Good

Greater Manchester West Mental Health NHS Foundation Trust

Community-based mental health services for older people

Quality Report

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Date of inspection visit: 11th 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 Foundation Trust Headquarters	Salford Older Adults Community Mental Health Team	M27 5WW

This report describes our judgement of the quality of care provided within this core service by Greater Manchester West. 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 and these are brought together to inform our overall judgement of Greater Manchester West.

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 older adults as good because:

- Safe

Teams had sufficient staff to meet patients' needs. Staff vacancies were being recruited into quickly. Staff reported that complexity of caseloads were reviewed in supervision to ensure equity. Team caseloads were at a manageable level. There were good lone working practices in the team and trust policy was followed. Staff knew about duty of candour. Patients had a crisis contingency plan in place in their care plan and staff knew how to respond to deterioration in a patients' physical or mental health. Staff had a good understanding of safeguarding processes and knew their responsibilities to protect patients from possible risk of abuse and harm. Staff showed a good understanding of incident reporting and there was good reporting of incidents.

- Effective

Staff attended a multidisciplinary group to review and problem solve complex cases, provide plans and anticipate care needs for those using health and social care services. There was a psychology team who provided input to patients, carers and staff. Care plans were holistic and person-centred. There was a staff development group who had protected time to meet on a monthly basis to undertake internal training. There were developments around the emphasis on physical health with some staff receiving specific training to support this. There was evidence of good inter-agency and multidisciplinary working.

- Caring

Staff treated patients who used the service with kindness, dignity and respect. Staff demonstrated warmth and compassion in their interactions with patients and their carers. Staff involved patients and their carers in decisions about their care.

- Responsive

There were five clinical pathways which gave clear and consistent support to patients. Patients reported that staff were flexible in their approach and quick to return phone calls. The service opened at weekends with reduced staffing in order to ensure flexibility and continuity of care. There was a duty system in place that ensured any urgent issues were dealt with in a timely manner. There were low numbers of complaints.

- Well-led

Staff were aware of trust values. Staff told us that managers listened and they felt valued and supported. Supervision and appraisal were comprehensive and up to date. Clinical audits were regularly undertaken. Staff morale had improved since managers had become established in their role.

However

- Mandatory training in basic life support was significantly below the trust target of 85% and below 75% for infection control.
- Compliance with mandatory training across all teams was lower than the trusts' target of 85%.
- Training levels in the Mental Capacity Act and Mental Health Act were both significantly low.
- The rights of patients subject to community treatment orders were not always being met. Patients were not referred to an independent mental health advocate after being placed on a community treatment order and their capacity to consent was not always recorded.
- Carers were not always offered a carers assessment to ensure their needs were being met.
- Patients were not always offered a copy of their care plan or given the opportunity to develop advanced statements about their care with staff.

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:

- There were enough staff in the older adults team to ensure that patients received appropriate support.
- Staff reported that complexity of caseload was reviewed in supervision to ensure equity.
- There were good lone working practices in the team and trust policy was followed.
- Staff we spoke to knew about duty of candour and had used this in their practice.
- Staff vacancies were well managed and there was active recruitment of these vacancies.
- Team caseloads were at a manageable level and were discussed in individual supervision.
- Staff and patients reported quick access to psychiatry.
- Staff undertook a risk assessment of patients' needs on initial assessment and at regular intervals throughout their care and treatment.
- Patients had a crisis contingency plan in place in their care plan and staff knew how to respond to deterioration in a patients physical or mental health.
- Staff had a good understanding of safeguarding processes and knew their responsibilities to protect patients from the possible risk of abuse and harm.
- Staff showed a good understanding of incident reporting and reported incidents when necessary.

However

- Compliance with mandatory training in basic life support was significantly below the trust target of 85% and below 75% for infection control level three.
- Compliance with mandatory training across all older adults teams was lower than the trust target of 85%.

Are services effective?

Good

We rated effective as good because:

- Staff attended a multidisciplinary group (MDG) to review and problem solve complex cases, provide plans and anticipate care needs for those using health and social care services. Patients could be referred directly into the older adults team from the MDG.

Summary of findings

- There was a psychology team who provided input to patients, carers and staff.
- Care plans were holistic, recovery oriented and person-centred.
- There was a staff development group which had protected time to meet on a monthly basis to undertake internal training.
- There were developments around the emphasis on physical health- five support workers had been trained in venipuncture, a support time and recovery worker had been trained in electrocardiogram.
- There was evidence of good inter-agency and multidisciplinary working.

However

- Training levels in the Mental Capacity Act and Mental Health Act were both low.
- The rights of patients subject to community treatment orders were not always being met. Patients were not referred to an independent mental health advocate after being placed on a community treatment order and their capacity to consent was not always recorded.
- Not all patients were given a copy of their care plan.
- Staff did not always offer carers assessments to carers.

Are services caring?

Good

We rated caring as good because:

- Staff treated patients with kindness, dignity and respect.
- Staff demonstrated warmth and compassion in their interactions with patients and carers.
- Staff involved patients and their carers in decisions about their care.

Are services responsive to people's needs?

Good

We rated responsive as good because:

- Patients were contacted quickly after initial referral and triage. They could be contacted on the same day if there was an urgent need.
- There were five clinical pathways which gave clear and consistent support to patients.
- Patients reported that staff were flexible in their approach to appointment times and quick to return phone calls.
- The service opened at weekends with reduced staffing in order to ensure flexibility and continuity of care.
- There was a duty system in place that ensured any urgent issues were dealt with in a timely manner.

Summary of findings

- There were low numbers of complaints. Feedback from complaints was discussed in team meetings and business meetings.

Are services well-led?

Good

We rated well-led as good because:

- Staff were aware of the trust values.
- Staff morale had improved since managers had become established in their role.
- Staff told us that managers listened and they felt valued and supported.
- There were good links with the local university who undertook research and development projects in the service.
- Supervision and appraisal were comprehensive and up to date.
- Clinical audits were regularly undertaken

Summary of findings

Information about the service

The Greater Manchester West Mental Health Foundation Trust provided a range of community based mental health services. During our inspection we visited one of the three community mental health services for older people. The three teams were based in Bolton, Salford and Trafford. We inspected the Salford older adults mental health team on the 11 February 2016.The team we inspected was based at Humphrey Booth Resource Centre.

Most appointments were carried out in the patients' homes. This was beneficial for those who had mobility, transport or other difficulties in attending appointments. Some patients and their carers had asked for appointments to be away from their home and a clinic had been set up at the nearby mental health unit to facilitate this.

The teams were made up of staff from multiple healthcare disciplines who provided mental health assessments, treatment, rehabilitation and support for patients primarily aged 70 and over who had range of mental health conditions including depression, schizophrenia, bipolar disorder, psychosis and organic disorders such as dementia. The teams undertook initial assessments to understand how they could meet patients' 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, social workers and an occupational therapist.

Most referrals came from GPs but the teams accepted referrals from wards and liaison psychiatry as well. A single point of access operated and there was a duty system for referrals to enable them to be triaged appropriately.

Post diagnostic support was available for patients with dementia and their carers. Patients had access to and input from clinical psychologists as recommended by the National Institute for Health and Care Excellence.

The service monitored patients' mental health and planned interventions to prevent relapse. Crisis plans were also in place in the event of a deterioration in mental health. Staff promoted independence and rehabilitation of social skills by supporting and encouraging patients to access and be involved with local services.

Our inspection team

The team was comprised of:

Chair: Dr Peter Jarrett

Head of Inspection: Nicholas Smith, Care Quality Commission

Team Leader: Sarah Dunnett, Inspection Manager Care Quality Commission

The team that inspected the community-based mental health services for older people included two CQC inspectors, three specialist advisors who were all mental health nurses, one Mental Health Act reviewer and one expert by experience. An expert by experience is someone who has gained expertise through using services or through contact with someone who has used them – for example, as a carer.

Why we carried out this inspection

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

Summary of findings

How we carried out this inspection

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

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

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

We carried out an announced visit on 11 February 2016 visiting:

Salford Older Adults Community Mental Health Team.

During the inspection visit, the inspection team:

- spoke with three patients
- spoke with five carers
- spoke with the team manager
- spoke with 20 other staff members; including psychiatrists, psychologists, nurses, social workers and administrative staff
- attended and observed three home visits
- attended and observed one multidisciplinary meeting
- attended and observed one multidisciplinary group meeting

We also:

- collected feedback from 14 patients using comment cards.
- Looked at 16 care records of patients
- Carried out a mental health act review
- 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 received 14 comment cards about patients' experience of community based mental health services for older people. All of these stated that the service was good and the staff were caring and compassionate. We spoke to three patients and five carers who were all positive about the service. They told us that staff were warm and flexible in their approach.

Good practice

We found good practice in the following areas:

There was a multidisciplinary group (MDG) attended by staff from the team. This was a group of professionals from both mental health and physical health backgrounds. The focus of the MDG was to review and problem solve complex cases, provide plans and anticipate care needs for those using health and social care services. Potential referrals for the community mental health team were discussed at this group and brought back to the team to promote timely intervention and treatment.

The service was involved in enabling patients to take part in research projects and had close links with the local university. Research undertaken was used to further advance knowledge of functional and organic disorders. Current research projects included young onset dementia, combined treatments in adults with psychosis and the influence of expressed emotion on dementia sufferers adjustment.

Summary of findings

Areas for improvement

Action the provider SHOULD take to improve

Action the provider SHOULD take to improve

- The trust should ensure that all staff receive mandatory training in basic life support and infection control.
- The trust should ensure that patients are informed of their rights at regular intervals throughout their community treatment order (CTO).
- The trust should ensure that all those on a CTO are referred to an independent mental health advocate.
- The trust should ensure that all staff have training in the Mental Health Act and Mental Capacity Act.
- The trust should ensure that carers are offered a carers assessment in line with best practice guidance.
- The trust should ensure that all patients are offered a copy of their care plan.

Greater Manchester West Mental Health 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
Salford Older Adults Community Mental Health Team	Greater Manchester West Mental Health NHS Foundation 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.

- Training in the Mental Health Act (MHA) was not mandatory. Training levels were at 10% across all older adults community teams however staff had a good knowledge of the MHA and there were staff in the who had specialist knowledge of the MHA.
- Section 132 rights under the MHA were not provided to two patients who were or had been under a community treatment order (CTO) at timely intervals through their CTO.
- Second opinion appointed doctor (SOAD) certification for the CTO was not updated for one patient who had been on a CTO.There was a time delay of up to eight weeks between the responsible clinician extending one CTO and MHA hospital managers reviewing the extension.
- There were missing detention documents in one of the CTO documents we viewed.
- We could not find evidence that patients on a CTO had been referred to an independent mental health advocate although staff told us that patients had been.

Detailed findings

Mental Capacity Act and Deprivation of Liberty Safeguards

- The trust attendance for Mental Capacity Act (MCA) training was 48%, however staff had a good understanding of capacity issues. There had been recent MCA, Deprivation of liberty safeguards refresher training completed in a team meeting.
- MCA assessments completed by the team were appropriate and there was evidence of the consideration of mental capacity in daily notes.
- There were best interest assessors in the team and we saw meetings where decisions were made around a patients' residential accommodation.
- Capacity to consent to interventions were not routinely assessed although community psychiatric nurses recorded consent at administration of depot.

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

The team had no facility for patients who used the service or their carers to attend the team base at Humphrey Booth Resource Centre. Most appointments were carried out in the patients' homes and this was beneficial for those who had mobility, transport or other difficulties in attending appointments. Some patients and their carers had specifically asked for appointments to be away from their home and in response a clinic had been set up on a weekly basis at the nearby mental health unit to facilitate this. Interview rooms could be booked at any time to enable patients to be seen away from their home. All areas of the mental health unit were clean and well maintained.

Safe staffing

There were 25 substantive staff posts in the Salford team up to December 2015. There had been five staff leavers over the past 12 months. Turnover was 20% and total vacancies were 18%. One full-time band five post had been lost because of efficiency savings in the trust. Staff sickness was 11% over the past 12 months. This was above the national average of 5%. Three staff were allowed to take leave at any one time and at a minimum there was always a manager, administrative staff, social worker, occupational therapist and nurses on duty. At the time of the inspection, there was one member of staff on long-term sickness but this post was being covered by an agency nurse. There were two vacancies for qualified nurses, however one of these had already been appointed to and was waiting for relevant documents to be finalised, while the other post had been advertised and shortlisted. Cover arrangements for sickness, leave and vacant posts were dealt with by the team manager who managed the rota. The team manager had initially been on a six month secondment but this had been extended by another year from March 2016.

Individual caseloads were reviewed during supervision. An average caseload for full time nursing staff was 30. During supervision caseloads and complexity were reviewed and workload agreed with the care coordinator and their supervisor. This would be dependent on how many hours staff worked per week. A social worker would be expected to have around 25 cases because of other commitments in their role such as undertaking work as an approved mental health professional (AMHP) and commissioning. Senior practitioners who worked full time hours but had some managerial responsibilities had an average of 15 cases. Caseload levels could be reduced in order to support clinicians if they had more complex cases or if they were stressed or under performing and required extra support or guidance. They could also be increased if cases were routine or one off assessments were to be completed.

Both staff and carers reported there was timely access to a psychiatrist when needed. There were two full- time consultant psychiatrists based with the team who covered for each other when on leave or sick.

The courses identified by the trust as mandatory were basic life support (BLS), equality and diversity, fire safety, immediate life support, infection control, information governance, safeguarding adults and safeguarding children. The average mandatory training compliance rate for staff in older adults' community mental health services was 73%. Trust data showed that training for the team we inspected was 53% for BLS, 70% for infection control level 3 and 81% for safeguarding adults, which fell below the trust target of 85%. However, staff demonstrated a good knowledge of safeguarding. The trust had recently introduced eLearning for staff but the staff we spoke to said that eLearning was difficult to accomplish during working hours as there was no protected time to undertake this.

Assessing and managing risk to patients and staff

During our inspection the team looked at 16 care records. All of these had risk assessments completed upon initial assessment and an up to date current risk assessment. The trust's own clinical assessment tool was used, the Standard Tool for the Assessment of Risk, version two (STAR v2). This tool was used to assess risks such as risk to self or other people and included information on historical and present risk. Personal strengths and protective factors were also identified.

There was a crisis plan contained in the standard care plan in the electronic recording system for the trust. All of the crisis plans viewed had good contingency planning in the event of a deterioration in a patients' mental health. The

Good

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team were able to respond promptly to this by stepping up care to the clinical pathway one which was the high intensity pathway. This offered intensive support for patients and their carers up to three times per day.

We did not see any examples of the use of advanced statements in the care records we looked at. This meant that patients who used the service may not have been able to give specific instructions regarding future medical and healthcare in the event of losing capacity to make those decisions.

The staff we spoke to demonstrated they knew how to make a safeguarding alert when appropriate. The safeguarding system is a preventative measure and response system to enable patients to live their lives free from harm, abuse and neglect and to have their health wellbeing and human rights protected. Training levels in safeguarding were below the trust target of 85% at 81%. However, staff had made 26 referrals to the safeguarding team in the past six months which demonstrated that staff knew the protocols for this. The team manager and the senior social worker in the team were responsible for reviewing all safeguarding alerts for both inpatient and community in the trust to see if they had met the threshold for a referral.

There were good lone working protocols in the team and the trust lone working policy was adhered to. We observed that staff recorded visits which included the name and address of the patient they were visiting. Staff were expected to phone in at the end of the day to say they were safe. If they didn't, this was escalated to the team manager who followed the trust lone working policy. All staff were aware of the safe phrase that was used when contacting colleagues to let them know they were in a risky situation. At weekends staff went on joint visits and were able to look at risk assessments on the electronic record system to maximise safety.

We observed that there was a robust system for receiving, storing and monitoring medication with full and accurate records of depot administration and lithium and clozapine monitoring. This had been managed by an advanced practitioner in the team who was on the medicine management committee. They had responsibility for feeding back any medication issues arising from the committee in team meetings or from team meetings to the committee. There had been a recent medication management audit that looked at security/storage of medication, governance, prescriptions, supply and controlled drugs. The audit showed that fridge temperatures were being checked, medicines were in date and stored correctly, that relevant staff knew about policy and procedure and they were aware of how medicines were obtained from pharmacies.

Track record on safety

There were two serious incidents in the last 12 months across all older adults community services. Both were unexpected deaths. There were no serious incidents for Salford Older Adults team.

Reporting incidents and learning from when things go wrong

The staff we spoke to reported that they knew how to report incidents through the trust incident reporting system and this was reflected in the number of incidents reported by the team. From January to December 2015, the trust reported 135 incidents for all community mental health services for older people. The highest incidence rates were deaths at 27, information governance at 22 and systems and equipment at 18. Salford Older Adults community mental health team recorded the highest number of incidents with 44. Of these, nine were deaths, seven of these were expected, seven were incidents related to patient care, six information governance and five medication incidents. Twenty seven of all the incidents reported were deemed to have resulted in no obvious harm.

There were clear processes to follow after a serious incident. An incident report would be completed via the trust incident reporting system where the team manager would action it. A three day review would then take place for all high level incidents followed by a root cause analysis. This would enable the root causes and contributory factors to be identified so that the trust could learn from the experience and mitigate future occurrences. Outcomes of investigations were used to improve patient safety, effectiveness of care and ultimately enhance patient experience.

There was good understanding of duty of candour and staff were able to explain the need for openness and transparency when dealing with an incident. Staff had recently completed training on duty of candour and this was demonstrated in their level of understanding.

Good

Are services safe?

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Staff were de-briefed immediately after an incident and there was another de-brief at intervals after this to ensure the wellbeing of staff. Staff were given feedback from lessons learned in team meetings and business meetings. We observed a standing agenda item in the business meeting minutes that demonstrated the ongoing nature of discussions and learning around incidents. An example of these discussions in a recent business meeting was that of a communication incident. Feedback had been given to the team with regard to how to minimise this incident reoccurring.

The trust produced a lessons learned newsletter on a quarterly basis to enable the sharing of information to continue in a positive way across all services.

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 Manchester Care Assessment Schedule (MANCAS) tool was used to inform the care needs of patients who used the service. This was a 20 item generic screening tool for mental health needs. It focused on the 'vulnerability', 'precipitating' and 'maintaining' factors of mental illness. The assessment included information about social factors including housing, income and substance misuse in addition to physical and mental health needs. Once completed the assessment was uploaded to the care records system in a timely manner.

We looked at 16 care records and all had an up to date care plan. Of these, 15 were holistic with one currently being completed and 14 were recovery orientated with one currently being completed. We found that all care plans were personalised, however five care plans were completed without the patient due to the advanced nature of their condition. Staff explained they found the templates for care plans on the new electronic recording system did not meet the needs of some of the patients who used the service as all sections of the care plan had to be written in the first person which was not always possible. In these cases staff completed care plans in the third person with little or no involvement from the patient although they did involve carers were appropriate. Where a patient was not involved in care planning this was always indicated in the care plan.

Six out of the 16 care records indicated that patients had been given a copy of their care plan, three had refused a copy and one patient had just entered the service. The other six patients had not been given a copy of their care plan. This was reflected when we spoke to patients and their carers, three of eight stated they had not received a care plan. The service was aware of this issue and had put systems in place to improve it which included the use of audit to monitor compliance. A care plan audit of older adults inpatient and community services had very recently been undertaken by central nursing and matrons to monitor compliance, the data from this had not been analysed at the time of our inspection.

Staff told us the implementation of the new electronic recording system had caused some issues in finding documents. They told us that although the trust had rolled out training in February 2015, the system had not gone live until September 2015. The trust had recognised that there had been issues and members of the implementation team had gone to the Salford team in order to hear these concerns so they could be fed back to the information technology team.

Social services staff used a separate electronic system to record social work activity. All administration staff in the service had access and were trained to navigate and upload documents to ensure transfer of information between the two systems.Social workers in the team also had access to the system and were available to support the team in gathering information if required. All staff were able to access the trusts electronic recording system.

All confidential papers were locked away in filing cabinets at the end of each day and any confidential papers to be disposed of were placed in a confidential waste bin.

Best practice in treatment and care

The team manager attended the clinical audit and National Institute for Health and Care Excellence (NICE) group meeting. NICE guidelines are evidence-based recommendations for health and care in England. At this meeting, all relevant NICE guidelines were discussed and action plans for teams were produced. We saw recent discussions around NICE guidance including;

- home care: delivering personal care and practical support to older patients living in their own homes
- quality standards for bi-polar in adults and
- personality disorder

Older people with social care needs and multiple long term conditions was scheduled to be discussed in February 2016. In addition, recent clinical audits were discussed and analysed with a focus on areas for improvement.

Patients had access to psychological input. We spoke with a clinical psychologist during the inspection. Dementia: supporting people with dementia and their carers in health and social care suggests that cognitive behavioural therapy may be considered as part of treatment for people with dementia and comorbid emotional disorders. The psychologists identified the types of therapy offered to patients as cognitive behavioural therapy (CBT) which focusses on the connection between a person's thoughts, feelings and behaviours. The team were actively involved in

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the local action plan regarding the National Audit of Schizophrenia. CBT training was being actively sought for staff but there had been some delays in this outside of the teams' control.

Staff could access a rapid formulation group on a weekly basis facilitated by the clinical psychologists. There was a psychology resources folder held on the shared computer drive that all staff could access.

Staff had been trained in the Newcastle model of behavioural and psychological symptoms of dementia (BPSD). The model used formulation and assessment to help treat challenging behaviour in the settings in which they were being exhibited. The model used a person-centred approach in addition to medication if appropriate. Its aims were to;

- work collaboratively with care facilities to improve the wellbeing of patients in care
- to prevent unnecessary admissions to hospital
- to facilitate effective discharges from hospital to appropriate care settings and
- to facilitate transfers of patients to appropriate care settings.

Annual health checks were currently GP led including appropriate blood and ECG monitoring for patients on long term depots. There was a six monthly joint community psychiatric nurse and medical review including the completion of a side effects questionnaire.

Staff were completing the health of the nation outcomes scale (HONOS) which measures the health and social functioning of patients with severe mental illness. They were designed to be used by clinicians before and after interventions, so that changes attributable to the interventions (outcomes) could be measured.

Staff took part in clinical audit and we saw recent examples of audits of medicines management, use of pathway one, clinical supervision, and the use of anti-depressant medication.

Skilled staff to deliver care

The team included and had access to a range of disciplines to support patients. This included managers, nursing staff, a psychologist, psychiatrists, social workers, support workers administrative staff and occupational therapists. They provided a range of therapeutic interventions to support patients' recovery in line with best practice guidance.

Staff we spoke with recognised the benefit of close working in a multidisciplinary setting and all of the staff we spoke to commented that the team were supportive of each other.

As well as mandatory training, the team had identified further training relevant to their work and they were encouraged to develop skills in specialist areas. Managers had been able to access leadership training. Staff had two hours protected time each month that been made available for them to undertake training on a range of subjects. Planned sessions included cognitive assessments, personality disorder, depression and anxiety disorders and models of care. Carers were also invited to speak during these sessions. We saw discussion about additional training noted in supervision records. There were opportunities for secondments and face to face clinical skills training. There were approved mental health professionals (AMHP) in the team and qualified social workers were expected to undertake AMHP training. One social worker in the team was a best interest assessor. All qualified staff had training in the delivery of the Addenbrookes Cognitive Examination (ACE- III), used in the assessment of dementia and other neurological disorders. There was a training budget for funding additional training in the team and staff told us that training monies could also be funded by the 'dragons den' initiative in the trust which funded small innovative projects across all services.

There were developments around the emphasis on physical health. Baseline observations were currently completed by the GP including blood tests and electrocardiogram (ECG), however physical health checks for all referrals were being introduced with support time and recovery workers (STaR) taking a lead role. Five STaR workers had been trained in venipuncture and one STaR worker had been trained in ECG.

Trust data showed that an average of 45% of staff had been given clinical supervision between February 2015 and January 2016 across the service. However only 13% of staff had received clinical supervision in the Salford team we inspected in line with trust policy. However, staff we spoke with about clinical and line management supervision told us they had recently begun receiving regular monthly clinical and line management supervision which they

Are services effective?

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found useful and supportive. We looked at the supervision records of six members of staff and found that all staff had recent supervision. If there had been missed supervision session these were re-arranged by the practitioner. Staff and managers discussed individual performance in supervision and we saw evidence of this in all the records we looked at. Staff told us that managers listened to their issues. The team manager told us that if a member of staff needed extra support this was discussed in supervision with options to look at reducing caseloads, referral to occupational health, counselling, physiotherapy and more regular supervision.

Trust data showed that the percentage of non-medical staff that had an appraisal in the last 12 months was 81%. Five of the six records we looked at had an up to date appraisal, the other record belonged to a new starter to the team.

We looked at six sets of minutes of team meetings that took place each month. They were well structured and gave staff the opportunity to speak about current issues in the team. There was evidence the meetings were used to provide information from the trust and senior managers as well as local issues. Discussion took place around such issues as team performance, training, safeguarding, trust safety alerts and communications, lessons learned and duty of candour. These were well attended although it was not always possible for every member of staff to attend each month.

Staff told us that the team delivered training in older adults mental health issues to other teams, nursing homes, local authority, the local university, adult wards and Age UK. Interventions in dementia, normal ageing and caring for yourself were some of the sessions completed. In 2015, 29 sessions were rolled out and 89 hours were spent training others.

There were no current grievances or disciplinary procedures. We were told that the trust or local authority disciplinary procedure would be followed if this was required.

Multi-disciplinary and inter-agency team work

Multidisciplinary team (MDT) meetings took place twice weekly. We observed one of these team meetings which was led by one of the two psychiatrists in the team. There were a range of disciplines present at the meeting including a community psychiatric nurse, a support time and recovery worker, an occupational therapist and the team manager. Contemporaneous notes were taken to ensure accuracy of discussion and outcomes of the meeting. Members of the MDT talked about five patients who presented with risk issues and to gain advice from the team. We found that the meeting was well-led, well structured with good communication and comprehensive discussions around patients' needs.

We also observed a multidisciplinary group (MDG) whose aims were to help patients aged over 65 in Salford achieve greater independence and improved wellbeing, by integrating care within communities. The group met once per week and was attended by a range of staff including mental health professionals including a senior nurse from the older adults team, a GP, practice nurse/advanced nurse practitioner, a social work advanced practitioner, community nurse, administrator and consultant geriatrician.

The focus of the MDG was to review and problem solve complex cases, provide plans and anticipate care needs for those using health and social care services.

There were indicators that triggered MDG discussion or the completion of a shared care plan and these included:

- Those who lived alone
- Patients showing signs of a low mood, anxiety or depression, or those who were socially isolated
- Older patients who suffered from multiple long term conditions, for example asthma, diabetes, heart disease
- Anyone who had begun to use health and social care services more often such as increased attendance at A&E
- Those who were providing or receiving care

The MDG discussed the patient and different professions offered their advice and services. For example staff at the older adults service offered anxiety management and relaxation techniques to assist a patient who contacted the emergency services when experiencing symptoms of their physical health condition. We found that there was good multidisciplinary working between mental health and physical health staff at the meeting. All staff opinions were listened to and valued and it provided some good alternatives to the use of crisis care services.

Are services effective?

Good

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

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

Data provided by the trust showed that 10% of staff across all older adults teams had attended Mental Health Act (MHA) training. Fifteen percent of staff in the team we inspected had completed training in the MHA. However the staff we spoke to demonstrated that they had a good knowledge of the MHA. This training had recently had been made available as eLearning. MHA training was not mandatory in the trust although we were told that there were plans to make it mandatory.

There was one patient who was currently subject to a community treatment order (CTO). We looked at the records of this patient and the records of two patients who had been discharged from their CTO. A CTO was used when patients were discharged from hospital after being on a section 3 or section 37 of the MHA. A CTO meant that patients had supervised treatment in the community and their responsible clinician could bring them back to hospital if they were not complying with the conditions of the order.

We found that capacity to consent to interventions was not routinely assessed although community psychiatric nurses recorded consent when administering a depot injection. The second opinion appointed doctor certification for one patient subject to a CTO had not been updated and evidence of the patients' capacity to consent was not recorded. We could not find evidence in two of the three records we looked at that section 132 rights under the MHA had been provided at timely intervals throughout the CTO. There was a time delay of up to eight weeks between the responsible clinician extending one CTO and MHA hospital managers reviewing the extension. This meant that the patient might have been subject to restrictions for longer than necessary if the decision of the managers had been to discharge the CTO.

There was a lack of training on the revised Code of Practice (CoP) which had been implemented in April 2015. This was being looked at by the training department. Information on the revised CoP was available centrally from the MHA administrators office.

We could not find evidence in the records we looked at that the three patients who were or had been on a CTO had been referred to an independent mental health advocate although staff told us that patients had been.

Good practice in applying the Mental Capacity Act

The data provided to us by the trust showed that training in the Mental Capacity Act (MCA) across all teams was 48% in the last six months. In the team we inspected this was 12%. However, when we looked at training records in the team we found that MCA training levels were 50%. It was recognised that MCA training was low in the team and as a result of this there had been MCA, Deprivation of liberty safeguards (DoLS) refresher training held during one of the teams business meetings. Fourteen members of staff had attended this training in January 2016.

When we looked at care records there was evidence in one of the 16 records that a mental capacity assessment had been completed and three had some evidence of the consideration of mental capacity. In addition to these we looked at six other mental capacity assessments taken from a sample of different care records. Two of these had been completed by other sources such as staff on inpatient wards. One of the documents had no identified location. Of the three completed by the team, these demonstrated that capacity had been assessed and recorded appropriately. They were completed on a decision specific basis and patients had been given assistance to make a specific decision for themselves before they were assumed to lack the mental capacity to make it.

We found evidence of best interest assessments in the records we looked at. A best interest assessor needs to decide whether a DoLS is occurring, or likely to occur, and, if so, whether it is in the best interests of the patient being assessed. There were qualified best interest assessors in the team. We looked at five best interest assessments and found that where a patient lacked capacity, decisions were made in their best interests around where they were to live recognising the importance of their wishes, feelings, culture and history.

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 observed three home visits with patients and their carers. On all three visits staff demonstrated warmth, compassion and respect to both patients and their carers. We observed an assessment being undertaken of a patients' nursing needs. The assessment was conducted in a professional and sensitive manner. The staff were person-centred in their approach and spoke directly to the patient when the assessment was undertaken. We observed that the patient remained relaxed throughout the assessment. We saw that appropriate information regarding treatment options for the patient was provided by staff to the patient and carers. Staff also considered what the carers' wishes were for the patient.

The five carers we spoke to commented that staff were always respectful and polite. They felt involved and listened to in the care planning process although some carers we spoke to had not been offered a carers assessment. However we found that there were plans in place to offer all carers a carers assessment and this was being rolled out. We saw that a carers pack had been developed which included information about the assessment process and support plan following this, a carers support information leaflet detailing where to go for additional practical help and emotional support and a carer feedback form. Useful telephone numbers were also provided which included the number for the out of hours service. If needed, the carers pack could be produced in alternative formats.

The involvement of people in the care that they receive

Patients were encouraged to be involved in care planning where possible but staff told us that for some patients with cognitive impairment this was not always possible. Carers told us they were involved in care planning with their relatives if this was appropriate. Staff gave patients and their carers clear information about their care and the support they could offer. The patients 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 access to the team was good, the service was flexible and that they received support when needed. The service was open at weekends with reduced staffing and there was an out of hours contact number available although three of the carers we spoke to were not aware of this number.

Carers were also provided with friends and family test forms which could be used to provide feedback on their experiences of services. We also viewed a compliments file held by the senior administrator in the team which detailed the many letters and cards of thanks from patients and their carers.

Patients and their carers were able to access advocacy services through the local MIND centre and staff reported that they assisted patients to do this by giving them advocacy leaflets, telephone numbers or contacting them on the patient or carers behalf.

There had been a service user engagement awareness away day in December 2015. Carers were present at this event. It had been agreed that a development workshop would begin in February 2016 and would be led by a senior occupational therapist. The purpose of the group was to directly involve patients and carers in discussions around improvement of service delivery.

There were two carers champions in the team who fed back any issues around this role.

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 majority of referrals were made to the team by GPs or other primary care providers through the single point of access, however referrals would also be accepted from the mental health liaison service, external consultant psychiatrists, and mental health professionals from the functional service.

Over the past six months there had been 183 referrals into the team. Staff told us that first contact with patients could be on the day of referral if after discussion with the consultant psychiatrist this was deemed necessary. All referrals from hospitals were seen within three to five working days. All other referrals were discussed at multidisciplinary meetings and on average it took 15 days from referral to the first face to face assessment and 14 days from assessment to treatment. This was in keeping with the operational policy.

There were robust clinical pathways in place to ensure that all patients who required a service were given the correct amount of support. Each patient accepted into the service was placed into one of five clinical pathways. These were:

- Pathway one - High intensity involvement. Patients could be seen up to three times per day on a time limited basis to try and prevent hospital admission. There was close working with inpatient wards throughout patients stay and to facilitate early discharge, frequent medical review and rapid holistic assessment. Treatments offered in this pathway were medication management, behaviour management, non-pharmacological interventions and short term solution focused therapy. Support with physical health care was also offered.
- Pathway two - Reablement and intervention. Short term intensive work for up to 12 weeks to include assessment, interventions, treatment and review, commissioning of packages of care carers assessment and support.
- Pathway three - Recovery focused long term interventions. Implementation and coordination of the agreed care plan and risk management plan. Collaborative working with other providers to ensure appropriate packages of care were commissioned.
- Pathway four - Ongoing review of commissioned packages of care. Ensuring that delivery of care met expectations. Assessment and review at appropriate intervals.
- Pathway five - Medication management pathway. Nurse led monitoring of compliance with medication such depot, clozaril and lithium with access to other service pathways as required.

Patients could be stepped up or down according to assessed need and the level of risk they presented with. All patients discharged from the service were discussed in the multidisciplinary team meetings on a weekly basis to ensure there was input from different disciplines in this decision.

We observed a duty system which was operated by a qualified member of staff on a rota basis. There was a dedicated duty desk where urgent calls were taken and dealt with. Referrals were reviewed, assessed and triaged for urgency by the qualified member of staff. Emergency assessments could be undertaken and liaison with approved mental health professionals completed as appropriate. Daily tasks were completed such as updating the team manager with issues that had arisen, arranging cover where necessary and ensuring that all members of staff were safe and accounted for at the end of the day as per the trust lone working policy.

There was a clear inclusion criteria for the service. Patients referred into the service were discussed on a case by case basis to ensure that there were no gaps in provision. Patients with a functional or organic mental illness could be referred for treatment. Patients were primarily aged 70 years or over but younger patients could also be included if they were experiencing moderate to severe dementia. The inclusion criteria included those with a co-morbid learning disability, physical health needs or substance misuse problems that resulted in cognitive deficits. In addition patients with a brain injury where they presented with severe confusion could also be referred.

If patients found it difficult to engage with the service, they were discussed in one of the multidisciplinary team meetings and different approaches were suggested in order to try and facilitate a visit or meeting.

The staff we spoke to had a flexible approach to appointments and these could be changed if it didn't suit the needs of the patient or carer. Carers told us that staff

Are services responsive to people's needs?

Good

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were flexible and readily changed appointment times if requested. If appointments needed to be cancelled by staff at short notice, the patient was contacted as soon as possible by either the staff member or duty worker and the patients and carers we spoke with confirmed this.

There was a robust out of hours system in place to ensure that patients and carers had access to a qualified member of staff at all times. The telephone number for the out of hours service was recorded on the team answerphone. The out of hours team sent details of any contact in an e-mail with the patients' initials, NHS number and details of the call to the care co-ordinator, team manager and senior practitioners. This was also copied to a generic email address which was checked by the senior administrator each morning. The administrators ensured that if the care coordinator was not in work the email was dealt with by another member of staff, usually the duty worker. Details of the call were recorded on the trust electronic recording system.

The facilities promote recovery, comfort, dignity and confidentiality

Patients were seen in their own homes or residential placements. However, in response to requests from patients who used the service and their carers, the service had set up a clinic at the local mental health unit which provided private interview rooms for patients whose preference it was to be seen outside of their own home.

Meeting the needs of all people who use the service

Leaflets were downloadable from the trust intranet in different languages which ensured that a range of information could be provided for those whose first language was not English. There was an interpreter service that could be accessed and audits had been completed around this. The audit showed that the interpreter service had been accessed on two occasions in the month prior to our visit.

Listening to and learning from concerns and complaints

Data provided by the trust indicated that there had been 13 complaints across all older adults community teams in the last six months. Two of the complaints had been fully upheld and six had been partially upheld. In the last six months there had been one complaint to the team we inspected. The matter had been looked into and a letter had been written to the complainant explaining what had been done to resolve the matter. Duty of candour had been used to apologise for any distress caused and to ensure that the complaint had been dealt with in an open and transparent manner.

The patients and carers we spoke to said that they would know how to complain but they were all able to talk to their care co-ordinator to resolve any issues they had without making a formal complaint. Staff told us that they would give patients or carers the trust complaints, comments and compliments leaflet. They would also signpost them to the Patient Advice and Liaison Service.

Staff told us that feedback from complaints were discussed in individual supervision or team meetings with the purpose of reflecting on what happened and what staff would do differently next time.

The older adults community teams had received 89 compliments over the last 12 months with the older adults team we inspected receiving six.

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

The trust had the following vision:

- to achieve improved lives and optimistic futures for individuals affected by mental health and substance misuse problems.

The trusts values were as follows:

- we are caring and kind
- we go the extra mile
- we value and respect
- we are welcoming and friendly
- we work together

Staff we spoke to were aware of the trusts vision and values. We found that staff were motivated and dedicated to give high quality care and treatment to patients in receipt of community mental health services in line with the values and vision. Staff were aware of who the most senior people in the trust were.

Good governance

We found the service was well managed. The team had recently been given more management support through the secondment of a team manager and the appointment of a service manager. Staff had clear roles and a management structure that was understood by staff. If there were identified shortfalls in the older adults team, managers told us they could escalate these onto the risk register.

Staff supervision over the past 12 months had been low but local systems had recently been developed to ensure staff were receiving supervision. Staff reported they had recent supervision by their line manager and that they were supported by them as well as by their peers. We saw evidence of this in the supervision files we looked at. Supervision sessions covered clinical issues, performance, development and staff issues and addressed matters outstanding from the previous meeting. Staff told us they found the supervision they received helpful and supportive. All staff had had an appraisal of their work performance.

Staffing levels and skill mix were sufficient to ensure safe, good quality care and treatment. There was a meeting structure to escalate and cascade information through all levels of staff. The meetings were well organised and covered appropriate governance issues relevant to the service and learning from incidents and complaints.

Staff had a good understanding of safeguarding, the Mental Health Act 1983 and the Mental Capacity Act 2005, however training levels in these areas was poor and below trust targets.

Staff were completing the health of the nation outcome scales (HONOS) which measures the health and social functioning of patients with severe mental illness. They were designed to be used by clinicians before and after interventions, so that changes attributable to the interventions (outcomes) could be measured.

The teams used Advancing Quality in psychosis and dementia targets to ensure that there were checks around reliability and consistency of healthcare. Targets for seven day follow up after discharge from hospital and gatekeeping for admission to hospital were also monitored.

Key performance indicators set by commissioning bodies were being met. There were several Commissioning for Quality and Innovation (CQUIN) targets such as ensuring that care programme approach meetings were completed within 10 days and recorded onto the trusts electronic recording system, the development of a training programme to support staff to provide psychological interventions and the development of a process to ensure that patients prescribed an anti-depressant were given both verbal and written information based on recommendations in line with NICE guidelines.

Team managers were aware of the trust risk register but there were no submitted items on this.

We saw evidence of robust local audits being carried out that were used to ensure that systems were working and to drive improvement. Completed audits included points for action and timescales for completion. We saw that these were up to date and actions had been completed within the timescales.

Leadership, morale and staff engagement

Staff told us morale had improved over the past six months. Staff commented that they really enjoyed their jobs although some reported it could be stressful because of the high number of referrals and caseload numbers. However, they told us they were supported in supervision to look at

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these if necessary. There had been some instability because of gaps in having a team manager but since the current team manager had been in post, staff told us they felt supported and were a lot more settled. A service manager post had also been created and it was felt by all staff that there was better focus and guidance now this structure was in place.

Staff knew how to raise concerns and felt able to do so if necessary. Staff told us they could raise issues without fear of victimisation and some staff said that they had recently raised an issue with managers which was then dealt with in a sensitive manner. They had felt listened to and valued during this experience. Staff were aware of the trust whistleblowing policy. They were aware of the need to be open and transparent with patients if and when something went wrong and recognised this as being their duty of candour.

Commitment to quality improvement and innovation

The team worked closely with the local university to enable patients with experience of mental health services to be involved in research projects to further advance knowledge of functional and organic disorders. This included research on young onset dementia, combined treatments in adults with psychosis and the influence of expressed emotion on dementia sufferers adjustment.

There was a Strategies for Relatives (START) project funded by the Alzheimers society which had begun in January 2016. This was a manual based, eight session intervention which promoted the development of coping strategies among family carers of patients with dementia. This included working with carers to identify individual difficulties and implement strategies to overcome these. Its aims were to reduce levels of anxiety and depression among carers.

A personality disorder strand of the older adults team was being developed. This was to be overseen by the psychologist and led by a newly appointed nurse.

There was a commitment by the trust to enhance the quality of life for patients with dementia and older patients with functional illness. They were continuing to support the 'Dementia Friendly Communities' agenda whose aims were to ensure that patients with dementia were understood, respected, supported to contribute to community life and to ensure they had choice and control over their day-to-day lives. The trust supported the 'Salford Together' partnership whose aims were to deliver better health and social care outcomes, improve the experience of service users and carers and reduce overall health and social care costs. The trust had also registered their interest on the national dementia research register to enable them to take part in further research studies in dementia.