Good

Greater Manchester West Mental Health NHS Foundation Trust

Community-based mental health services for adults of working age

Quality Report

Greater Manchester West Mental Health NHS Foundation Trust – HQ
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Date of inspection visit: 8 – 12 February 2016
Date of publication: 03/06/2016

Locations inspected

Location ID	Name of CQC registered location	Name of service (e.g. ward/ unit/team)	Postcode of service (ward/ unit/ team)
RXV00	Greater Manchester West Mental Health NHS Foundation Trust - HQ	Bolton Early Intervention in Psychosis Team (EIT)	BL3 2RX
RXV00	Greater Manchester West Mental Health NHS Foundation Trust - HQ	Bolton South Functional Community Mental Health Team	BL3 2RX

Summary of findings

RXV00	Greater Manchester West Mental Health NHS Foundation Trust - HQ	Ramsgate House CMHT	M7 2YL
RXV00	Greater Manchester West Mental Health NHS Foundation Trust - HQ	Salford Early Intervention Team	M6 5EJ
RXV00	Greater Manchester West Mental Health NHS Foundation Trust - HQ	Trafford CMHT – North and West Locality	M33 7FT
RXV00	Greater Manchester West Mental Health NHS Foundation Trust - HQ	Trafford Early Intervention Service	M33 7FT

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

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

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

Summary of findings

Ratings

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

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

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

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

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

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

Summary of findings

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Summary of findings

Overall summary

We rated community-based mental health services for adults of working age as good because:

- Staff prioritised keeping people who use the service safe; records we reviewed had comprehensive risk assessments in place.
- Staff had a good understanding of people's needs and relapse triggers and increased support when needed.
- The trust kept staff safe, staff were aware of and followed the lone worker policy and provided support in pairs where risks necessitated.
- If there was a serious incident, people were supported and offered debriefs. Managers shared learning from incidents amongst teams to reduce the likelihood of reoccurrence.
- Staff received supervision, appraisals and attended regular team meetings; managers disseminated information from senior managers to teams.
- Staff were aware of best practice and guidance and followed this, including offering friends and family groups within the early intervention service to raise awareness of psychosis.
- Teams prioritised physical health, with a physical health lead in each team. Staff facilitated activities to improve health and wellbeing including badminton groups and recovery groups.
- People using the service reported staff were respectful, caring and supportive. Staff had a good knowledge of individual needs and preferences. Interactions observed were positive and respectful of individuals.
- People who use the services had access to advocacy, both independent Mental Health Act advocates (IMHA) and independent Mental Capacity Act advocates (IMCA).
- The community teams provided support in an early evening and at a weekend.
- Staff processed referrals quickly and had a clear eligibility criteria and prioritisation of referrals for assessments.
- Managers had embedded learning from feedback in practice, including informing people who use the services if their worker is temporary.
- Information in relation to mental health conditions and therapies was available in a variety of languages. Joint working took place with community organisations to engage with people from different cultural backgrounds.
- There was a nurse led clinic in Salford to provide a gradual discharge from the community mental health team. People who accessed the clinic talked positively about the support offered.
- Staff reported being valued and feeling supported in their role, by their team and managers. Morale was high within teams and staff enjoyed working for the trust and making a difference in the lives of people they supported.

Summary of findings

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

Are services safe?

Good

We rated safe as good because:

- All records reviewed had comprehensive risk assessments in place.
- Staff were aware of and followed the lone worker policy.
- Staff had a good understanding of safeguarding and knew how to respond to a safeguarding concern.
- Clinic rooms were well equipped.
- Staff were aware of the incident reporting policy and were able to provide examples of incidents.
- Managers shared learning from incidents in team meetings.
- Staff, people who use the services and their carers felt supported following a serious incident.
- Teams discussed changing levels of risk of individuals several times a week within zoning meetings.

However:

- The medication storage at Salford early intervention team (EIT) was in a hot room.
- Care coordinators did not always review risk assessments and update them following changes in individual's needs and presentation.
- Basic life support (BLS) training attendance was low, the trust had cancelled several courses and staff reported it was difficult to book onto the BLS training due to limited spaces.

Are services effective?

Good

We rated effective as good because:

- Care records reviewed had individual care plans.
- The early intervention teams used the recovery star for planning goals and identifying aims with individuals.
- Staff were knowledgeable in relation to National Institute for Health and Care Excellence approved therapy including cognitive behavioural therapy (CBT), family therapy, and support in relation to employment.
- The early intervention teams offered family and friends groups to raise awareness in relation to psychosis and associated topics.
- There were physical health leads in each team that completed physical health screening tools and there was a nurse led clinic in Salford.

Summary of findings

- Teams planned activities for people using the service in relation to improving health and wellbeing, including badminton, boxing and running.
- All teams were multi-disciplinary and included assistant practitioners, nurses, occupational therapists, psychiatrists, psychologists, social workers and support time and recovery workers.
- Staff were able to access additional training relevant to their role including CBT, family therapy and motivational interviewing.
- Staff received regular clinical and managerial supervision.
- Regular team meetings took place.
- Staff had annual professional development reviews.
- There was good multidisciplinary working including with the home based treatment and inpatient services.
- Staff were aware of the MHA and MCA and their role in relation to this.
- Staff were following the MHA requirements for those people on a Community Treatment Order including explaining the rights to individuals.
- Staff were aware of the advocacy services and how to access them.

However:

- The trust did not have a perinatal pathway or guidelines in place in Bolton, staff did not provide additional support for people pre or post birth.
- There was no permanent psychiatrist for Salford EIT, resulting in people who use the services not receiving consistent oversight in relation to their treatment.
- Staff had not received training in how to complete the new style care plans, which were more recovery focused.

Are services caring?

Good

We rated caring as good because:

- People using the service reported staff were respectful, caring and supportive.
- Staff had a good knowledge of individual's needs and preferences.
- Services users and their carers valued the friends and families groups to offer support and information.
- Interactions observed were positive and respectful of individuals.
- People who use the services had access to advocacy, both IMHA and IMCA.

Summary of findings

- Have your say events had been held.
- Questionnaires in relation to giving feedback regarding their support were available in all community bases.
- People who use the services were involved in the recruitment and selection of staff.
- People using the service were encouraged to complete recovery questionnaires at the point of discharge from the service.
- Group sessions we observed were person centred and the facilitators tailored the session to meet individual preferences.

However:

- Not all patients were involved in the creation of their care plans, people reported their care coordinator brought a completed care plan to comment on and agree.
- Care plans were not routinely reviewed when an individual's presentation or circumstances changed.

Are services responsive to people's needs?

Good

We rated responsive as good because:

- The early intervention teams had a target of two weeks from referral to allocating a care coordinator.
- Information management collated assessment to treatment data and shared this with team managers on a weekly basis.
- The triage of processing referrals allowed staff to assess urgent referrals within five days.
- The community team offered support in an assertive approach, meeting people at home, or local community venues of their choice.
- Psychiatric appointments and physical health checks took place at community venues and at people's own home if they could not access a community venue.
- The community teams provided a seven-day service.
- Within the early intervention team, staff provided support to families with the aim of enabling the individual to engage.
- Managers had embedded learning from feedback in practice, including informing people who use the services if their worker is temporary.
- Information in relation to mental health conditions and therapies was available in a variety of languages.
- Joint working took place with community organisations to engage with people from different cultural backgrounds.
- Access to translators was available and we observed this service in use for a home visit.

Summary of findings

- There was a nurse led clinic in Salford to provide a gradual discharge from the CMHT.

However:

- Not all teams provided information to people who use the services of how to complain about the service.
- Records reviewed did not evidence discharge planning being discussed or as an aim with individuals.

Are services well-led?

Good

We rated well led as good because:

- Staff were receiving regular supervision and annual appraisals.
- Regular business meetings and multi-disciplinary team meetings took place.
- Staff felt supported by their managers and teams.
- Senior managers were visible and approachable.
- The EIT steering group shared good practice across the boroughs of Salford, Trafford and Bolton to offer consistency and peer support for managers.
- People who use the services co-facilitated training as part of the recovery academy.
- Team managers had accessed leadership and development training.
- Staff were aware of the Duty of Candour and provided examples where they had applied the principle.
- Team managers were aware of the key performance indicators and Commissioning for Quality and Innovation targets they were working to.
- Managers were aware of the risk register and the items on the register that applied to their service.
- There was high staff morale within teams and staff felt supported by their colleagues.
- Teams supported individuals to be involved in research in relation to mental health.

However:

- Information provided by the trust in relation to performance is not consistent with the information held locally by teams.

Summary of findings

Information about the service

The provider has a variety of community mental health services for adults of working age, 18 teams in total.

- General practitioners can refer people for psychological therapies. Psychological services provided include:
- the Eating Disorder Service for Salford, Wigan, and across the North West
- Early Detection and Intervention Team (EDIT), a specialist psychological therapy service that works with young people aged 14 – 35 years, people can self-refer to EDIT
- primary care psychological therapy services in Bolton, Salford and Trafford providing a variety of time limited therapies including behavioural activation, cognitive behavioural therapy and counselling
- military veterans service in Cheshire and Merseyside (excluding Liverpool),family members and people can self-refer to this service
- specialist psychotherapy service providing a range of specialist therapies for people experiencing personality disorders and severe interpersonal difficulties.

The provider has three early intervention teams for people who have experienced their first episode of psychosis; currently they support people from age 14 to 35 however, from April 2016, they will not have an upper age limit to reflect the changes in National Institute for Health and Care Excellence (NICE) guidance.

The community mental health teams(CMHTs) support people with enduring mental health needs, usually on the care programme approach(CPA), where individuals have a care coordinator. The CPA provides assessment, planning, co-ordination and reviews of people's care. The CMHTs focus geographically to cover regions within the borough:

- Bolton has two teams covering the north and south of the borough and a single point of access based at the hospital.
- Salford has three community teams based in Eccles, Little Hulton and Higher Broughton.
- Trafford has two community teams, one covering the north and west locality and the other covering south and central locality. Trafford also has an extended service offering assessments and post diagnosis support for people in relation to autistic spectrum condition and attention deficit hyperactivity disorder.

We visited six of the 18 teams within this core service.

Our inspection team

The team was led by:

Chair: Dr Peter Jarrett

Head of Inspection: Nicholas Smith, Head of Inspection Care Quality Commission

Team Leaders: Sarah Dunnett, Inspection Manager Care Quality Commission

The team that inspected the community service for adults of working age comprised a CQC inspector, a nurse, an occupational therapist and a social worker all with experience of community mental health services for adults of working age.

Summary of findings

Why we carried out this inspection

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

How we carried out this inspection

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

- Is it safe?
- Is it effective?
- Is it caring?
- Is it responsive to people's needs?
- Is it well-led?

Before the inspection visit, we reviewed information that we held about these services, asked a range of other organisations for information and sought feedback from staff and people who use the service at focus groups in the three boroughs.

Representatives who attended the focus groups in relation to community services for adults of working age were:

- Bolton: six qualified staff, 10 unqualified staff, nine other health professionals and four people who have used the service.
- Salford: four qualified staff, five unqualified staff, five other health professionals and five people who have used the service.
- Trafford: three qualified staff, three unqualified staff, five other health professionals and four people who have used the service.

During the inspection visit, the inspection team:

- spoke with 20 people who were using the service
- spoke with five carers of people who use the service
- spoke with the team managers of each of the teams we visited
- spoke with 21 other staff members; including doctors, nurses, occupational therapists, psychologists and social workers
- shadowed six home visits
- observed three group activities
- toured four community bases and clinics where appointments were held with people using the service
- attended and observed three multi-disciplinary meetings and four zoning meetings

We also:

- reviewed 26 care records
- collected feedback from 30 people using comment cards
- looked at a range of policies, procedures and other documents relating to the running of the service.

What people who use the provider's services say

We spoke to 13 people who had experience of using the community mental health services at the focus groups and 20 people during the inspection.

We also spoke to five carers during the inspection and received written feedback from a carer.

People who used the community services reported that the staff that supported them were caring, respectful and positive. They reported the service was responsive if they were deteriorating, staff would prioritise their support. Staff including doctors provided home visits where people struggled to get to a community appointment.

Information regarding treatment and their condition was shared with individuals and people felt informed regarding their care.

Summary of findings

People talked positively about being involved in recruiting staff and delivering training at the recovery academy.

Not all people were aware of how to complain about the service. People who had support from staff based at Ramsgate house and Crossgate house reported the phone system was not effective and there were several occasions when they couldn't get to speak to someone. This had an impact on individuals if they were low in mood.

There were occasions for some individuals where they had had a variety of staff involved in their care, including different care coordinators. People reported that it was difficult to build a trusting relationship with new staff and found the change disruptive.

Feedback from carers was that the community services were proactive and respectful. The support provided was holistic, included support in relation to physical health needs, and referred people to other professionals. Carers reported being included in the consultation regarding the trust's carers strategy. Carers felt included in their relatives care and the care coordinators were approachable if they needed information or advice.

Good practice

Each team we visited had a physical health lead. The physical health leads were assertive in approach, and would visit people in their own home to complete physical health screening and tests.

Teams were involved in enabling people with experience of mental health services to be involved in research; the psychosis research unit led the research.

The nurse led clinic at Salford provided a step down provision to people who had previously been accessing support from the community mental health teams and were ready for gradual discharge from the service.

Areas for improvement

Action the provider SHOULD take to improve

- The provider should review the medication storage at the Salford EIT and monitor the temperature of the facilities.
- The provider should ensure that they review risk assessments and care plans following changing needs and presentation of individuals.
- The provider should ensure that there are enough courses available for staff to attend the mandatory training course of basic life support.
- The provider should review their policies across the three boroughs to include a perinatal pathway to reflect the support provided to services users prior to and post giving birth.
- The provider should ensure consistency of psychiatric input to Salford EIT for the benefit of people who use the services accessing the service.
- The provider should ensure that staff receive training in the implementation of the new recovery focused care plans to ensure they have the skills, understanding and competence to provide a consistent recovery based model of care, which is accurately documented in individuals care plans.
- The provider should ensure that each community team provides individuals accessing the service with details of how to complain about the service.
- The provider should ensure that discharge planning is captured within care records.
- The provider should review their information management systems to ensure that they are consistent with data held at a team level.

Greater Manchester West Mental Health NHS Foundation Trust

Community-based mental health services for adults of working age

Detailed findings

Locations inspected

Name of service (e.g. ward/unit/team)	Name of CQC registered location
Bolton Early Intervention in Psychosis Team (EIT)	Greater Manchester West Mental Health NHS Foundation Trust - HQ
Bolton South Functional Community Mental Health Team	Greater Manchester West Mental Health NHS Foundation Trust - HQ
Ramsgate House CMHT	Greater Manchester West Mental Health NHS Foundation Trust - HQ
Salford Early Intervention Team	Greater Manchester West Mental Health NHS Foundation Trust - HQ
Trafford CMHT – North and West Locality	Greater Manchester West Mental Health NHS Foundation Trust - HQ
Trafford Early Intervention Service	Greater Manchester West Mental Health NHS Foundation Trust - HQ

Detailed findings

Mental Health Act responsibilities

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

Training in relation to the Mental Health Act was not mandatory. Across the community teams, attendance at MHA training was 19%. However, staff that we spoke to had a good understanding of the Act and could explain their role including preparing reports for tribunal if people were on a community treatment order (CTO), ensuring people understood their rights. The consultants reviewed the mental state of people on a CTO.

Records we reviewed for people on a CTO showed staff follow the legal process for renewal of CTO and accurately evidenced and recorded this.

Mental Capacity Act and Deprivation of Liberty Safeguards

Training in relation to the Mental Capacity Act (MCA) was not mandatory. Across the community teams, attendance at MCA training was 36%. However, staff we spoke to had an understanding of the five principles including an awareness that capacity is decision specific.

The initial assessment tool had a section on capacity and records we reviewed included assessments of people's capacity.

Staff reported being involved in best interest meetings for individuals. Reasons for the meetings included an individual's ability to manage their finances and the decision-making ability in relation to where people lived.

Good

Are services safe?

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

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

Our findings

Safe and clean environment

Four of the six teams that we visited had appointments with people at their bases. All of the interview rooms were fitted with alarms and staff carried personal safety alarms too.

The three clinic rooms that we visited were clean. The staff monitored medication that was stored in fridges twice a day via temperature checks, which we observed. However, the medication storage room at the Salford Early Intervention Team (EIT) was very warm, and staff reported and we experienced it being very uncomfortable to work in. There was no temperature monitoring in place for medication that should be stored at room temperature. This meant that there was a risk that medicines would not be as effective if they were exposed to high temperatures.

Staff delivered medication to people who were receiving support via the assertive outreach pathway. The hospital pharmacy delivered the prepared medication in individual containers that were clearly labelled with individual's details. Staff completed a medication-recording chart to confirm that staff had delivered medication to individuals.

Safe staffing

Name of location	No. of staff	Leavers	Turnover	Vacancies	Sickness
Bolton EIT	16	5	31%	5%	8%
Bolton South Functional	32	2	6%	0%	7%
Salford Ramsgate House	28	1	4%	3%	5%
Salford EIT	14	2	14%	0%	4%
Trafford CMHT North	23	2	9%	0%	9%
Trafford EIT	8	2	25%	15%	2%

Number of substantive staff is as at 31 December 2015.

Whilst on inspection managers informed us that the early intervention teams across the three boroughs had been successful in receiving additional funding for new posts. They were in the process of recruiting additional staff in the disciplines of psychology, care coordinators and support time and recovery workers.

Senior managers had reviewed staffing levels for Ramsgate House in Salford using data from the local deprivation index, which highlighted their catchment area as having high levels of deprivation. The team has a target of 25 cases for a full time care coordinator, currently the average caseload was 27.

Bolton community mental health team (CMHT) used caseload rating where staff rated cases on a scale of one to five and managers reviewed this with staff in supervision. The average caseload at Bolton south was 31.

Trafford CMHT current average caseload was 28; this had reduced recently due to more stability in the staff team.

The community teams were aware of the complexity of the cases and considered this at allocation meetings. Managers allocated band 5 nurses to people who were stable and required monitoring. Managers allocated people using the service who were more chaotic and those individuals on the assertive outreach or personality disorder pathway to band 6 nurses or equivalent, which meant patients with more complex needs, were being managed by a senior member of staff.

The target caseload for EIT is 18 cases, Salford had an average caseload of 20 and Bolton had an average caseload of 22. Trafford EIT caseload averaged 18 cases per whole time equivalent post.

Staff told us and records confirmed that caseloads were reviewed in all staff supervisions.

There were six people at Bolton EIT, two people at Bolton South CMHT, three people at Salford EIT, two people at Ramsgate House CMHT, three people at Trafford EIT and none at Trafford North CMHT awaiting allocation of a care coordinator.

All teams were able to request bank and agency staff to cover long periods of sickness and other vacancies including secondments. There was agency staff at Ramsgate house, Bolton EIT, Trafford North and Trafford EIT to ensure consistency of care for individuals.

Good

Are services safe?

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

Urgent psychiatrist appointments were available to people who used the service that showed signs of relapse in their mental state. Psychiatrists also visited people at home when necessary.

The courses identified by the trust as mandatory were basic life support, equality and diversity, fire safety, infection control, information governance, safeguarding adults and children. The average mandatory training rate for staff in adult community services was 75%. Basic life support training attendance was low within the teams, with Bolton EIT attendance rate at 67%, Bolton South at 70%, Ramsgate house at 75%, Trafford North at 46%, Trafford EIT at 25% and Salford EIT at 31%. When explored with the teams, staff reported the trust had cancelled a number of the courses or there were no spaces available when they tried to book a course. Fire safety training was low at Salford EIT with attendance at 50%. Infection control training level one attendance was low at Ramsgate House with 60%, Trafford North 50%, Trafford EIT 33% and Salford EIT with 50% attendance. Information governance training attendance was low at Bolton South with 74% and Trafford North with 70% attendance. Staff reported it was easier to access training now that the trust had recently introduced eLearning.

Assessing and managing risk to patients and staff

We reviewed 26 care records. All care records had a completed standard tool for the assessment of risk version 2 (STAR) risk assessment in place. Three of the risk assessments were over a year old. Despite changes in circumstances, risk assessments within a year old did not always reflect changes within risk and the individual's presentation. Contingency plans were included within the risk assessments.

We observed staff responding to deterioration in people's mental health by arranging to see them on the day that people raised concerns.

Referrals to the CMHT indicated whether the referral was an emergency (where the target was to assess an individual within 24 hours), urgent (where the target was to assess people within five working days) or routine (where the target was to assess people within 20 working days). The staff on duty would liaise with the referrer to gather additional information and assess the level of need and urgency of individuals waiting for an assessment. Within the EIT, the target was to assess an individual within 10 working days of the receipt of referral and identify a care coordinator. Each of the teams had two staff on duty every day to enable assessments to take place on the day.

Staff received training in safeguarding adults and children, attendance was over 75% for the teams. Staff had a good understanding of the safeguarding procedures within the trust including recording safeguarding concerns as an incident. Staff were able to identify the safeguarding leads that they could approach for information and guidance. Team managers had chaired strategy meetings and supported their team through the process. Staff were aware of 'prevent', which focused on support to stop vulnerable people from becoming radicalised into terrorism or becoming terrorists.

The service had embedded lone working policies and practices within the teams; staff were following the lone worker policy and were aware of the safe phrase to use if they were concerned about their safety whilst out on a visit. Staff recorded within their bases where they were going on their visits and their expected time of return. The duty officer had the role of ensuring twice a day that staff had made contact with the office and were safe and well. Buddy arrangements were in place for any visits out of core working hours. The additional support offered to individuals at a weekend may not be from their regular care coordinator; staff visiting people at a weekend who they may not know were provided with an aim of the sessions and a copy of their risk assessments via the electronic record system to read prior to the visit. Staff facilitated joint visits where risk presented and gender specific visits where the need dictated.

Track record on safety

From January 2015 to January 2016, there were 20 serious incidents across the community teams. Fifteen were unexpected deaths, two were attempted suicides, two were falls and one was an allegation of financial abuse.

To reflect the high levels of deprivation and alcohol and drug use in the catchment area of Ramsgate House, they negotiated an increase in staff to meet the demands of the service. An additional three members of staff were in post.

Following a serious incident access to offices are restricted; staff had passes that enable access. Staff also had access to personal safety alarms for use within the interview rooms at the bases.

Good

Are services safe?

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

Reporting incidents and learning from when things go wrong

Staff we spoke to were able to describe what would be an incident and how they would record it on the electronic recording system. Managers would receive the report via the system to review and action accordingly.

From January 2015 to December 2015, the trust reported 715 incidents for adult community locations. Bolton reported 231 incidents, Salford reported 285 and Trafford reported 199. The category with highest incidents reported was self-harm at 185, then violence or aggression to other people using the service at 86; violence or aggression to staff was 77 incidents; medication incidents were 66 and deaths were 57. Salford borough recorded the highest number of incidents with 285. At location level, Crossgate North Locality CMHT in Bolton had recorded the highest number of incidents with 97.

Managers were able to give examples where they were open and transparent and explained to patients or their family when something went wrong. An example shared was in relation to the conclusion of an investigation where the trust could have improved pathways of communication between services. The service shared the learning with the family and home visits took place.

Staff reported being well supported within their teams following incidents; they received debriefs and informal support. Records confirmed that managers shared learning from incidents at team meetings. Some staff were aware of the trust wide post incident debrief support team available following incidents. The trust sent emails to staff and learning posters were on display in the community teams to disseminate learning from events. When staff were required to attend the coroner's court, both a senior manager and a team member would accompany and support them.

Examples of changes following incidents included the introduction of an email to the duty worker email address and the team manager from the new helpline to ensure that the care coordinator or the person on duty could contact an individual if they had needed support out of hours. Another example was where there was a missed opportunity for an individual to be referred to the early intervention team; to reduce this reoccurring managers were in the process of raising the profile of the team and communicate the change in referral criteria. When an individual staff member on reflection should have responded differently to a situation, managers discussed this individually in supervision and records confirmed this.

Are services effective?

Good

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

Our findings

Assessment of needs and planning of care

The trust used the short initial assessment tool for the initial assessment. This covered confidentiality, capacity and consent to treatment, reason for referral, physical health, family and personal history, culture and faith, social circumstances, children, accommodation, employment, daily living, substance and alcohol use, forensic history, mental state. The document concluded with risks identified, formulation, management plan and recommendations.

We reviewed 26 care records. There were care plans in all but one record we reviewed. Care plans were person centred, recovery orientated and contained crisis and relapse prevention plans within them. There were examples of care plans linking to section 117 aftercare arrangements. Records evidenced the involvement of carers in care planning. However, not all care plans were current to include changes in an individual's MHA detention status, safeguarding concerns or change of accommodation. Two care plans were over a year old and the service had scanned them in from the old system. Care records we reviewed did not include any discharge planning.

Due to the electronic recording system changing in September 2015, there were challenges with locating certain documentation on the system. Staff had variable levels of knowledge and skills in relation to the system. The care plans had changed with the new system to be more person centred and based on the recovery star model. However, staff had not received training on the new care plan documentation.

Care records showed good multidisciplinary working, including home visits from the psychiatrist and referrals to psychology. Progress notes were detailed and cross-referenced to risk assessment and care plan documentation. Staff documented capacity to consent to treatment in the records where appropriate.

Best practice in treatment and care

Staff in the early intervention teams were aware of National Institute for Health and Care Excellence (NICE) guidance in relation to responding to people who have experienced their first episode of psychosis. Bipolar disorder, psychosis and schizophrenia in children and young people NICE quality standard [QS102] Published date: October 2015 and Psychosis and schizophrenia in adults NICE quality standard [QS80] Published date: February 2015.The provider had an early intervention team in each of the three boroughs: Trafford, Bolton and Salford. Staff were able to explain the NICE recommendations they were providing of family intervention and friends and family groups, the support in relation to education and employment, led by the occupational therapists in the teams. The guidance specifies that referral to treatment should be within two weeks and the EIT had this as their target.

Within the community teams, they followed the NICE recommendation on Bipolar disorder: assessment and management (CG185) in relation to monitoring physical health. Each team had a physical health lead and they were completing the physical health information tool and metabolic and cardiac screening, records confirmed this.

One of the people who used the service we met who were receiving support from the CMHT had recently given birth; there was no evidence of the support increasing prior to birth or post birth. The NICE guidance, Antenatal and postnatal mental health: clinical management and service guidance [CG192] recommends "the monitoring regularly for symptoms throughout pregnancy and the postnatal period, particularly in the first few weeks after childbirth." Trafford had a Perinatal Maternal and Infant Mental Health Pathway involving other providers in the borough including the local authority. Salford had a flowchart of the perinatal involvement with the midwifery provision. Bolton did not have a protocol or policy in relation to perinatal provision.

Psychological therapies offered included cognitive behavioural therapy (CBT), dialectical behaviour therapy (DBT) and family intervention, as recommended by NICE guidance NICE quality standard [QS80].

The services completed the mental health-clustering tool of people's presentation early in their support and at regular intervals. Staff introduced the recovery star model for some individuals within the EIT service to capture peoples ratings early in their support and as their support progressed. Recently within Bolton, they had given people recovery questionnaires to complete at the end of their support from the team. Collated results showed 82% agreed they felt well enough for discharge.

Are services effective?

Good

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

Clinical staff were involved in local audits of internal data and systems including clozapine prescribing and the audit and service evaluation of single point of access service in Bolton.

The trust participated in the national audit of schizophrenia, the report from the Royal College of Psychiatrists in 2014 highlighted actions of: improving access to psychological therapies, including family intervention, increase the monitoring of BMI and glucose control, increase intervention for people with abnormal results in relation to stopping smoking and documentation of investigation for people with poor symptom response. The trust had reviewed their actions and records confirmed that they offered family intervention to people who were in close contact with their families. Several staff were trained in family intervention. In addition, the EITs offered group awareness sessions on psychosis and related topics for friends and families. The trust rated the action as green. The trust action plan dated October 2015 recorded five staff in Trafford had completed CBT training to a diploma or certificate level and all CMHT staff had completed foundation level CBT. Bolton and Salford had a CBT training plan in place. The trust rated the action as amber. The physical health leads in each team completed the physical health information tool, which included BMI, glucose control and intervention in relation to stopping smoking. Thirty-two community staff had completed venepuncture training to increase the capacity for taking blood, including the option to take blood in people's own homes. The trust rated this action as green. The trust had created an audit tool for prescribing practice, agreed at the medicines management committee, and they rated this action as green. The trusts had made significant progress from their first action plan dated March 2015 and their reviewed action plan in October 2015.

Skilled staff to deliver care

The community teams had a variety of disciplines within the teams including nurses, occupational therapists, psychologists, psychiatrists, social workers and support time and recover workers. However, Salford EIT had not had a psychiatrist within the team. Staff at EIT Salford had to refer people for psychiatrist appointments via the other community teams in Salford, this presented challenges due to the timeliness of getting appointments and the variety of psychiatrists that people who use the service have had appointments with. There had been a locum psychiatrist within the team since December 2015, with positive results of providing consistency and contributing to risk meetings within the zoning meetings. However, the locum psychiatrist was due to leave in the middle of February, which could lead to another period of instability until they recruited. The trust were in the process of recruiting a psychiatrist to a permanent role within the team.

Staff received a three day corporate induction including orientation to the trust, mental health awareness, equality, diversity and values, servicer user and carer involvement, safeguarding children and adults, carer awareness, fire safety, infection control, basic life support and conflict resolution. After the corporate induction, staff received a local induction to the team and completed an induction workbook, which was stored within their personnel files. The local induction included time spent shadowing more experienced members of the team.

The trust supervision policy dated May 2012 stated that all staff should receive management supervision from their line manager at least six times a year. Clinical supervision can take place as one to one or group supervision. The policy stated that the supervisor and supervisee should complete a supervision contract to include the format of supervision, frequency and roles. We saw completed supervision contracts within supervision files. Staff told us of group supervision available for people supporting people who used the service on the personality disorder pathway in Bolton; people could drop into this group and found this helpful. Agendas for supervision included workload, caseload, professional studies, training, risk, safeguarding, staff management and areas for improvement. We reviewed 30 supervision records, 23 of these recorded supervision at least every 2 months. Salford EIT were not achieving this target, staff were receiving supervision approximately every four months.

Data provided by the trust showed an average of 67% across all community teams for adults of working age achieved the target of six supervisions per year.

Staff told us and records confirmed that staff had received their individual personal development review. Data provided by the trust showed an average of 86% of community staff had received their annual personal development review.

All teams had regular team meetings, usually on a monthly basis and topics included information management, professional updates, health and wellbeing, safeguarding,

Are services effective?

Good

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

policies and procedures and health and safety, learning from incidents and positive feedback. Team meeting minutes reviewed also evidenced guest speakers that attended the meetings to raise awareness of relevant services or topics.

Staff were positive about the additional training that they could access including the training at the recovery academy. Several staff within the early intervention teams had received training in behavioural family therapy. Staff accessed training in cognitive behavioural therapy and motivational interviewing. Managers reported accessing leadership training. Staff reported the trust were providing wellbeing sessions in an evening to limit the impact on their working day.

Managers told us and records confirmed that staff performance was addressed individually in supervisions. If the nature of the incident or action was too serious for managers to manage locally, managers implemented the disciplinary policy. Team managers had managed four staff under the disciplinary policy within the community services from February 2015 to February 2016.

Multi-disciplinary and inter-agency team work

Multidisciplinary meetings took place at least once a week within the teams. Salford and Trafford held zoning meetings daily. Zoning was a whole-team approach to individuals using the service, enabling a targeted clinical response that could adapt quickly to changes in needs and risk. It encompassed a traffic light system whereby staff placed people using the service in different zones dependent on level of need and risk, which determined the type of interventions staff offer. The aim of zoning was to provide a team approach to care which enabled shared casework and risk management. All meetings had representatives from all disciplines within the teams. We observed six MDTs including zoning meetings. Meetings incorporated discussions in relation to the Mental Health Act and safeguarding concerns. Staff had extensive knowledge of people who used the service and were able to provide a clear rationale for stepping people who used the service up or down within the zones.

We attended a complex case meeting which had representatives from different teams and disciplines, we saw evidence of the care coordinator maintaining contact whilst the individual was an inpatient. There was clear joint working and information sharing between the community team and home based treatment service to provide as holistic and comprehensive support package as possible. Their focus was on the least restrictive option of avoiding a further hospital admission and explored positive risk taking.

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

Training in the MHA is not mandatory within the trust. Staff attendance at the training was an average of 19% across the community teams. The training had just become an eLearning course, which made it easier for staff to access. Managers told us that they had accessed in house training recently from the clinical lead.

Staff we spoke to were able to explain their role in relation to the MHA including their requirements for people on a CTO, they had been involved in writing reports for tribunals. The consultant psychiatrists reviewed all people on a CTO to monitor their mental state.

There were approved mental health practitioners (AMHP) within the majority of the teams who were knowledgeable about the MHA and their role in regards to assessing people under the Act. Teams who did not have an AMHP on the team were aware of the process to arrange for a MHA assessment.

Staff were aware of the Independent Mental Health Act advocacy service and how this could be accessed.

Records we reviewed for people on a CTO had followed the legal process for renewal of CTO; staff had accurately evidenced and recorded the process and decision. There was evidence that people had had their rights explained to them.

The trust had a central MHA administrator that staff could access for support if required.

Good practice in applying the Mental Capacity Act

Training in relation to the Mental Capacity Act (MCA) was not mandatory. Across the community teams, attendance at MCA training was 36%. However, staff we spoke to had an understanding of the five principles including awareness that capacity is decision specific. Staff were aware of the Mental Capacity Act policy and could access this via the intranet. Staff were able to explain how they assess capacity and record this.

Are services effective?

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The initial assessment tool had a section on capacity and records we reviewed included assessments of people's capacity. A best interest assessor within Salford EIT was involved in the capacity assessments of complex individuals.

Staff reported being involved in best interest meetings for individuals. Staff had attended best interests meetings in relation to dialysis for an individual, an individual's ability to manage their finances and the decision-making ability in relation to where people lived. The Trafford team had a borough specific form that staff completed for capacity assessments; once completed, staff uploaded the form to the computerised record system. Records confirmed that best interest meetings took place.

Staff were aware of the Independent Mental Capacity Advocacy (IMCA) service and records confirmed that staff had referred individuals to the IMCA service.

Good

Are services caring?

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

Our findings

Kindness, dignity, respect and support

We spoke to 20 people who were using the service, shadowed six home visits, observed three group activities and received 30 completed comments cards. People we spoke to reported staff treated them with respect, were polite, kind, friendly, and caring and staff were interested in them. Staff were helpful and people reported staff always listened to them.

Observations of staff interacting with individuals was positive, staff knew the support needs of people who use the service, including historic events, relapse triggers and risks. Staff had a clear plan of the sessions with people who use the service and individuals were aware of the focus of the sessions. Staff were reassuring and encouraging to individuals to be open and honest and share how they were currently feeling. Staff explored topics with people who use the service in a respectful and nurturing manner. Within the sessions, staff shared the progress made in their recovery and offered additional support to individuals if their mental state was deteriorating. Staff advised individuals to phone them if they needed support between their visits. Sessions were summarised by the care coordinator with the individual at the end of the visit and next steps agreed.

Feedback from 22 comment cards was positive, included staff were caring, they listen to you and do not judge you. Staff were understanding and people who use the service felt able to talk to staff, as they knew the information they shared was confidential and staff respected their confidentiality.

The involvement of people in the care that they receive

Of the 12 people asked about care plans, nine individuals told us they were involved in the creation of their care plan. Three people reported their family were involved in the process too. Two people had received a copy of their care plan.

Another person reported feeling in control of their care and treatment and fully involved in the planning of their care. In addition, two individuals reported staff had incorporated their views in relation to medication into their care plan.

One person who used the service reported their care coordinator shared their care plan with them to agree it, however, they did not feel involved in the creation of the care plan. Two people were waiting for copies of their care plans.

One person who used the service reported not having a care plan or being involved in the process.

People reported receiving information regarding their care and treatment and felt this was helpful with their understanding of what was happening and being involved in decision making regarding their treatment. We observed, on two home visits, staff ensuring individuals had contact numbers and their crisis plan was current with strategies in place and numbers to contact for assistance.

Within the recovery group we observed, staff were encouraging people who use the service to participate, they were welcoming and knowledgeable of their likes and preferences and tailored the scenarios and examples accordingly to generate interest from individuals.

People using the service reported it was a joint agreement between themselves and their care coordinator as to whether additional support was required. People reported staff had helped them to understand their mental health needs.

The early intervention teams (EIT) facilitated friends and family groups to raise awareness of psychosis and associated topics. Staff sent flyers to families and made contact via phone to ascertain people's level of interest and times of day that would be most convenient. The people receiving care from the team were also welcome to attend. People who receive support from the EIT were also involved in the creation of a short psychosis film to raise awareness of first episode of psychosis, including how experiencing psychosis feels and what support is available.

The trust had a carer's strategy, which will run from 2015 to 2019, which refers to the Care Act 2014. The trust had carer champion support workers, there was one based within each of the bases we visited. Carers were encouraged to attend the training offered by the recovery academy to raise awareness of topics relating to mental health.

Good

Are services caring?

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

At assessments of new referrals staff identify if carers are involved with an individual and if so, they provide a carers pack which included information about the trust, how to contact the team and a referral form to have a carers assessment completed.

Records confirmed people accessed advocacy; of the people asked about advocacy, they confirmed they did have access to the service.

The trust had held have your say events in Bolton and Trafford to enable people to give their views on the service they receive. Questionnaires in relation to giving feedback regarding their support were available in all community bases. There were people attending steering groups who had experience of using the services.

People who use the services were involved in the recruitment and selection of staff and the facilitation of training courses at the recovery academy. Staff had also attended training at the recovery academy alongside people who they were care coordinator for and enabled individuals to attend.

Services users were encouraged to complete recovery questionnaires at the point of discharge from the service at Bolton.

Are services responsive to people's needs?

Good

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

Our findings

Access and discharge

The CMHT had a set target for assessing new referrals. The target was for staff to assess emergency referrals within 24 hours, urgent referrals within five working days and routine referrals within 20 working days. Records showed that the trust was meeting these targets and people were receiving care when they needed it. The CMHT had two people on duty at any time to enable staff to achieve the target of assessing emergency referrals within the timescale. Data from the trust for six months, from August 2015 to January 2016 reported Bolton had 673 referrals; the average wait for an assessment was 21 days; from assessment to allocation of care coordinator, the average wait was 11 days. Salford CMHT had 526 referrals, the average wait for an assessment was 19 days and the average wait from assessment to allocation of care coordinator was 15 days. Trafford had 214 referrals, the average wait for an assessment was 16 days and the average wait from assessment to allocation of care coordinator was 15 days.

The early intervention teams (EIT) reviewed the changes in National Institute for Health and Care Excellence (NICE) guidance in relation to timescale from referral to assessment and allocation of a care coordinator for a person presenting with first episode psychosis. The guidance states a 2-week timescale; they submitted a business case and in negotiation with their commissioners all three EIT received additional funding for new posts to meet the referral to assessment timescale. Data from the trust for six months, from August 2015 to January 2016 reported Bolton EIT received 52 referrals and from referral to assessment and allocation of a care coordinator was an average of 10 days. Salford received 44 referrals and from referral to assessment, their average wait was 13 days and from assessment to allocation of care coordinator the average wait was 20 days. Trafford received 40 referrals, the average wait for an assessment was nine days, and the average wait for allocation of a care coordinator from assessment was seven days.

Staff on duty would talk to people who use the service and offer support if an individual's care coordinator were off or unavailable. An out of hours telephone helpline was available to people using the service, if a person telephoned the helpline the person they spoke to would email their care coordinator, duty officer and manager of the team to ensure they were aware and could follow up with additional support if required.

The trust had a clear eligibility criteria for the teams, highlighting the three pathways that an individual could follow including; personality disorder, psychosis and non-psychosis. The eligibility criteria also included non-inclusion criteria, which included people with an organic mental health need; the older people's mental health services would support these individuals. The operational policies included the definition of people requiring an assertive outreach intervention, those individuals who find it difficult to engage in services. Teams provided support to this group of people in an early evening and at the weekend.

Core hours of the teams were Monday to Friday 9am to 5pm, however staff provided support in the early evening where needed and there were two practitioners in each borough that worked on a Saturday and a Sunday and provided planned interventions. Teams could request visits from the weekend staff for an individual on their caseload, they would state the aim of the session, and specific risk, and provide a summary via the electronic recording system and the plans would be finalised on the Friday prior to the weekend.

We observed a care coordinator ringing an individual and their family to apologise for having to cancel a visit and rearranging the visit for a mutually convenient time.

Care plans we reviewed did not include discharge plans and individuals who used the service we spoke to were not clear of their plans with the aim of discharge.

The facilities promote recovery, comfort, dignity and confidentiality

All of the venues where individuals had appointments were clean and well maintained. The meeting rooms were on the ground floor with access for people with mobility difficulties. There were accessible toilets in the waiting areas. There were suggestion boxes for people to give feedback in the reception areas.

Ramsgate House had books in reception for people to take or borrow and a variety of leaflets and other information on

Are services responsive to people's needs?

Good

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

notice boards including activities available and people's rights. Current information on medication was available for people who use the service. Rooms had adequate soundproofing.

Bentley House had leaflets available and information on nice boards including information on healthy lifestyles, medication, treatment and mental health conditions, carer support, activities available. Some of the interview rooms at Bentley House had poor soundproofing and there was a sign displayed that advised this.

There were no information leaflets on display in other languages or large print; however, staff could provide these if required. Bentley House had a large folder with information leaflets on mental health needs, medication and treatment in a variety of languages that the service had created in conjunction with a local service and staff could photocopy these when required.

The service kept an interview room free at each of the venues to allow staff to see people urgently.

Salford and Trafford EIT and Trafford North and West teams did not have meeting rooms available within their buildings. Staff conducted appointments either at people's own homes or at local community facilities including GP practices, community centres and venues that were convenient to people who use the service.

The clinic rooms were clean, well presented and provided adequate space for examinations to take place. Leaflets were available within the clinic room at Ramsgate house in relation to medication and treatment.

Meeting the needs of all people who use the service

Meeting rooms were on the ground floor, there was a buzzer at the door for staff to open the door for individuals and there were accessible toilets available for people.

Teams had access to interpreters and we observed this service in use for one of the home visits we attended.

Staff had tried to network with local faith communities to raise awareness of cultural expectations, and the signs of mental illness that they could be aware of and be alert to. Staff were aware of different religious holidays and celebrations and would plan their support around these events.

Bolton had team members who spoke Urdu, Punjabi and Gujarati. Staff had made links with local services that provided support for people with different needs including people experiencing domestic violence.

Bolton had a file with resources and guidance written by the Royal College of Psychiatrists translated into 11 different languages that staff could photocopy as required.

Trafford had made links with the black and minority ethnic (BME) team in Trafford who provided mental health advocacy to people from different ethnic backgrounds. They had also met with the Pakistani resource centre to raise awareness of cultural needs and mental health needs.

Listening to and learning from concerns and complaints

Data provided by the trust showed there had had been 80 complaints across all the CMHT and EIT in the trust over the last 12 months. Ten of the complaints were fully upheld, 20 were partially upheld and four were referred to the ombudsman (one upheld).

People using the service we spoke to did not know how to complain about the service, the information leaflets about the EIT did not contain information regarding the complaint process.

Staff reported that the majority of the complaints were resolved locally; the trust customer care policy dated July 2012 states that for concerns received by the team that are resolved by the end of the next working day consideration should be given to logging them locally. Managers reported that they logged them within the progress notes of people who use the service.

Complaints made to the customer care team were recorded on the electronic incident system and rated from level one to five dependant on the seriousness of the impact. The customer care team then allocated an investigating officer, trained in investigating complaints. Staff confirmed they received results and the outcome, and any actions are communicated to the complainant in writing and recorded on the electronic incident system, then any learning shared with the team.

Changes in practice had occurred as a result of complaints. We saw evidence of letters being sent out to people using the service to advise if their worker was temporary, or to prepare them that they will have a change of care coordinator in the future. There had also been phone calls

Are services responsive to people's needs?

Good

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

to advise of changes in workers which were recorded within the progress notes. Staff supervision records also captured learning from complaints in relation to team member's practice, which managers discussed within supervision. Complaints were on the agenda at team meetings at Bolton South.

The community teams in the trust had received 25 compliments in the last 12 months. The teams encouraged feedback via suggestion boxes, posters advertising how to give feedback in waiting rooms and at the have your say events.

Are services well-led?

Good

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

Our findings

Vision and values

Staff were aware of the trusts values. Teams had away days to plan and create aims as a team.

The early intervention teams (EIT) had a steering group, which met monthly and included team managers, service managers and lead professionals in the field of EI. Meetings were held monthly and minutes confirmed that they shared good practice, service developments, commissioning for quality and innovation (CQUINs) targets and challenges with the aim of providing consistency across the three boroughs. The EITs were involved in AQuA (advancing quality alliance). AQuA's aim is to "improve standards of healthcare provided in hospitals and clinical commissioning groups across the northwest of England, so that more patients have a better outcome from their treatments." AQuA focus on several areas of healthcare, first episode of psychosis being one. Staff had attended development events and reported feeling up to date with changes within EIT. Members of the steering group developed a training programme to provide staff with a comprehensive training package relevant to the field of EI.

Staff were able to identify who senior staff were. Service managers and community teams were together within the same building at Bolton. Senior managers at Salford and Trafford visited the teams regularly and had attended team meetings. Staff reported senior managers were approachable and supportive.

Good governance

Managers meeting were held in each of the boroughs, minutes confirmed the topics discussed were disseminating information from senior meetings to team managers and having the opportunity to discuss management issues including staffing, complaints and learning from incidents, policies and training and sharing an update of the teams.

The trust received commissioner reports monthly for each of the boroughs. NHS Monitor targets that the trust were assessed against in community were CPA 7 Day Follow Up, Completed CPA, and Psychosis Early Intervention referrals accepted. Feedback from commissioners and progress against targets including CQUINs were on the agenda of community managers meetings. Administration team members processed information with targets of copying letters to GPs within 10 days, making carer contact and providing carer assessment information within 10 days, and CPA forward planning for booking dates at 10 months. Reports from commissioners in December 2015 showed the trust were meeting the community targets for CPA 7 day follow up and competed CPA meetings and acceptance of referrals to the early intervention teams (EIT). The commissioners noted that the increase in staff within EIT had a positive impact on referrals accepted.

Team managers were aware of the trust risk register and had submitted items to the risk register, including the phone system at Ramsgate House.

Mandatory training attendance was low for BLS; mandatory training was on the trust's board assurance framework as a key priority for improvement.

Leadership, morale and staff engagement

Sickness absence rates across the teams we visited averaged 5.8%; the average across all of the community teams was 4.6%. Managers reported that if staff were off on long term sick they could employ agency staff.

Collated results for the Bolton recovery survey showed 82% would recommend the service and 82% of people surveyed felt well enough for discharge from the service. Of the people discharged 71% reported receiving information about their medication, 23% reported receiving their care plan and 6% reported receiving information about their condition. Of people given information, 94% of them said the information was helpful.

There had been two grievances received from the community teams for adults of working age by the trust. One went to a grievance hearing and the trust upheld the grievance. One was resolved locally with a senior manager.

Staff we spoke to were aware of the whistleblowing policy. Staff reported feeling able to raise concerns with their managers. Staff reported feeling valued and supported by their teams. Staff reported morale was good in the team, particularly as there had been increased investment in the EIT to increase the size of the team and recruitment was well underway.

Several staff we spoke to had worked for the trust for over 10 years, within that time they had progressed and been successful in promotion. They reported the trust invested in staff including leadership training.

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.

Managers gave examples where they apologised to people receiving the service and their family when things had gone wrong, errors included communication and pathways between services.

Commitment to quality improvement and innovation

The EIT were involved in the Early Intervention in Psychosis (EIP) benchmarking exercise, which summarises work undertaken across England to explore the First Episode Psychosis (FEP) pathways. The report addresses issues around service capacity, training and skills and new waiting time targets for FEP. The trust received the report from the NHS Benchmarking Network in February 2016 and they scored above the average in the completed analysis reports.

Teams encouraged individuals to be involved in the psychosis research unit; recent research projects included the compare study where participants engaged in cognitive behavioural therapy (CBT) or medication and CBT. Records confirmed the research unit offered people the opportunity and accepted them onto the research projects. Staff discussed research opportunities at the EIT steering group.

Staff discussed changes in practice and improvements in practice at the EIT steering group, which managers attended and then shared the findings with their teams including increases in medication and the need for more physical health interventions.