Requires improvement

Rotherham Doncaster and South Humber NHS Foundation Trust

Community-based mental health services for adults of working age

Quality Report

Woodfield House, Tickhill Road Hospital, Tickhill Road, Balby, Doncaster, DN4 8QN
Tel: 01302 796000
Website: www.rdash.nhs.uk

Date of inspection visit: 12 September - 15 September 2016
Date of publication: 12/01/2017

Locations inspected

Location ID	Name of CQC registered location	Name of service (e.g. ward/ unit/team)	Postcode of service (ward/ unit/ team)
RXE00	Trust Headquarters	Rotherham Social Inclusion Team	S61 1AJ
RXE00	Trust Headquarters	Rotherham Community Therapies Team	S61 1AJ
RXE00	Trust Headquarters	Doncaster Recovery Team	DN4 9LJ
RXE00	Trust Headquarters	Doncaster Assertive Outreach Team	DN4 8QN
RXE00	Trust Headquarters	North Lincolnshire Recovery Team	DN16 2RS
RXE00	Trust Headquarters	North Lincolnshire Community Therapies Team	DN16 2RS

Summary of findings

RXE00	Trust Headquarters	Rotherham Assertive Outreach Team	S26 4TH

This report describes our judgement of the quality of care provided within this core service by Rotherham, Doncaster and South Humber 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 Rotherham, Doncaster and South Humber NHS Foundation Trust and these are brought together to inform our overall judgement of Rotherham, Doncaster and South Humber 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	Requires improvement 
Are services safe?	**Requires improvement** 
Are services effective?	**Requires improvement** 
Are services caring?	**Good** 
Are services responsive?	**Good** 
Are services well-led?	**Requires improvement** 

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

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

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

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

Summary of findings

Contents

Summary of findings

Overall summary

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

- Systems in place did not ensure that all staff received up to date mandatory training and a performance appraisal. We found that mandatory training, which included training to ensure the safe delivery of care and treatment, was not up to date and not all staff received an appraisal of their performance.
- Overall training compliance rate for Mental Health Act training was 61%. This meant that all staff did not have up to date training in the Mental Health Act and Mental Health Act code of practice 2015. We found that staff knowledge in the Mental Health Act was variable.
- We found issues with medicine management practices. Most medication charts did not contain information about patients' allergy status. Staff did not always check the identity of allergy status of patients' before administering medication. Appropriate action was not always taken when temperatures of fridges were outside the recommended range. Systems could not ensure that missing blank individual prescriptions would be identified.
- Some teams did not have access to psychologists which meant that they did not have a full range of disciplines available to provide effective care and treatment.

However:

- Patients' care and treatment records had comprehensive and up to date risk assessments and care plans were recovery focused including the patients' perspective.
- The trust developed a health and well-being strategy and was in the process of rolling out across the community mental health services. Dedicated health and well-being clinics were starting and support workers had received training in completing baseline physical health checks.
- The trust had made improvements in the systems to manage medicines. Since our last inspection, we found that standard operating procedures had been introduced, all teams and pharmacists worked with teams to provide support and auditing of medicines management practice used a consistent and standardised system for medicines administered and removed from patients' homes.
- North Lincolnshire teams had a recovery college which had developed a range of therapeutic courses and groups which patients' could access to aid their mental health recovery.
- Teams in Rotherham used social prescribing to refer patients' to an external agency to access meaningful and recreational activities.
- Staff felt supported by their managers and colleagues. The trust provided opportunities for staff to give feedback on the development and transformation of services and the trust communicated developments to staff regularly.
- The trust investigated incidents appropriately and implemented action plans to make changes from lessons learned. This was communicated to all staff through team meetings and other communications from the trust.

Summary of findings

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

Are services safe?

Requires improvement

We rated safe as requires improvement because:

- The compliance rates of mandatory training courses showed that a number of training requirements were not up to date across all teams. Some of this training was essential to ensure that staff had the correct training to ensure the safe delivery of care and treatment.
- Twenty eight out of 37 medication charts did not contain information about patients' allergy statuses.
- We observed that staff did not always check the identity or allergy status of patients when administering medicines.
- Staff did not always take the appropriate action when fridge temperatures were out of the normal range this meant that the optimum effectiveness of medicines could not be assured.
- The system for blank prescription pads could not detect and track individual prescriptions. This meant that if any blank prescription sheets were missing this would not be identified.

However:

- Most patients' records had an up to date and comprehensive risk assessment.
- All teams had standard operating procedures for the managing of medicines.
- A consistent and standardised system was in place for administering and removing medicines in patients' homes.
- The trust investigated incidents and there was evidence of lessons learned and subsequent changes to practice. This was communicated to staff in team meetings and other communications from the trust.

Are services effective?

Requires improvement

We rated effective as requires improvement because:

- Not all staff received a regular appraisal of their performance. The appraisal rates were as low as 13% for North Lincolnshire recovery team, and 22% for North Lincolnshire intensive community therapies team.
- Training in the Mental Health Act and Mental Health Act code of practice 2015 was not up to date. Teams had an overall compliance rate of 61%. Only 37% of staff in North Lincolsnhire and 59% of staff in Doncaster had completed up to date

Summary of findings

training in the Mental Health Act and the Mental Health Act code of practice 2015. We found that staff had variable knowledge of the Mental Health Act and the Mental Health Act code of practice 2015.

- Doncaster recovery team did not have access to psychology input. Doncaster assertive outreach team did not have dedicated psychology input. Rotherham assertive outreach team had access to two psychology sessions per week. This meant that these teams did not have access to the full range of mental health disciplines required to provide care and treatment.

However:

- The provision of physical health monitoring had increased since the last inspection. Physical health monitoring was being completed and teams were starting dedicated health and wellbeing clinics.
- Teams used social prescribing as an alternative and addition to psychological and pharmacological therapies.
- The recovery college in North Lincolnshire provided a range of courses and groups available to build resilience and equip patients with skills to manage mental health conditions.

Are services caring?

Good

At the last inspection in September 2015 we rated effective as **good.** Since that inspection we have received no information that would cause us to re-inspect this key question or change the rating.

Are services responsive to people's needs?

Good

At the last inspection in September 2015 we rated effective as **good.** Since that inspection we have received no information that would cause us to re-inspect this key question or change the rating.

Are services well-led?

Requires improvement

We rated well-led as requires improvement because:

- Systems in place did not ensure that all staff received up to date training and appraisal of their performance. We found that mandatory training compliance was low across a number of training requirements across the teams that we inspected. Staff appraisal rates showed that not all staff received a performance appraisal.

However:

Summary of findings

- The trust had implemented a health and well-being strategy to increase the provision of physical health monitoring for patients. Dedicated health and wellbeing clinics were due to start and support workers had received training to complete baseline health checks.
- A quarterly review identified how well teams performed against their key performance indicators and actions were put in place to address areas where improvements were required.
- Staff had been involved in the development of the service in transformation through consultation. The trust regularly requested feedback from staff to update them on the development of the transforming services project.
- Staff felt supported by their managers and their colleagues.
- In response to serious incidents there was communication, openness and transparency with the people involved.

Summary of findings

Information about the service

Rotherham Doncaster and South Humber NHS Foundation Trust provide community-based mental health services for adults of working age across Rotherham, Doncaster and North Lincolnshire. The teams work with adults between 18 and 65 years of age that have a mental health illness which requires the involvement of secondary care services. There are 19 community teams which provide mental health services for working age adults. The trust also provides an early intervention in psychosis service in Manchester for adults aged between 18 and 35 years of age. Early intervention services are aimed to provide a quick period of involvement including therapy when symptoms of mental health illness are first identified to try and reduce the severity and length of mental health issues.

Teams consisted of health and social care disciplines which included: consultant psychiatrists, psychologists, cognitive behavioural therapists, community psychiatric nurses, occupational therapists, social workers, mental health officers, support workers and administrative staff.

The services are divided into the localities of Rotherham, Doncaster and North Lincolnshire where there are teams that provide needs defined services across the locality. Each of the three localities has:

- an access team
- an assertive outreach team
- an intensive community therapies team
- a community therapies team
- a recovery team

In addition Rotherham and Doncaster each have a social inclusion team. North Lincolnshire has an options team. A carer support team is also provided in Rotherham.

The access teams operate 24 hours a day and seven days a week. They provide the initial assessment of new referrals and allocate to the most appropriate team. Assertive outreach teams worked with patients that had severe or enduring mental illness (psychosis) who find engagement with services difficult. The intensive community therapies teams provided services to patients experiencing non-psychosis mental health including, severe depression and anxiety disorders, obsessive compulsive disorders, eating disorder and personality disorder.

Community therapies teams worked with patients experiencing mental health such as mild to moderate anxiety or depression. Recovery teams worked with patients with psychotic illnesses including bipolar disorder and major mood disorders. The social inclusion teams provided low level support for patients with psychotic illnesses or mood disorders.

These teams provided a range of interventions which includes medication, psychosocial interventions, group activities and community inclusion as part of care and treatment provided.

The options team in North Lincolnshire provides vocational and recreational recovery through participation in courses and activities.

The carers support team in Rotherham provides advice, information, education and support to people caring for someone with a mental illness.

Our inspection team

That team that inspected the services provided by Rotherham, Doncaster and South Humber NHS Foundation Trust was led by Jenny Wilkes, Head of Hospital Inspection (North East), Care Quality Commission.

The team that inspected community-based mental health services for adults of working age comprised four people: two CQC inspectors, one CQC pharmacist specialist and one psychologist specialist advisor.

Summary of findings

Why we carried out this inspection

We undertook this inspection to find out whether Rotherham, Doncaster and South Humber NHS Foundation Trust had made improvements to their community-based mental health services for adults of working age since our last comprehensive inspection of the trust on 14 - 18 September 2015.

When we last inspected the trust in September 2015, we rated community-based mental health services for adults of working age as 'requires improvement' overall. We rated the core service as 'inadequate' for Safe, 'requires improvement' for Effective, 'good' for Caring, 'good' for Responsive and 'requires improvement' for Well-led.

Following that inspection we told the trust it must take the following actions to improve community-based mental health services for adults of working age:

- The trust must ensure that systems are in place to collate mandatory training figures accurately.
- The trust must ensure that staff can access information relating to people who use services when required.
- The trust must ensure that all people who use services have an up to date risk assessment and care plan, which accurately reflects their needs.
- The trust must ensure that medication management practices are in line with the trust policy and national guidance in relation to the storage, prescribing, administration and recording of medicines.
- The trust must ensure that the physical health needs of people who used services are assessed and monitored appropriately and this is evidenced in peoples' care records.

We also told the trust that it should take the following actions to improve:

- The trust should ensure that alarms are available in all interview rooms to make sure staff can call for assistance if required.
- The trust should ensure teams implement the lone worker policy consistently to support staff safety.
- The trust should continue to increase the provision of consultant psychiatrist to the Rotherham Social Inclusion Team.

We issued the trust with five requirement notices in relation to community-based mental health services for adults of working age. These related to:

- Regulation 9 HSCA (RA) Regulations 2014 Person-centred care
- Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment
- Regulation 17 HSCA (RA) Regulations 2014 Good governance

How we carried out this inspection

To fully understand the experiences of people who use services, we always as the following questions of every service and provider:

- Is it safe?
- Is it effective?
- Is it caring?
- Is it responsive?
- Is it well-led?

Before the most recent inspection, we reviewed information that we held about community-based mental health services for adults of working age. This information suggested that the ratings of 'good' for caring and responsive, that we made following our September 2015 inspection, were still valid. Therefore, on this inspection we focussed on those issues that caused us to rate the service as 'requires improvement' for safe, effective and well-led.

This inspection was unannounced, which meant that the service did not know we would be visiting.

Summary of findings

We visited a sample of seven teams that provide community-based mental health services for adults of working age. The teams that we visited were:

- Rotherham social inclusion team based at Ferham Clinic
- Rotherham community therapies team based at Ferham Clinic
- Doncaster recovery team based at the Stapleton Centre
- Doncaster assertive outreach team based at the Opal Centre
- North Lincolnshire recovery team based at Ashby Road
- North Lincolnshire intensive community therapies team based at Ashby Road
- Rotherham assertive outreach team based at Swallownest Court.

During the inspection visit, the inspection team:

- visited seven of the community-based mental health teams for adults of working age and looked at the quality of the environment and observed how staff were caring for patients
- spoke with nine patients who were using the service
- spoke with the managers or acting managers for six of the teams
- spoke with 26 other staff members; including doctors, nurses, psychologists, social workers, occupational therapists, cognitive behavioural therapists and support workers.
- interviewed the divisional director with responsibility for some of these services
- attended and observed two multidisciplinary meetings
- attended one group session
- observed seven interactions between staff and patients
- spoke with two carers of patients who were using the service
- looked at 28 care and treatment records of patients.
- carried out a specific check of the medication management at all teams and reviewed 37 medication 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

People who used the service and their carers gave us positive feedback about staff and the services that they accessed. They told us that staff have a warm and empathetic approach and understand their needs. Patients said that when they visit the teams that they feel welcome, comfortable and staff explain information to them clearly so that they can be included in their care and treatment. One carer told us that their relative is more open about their mental health fluctuation and needs with their care coordinator than with close family.

Good practice

North Lincolnshire recovery college continued to develop and widen its resource to the community by providing courses and group activities for patients to access. The recovery college provided a range of meaningful and accessible courses aimed at improving mental health and well-being by equipping patients with skills to build resilience, coping mechanisms to facilitate mental health recovery.

Teams in Rotherham continued to develop 'social prescribing' with an external organisation to support patients to be referred onto access meaningful activities to support mental health recovery.

Summary of findings

Areas for improvement

Action the provider MUST take to improve

The trust must ensure that all staff receive up to date mandatory training.

The trust must ensure that all staff receive an appraisal.

Action the provider SHOULD take to improve

The trust should ensure that staff make regular checks of documentation in relation to the prescribing, administration and recording of medicines to ensure that this is completed fully.

The trust should ensure that staff review the record keeping arrangements for blank prescription pads in accordance with national guidance.

The trust should ensure that they review with commissioners the provision of psychology to community-based mental health service for adults of working age.

The trust should continue to improve the provision of physical health checks for people taking antipsychotic medicine.

The trust should ensure that all staff receive up to date training in the Mental Health Act and Mental Health Act code of practice 2015.

Rotherham Doncaster and South Humber 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
Rotherham Social Inclusion Team	Trust Headquarters
Rotherham Community Therapies Team	Trust Headquarters
Doncaster Recovery Team	Trust Headquarters
Doncaster Assertive Outreach Team	Trust Headquarters
North Lincolnshire Recovery Team	Trust Headquarters
North Lincolnshire Intensive Community Therapies Team	Trust Headquarters
Rotherham Assertive Outreach Team	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 was not up to date. Teams had an overall compliance rate of 61%. However; all staff knew where to seek advice around the Mental Health Act from in the trust. Staff knowledge around the Mental Health Act was variable. Some staff had a basic understanding of

Detailed findings

the act and code of practice however, the staff that regular worked with patients subject to the Mental Health Act had a more in depth and detailed knowledge of the act and code of practice.

When patients were detained under the Mental Health Act to inpatient wards, where a Mental Health Act tribunal was to take place staff from community teams wrote and presented social circumstances reports for patients.

We found that consent to treatment for patients subject to community treatment orders was sought in line with legislation and guidance and Mental Health Act documentation was up to date and appropriate. Care coordinators informed patients of their rights at regular intervals as outlined by section 132 of the Mental Health Act.

The trust's Mental Health Act office audited Mental Health Act documentation and fed back to teams where action needed to be taken.

All teams displayed information in relation to independent mental health advocacy.

Mental Capacity Act and Deprivation of Liberty Safeguards

The Mental Capacity Act is a piece of legislation that maximises an individual's potential to make informed decisions wherever possible. It provides guidance and processes to follow where someone is unable to make a decision. As part of our inspection we looked at the application of the Mental Capacity Act. We found that staff received up to date training in the Mental Capacity Act and the code of practice.

We found that knowledge of the Mental Capacity Act was variable across staff that worked in the teams. We saw that some staff had a basic understanding of the principles of the act however, most staff could describe the principles of the act in detail and how these applied to their everyday work with patients. Staff knew where they could seek advice from when they needed support with the application of the Mental Capacity Act.

Care and treatment records showed that staff obtained consent in line with legislation and guidance. There was evidence of recording patients' informed consent and capacity assessments were completed appropriately.

During our inspection, we saw examples of staff interacting with patients and undertaking conversations to establish patients' capacity to make decisions. We saw that these considered whether or not patients' understood the possible risks of making a particular decision when assessing if they had capacity. We found that this showed adherence to main principles of the Mental Capacity Act which states that people that have capacity to make decisions which may seem unwise or eccentric to others.

Information was available about access to independent Mental Capacity Act advocacy services.

Requires improvement

Are services safe?

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

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

Our findings

Safe and clean environment

As part of our inspection we visited seven of the community mental health teams that provided service. These teams were based across five locations, Rotherham, Doncaster and North Lincolnshire. We found not all interview rooms were fitted with alarms and a variety of arrangements were in place across the teams that we visited. Interview rooms used by the teams based at Ferham clinic in Rotherham had alarms attached to the key for the room. Interview rooms at Ashby Road in North Lincolnshire had mobile alarms in place. The Stapleton centre in Doncaster did not have alarms however, staff told us that mobile alarms could be used and these were held by reception. The Opal Centre used by Doncaster assertive outreach team did not have alarms in place. Staff told us that where an increased risk was identified, staff worked in pairs and would make arrangements to see patients at locations where patient risk was the most manageable. Rotherham assertive outreach team did not see patients at their team base. All staff were aware of the arrangements in place at the teams that they worked in.

Patients accessed clinics based at Ferham Clinic in Rotherham, Bungalow 4 at the Tickhill Road site in Doncaster and Ashby Road in North Lincolnshire for clinical interventions and physical health checks. Clinic rooms had the necessary equipment to carry out physical health examinations include baseline monitoring and point of care haematology analysis machines. These were used to test blood samples to monitor levels of clozapine. We found that all stock was in date.

Equipment was well maintained and clean. We saw that stickers were in place to show equipment had been checked and these were in date. All areas were clean and well maintained. Cleaners completed cleaning of sites each day between Monday and Friday. Doncaster recovery team on Stapleton Road used an external cleaning contractor.

All teams had adequate handwashing facilities. All clinic rooms contained sinks. Team bases had hand sanitising products placed throughout which staff and visitors could use. We saw that teams displayed information about good hand hygiene practice which included instructions of how to wash hands to minimise the risk of bacteria and infections spreading.

Safe staffing

Teams did not use a structured approach to determine staff levels and skill mix required. Recruitment processes were underway for posts with exception of vacancies for consultant psychiatrists and psychologists. These posts were on hold awaiting the outcome of a transformation review of the service. The outcome of the review could have resulted in changes to the team compositions. Teams used bank and agency staff to temporarily fill some of the services' vacancies.

At the time of our inspection, the trust provided information about bank and agency staff usage per team. This was as follows:

- North Lincolnshire intensive community therapies team: Social workers 2.0 whole time equivalent agency, consultant psychiatrist 1.0 whole time equivalent
- North Lincolnshire recovery team: social worker 1.0 whole time equivalent
- Rotherham community therapies team: Consultant psychiatrist 1.0 whole time equivalent
- Rotherham assertive outreach team – consultant psychiatrist 1.0 whole time equivalent
- Doncaster recovery team: Administrator 1.0 whole time equivalent bank
- Doncaster assertive outreach team – consultant psychiatrist

Managers limited the amount of staff that could take leave at the same time to ensure that there was adequate staff cover for the teams at all times.

Information relating to staff sickness absence over the last year showed that the average sickness rate across the teams that we visited was 6%. The team with the lowest sickness absence rate was North Lincolnshire recovery team which was less than 1% and the highest sickness absence rate was Doncaster recovery team at 10%. The national average sickness rate is 5%.

Requires improvement

Are services safe?

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

The average staff turnover was 7%. The team with the highest turnover rate was North Lincolnshire intensive community therapies team at 25%. However, this only represented three staff out of a team of twelve who had left. Doncaster assertive outreach team, North Lincolnshire recovery team, Rotherham social inclusion team had 0% staff turnover rate. This meant that no staff had left these teams. The trust did not provide any sickness absence rate or staff turnover rate for Rotherham community therapies team. This team is not reflected in the above figures.

The average amount of cases per care co-ordinator across the five community mental health teams that we visited was 17. The average caseload of care co-ordinators from assertive outreach teams was 12. At the time of our inspection, North Lincolnshire intensive community therapies team had four patients waiting allocation for a care co-ordinator. Other teams did not have any patients awaiting allocation of a care co-ordinator.

Managers discussed caseloads in staff supervision. Teams rated cases based on the level of risk and involvement required. These represented a system which rated cases as red, amber and green. Red represented cases of high patient risk and intensive involvement required, amber moderate risk and regular contact required and green cases presented low risk and minimal involvement required. Cases that were rated low risk represented patient moving towards discharge back to primary care services or to a team which provided less intensive community mental health services. For example, assertive outreach teams would usually transfer cases to other teams including recovery teams or intensive community therapy teams. Managers balanced staff caseloads to ensure complex cases were allocated fairly across the teams.

During this inspection, we asked the trust to provide information on mandatory staff training completion. This showed that a number of mandatory training courses were not up to date and this included training required to ensure the safe delivery of the services provided. Staff had not received up to date training in the following areas:

- Rotherham assertive outreach team – resuscitation level one 10%, reducing restrictive interventions personal safety and conflict resolution 17%, moving and handling for people handlers 30%, information governance 33%, infection control level two 40%, safeguarding adults level three 67%, safeguarding children level three 67%, prevent level three 67%, equality, diversity and human rights 67%, fire safety 67% and health and safety 67%,
- Rotherham intensive community therapies – safeguarding children level three 22%, moving and handling for people handlers 22%, fire safety 37%, information governance 37%, safeguarding adults level three 44%, infection control level two 57%, moving and handling of inanimate loadhandlers 60%, prevent level three 67%, reducing restrictive interventions and personal safety and conflict resolution 69%.
- North Lincolnshire intensive community therapies team – safeguarding adults level three 0%, safeguarding children level three 0%, reducing restrictive interventions core training 0%, information governance 58% and fire safety 67%.
- North Lincolnshire recovery team – safeguarding adults level two 0%, safeguarding adults level three 0%, safeguarding children level three 33%, reducing restrictive interventions core training 0%, prevent level three 33%, moving and handling for inanimate load handlers 70% and infection control level two 72%.
- Rotherham social inclusion team – safeguarding adults level two 0%, prevent level three 38%, information governance 45%, resuscitation level one 60%, fire safety 64%, reducing restrictive interventions, personal safety and conflict resolution 64% and safeguarding adults level three 71%.
- Doncaster assertive outreach team – resuscitation level one 28%, information governance 31%, moving and handling for people handlers 35%, moving and handling for inanimate load handlers 50% and safeguarding adults level three 70%.
- Doncaster recovery team – safeguarding adults level two 0%, resuscitation level one 60%, fire safety 64% and moving and handling for people handlers 66%.

Assessing and managing risk to patients and staff

A single point of access team undertook an initial triage and risk assessment of all new patient contact and referrals. The access team then referred cases to relevant community mental health teams depending on patient need. All teams used a recognised risk assessment tool. This was the Functional Analysis of Care Environments risk

Requires improvement

Are services safe?

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

assessment. During our inspection we reviewed 28 care and treatment records. We found that most patient records contained up to date comprehensive risk assessments. Of the 28 records that we reviewed, we found that 26 patients records contained a completed a risk assessment, 24 records had risk assessments that had been reviewed regularly and 24 records had risk assessments that contained holistic and detailed information about patient risk.

All teams provided information to patients, carers and professionals about what to do in the event of a crisis or sudden deterioration in mental health. This was in the format of a 'crisis plan'.

We found that most records contained detailed crisis plans. Of the 28 records that we reviewed, 27 contained detailed crisis contingency plans.

All teams had a duty system. This meant that a member of the team was allocated to respond to incoming contact regarding patients each day. The duty worker would respond promptly to urgent information that related to sudden deterioration in patient's health. When needed, visits could be completed to patients the same day and appropriate action taken. This included contacting a consultant psychiatrist for advice.

Not all staff had received up to date training in safeguarding adults and children. However, all staff knew we spoke to described to us the types of concerns that would constitute a potential safeguarding issue. Staff told us that they would ensure that the individual at risk was safe and would report their manager immediately. Information about safeguarding processes including leaflets was displayed by all teams.

We checked the arrangements for managing medicines at the trust. Medicines were supplied by a community pharmacy contractor under a service level agreement. We checked medicines in the treatment rooms and medicine refrigerators and found they were stored securely with access restricted to authorised staff. Maximum and minimum fridge temperatures were recorded daily on all wards in accordance with national guidance. However, at Rotherham social inclusion team there were gaps in recorded temperatures and nursing staff we spoke with were unaware of the safe temperature range for storing medicines. In addition, the records we reviewed indicated fridge temperatures had been outside the normal range on two occasions and no action had been taken or documented in the temperature records. This meant we could not be sure medicines stored in this fridge were safe to use. There were appropriate arrangements in place for the disposal of sharps and waste medicines.

The trust had recently introduced standard operating procedures for the management of medicines which covered ordering, receipt, storage, transfer, administration and disposal. We found these were available and in use at all the sites we visited, however not all staff had signed the standard operating procedures to confirm they had been read and understood.

At our previous inspection we also identified inconsistencies in the recording of medicines, including those administered in and removed from patient's own homes. During this inspection we checked to see what improvements had been made. The trust had rolled out standardised documentation across all community teams and staff had accounted for all medicines appropriately. The trust had also introduced a 'record of removal of medicines from a community patient' document to record medicines removed from patients' homes. We checked eight of these records at the Doncaster assertive outreach team and found consent to remove the medicines had not been obtained on five occasions.

We checked 37 depot injection record cards across the teams that we visited and found patients' allergy status had not been completed on 28 of them. Depot injections are used to administer medication directly into the muscle as an alternative to taking medication by other routes. This increases the risk of a patient being given a medicine that they may have an allergy to. The electronic patient care records contained information about patients' allergy status. In addition, we found nursing staff had not recorded the batch number or expiry date of the depot injections they had administered on seven of the cards. We observed six depot injections being administered at Rotherham social inclusion team and North Lincolnshire recovery team and found that both staff did not check patients' identification or allergy status before administering any injections in accordance with trust policy. During our inspection we raised these concerns with managers and they assured us that this would be addressed immediately.

Requires improvement

Are services safe?

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

Some of the teams held blank prescription pads; whilst we found these were stored securely, records were not maintained in accordance with national guidance to enable tracking from receipt to issue.

The pharmacy department conducted regular audits on the safe and secure handling of medicines. Audits had identified problems with fridge temperature recording, the recording of prescription pads, and the signing of standard operating procedures; the action plan stated necessary actions would be completed by March 2016; however these areas remained a concern during our inspection.

The trust had a policy and standard operating procedure relating to lone working. Each team had a risk assessment in place for lone working. Information in the policies, procedures and risk assessments detailed risk reduction techniques such: completing visits in pairs, meeting high risk patients in public places and ensuring that they recorded their locations and expected end time of visits. Team risk assessments stated that all staff should be compliant in reducing restrictive interventions training. However, of the seven teams that we visited five teams were not compliant with this training.

Staff told us that there were areas of localities which staff did not visit due to the potential risk from the community. They also told us that they record all of their appointments in electronic diaries, signed in and out of team bases and used whiteboards to record where they were going and their expected time they would leave the visit. Staff did not routinely contact their team base at the end of each visit to confirm their safety. However, staff told us that where there was a potential risk identified they would visit in pairs and inform the duty worker what time they expected to leave. On these visits staff told us they would contact the team base to report that they had left the visit safely. At the end of the working day all workers out in the community contacted the team to sign off shift. Assertive outreach teams operated until 8pm between Monday and Friday. Two staff worked until 8pm and they were 'buddies' for each other. If staff had not returned as planned and could not be contacted this was escalated to team managers who would contact staffs' next of kin and the emergency services if needed.

Managers told us that the trust was implementing a pilot project on lone worker devices. This device had integrated listening and global positioning system. When activated by staff or by the device being struck suddenly it would raise the alarm and link to a call centre who could summon the emergency services to respond if needed. The global positioning system would enable staff whereabouts to be identified in the event of staff not being able to respond to the call operator.

Track record on safety

Information provided by the trust reported that there were 30 serious incidents in the last 12 months in relation to community-based mental health services for adults of working age. The trust had investigated or was in the process of investigating serious incidents using a root cause analysis. We saw that all serious incidents had a breakdown of findings which reported: any key service delivery problems, actions to be put in place and good practice identified.

Teams received a monthly organisational learning forum newsletter which was in a poster format and communicated the key messages from lessons learnt from serious incidents.

Reporting incidents and learning from when things go wrong

An electronic incident reporting system was used. All staff had access to the system and knew how to report incidents. Staff knew what types of occurrences must be reported.

The trust had a policy on the duty of candour. This outlined staff responsibility in relation to incidents or near misses in patient care and treatment. All staff could explain that they would be honest and transparent with patients if something went wrong.

Teams received feedback from the outcome of investigations of incidents in team meetings and supervision. Some staff gave us examples of how team practice had been changed as a result of incidents. Staff told us that they received support from their manager and senior managers which included a debrief following a recent serious incident.

Are services effective?

Requires improvement

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

Our findings

Assessment of needs and planning of care

The single point of access team completed first contact following receipt of new referrals. This team recorded presenting information in the assessment of needs before they sent referrals to the appropriate community-based mental health teams. When community-based mental health teams completed their initial appointments they collected further information about patients' needs. Staff told us that nurses, social workers or doctors were usually included in the assessment of needs process. The assessment of needs covered the relevant information to enable staff to formulate patient needs. We reviewed 28 patient care and treatment records and found all records contained a completed comprehensive assessment of need.

Teams used care plans to outline how needs would be met through goals. These detailed the actions required, who was responsible for completing and the expected timescale for the goal to be achieved. Of the 28 patient care and treatment records that we reviewed we found that 27 records had a care plan, 26 records showed that the patient's care plan was reviewed regularly and 25 care plans were holistic and recorded the patient's views. All records were recovery orientated.

All teams used an electronic patient care record system. We found that patients' care and treatment records stored information consistently as all records stored the same type of information in the same place in the system. Staff told us that some areas in the trust operate using a different electronic patient care record system and the community mental health teams could not access information they recorded. However, staff informed us that the trust was rolling out the use of one system to all departments by July 2017 and when needed staff contacted the appropriate team to access information needed if it was not immediately accessible to them.

Best practice in treatment and care

Consultant psychiatrists, and in some teams nurses that had completed additional training, prescribed medication to patients. Staff told us that they referred to guidance from the National Institute of Health and Care Excellence, the Royal College of Psychiatrists and the Prescribing Observatory for Mental Health when prescribing medication and were able to give us examples. Nurse prescribers worked with patients on stable medication and received regular case supervision from consultant psychiatrists to support prescribing they completed.

Information provided by the trust reported that teams we inspected had the following provision to provide psychological therapies:

- Rotherham assertive outreach team had two psychologist sessions per week.
- Doncaster assertive outreach team had no dedicated psychology support.However; the trust reported that psychological support could be accessed from inpatient services. Information provided by the trust stated that the capacity was one patient at a time could access psychological therapies from this provision.
- Doncaster recovery team had one part time cognitive behavioural therapist.
- North Lincolnshire recovery team had one psychologist and one cognitive behavioural therapist for two days each per week.
- North Lincolnshire intensive community therapies team had two psychologists both dedicating two days per week and cognitive behavioural therapists.

We did not receive information about qualified staff available to provide psychological therapy for the social inclusion and community therapies teams in Rotherham. However, vacancy data provided by the trust showed that at the time of our inspection that Rotherham community therapies team had two vacancies for psychologists and these posts were on hold and had not been covered by bank or agency staff.

However, we found that the following teams used their resources to provide psychological based individual and group sessions:

- Rotherham community therapies provided understanding anxiety, mood management, emotional coping skills, panic, obsessive compulsive disorders, wellness recovery action planning and compassion focussed mindfulness.

Are services effective?

Requires improvement

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

- Rotherham social inclusion team provided groups on anxiety management, cognitive behavioural therapy, wellness recovery action planning, mood management, hearing voices, voice dialogue and individual psychology.
- Doncaster assertive outreach team provided anxiety management, hearing voices, living with bi polar disorder, wellness recovery action planning, art group and mood master.
- Doncaster recovery team provided groups on anxiety management, heating voice and living with bipolar disorder.
- North Lincolnshire intensive community therapies team provided a dialectical behavioural therapy skills group which was a 20 week programme facilitated by two psychologists.
- North Lincolnshire recovery team provided individual therapy determined by patient need.

Rotherham Assertive outreach team did not provide any group sessions or individual psychological therapies.

In Rotherham, the teams were using 'social prescribing' to refer patients to access activities provided by an external organisation in the community. Doncaster assertive outreach team provided support with eating on a budget, health eating, exercise and gym and walking group.

The community mental health services in North Lincolnshire ran the recovery college at Ashby Road. The recovery college provided courses on a range of subjects which included: managing low mood, really useful toolbox, anxiety management, assertiveness, a good night's sleep, self-esteem and confidence building, smoke free life, mindfulness, relaxation, motivation and making positive changes. During our inspection we observed the managing low mood group. This group included a facilitator who had previously used mental health services and had recovered. The facilitator explained the cognitive behavioural therapy model and the attendees discussed some of the myths around mental health.

Staff told us that they provided support with employment, housing and benefits frequently as many patients who access the team regularly experienced issues with accommodation and financial difficulties which led to debt and not having enough money to buy food. Staff reported to have the contacts needed to support patients with accessing the relevant agencies in order to resolve these issues and meet their basic needs.

Since our last inspection, the trust had developed a physical health and wellbeing strategy to improve the physical health monitoring of patients taking antipsychotic medicines. This strategy involved the implementation of dedicated physical health and wellbeing clinics. These would be dedicated to the monitoring of physical health for patient prescribed one or more anti-psychotic medication therapies and those patients that have co-existing health conditions including, asthma and diabetes. At the time of our inspection some support workers had received training to enable them to complete baseline monitoring including, blood monitoring and electrocardiograms in the upcoming health and wellbeing clinics. The dedicated health and well-being clinics were scheduled to start at the end of September 2016.

At the time of this most recent inspection physical health monitoring was completed in three locations. In Rotherham this was provided at Ferham Clinic, in Doncaster at bungalow 4 at Tickhill road and in North Lincolnshire patients attended Ashby Road. We saw that improvements in physical health monitoring had been rolled out to some teams. However, we found the level of monitoring undertaken was variable. Some of the teams we visited could not readily identify people who were overdue a review of their physical health. We were told that the electronic patient record had recently been updated to include physical health monitoring and reporting functions, which would allow prioritisation of those people at greatest need of follow-up. We also found that not all records contained information around physical health. We reviewed 28 patient care and treatment records, staff had not recorded information about physical health in seven records.

Staff used a range of recognised outcome measures to assess severity of mental health and side effects of medication. The outcomes measures used by teams included: the Glasgow anti-psychotic side effect scale, the Health of the Nation Outcome Scales, and the mental health clustering tool. Teams used the mental health clustering tool to score and cluster patients based on their

Are services effective?

Requires improvement

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

needs and risk. In order to compare progress through care and treatment clustering was completed to identify whether mental health needs had become more or less stable and risks reduced or managed better.

The trust had a clinical audit programme for community-based mental health services for adults of working age. Staff told us that some of the audits that teams regularly completed were Mental Health Act audits, care plan and risk assessment audits and prior to our inspection the pharmacist had completed a medicines audit across the teams. We saw an example of a care plan audit that showed that in the Doncaster assertive outreach team that 98% of patient records had a recently reviewed risk assessment and 96% had a complete care plan. An audit in relation to Doncaster recovery team showed that 84% of patients had an up to date risk assessment and 85% had an up to date care plan. We saw that teams had action plans to address issues identified in audits completed.

Skilled staff to deliver care

Not all teams had full access to all disciplines required to provide the required care and treatment. We found that there was limited access to psychologists across all teams. However, information provided by the trust showed that there were only two vacancies against team establishments for psychologists across all localities. These two vacancies related to the Rotherham community therapies team. The trust had not started any recruitment process to fill these posts and these were not covered by bank or agency staff. These posts were on hold awaiting the outcome of a transformation review of the service. The outcome of the review could have resulted in changes to the team compositions.

Other teams that had vacancies which were not filled by bank or agency staff were as follows:

- Rotherham social inclusion team had one vacancy for social worker.
- Rotherham assertive outreach team had one vacancy for social worker.
- Doncaster recovery team had a 0.6 WTE equivalent vacancy for an occupational therapist.
- North Lincolnshire recovery team had a vacancy for one social worker and one mental health officer.

Staff from Doncaster recovery team reported that they could not provide adequate access to psychological therapies due to not having any dedicated psychologist time in the team.

At our previous inspection in September 2015, we identified a lack of direct pharmacy support to the community mental health teams. A business case had since been agreed as part of the medicines optimisation strategy to provide support to all three localities, and recruitment was in progress to fill these posts. At the time of our inspection we saw that there was a pharmacist who worked alongside the teams each week to monitor and audit medicines practices.

We found that staff employed were suitably qualified and experienced for the role they were performing. All new staff received an eight week local induction which included mandatory training courses and on the job familiarisation with the team and the trust's policies and procedures.

Information provided by the trust showed that that not all staff receiving regular appraisal. As of 15 September 2016 the completion rates of staff appraisals were as follows:

- North Lincolnshire recovery team – 13%
- North Lincolnshire intensive community therapies team – 22%
- Rotherham social inclusion team – 55%
- Rotherham assertive outreach team – 64%
- Doncaster recovery team – 71%
- Doncaster assertive outreach team 87%.

We did not receive any information about appraisal rates for Rotherham community therapies team.

We requested the trust to provide supervision rates for the teams that we visited as part of this inspection. The trust did not provide us with supervision rates so we could not identify if these met the target of every 2 months as stated in the trust policy. However, all staff told us that they received regular clinical and management supervision and had access to attend team meetings. The trust had a policy on supervision which stated that clinical staff should receive supervision every 2 months.

Staff told us that they had received some specialist training to support them in their role. Examples of this included Autism training. Unqualified staff across the teams received

Are services effective?

Requires improvement

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

training in completing baseline physical health monitoring including phlebotomy and electrocardiograms to enable them to work in the health and wellbeing clinics as part of the physical health strategy. Unqualified staff had access to diplomas to further their knowledge in health and social care.

Managers told us that they used the personal development record to monitor staff performance. Where staff underperformed in their role, managers told us that they would use the trust's policies and procedures in order to manage performance through capability or disciplinary procedures.

Multi-disciplinary and inter-agency team work

Most teams had social workers employed by the local authority which were seconded to work in community mental health teams. Teams reported that they felt this strengthened the working links between health and social care.

Teams had weekly meetings. The assertive outreach teams had daily morning meetings which all members of the multidisciplinary teams attended. Assertive outreach teams used morning meetings to share information regarding patient care and risk from the previous day. We saw team meeting agendas had standard items which included: safeguarding, lessons learned and any team performance issues. Staff told us that regularly guest speakers attended team meetings. Rotherham social inclusion team had speakers to inform staff of local fire and rescue services and domestic abuse awareness. Administrative staff ensured that team meetings were emailed to all staff.

Staff reported to have working links to a range of external organisations such as, substance misuse services, food banks, local authority social services, housing associations, homelessness services, financial services and benefits advice services. Staff told us that they regularly working alongside and sought the services of these other agencies in order to ensure that patients' had the amenities and services that they needed.

When patients accessing community teams were admitted to inpatient wards staff remained in contact with the wards throughout their stay. Staff from community teams attended ward round meetings and were involved in discharge planning from the wards. During our inspection, we observed staff from an assertive outreach team attend a meeting at an inpatient ward to be involved in discussions about this patient's ongoing care and treatment.

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

We found that staff had a variable knowledge around the Mental Health Act and the Mental Health Act code of practice. Staff across the teams worked with patients with a wide range of mental health needs and the knowledge of staff reflected their experience of working with patients subject to the Mental Health Act. Staff from teams such as the social inclusion team and community therapies team reported that they did not regularly work with patients subject to the Mental Health Act. We found that these staff had a basic understanding of the Mental Health Act and code of practice. Whereas, staff who worked in teams such as assertive outreach teams worked with patients subject to the Mental Health Act more frequently. We found that these staff had more detailed knowledge about the Mental Health Act and code of practice.

Information provided by the trust showed that at the time of our inspection that training in the Mental Health Act was not up to date. The trust reported that the overall compliance rate was 61%. North Lincolnshire teams had the lowest compliance rate which was 37%. This was followed by Doncaster teams which were at 59% compliance.

Staff told us that if they needed advice regarding the Mental Health Act that they could:

- Access the trust's policy on the intranet
- Ask their colleagues for advice
- Speak to approved mental health professionals in their team
- Contact the trust's Mental Health Act office

We found that consent to treatment for patients subject to community treatment orders was sought in line with legislation and guidance. Patients had the appropriate and up to date Mental Health Act documentation. Care co-ordinators ensured that patients were informed of their rights at regular intervals. However, staff at Rotherham assertive outreach team told us that there was not a system to prompt staff in advance that patients' rights were due to be informed. The trust's Mental Health Act office audited

Are services effective?

Requires improvement

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

the adherence to the Mental Health Act. The office would inform teams if patients' rights had not been informed for some time and of any out of date or incorrect documentation. Staff told us that the Mental Health Act office often contacted teams to inform them of issues that they had identified that they addressed these promptly.

When patients were detained under the Mental Health Act to inpatient wards, where a Mental Health Act tribunal was to take place staff from community teams wrote and presented social circumstances reports for patients.

All teams displayed information in relation to independent mental health advocacy.

Good practice in applying the Mental Capacity Act

The Mental Capacity Act is a piece of legislation that maximises an individual's potential to make informed decisions wherever possible. It provides guidance and processes to follow where someone is unable to make a decision. As part of our inspection we looked at the application of the Mental Capacity Act.

All eligible staff had completed up to date training on the Mental Capacity Act. Staff told us that if they needed support with the Mental Capacity Act the could seek advice from:

- The trust's policy that was accessible on the intranet.
- The Mental Capacity Act trainer
- Staff qualified as best interest assessors that worked in some of the teams
- The trust's barrister for complex Mental Capacity Act issues

A best interest assessor is a qualified staff member who has completed training to assess whether or not individuals are being deprived of their liberty. This involves gathering information and assessing individual's capacity to consent to any restriction on their care or treatment which results in being subject to continuous control and not free to leave.

We found that knowledge of the Mental Capacity Act was variable across staff that worked in the teams. We saw that some staff had a basic understanding of the principles of the act however, most staff could describe the act in greater detail and how these applied to their everyday work with patients.

We reviewed 28 patient care and treatment records and we found that 23 records showed that consent to care and treatment was present. Some records showed that patients gave informed consent and other records showed that capacity assessments were in place to assess patients' capacity to consent to their care and treatment.

Staff told us that where patients' lacked capacity to make a particular decision then a best interest meeting was conducted involving the patient. For example, staff told us of some cases where patients' did not have capacity to make decisions about their financial affairs and in their best interests it was decided that this was managed by a corporate appointee.

During our inspection we observed a member of staff assessing capacity of a patient to make what may be considered as an unwise decision. We saw staff explored the reasons for the patient wanting to make this choice and whether they understood the potential consequences of that decision. The patient understood the risks involved and we saw that staff respected this decision. This practice was in line with the principles of the Mental Capacity Act. One of the principles of the act states that individuals that have capacity have the right to make unwise or eccentric decisions.

Information was available about access to independent mental capacity act advocacy services.

Good

Are services caring?

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

Our findings

At the last inspection in September 2015 we rated effective as **good.** Since that inspection we have received no information that would cause us to re-inspect this key question or change the rating.

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

At the last inspection in September 2015 we rated effective as **good.** Since that inspection we have received no information that would cause us to re-inspect this key question or change the rating.

Are services well-led?

Requires improvement

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 a strategic triangle which detailed that their vision was "Leading the way with care". The trust had a mission statement which stated that they aimed to promote health and quality of life in partnership with people and communities. The trust had six key values:

- Passionate
- Reliable
- Caring and safe
- Empowering and supportive of staff
- Open transparent and valued
- Progressive

Staff were aware of the trust values and we saw staff displayed these values in our observations of practice during our inspection. Staff told us that they knew who senior managers in the trust were and these visited the teams.

Good governance

Systems did not ensure that staff received up to date training and appraisal. Information provided by the trust showed that a number of mandatory training courses were not up to date across all teams and not all staff received a regular appraisal. The trust did not provide us with information on supervision rates that we requested.

All teams followed procedures in relation to safeguarding and adherence to the Mental Health Act and Mental Capacity Act. We saw that teams reported incidents appropriately.

Teams had key performance indicators to measure their performance. The trust measured the performance of the teams by locality area against key performance indicators each quarter of the financial year. We reviewed the Doncaster, Rotherham and North Lincolnshire performance and quality reports for July 2016 and found that North Lincolnshire community teams met their key performance indicators and Doncaster and Rotherham community teams did not meet one target by a minimal percentage.

Staff participated in clinical audits. Audits that identified team performance issues had related team action plans with expected timescales for completion. Action plans were reviewed regularly with updates on action taken to address performance issues identified.

Managers told us that they had sufficient authority to complete their duties and adequate administrative support. Staff at Doncaster recovery team told us that they felt that they required additional administrative support. At the time of our inspection there was bank and agency providing additional administrative cover for the team.

There was an escalation process for issues identified by teams. Issues discussed at team meetings could be escalated by managers for consideration for the risk register. We reviewed items on the risk register in relation to community-based mental health services for adults of working age during our inspection. We found that items on the risk register showed issues that we identified during our last inspection were recorded including risk assessments, medicines management and physical health checks. The risk factors calculation score for these issues had reduced as actions had been completed by the trust.

Leadership, morale and staff engagement

The overall sickness absence average across the teams that we inspected was average at 6%. There were no reported cases of bullying or harassment. Staff knew how to raise concerns when needed. Staff told us that they would raise any concerns initially to their line manager and reported that they would feel confident to do so. If they thought that their concerns had not been addressed then staff said that the most important thing to consider was the safety of the patient and they would not have any concerns in whistleblowing if needed. Staff knew where they could find information about whistleblowing on the trust's intranet page.

Staff that we spoke with reported that they enjoyed their roles and found that team members were supportive of each other offering their strengths to support others in the team. They felt this enabled them to provide a better service to patients. Staff reported that there was stress associated with the role but that this was expected due to the nature of their work. Staff who worked in assertive outreach teams reported higher levels of stress. They told us that this was often due to the unexpected circumstances

Are services well-led?

Requires improvement

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.

that they encounter when working with the higher patient need and risk level in the community. However, all staff reported that they received support from their colleagues and managers to enable them to manage this.

There were opportunities for leadership development. We saw that some staff had undertaken post graduate qualifications in management which was funded by the trust. Some staff were completing secondments as team managers.

During our inspection we saw that staff understood the duty of candour. Staff gave us an example of when this had been used following a serious incident and explained the communication, openness and transparency they had provided to the individuals involved.

The trust had groups which were called listening into action groups. These were set up as small work streams to address specific issues that had been put forward by staff. At the time of our inspection there were 20 groups working on small projects. Once these were completed the trust would consider the solutions put forward by the groups to consider an outcome.

During our inspection community-based mental health services for adults of working age were going through a transformation of services. At the time of our inspection teams were waiting for feedback from the trust to show what the service and teams would look like. Staff told us that they felt included in consultations about the services and informed of updates and developments throughout the transformation process. Staff took part in themed conversations to contribute their views on what they thought a great service looked like. The trust sent out regular newsletters to staff with information about the transformation project updates.

Commitment to quality improvement and innovation

The trust had developed a physical health and well-being strategy to improve the physical health of patients. This involved the development of designated health and well-being clinics which would to provide physical health monitoring, interventions and advice around healthy lifestyles. The trust had trained support workers to gain skills to support the running of these clinics. At the time of our inspection these clinics had not started but this was scheduled to start by October 2016.

Staff took part in the 'Recovery steering group' which was aimed at understanding what recovery looks like and how it can be achieved. The group was forming a strategy on promotion of recovery which was due to be presented the trust in October 2016.

North Lincolnshire recovery college received the July 4 Candles Award from the Academy of Fab Stuff. The academy of fab stuff is a collaboration to share best practice, ideas and solutions across the NHS and social care.

Patients from teams took part in research completed. Research specific to adults of working age with mental health illnesses included deoxyribonucleic acid (more commonly known as DNA) polymorphisms in mental illness and research into clinical effectiveness of a bespoke smoking cessation for people with severe mental ill health. Deoxyribonucleic acid polymorphisms in mental illness was a large scale study which was investigating the role of deoxyribonucleic acid polymorphisms as a cause of different mental illness.

This section is primarily information for the provider

Requirement notices

Action we have told the provider to take

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

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 18 HSCA (RA) Regulations 2014 Staffing How the regulation was not met: Staff did not receive up to date training in a number of mandatory training courses. Not all staff received an appraisal. Regulation 18 (2) (a)