lea, staff proactively referred people with a new diagnosis of dementia for a 'safe driving' assessment to evaluate the physical and cognitive ability of the individual to drive a motor vehicle in safety and comfort, although this was not local. This was in line with DVLA current medical guidance that summarises the advice of the Secretary of State's Honorary Medical Advisory Panel on fitness to drive. The guidance is intended to assist doctors in advising their patients whether they should inform the DVLA of their medical condition and what the outcome of medical enquiries is likely to be.

Are services effective?

Requires improvement

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

The team at Upton Lea provided written information about dementia and dementia services. This is in line with National Institute for Health and Care Excellence guidelines.

At Upton Lea, staff were able to explain how they incorporated best practice guidance into their practice.

We saw a number of initiatives at Upton Lea, such as restructuring the service to meet the needs of the people who used it, a memory service, a post-diagnostic support clinic for people with dementia, a nurse-led review clinic and weekend support. However, we did not find evidence that staff evaluated the success of these initiatives.

We found little evidence that staff measured outcomes. At Vale House, the care home liaison service was hailed as a success. We heard anecdotal evidence; for example that the service had reduced prescribing of anti-psychotic medication for people with dementia but we did not see any documentary evidence of this. We asked how outcomes were measured but staff told us they were not measuring outcomes. At Upton Lea there were several good examples of initiatives being introduced to meet the needs of patients who used the CMHS but outcomes were not being measured.

Health of the Nation Outcome Scales (HoNOS) were being used but were not completed consistently. HoNOS are scales used to measure the health and social functioning of people with severe mental illness. They are designed for clinicians to use before and after interventions, so that changes attributable to the interventions (outcomes) can be measured. HoNOS scores were not being collated so that progress could be measured. Staff told us that as the HoNOS were not being used to measure progress, they did not complete them consistently.

Skilled Staff to deliver care

The teams identified training relevant to their work and managers encouraged them to develop skills in specialist areas. For example, some staff had undertaken training in cognitive stimulation therapy or as assistant practitioners. The team at Upton Lea participated in the trust's six-weekly rolling training programme and had invited speakers to their team to enhance skills and knowledge.

Staff were supported to deliver effective care by means of supervision and appraisal processes, to identify additional training requirements and manage performance. At Upton Lea, staff were also expected to demonstrate how they incorporated the trust's values into their practice. In the records we reviewed, all staff supervision was up to date.

Multi-disciplinary and inter-agency team work

At Vale House, there was little evidence of real multi-disciplinary working in the CMHS. The team consisted only of nurses and psychiatrists. There was access to other health professionals, such as social work staff and occupational therapists, within the trust but the staff we spoke with did not demonstrate that they recognised the benefit of close working with such allied health professionals. We looked at six care records and minutes of an allocation meeting held in June 2015 that included discussion of 9 new referrals and 36 ongoing cases. We did not see any evidence that health professionals outside the team were involved, other than the person's GP or where there was doubt about the person's mental capacity.

The team at Upton Lea included a range of disciplines to support patients. This included nursing staff, psychiatrists, social workers, support workers and allied health professionals such as assistant practitioners and occupational therapists. They provided a range of therapeutic interventions to support people's recovery in line with best practice guidance.

The CMHS teams did not include psychologists and staff made referrals when psychology input was needed. However, we were told there could be a wait of up to three months before an appointment was available. There were no plans to reduce this waiting time.

Both teams made links with organisations external to the trust. We saw a range of information on display about how to access neighbourhood groups.

The CMHS at Vale House had developed a care home liaison service. This was an opportunity to develop good working links and had been well accepted.

The CMHS at Upton Lea comprised smaller teams working with client groups with different needs. They referred internally and worked together according to need.

Both teams held a daily multi-disciplinary team (MDT) meeting to review and discuss current cases.

Are services effective?

Requires improvement

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

Adherence to the MHA and the MHA Code of Practice

Take-up of mandatory MHA training was 76% across the teams against the trust's target for compliance of 85%. However, staff we spoke with were able to explain their responsibilities in relation to the MHA and we were assured they understood the statutory requirements of the MHA.

Good practice in applying the MCA

Take-up of mandatory MCA training was 85% across the teams against the trust's target for compliance of 85%. Staff we spoke with understood that capacity fluctuated and that people may have capacity to consent to some things but not others. They were able to explain their responsibilities in undertaking capacity assessments and continuous monitoring to ensure people were able to understand and agree to decisions being made or if not that they were made in the best interest of the person. They understood the circumstances when an independent mental capacity advocate (IMCA) would be accessed. The 11 care records we looked at showed that capacity assessments were carried out where they were necessary but at Vale House, four out of six assessments were not specific to the decision needing to be made. This meant that people may not always receive appropriate support to help them make specific decisions.

Good

Are services caring?

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

Summary of findings

Our findings

Kindness, dignity, respect and support

Staff treated patients with respect, kindness and dignity. When we accompanied staff visiting patients, it was clear that they had a good understanding of their needs. We observed staff treating patients with respect, kindness and dignity. They were caring, compassionate and supportive. All the staff we observed demonstrated this. The patients we spoke with were positive about the support they had been receiving and the kind and caring attitudes of the staff. We saw people were comfortable both in the services we visited and when staff visited them at home.

Staff gave patients and their carers and families clear information about their care and the support they could offer. The patient and carers we spoke with all said staff were helpful and they could ask about anything. Carers told us staff kept them informed and they felt involved in making decisions about their relative's care and treatment. They said staff listened to their views. They said access to the CMHS was good, the service was flexible and they received support when they needed it.

All the staff teams maintained patients' confidentiality at all times. When we accompanied staff on home visits the staff members asked if the patient was happy for a Care Quality Commission team member to be present prior to the visit. All staff we spoke with were aware of the need to ensure confidential information was kept securely. Access to electronic case notes was protected by passwords.

The involvement of people in the care they receive

Patients told us they felt involved in planning their care. All the records we looked at contained a care plan. Their feedback was positive, particularly about the way staff treated them. They told us staff listened to them and supported them during their care and treatment. Copies were provided unless the person had said they did not want a copy and this was clearly recorded.

Patients' family and carers were involved in their care if the patient wished. Family members were able to attend review meetings and were encouraged to be involved.

We observed clinical appointments during which patients were involved in their care and supported emotionally. Staff were sensitive and respectful of patients' wishes and were committed to providing personalised care based upon their needs. Carers and family members we spoke with told us they had the opportunity to provide feedback about the services and to monitor their stress levels. The teams asked people to complete the 'friends and family' test. Feedback was discussed at the monthly business meetings but it was not specific to the services we inspected.

People were supported to attend activities in their local community; for example, neighbourhood groups, and at Upton Lea there was a post-diagnostic service for people with dementia that explained the practical help and benefits available to them and their carers. This enabled patients to maintain their independence as far as possible.

Are services responsive to people's needs?

Good

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

Summary of findings

Our findings

Access, discharge and transfer

The Community Mental Health Services (CMHS) focused on assisting people to remain within the community and avoid admission to hospital where possible. They also facilitated early discharge from hospital for some people by offering them intensive support during the move from hospital to the community.

The CMHS at Upton Lea accepted referrals from GPs, in-patient wards and other trust services. The manager triaged referrals and allocated them at a weekly multi-disciplinary team (MDT) meeting. Patients were seen within a week of allocation. People who were acutely unwell or at risk were 'fast-tracked' and seen sooner. The CMHS at Vale House told us they only accepted referrals from GPs. Those from any other source were referred back to the GP before they were accepted. This meant there could be delays before people were able to access services. At Vale House, we were told that there was no duty system as it had been tried and had not worked; however, one member of staff we spoke with referred to being on 'duty' that week.

At Upton Lea we found clear care pathways and structure for care. At Vale House, care pathways were unclear and access was not always timely; for example, there was a wait of six to eight weeks to see a consultant. We could not establish the reason for this and staff had no plans to reduce the waiting time. There were waiting lists at both services we visited; however, at Upton Lea steps had been taken to reduce waiting times and ensure access to care and treatment was timelier, such as introducing a nurse-led review clinic.

People were supported to attend community groups; for example, neighbourhood groups, learning or volunteer opportunities. The team at Upton Lea had initiated a post-diagnostic service for people with dementia which explained the practical help and benefits available to them and their carers. This meant that patients were enabled to participate in the activities of the local community so that they could exercise their right to be a citizen as independently as they were able to.

Staff attempted to engage people who missed appointments, mainly by phone calls and letters and discharged them if they no longer accessed the service.

Patients told us they had not experienced any cancelled groups or appointments.

Transport was available so that people could access the service. People who could make their own way to groups or clinics were encouraged to do so, thus maintaining their independence.

Managers triaged each referral made to the CMHS but there was no clear system for prioritising referrals.

Staff supported patients to access activities for groups and activities in the community. This encouraged independence from the service and access to continuing support from the wider community and other services following assessment.

Facilities promote recovery, dignity and confidentiality

The locations where patients were seen were clean, welcoming and comfortable. There were facilities for various activities; for example, a wellbeing group and depot clinics.

Meeting the needs of all people who use the service

The staff respected people's diversity and human rights. They made attempts to meet individual needs including cultural, language and physical needs. Interpreters were available to staff if required. Both premises were accessible to people who had physical disabilities. At Upton Lea we saw leaflets produced in several languages.

At Upton Lea, there were good examples of practice designed to improve patients' experience, such as restructuring the service to meet the needs of the people who used it. There was a memory service accredited as 'excellent' by the Royal College of Psychiatrists. Clinics had been introduced to meet people's needs, such as a 'What's next?' post-diagnostic support clinic for people with dementia, which looked at practical help and benefits available. There was also a nurse-led review clinic introduced to reduce waiting lists and weekend support for people who needed intensive home treatment. We were

Are services responsive to people's needs?

Good

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

told about plans for more new initiatives such as local access to the 'safe driving' assessment for people with a diagnosis of dementia but we did not see any documentation relating to this.

Listening to and learning from concerns and complaints

Patients told us they knew how to complain if they wanted to. We saw posters in the reception areas telling people how to complain or offer suggestions or compliments.

The services managed complaints and concerns by sending them directly to the Patient Advice and Liaison Service (PALS). This was not in line with the spirit of the trust's complaints policy, which refers to complaints, particularly informal complaints, being resolved at local level. The policy states at paragraph 19.5 that concerns and complaints should be triaged jointly by the clinical service line and the PALS complaints team. The managers ensured that learning from issues people raised was shared with the teams.

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.

Summary of findings

Our findings

Vision and values

The trust made staff aware of its vision and values through emails and newsletters. The trust also made use of social media to disseminate information. We saw posters of the trust's vision and values displayed in the offices and used as screen savers on computers.

Staff at Upton Lea were clear about the vision and direction of the service they worked in at local level and about how their work linked into the trust's vision and values. At each supervision session, they were expected to demonstrate how they incorporated them into their practice. At Vale House, staff had difficulty explaining their understanding of the trust's vision and values or how they incorporated them into their practice.

Good governance

There were local systems to ensure staff were well supported and received adequate training to do their job.

We saw minutes of team business meetings. The meetings were well organised and covered appropriate governance issues relevant to the service. Learning from incidents and complaints was shared with the teams.

There was a locality risk register but the teams did not hold risk registers. They could put issues forward so matters were escalated but they did not have direct access to the risk registers.

Appraisal meetings had been carried out with all staff.

Supervision was structured, and it addressed matters outstanding from the previous meeting. Sessions covered performance, development and staff issues. The trust had adopted a set of principles called the '6 Cs' as its values. The '6 Cs' were developed in 2012 by the NHS Commissioning Board against a backdrop of concerns about standards of nursing care in England. At Upton Lea, staff were expected to demonstrate how they incorporated the '6 Cs' into their practice. They are care, compassion, competence, communication, courage and commitment. In the records we reviewed, all staff supervision was up to date.

Leadership, morale and staff engagement

Staff told us they felt well supported by their local managers and peers. However, we found significant differences in local leadership. At Upton Lea, we saw clear examples of strong local leadership from the service manager, such as restructuring the service to meet the needs of patients and ensuring the trust's vision and values were embedded into individual practice and service delivery. At Vale House, there was little recognition of the service manager as the leader of the team. Instead, staff referred to the clinical lead as their manager.

Staff were aware of the whistleblowing process and said they would use it to escalate concerns.

Commitment to quality improvement and innovation

At Upton Lea, there was a clear commitment from managers and staff to develop services. We found some very good examples of practice designed to improve services, such as restructuring the service to meet the needs of the people who used it. There was a memory service accredited as 'excellent' by the Royal College of Psychiatrists. Clinics had been introduced to meet people's needs, such as a 'What's next?' post-diagnostic support clinic for people with dementia, which looked at practical help and benefits available. There was also a nurse-led review clinic introduced to reduce waiting lists and weekend support for people who needed intensive home treatment. We were told about plans for more new initiatives such as local access to the 'safe driving' assessment for people with a diagnosis of dementia but we did not see any documentation relating to this.

The CMHS used clinical tools such as Health of the Nation Outcome Scale (HoNOS). However, these were not being used consistently or effectively to audit the effectiveness of an intervention.

We found little evidence of local audits being carried out, or evidence to show how the CMHS used audits, performance indicators or quality outcome measures to improve service provision in either team.

The teams asked people to complete the 'friends and family' test. Feedback was discussed at the monthly business meetings but it was not specific to the services we

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.

inspected. We did not find any evidence to show how patients' views and experiences were gathered locally so that they could be used to drive improvement or influence service development.

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.

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 How the regulation was not being met: The trust had not taken proper steps to ensure that each patient was protected against the risks of receiving care or treatment that was inappropriate or did not reflect their personal preferences. Although managers carried out a safety metrics audit every two months, the completed audit document we saw was not consistent. It scored the quality of care plans, crisis and contingency plans and risk assessments as 'high quality' but it also found that none of the five care plans audited contained goal-based outcomes. Of the 11 care and treatment records we looked at, eight contained information that was not complete. Six records contained no comprehensive assessment of physical health; for example, staff had not recorded smoking status, medication and other illnesses. Four out of six mental capacity assessments were not specific to the decision needing to be made. Two records we reviewed were not holistic or recovery-based and they did not reflect the patient's involvement in planning their care. One contained no information in three of five domains for care planning. In one, a physical need was evident but staff had not addressed it. This meant staff did not have a clear and accurate understanding of individual needs thus may not always be providing appropriate care. This was a breach of regulation 9 (1) (c); 9 (3) (b); 9 (3) (c); 9 (3) (d).