Good

North Staffordshire Combined Healthcare NHS Trust

Community-based mental health services for adults of working age

Quality Report

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Locations inspected

Location ID	Name of CQC registered location	Name of service (e.g. ward/ unit/team)	Postcode of service (ward/ unit/ team)
RLY100	Trust Headquarters	City CMHT: Greenfield Centre	ST1 2BX
RLY100	Trust Headquarters	Newcastle CMHT: Lymebrook Centre	ST1 2BX
RLY100	Trust Headquarters	Moorlands CMHT: Ashcombe Centre	ST1 2BX
RLY100	Trust Headquarters	Early Intervention Team: The Hope Centre	ST1 2BX

Summary of findings

RLY100	Trust Headquarters	Approved Mental Health Professional/Best Interests Team: The Hope Centre	ST1 2BX
RLY100	Trust Headquarters	Resettlement and Review Team: The Hope Centre	ST1 2BX
RLY100	Trust Headquarters	Carers Service: The Hope Centre	ST1 2BX
RLY100	Trust Headquarters	Community Day service Support, time recovery team: The Hope Centre	ST1 2BX
RLY100	Trust Headquarters	Growthpoint: The Hope Centre	ST1 2BX

This report describes our judgement of the quality of care provided within this core service by North Staffordshire Combined Healthcare NHS 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 North Staffordshire Combined Healthcare NHS Trust and these are brought together to inform our overall judgement of North Staffordshire Combined Healthcare NHS Trust.

Summary of findings

Ratings

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

Overall rating for the service	Good
Are services safe?	Requires improvement
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 changed our rating of community-based mental health services for adults to good since our last inspection because:

- During our most recent inspection, we found that the services had addressed the issues that had caused us to rate them as requires improvement in our September 2015 inspection. We saw many improvements to the services since our last inspection .
- During our last inspection in September 2015, we found that patient care was not personalised and that patients were not involved with their care planning. During this inspection we saw staff ensured improvements in care planning, care was were personalised, collaborative and care plans included patients' narrative.
- During our last inspection in September 2015, we found staff were not recording patient risk in an accurate and complete way. During this inspection, our team found that staff had improved the way they worked to keep patients safe. Every patient we reviewed had a detailed risk assessment with a thorough risk management plan
- During our last inspection in September 2015, we found that staff were not receiving regular, formal supervision and that appraisals were not consistently completed and recorded. During our most recent inspection, we found that appraisal levels had increased and that formal supervision was regularly taking place including profession specific supervision.
- During our last inspection in September 2015 we found that a refrigerator was not working and as a result medicines could not be stored on site. During our most recent inspection we found that this had been corrected and that the refrigerator was maintained and in working order.

However:

- Waiting lists were long for some services. Waiting times for psychological interventions were lengthy, which prevented patients receiving treatment when they needed it. Waiting lists for the approved mental health professionals and best interest assessors were also long, which meant that people had to wait for deprivation of liberty assessments.
- In the community mental health teams, medicine was not always stored safely as staff did not consistently monitor the temperatures of fridges and rooms where it was stored. Also patients' medicine cards did not consistently contain information about their allergy status.

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:

- At City community mental health team (CMHT,) medicines were not always stored safely as staff did not carry out daily monitoring of the temperatures of fridges and rooms where medication was stored.
- In all CMHTs, medicine cards did not always contain important information about patients' allergy status. Sixty-five percent of the cards that we examined did not contain this information.

However:

- There was rapid access to psychiatrists. Nursing staff were also available for urgent issues. The teams' psychiatrists provided cover during office hours and the crisis team provided this out of hours.
- Staff completed thorough risk assessments and risk management plans. Staff reviewed these regularly and often carried this out in collaboration with the patient.
- Environments were visibly clean and well maintained. There was hand hygiene information displayed in all the teams we visited and there was a lead member of staff for infection control in each of the CMHTs.
- We saw safe working environments for staff, there were alarm systems available for staff to use in interview rooms. Staff worked safely in the community following the lone working policy and ensured that team members knew where they were and when they would return.
- Teams reported and reviewed incidents and learning was shared with teams. Teams discussed learning from incidents at their local meetings, there was also information communicated through an online bulletin.

Are services effective?

Good

e rated effective as good because:

- Care plans were holistic, individual and reviewed regularly. They contained the views of patients and were detailed.

Summary of findings

- The services we visited provided treatment and care in line with national institute for health and care excellence (NICE) guidelines. Prescribing of medication and the provision of psychological interventions followed NICE guidance.
- Teams consisted of a range of disciplines including psychiatrists, nurses, psychologists, occupational therapists, support workers and social workers. The multidisciplinary teams provided patients with holistic care.
- Staff received regular supervision. This included robust case management supervision, using a case management tool.
- Staff were skilled and there were opportunities for training and learning in areas of interest.
- Staff regularly completed audits. There was evidence of learning following audits, there had been a specific focus on the quality of care plans and risk assessments and this had helped improve standards.
- Ninety percent of staff had completed their Mental Health Act and Mental Capacity Act training. Staff showed a good understanding of the acts and how they were applied in practice.
- Staff supported patients to access employment housing and benefits, referring them to employment support staff. The Growthpoint service offered opportunities for patients to learn new skills and gain employment.

However:

- Not all Mental Health Act paperwork was stored correctly; we found that assessment of capacity forms were not stored in patients' care records.
- At Moorlands community mental health team, we found that not all care plans and risk assessments were not entered on the electronic records system which meant that staff in other teams could not access this information.
- Personnel files did not always contain consistent information about staff. The files varied in the information that they contained.

Are services caring?

We rated caring as good because :

Good

Summary of findings

- Staff were kind and compassionate in their interactions with patients; they demonstrated understanding and staff made patients feel welcome. They were polite and respectful in the way they talked to patients.
- Patients told us staff understood their individual needs and that they helped and supported them. Staff told us about the way that they supported patients to make positive changes.
- Staff consistently involved patients in the care that they received and patients took an active role in care planning. Care plans were written collaboratively by staff and patients.
- There was a dedicated carer's team and carer's assessors who provided sign posting and a wide range of support and opportunities for carers. Carers were encouraged to be involved in the treatment of the people that they cared for.
- Patient feedback about the services was actively encouraged and there was accessible information about local service user groups. Feedback boxes were present in reception areas.

Are services responsive to people's needs?

Good

We rated responsive as good because:

- Teams responded to urgent referrals promptly. There was a duty response system in community mental health teams and the early intervention team.
- Teams took proactive steps to engage patients who were reluctant to engage with services. Staff followed up missed appointments with phone calls and home visits.
- All teams had access to staff that had been trained in communicating using British sign language and knew how to access interpretation services for patients with communication needs.
- Patients knew how to make a complaint, there was available information available explaining how to make a complaint in all teams that we visited.

However:

- Waiting lists for psychological therapies were long and this meant that patients did not always have timely access to treatments; however, the trust was taking active steps to reduce this further.

Summary of findings

- Waiting lists for the approved mental health professionals and best interest's assessors were long; this meant that people had to wait for Deprivation of Liberty Assessments.

Are services well-led?

Good

We rated well led as good because:

- The teams used key performance indicators (KPIs) to measure their performance and worked towards specific goals to improve the quality of their services.
- Staff consistently reported that they felt that their managers were supportive and accessible. Staff talked about occasions when their managers had helped them.
- Staff were aware of the trust's whistle blowing policy and felt that they could raise concerns openly without fear of victimisation. Staff told us they were listened to and that their managers were interested in their feedback.
- Morale in the teams was good, staff identified that their workload was stressful. However, they said that their managers supported them and there were processes in place to help them to manage their work.
- There was evidence of learning from incidents, complaints and other feedback being shared across the teams in the directorate.

However:

- Not all staff had received an annual appraisal. This meant that some staff were not having their performance and development reviewed. Staff in community mental health teams and the approved mental health professionals and best interests assessment team had appraisal rates that were lower than the rest of the other teams in the directorate.

Summary of findings

Information about the service

The community mental health teams (CMHTs) provide services throughout the county. They are made up of consultant psychiatrists, psychiatric nurses, occupational therapists, social workers, support workers and psychologists and provide a range of treatments, interventions and assistance to adults aged 16-65. City CMHT is located at Greenfields Centre, Newcastle CMHT is located at Lymebrook Centre and Moorlands CMHT is located at Ashcombe Centre. Moorlands CMHT also used two satellite community venues to see patients so that they did not have to travel too far, we did not visit the satellite services.

The early intervention team is located at the Hope Centre. The team assists young adults aged between 14 and 65 experiencing early signs of psychosis. The early intervention team provides a range of support including; coping with worries and stress, managing and recognising distressing symptoms, how to maintain social activities and education and help returning to work. The early intervention team provided support and advice to family members and carers for people experiencing their first episode of mental ill health.

The carer's service is based at the Hope Centre and carries out assessments for people who are caring for someone experiencing mental health difficulties. Referrals are accepted from carers or professionals supporting the cared for person.

The approved mental health professionals and best interest assessor team (AMPH and BIA) is located at the Hope Centre. The team undertakes assessments under the Mental Health Act and Deprivation of Liberty Safeguards in the Stoke-on-Trent area. A Mental Health Act assessment requires an approved mental health professional and two doctors to consider if individuals experiencing a mental health crisis need to be detained in hospital under section, admitted voluntarily or supported at home.

The resettlement and review team is located at the Hope Centre the team are responsible for the care management of patients in funded placements across the city of Stoke.

The Growthpoint scheme is located at the Hope Centre and provides a therapeutic approach through creating training programmes. The project is for adults aged 18 to 65 providing a structured approach to practical skills, which encourages development, the encouragement of social inclusion and improvement in patients' well-being.

The support, time and recovery team is located at the Hope Centre. The team works in the community to deliver social, leisure and skill acquisition groups. The team also helps patients to develop support networks and promote social inclusion.

The trust was inspected in September 2015. We inspected community-based mental health services for adults of working age as part of this process.

Our inspection team

Our inspection team was led by:

Chair: Beatrice Fraenkel; chairman Mersey Care NHS Foundation Trust

Team Leader: James Mullins; Head of Hospital Inspection (mental health) CQC

Inspection Manager: Kathryn Mason

The team that inspected the community-based mental health teams consisted of two CQC inspectors, a psychologist, three nurses and a social worker. All of the team members had recent mental health service experience.

Summary of findings

Why we carried out this inspection

We carried out this inspection to find out whether North Staffordshire combined healthcare NHS trust had made improvements to community mental health services for adults of working age since our last comprehensive inspection of the trust on 7 – 11 September 2015.

When we last inspected, we rated community mental health services for adults of working age as requires improvement overall. We rated the core service as requires improvement for safe and effective, good for caring and requires improvement for responsive and well led.

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

- The provider must ensure that all relevant care records contain a risk assessment and that this risk assessment contains detailed and consistent information about historical risks of the people that use the services.
- The provider must ensure that care plans completed for the people who use their services are recovery oriented with the person's strengths and goals evident within them.
- The provider must ensure that a person's relative or carer's involvement in the care planning /management plan process is evident within care records where appropriate.
- The provider must ensure that consent to care and treatment and information sharing is consistently recorded within the care records of people using services.
- The provider must ensure that individual caseloads within the ICMHT's remain within the guidance of the mental health policy implementation guide for community mental health teams and that teams have adequate staffing provision.
- The provider must ensure that where people's rights under the mental health act are explained to them, this is recorded consistently within care records.
- The provider must ensure that the statutory and mandatory training compliance is monitored regularly and that outstanding areas of non-compliance are addressed.
- The provider must ensure that where clinical supervision takes place it is consistent with the guidance of the provider's generic supervision policy and is recorded accurately.
- The provider must ensure that where refrigerator equipment for medication is available within community teams, that equipment must be fit for purpose.

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

- The provider should ensure that all staff who undertake home visits to people in the community are aware of their responsibility to check the electronic records system prior to doing so as stated in the providers lone worker policy procedure.

We issued the trust with four requirement notices that affected community mental health services for adults of working age. These related to:

- Regulation 9 HSCA (RA) Regulations 2014 Person centred care. This was breach of regulation 9 (3) (b,c,d,e,f)
- Regulation 12 HSCA (RA) Regulations 2014 Safe Care and Treatment. This was breach of regulation 17 (2) (a,b)
- Regulation 18 HSCA (RA) regulation 2014 Staffing. This was breach of regulation 18 (2) (a)
- Regulation 15 HSCA 2008 (RA) regulation 2010 Safety and Suitability of Premises. This was a breach of regulation 15 (1) (e)

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, we reviewed information that we held about community-based mental health services for adults of working age and requested information from the trust.

During the inspection visit, the inspection team:

- visited nine community-based teams
- spoke with the managers and senior managers for each team
- spoke with 19 patients who were using the service
- spoke with 50 staff members; including doctors, nurses, support time recovery workers, health care support workers, occupational therapists, psychologists and social workers
- spoke with the divisional director and clinical director with responsibility for these services
- attended and observed one meeting, three multi-disciplinary meetings, a carer's forum, a music production group and a best interests assessment
- collected feedback from patients using comment cards
- looked at 41 care records of patients and 83 medication charts
- observed seven appointments in the community and at the teams we visited
- spoke with 14 carers or family members.
- reviewed 20 personnel files
- reviewed the minutes from 28 team meetings
- carried out a specific check of the medication management of three locations
- looked at a range of policies, procedures and documents relating to the services we visited

What people who use the provider's services say

All patients told us staff treated them with respect, dignity and compassion; they said staff were kind and considerate. They said they felt welcome.

The 19 patients our inspection team spoke to were happy with the treatment they received, they were clear that the service met their needs. They were happy with the appointments they were offered

Patients told us they were involved in making choices about their care and they were in control of their treatment. They described problem solving with the staff collaboratively.

Patients told us services were clean, tidy and well maintained and that the buildings were appropriate.

Carers told us staff invited them to meetings, including Care Programme Approach meetings and that this was an opportunity for them give their opinion about the treatment of the person they cared for and for staff to share information with them.

Patients told us when they asked for help staff responded and they could talk to staff about anything.

All patients said they knew how to make a complaint and would feel confident to give feedback to staff.

Summary of findings

Good practice

Newcastle community mental health team (CMHT) had clinics for patients prescribed anti-psychotic medication, they were able to access direct blood results in these clinics for physical health monitoring.

Areas for improvement

Action the provider MUST take to improve

Action the provider MUST take to improve:

- The trust must ensure that there is daily monitoring of the temperature of fridges and rooms where medication is stored, to ensure medicine is stored safely
- The trust must ensure that patients' allergy status is clearly defined on medication prescription charts

Action the provider SHOULD take to improve

Action the provider SHOULD take to improve:

- The trust should ensure all staff know where emergency medication is located.
- The trust should ensure daily cleaning records are completed and that staff use clean stickers to indicate clinical equipment has been cleaned.
- The trust should ensure staff record information about patient allergies on medication cards.
- The trust should ensure staff complete their statutory and mandatory training to meet the local target set.
- The trust should ensure that all Mental Health Act paperwork is up to date and stored correctly.
- The trust should ensure all care plans and risk assessments are recorded on their electronic system.
- The trust should ensure waiting lists are reduced so that patients can access assessment and treatment in a timely manner.
- The trust should ensure all staff complete an annual appraisal.

North Staffordshire Combined Healthcare NHS 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
North Staffordshire Combined Healthcare NHS Trust	City CMHT: Greenfields Centre
North Staffordshire Combined Healthcare NHS Trust	Newcastle CMHT: Lymebrook Centre
North Staffordshire Combined Healthcare NHS Trust	Moorlands CMHT: Ashcombe Centre
North Staffordshire Combined Healthcare NHS Trust	Early Intervention Service: The Hope Centre
North Staffordshire Combined Healthcare NHS Trust	Approved Mental Health Professional/Best Interests Team: The Hope Centre
North Staffordshire Combined Healthcare NHS Trust	Resettlement and Review Team: The Hope Centre
North Staffordshire Combined Healthcare NHS Trust	Carers Service: The Hope Centre
North Staffordshire Combined Healthcare NHS Trust	Community day service, support time recovery team: The Hope Centre
North Staffordshire Combined Healthcare NHS Trust	Growthpoint: The Hope Centre

Detailed findings

Mental Health Act responsibilities

- The trust provided training for community staff in the Mental Health Act (MHA). The trust data showed that 90% of staff had completed their MHA training and this complied with the trust's mandatory training target of 90%.
- Most staff could demonstrate a satisfactory understanding of the MHA, Code of Practice and Guiding principles.
- Our inspection team found the majority of Community Treatment Order documentation was up to date, completed properly and stored correctly. However, we found two files that did not contain capacity to consent documentation. Staff had given all patients their section 132 rights in line with the Mental Health Act Code of Practice.
- Staff were able to access administrative support and legal advice from the trust's central mental health act law team. There was also support around the MHA from the approved mental health professionals and best interest assessment team.
- Staff audited MHA paperwork regularly to ensure the MHA was being applied properly in patient care.

Patients were able to access an independent mental health advocate and knew how to refer patients to this service.

Mental Capacity Act and Deprivation of Liberty Safeguards

- The trust provided training for community staff in the Mental Capacity Act. The trust data indicated 90% of staff had completed their MCA training and this complied with the trust's mandatory training target of 90%.
- Most staff were able to describe the five guiding principles of the MCA and how they would assess capacity when working with patients.
- All staff knew where to access the policy on MCA.
- Capacity assessments we reviewed were thorough and had been recorded appropriately
- Staff could access support from the central mental health act law team in regards to MCA.
- MCA paperwork was audited to ensure that the MCA was being applied correctly.

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

- All locations that our inspection team visited had alarm systems. Staff told us they were familiar with the alarm call system and were able to demonstrate how it operated. At City community mental health team (CMHT), each room contained an alarm. At Newcastle and Moorlands CMHTs, alarms were in the reception area and staff took them into interview rooms as required. Staff tested the alarms on a weekly basis. Interview rooms at The Hope Centre had been fitted with alarms for staff to request assistance, if needed.
- Our inspection team visited clinic rooms at each of the three CMHTs. All clinic rooms were well equipped. The clinic rooms did not have an examination couch but there was a chair, which staff used for observations and taking blood samples. Staff checked clinic equipment on a regular basis, including the defibrillator and contents of the emergency bag. However, at City CMHT, staff did not check the defibrillator consistently. We reviewed this and found staff had checked on 42 occasions out of a possible 50. The community teams based at the Hope Centre did not use a clinic room. Instead, patients' GPs carried out physical health monitoring. CMHTs had anaphylaxis kits available for staff who administered injections. Anaphylaxis kits contained medication staff could use to treat severe allergic reactions. At City CMHT, the team manager was unable to locate the emergency medication, which meant there could be delays. When asked, another member of staff was able to locate it straightaway.
- All of the environments that we inspected were visibly clean, tidy and well maintained. The reception areas were tidy and welcoming. All CMHTs had a cleaning schedule: however, we did not see full cleaning records for the CMHTs that we visited. We did see cleaning records for toilets at both Newcastle and Moorlands CMHTs.
- We observed there was hand hygiene information throughout all of the locations. There were hand-sanitising stations available in all the venues we visited. Each CMHT had a member of staff who took the lead in infection control.
- Safety testing of electrical equipment was visible and in date in all of the locations. We found that fire extinguishers were in date. Clinical equipment in clinical rooms was calibrated; this meant that equipment such as blood pressure monitors, thermometers and weighing scales were safe to use. Clinical equipment was clean; however, at City CMHT, we did not see stickers to show that staff had cleaned clinical equipment.
- The Hope Centre and all of the CMHTs completed an environmental ligature risk assessment in 2016. A ligature risk assessment identifies places where patient's intent on self-harm might tie something to strangle themselves. The completed audits contained a rating for each identified risk and a detailed plan of mitigating factors to ensure the safety of patients using the service.

Safe staffing

- Staffing levels were calculated by the trust, taking into account service need and local population demands.
- Between 1 August and 31 July 2015, 32 staff had left the trust, this turnover equalled 12%.
- Across community services there were 52.7 whole time equivalent nurses and 36.1 whole time equivalent nursing assistants, the nursing assistants were either support time recovery workers or healthcare support workers.
- Vacancy rates across the service were low at 6% and the recorded sickness rates at 5 %. Managers had filled vacant posts or recruitment was taking place. At Newcastle community mental health team (CMHT), there had been a higher level of staff leaving posts. However, recruitment was taking place and there was only one nursing vacancy at the time of the inspection.

Requires improvement

Are services safe?

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

Three of the four staff who were leaving this team were remaining within the trust. At Moorlands and City CMHT, there were no nursing vacancies. None of the CMHTs had any support worker vacancies.

- The average caseloads in the resettlement and review team and in the early intervention team were 25 and 20 respectively for each care co-ordinator. Caseloads in the CMHTs varied; at Newcastle CMHT, full time care coordinators had caseloads of between 32 and 37 patients. City CMHT had caseloads of between 31 and 55 patients. At Moorlands CMHT, full time staff had caseloads of between 20 and 47 patients. CMHT staff in the role of assertive outreach had smaller caseloads due to the nature of work that they carried out. Caseload numbers varied significantly in the teams as team managers considered both numbers on caseload and complexity, for example, larger caseloads often included patients with a lower level of complexity or those who required less frequent appointments.
- There were no service users awaiting allocation of a care co-ordinator at any of the teams we inspected.
- Staff at City and Newcastle CMHT told us that it was not always easy to manage their caseloads but they said they worked well as a team and their managers were supportive, which meant they could meet the needs of the people who used their service. They described effective monitoring and review procedures in the form of regular supervision, team meetings and multidisciplinary team meetings. Teams used a caseload tracker and a robust case management system. Managers within the community services were able to give examples of how they allocated caseloads according to the complexity of patients and the clinical experience of care co-ordinators. There was a directorate level action plan to ensure that caseloads were safe and manageable and the senior management team reviewed this regularly.
- There had been limited use of bank and agency staff within the community services, any use had only been within the CMHTs and these temporary staff were used to manage vacancies while decisions were made about recruitment or while recruitment took place. Recruitment for vacant posts within teams was evident and managers said they felt the trust were responsive to filling staffing vacancies.
- There was rapid access to a psychiatrist out of hours through the crisis team based at Harplands Hospital. All of the CMHTs had rapid access to a psychiatrist during working hours. Staff consistently told us that they could always access a psychiatrist when required. Psychiatrists told us how they ensured that staff could contact them when they were not on site.
- Across all of the teams, 91% of the staff were up to date with mandatory training. The trust provided a range of mandatory training including conflict resolution, information governance, infection control and mental health law, which included the Mental Health Act and Mental Capacity Act. There were some teams where compliance fell below 75% in specific training areas. At the community day service and carer's service, 63% of staff had completed conflict resolution. At Newcastle CMHT, 68% of staff had completed conflict resolution and 74% of staff had completed resuscitation training (CPR). There were effective systems and processes were in place to monitor this.

Assessing and managing risk to patients and staff

- Our inspection team reviewed 41 records relating to the care and treatment of patients during our inspection of the community services. All records contained a risk assessment. Staff completed risk assessments at the initial point of contact and updated them at a minimum of every six months or if there were changes to patients' risk levels. In community mental health teams (CMHTs), care records demonstrated that staff were regularly completing risk assessments, often collaboratively with patients and that these detailed triggers for risk and plans of how to reduce and manage risk.
- Most care records reviewed demonstrated crisis plans for patients. We observed that staff had documented who to contact in an emergency, what patients' wishes were if they became unwell and what strategies staff could use to help them in a crisis. There was evidence in patient records of advance decisions being recorded.
- The CMHTs and early intervention team operated a duty rota system; this enabled staff to respond immediately to patients under the care of the team if they were unwell or were in crisis. Information about the duty service in CMHTs was available to service users and could be located in all reception areas. Early intervention team staff described using an assertive

outreach model to support patients that were experiencing an increase in mental health symptoms. This included increased visits from the team, daily if necessary and working collaboratively with the home treatment team. Each CMHT had assertive outreach workers who worked with patients with complex needs who struggled to engage with the wider team.

- The CMHTs and early intervention team did not have a waiting list. The CMHTs monitored people at triage to assess risk and patient needs to ensure that they were receiving the care they needed at the right time. The approved mental health professionals and best interests assessment team had a waiting list, the team manager triaged referrals using a red, amber or green standardised assessment. Referrals rated as red or amber were categorised as urgent and requiring assessment within 14 days, green were routine referrals with a target timescale for assessment of 21 days. Although waiting lists existed in the carer's service, they were monitored and there were sufficient staff to complete urgent referrals. There were waiting lists for psychological therapies in CMHTs. The psychology teams based in the CMHTs told us how they monitored patients on the waiting list to assess and respond to risk. They also provided a weekly update on the waiting list at the MDT that enabled planning and referral into psychological groups if appropriate.
- Staff within the community teams had access to safeguarding children and adults training as part of the trust's mandatory training package. The community teams average compliance rate for safeguarding children training in August 2016 was 88%. The average compliance rate for safeguarding adults training was 89%. In addition, the trust had introduced in-depth safeguarding level three training and some staff had already completed this training. Staff in the CMHTs demonstrated that they knew how to create a safeguarding alert and gave examples of how they had made referrals. Staff knew that they could seek support from their managers about safeguarding and all staff could identify the trust wide safeguarding lead. They were able to ask for advice and guidance from the trust's safeguarding lead if they had a concern or question.
- The trust had a lone working policy and procedure in place for the use of all staff. All community staff that we spoke with were aware of the lone working policy. Teams used a combination of signing in and out books, whiteboards in communal offices and outlook calendars to document their whereabouts and expected duration of community visits. Staff completed a risk assessment of all patients before undertaking community visits. Staff visited patients in pairs or saw them on trust premises if they identified a safety issue. The CMHTs allocated a member of staff to check if all staff had reported in to the office before the end of their working day.
- In all of the CMHTs, medicine was stored securely and medicine transported in lockable containers. However, there was variation in the storage and monitoring of medication in CMHT clinic rooms. Staff systematically monitored temperatures of both fridges for storing medication in clinic rooms at Newcastle and Moorlands CMHTs. At City CMHT, fridge temperature monitoring forms were available from 1 April 2016 through to 12 September 2016; we reviewed these and found that staff had monitored the temperature of the fridge on 68 occasions out of a possible 114. Audits seen from the period January to March 2016, showed only two entries on the refrigerator monitoring forms. We reviewed the room temperature monitoring forms from 1 July 2016 through to 13 September 2016 temperatures had been recorded on 39 occasions out of a possible 51, this meant that medication might not be safe to use. The early intervention team used a locked medication cabinet for the storage of medication. Records showed that staff carried out temperature checks of the medication cupboard and the room it was stored in, staff logged these daily, and temperatures were within the recommended safe range. Staff reported medicine errors using the incident reporting system, however there was no regular clinical pharmacist involvement in patient medicine requirements. The trust wide medicine audit was last completed 18 months ago. Of the 83 medication cards that we examined, we found that 54 had no documented allergy status for patients.

Track record on safety

- There had been 13 serious events requiring investigation across community services during the period 1 April 2015 – 31 March 2016. Senior managers and team managers told us how they conducted a thematic review of the incidents and provided evidence of learning and action plans, which came about following analysis of the events.

Requires improvement

Are services safe?

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

- The recommendations following the serious incidents did not identify any root causes but there were improvements identified in the process related to writing up care records and recording information. Action plans identified the following. The quality of care plans and risk assessments should be improved and these should be regularly reviewed. Patients who did not attend their appointments repeatedly should be discussed at multidisciplinary team meetings. Finally, when staff were absent their caseload should be managed properly by another member of staff. The action plan also identified that staff training should take place about the action points identified. We saw that all of these actions were taking place.

Reporting incidents and learning from when things go wrong

- All staff that our inspection team spoke with knew how to report incidents and had access to the trust's electronic incident reporting system. Staff told us that they reported all incidents and near misses and that they received data about this as part of their team management and key performance indicator data.
- All community teams were regularly reporting incidents; they shared evidence of particular incidents and learning with us such as examples of partnership work with the fire service and training that was delivered regarding hoarding and fire risk. The trust used a learning lessons booklet, published monthly by the patient and organisational safety department. The aim of this was to learn from incidents that had taken place at a team level and within the trust.
- Duty of candour guidance was provided as part of the learning lessons booklet and included guidance from the nursing and midwifery council and the general medical council for doctors. Senior managers of the community services gave examples where they had been open and honest with families and had engaged families in incident review processes. Staff gave examples of when they had apologised to patients and managers showed us examples of process when apologies had been made in responses to complaints.
- Staff met to discuss incidents and the team discussed these at team meetings and governance meetings. The inspection team saw meeting minutes, which showed that this took place.
- The managers in each community mental health team (CMHT) gave examples of changes that the team had made because of recent incidents and how they had shared this with their team. At City CMHT, there had been a review of their duty process following an incident. They demonstrated how they had worked with the police to learn from this and that they were reviewing how they managed their duty response service at certain times of the day. The manager discussed this incident in the local governance meeting and shared learning with the wider team.
- Staff that our inspection team spoke with were able to discuss the debrief process that took place following a serious incident. Some staff in CMHTs had completed training in debriefing and had used this skill in their teams. Staff told us they had received support from local and senior management within the trust following serious incidents. A staff counselling service was in place and the inspection team were given examples of where this had been used when required. Staff that we spoke to in the CMHTs told us that their mangers had supported them well when they had been involved in incidents

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

Assessment of needs and planning of care

- Our inspection team reviewed 41 records relating to the care and treatment of patients during our inspection of community services. We found that all records showed evidence of patients that used the services receiving a comprehensive assessment of their needs in a timely manner.
- All of the care plans reviewed across the teams' demonstrated evidence of a holistic consideration of patients' individual needs. Care plans were personalised and reflected the wishes of patients using the service. We saw evidence of collaborative working between staff and patients to maintain the recovery and narratives from patients that included their views and wishes. Thirty-nine of the 41 care plans that we saw had been reviewed and were up to date. The carer's service, support time and recovery day services team and Growthpoint all maintained service plans within patient files. We reviewed 12 of these and found that all service plans showed evidence of treatment goals and planned interventions being developed between staff and patients. Staff had recently reviewed service plans and these contained signatures of patients and consent to engage in treatment had been documented.
- All information needed to deliver care was stored securely. The electronic system enabled all community teams to have access to the same information; paper care records had been transferred to this system. A limited amount of information, such as letters and results received, were stored securely in paper files. This was because the electronic system could not accept scanned documents. However, at Moorlands CMHT, staff had not transferred all information onto the electronic system, this meant that other community mental health teams could not view some risk documentation. Staff at the approved mental health professionals and best interests assessment team could describe how they used the trust's electronic record keeping system and that of the local authority to ensure all information was readily available to staff.

Best practice in treatment and care

- All community teams ensured that staff followed NICE guidelines when prescribing medication. The consultant psychiatrists provided CMHTs with guidance following national institute for health and care excellence (NICE) guidelines for prescribing. The community mental health teams were delivering interventions for the treatment of psychosis and schizophrenia in line with NICE CG178 and for bi-polar disorder NICE CG38.
- Community teams offered psychological therapies recommended by NICE. Community mental health teams (CMHTs) had a psychology team who offered a range of interventions in line with NICE guidelines including CG90 for treating depression and CG78 for treating psychosis. The psychology staff offered a range of therapies including cognitive behaviour therapy, dialectical behaviour therapy and group programmes including mindfulness. The psychology staff offered training and support for staff to deliver psychological interventions to their patients. The early intervention team delivered psychological interventions to patients in line with the NICE and quality standards for the treatment of psychosis and schizophrenia, CG155 and QS102 for children and young people and CG178 and QS180 for Adults. The interventions included cognitive behavioural therapy for psychosis and family interventions. All staff within the early intervention team were trained in delivering family therapy to meet the needs of families and carers for patients experiencing a first episode of psychosis. Newcastle CMHT ran a hearing voices group at a local community venue and all patients across the service could access this. All CMHTs ran anxiety and depression groups. City and Newcastle CMHT were developing a joint women's psychotherapy group. Patients could access any of the support and therapeutic groups run by any CMHTs if they were able to travel.
- The early intervention team had introduced a clinical pathway to increase client access to psychological therapies, this included access to family interventions and psychosocial interventions offered by care co-ordinators, as well as access to more specialised psychological interventions offered by the team's clinical psychologist. Moorlands CMHT had developed specific clinical pathways for patients with eating disorders, autistic spectrum disorder and attention deficit hyperactivity disorder to improve patient

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outcomes. There were staff at Newcastle CMHT who were trained to carry out adult Asperger assessments; they could support the other CMHTs with these assessment skills.

- Community teams supported patients to access employment, housing and benefits. They referred patients to local charitable organisations for specialised help. City CMHT worked with the trust's employment team "Step On" and Newcastle and Moorlands CMHTs worked with an external provider. All CMHTS had information in their reception area about accessing employment support and details of numbers of patients who had been successful accessing work. Community day services staff delivered a wide range of interventions to support patients with vocational and educational therapeutic goals. Services included social groups, carers groups, gender specific groups for both male and female patients and music and arts group with access to a fully equipped music studio. We attended a number of groups and saw staff worked collaboratively with patients to improve social inclusion, empowerment and wellbeing and to support them to access volunteering, education and employment. Growthpoint offered opportunities and training to patients in the community, including horticulture, landscape gardening, furniture restoration and building and plumbing. Qualifications in horticulture and plumbing were delivered by staff, assessed, and accredited by the open college network. Staff and patients at Growthpoint delivered landscaping and gardening contract work in the community. Staff helped patients using the service to obtain qualifications and some patients had become employed by the trust.
- CMHT staff assessed patient's physical health on an annual basis and we saw consistent evidence of physical health interventions in care records. Where patients were prescribed anti-psychotics or lithium, there was increased physical health monitoring in line with NICE guidelines CG185 and CG 178. There was evidence of flexibility in engaging patients in physical health interventions in all CMHTs. The early intervention team participated in the national commissioning for quality and innovation framework for physical healthcare for patients. The identified outcome was that 90% of patients would receive a review of their physical health needs using the Lester tool to assess their cardiac and metabolic health.
- Community services used a variety of outcome measures and rating scales to measure the severity of patients need and the effectiveness of clinical interventions. Outcome measures used by the teams included the health of the nation outcome scales which is a tool developed by the Royal College of Psychiatrists to measure the health and social functioning of people with severe mental illness. The CMHTs used the abnormal involuntary movement scale and the Liverpool university side effect rating scale to monitor patients prescribed anti-psychotic medication. The early intervention team used the process of recovery questionnaire and the psychotic symptom rating scale as part of their patient rated outcome measures assessments and the process of recovery questionnaire, which looked at aspects of recovery that were meaningful for patients who have experienced psychosis. Staff used the psychotic symptoms rating scale to measure how distressed patients had been by voices or beliefs during the previous week. The early intervention team had developed a case management tool to identify when staff should use outcome measures and carry out reassessments.
- Staff were involved in clinical audits. CMHT staff regularly audited the quality of care plans and risk assessments; this had helped the teams improve care standards. All CMHTs had completed an audit about monitoring patients who were prescribed lithium and prescribing for patients with bi-polar disorder. City and Newcastle CMHT had audited prescribing for attention deficit hyperactivity disorder (ADHD). The approved mental health professionals and best interest's assessment team had audited reports completed by approved mental health practitioners, outcomes from the audit were reviewed with the team and learning points shared with the approved mental health practitioner forum. Audits were completed in the early intervention team to review completeness of care plan documentation by care co-ordinators. This included a review of the full range of patient needs and evidence of patient involvement. The best interest assessment team had completed a 2016 audit to review the completeness of Deprivation of Liberty Safeguards paperwork in accordance with guidance published by the West Midlands regional Deprivation of Liberty Safeguards Lead Group. This followed changes in the assessment paperwork because of the March 2014 Supreme Court

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judgement about what may constitute a Deprivation of Liberty. Areas covered within the audit included the views of the relevant person and others involved in their care, that the best interest requirement had been met and that the Deprivation of Liberty was a proportionate response to the likelihood of harm occurring. The results from the audit were very positive with only two red scores denoting lack of evidence in the 384 domains reviewed over 32 case records. Medication audits were completed monthly by the pharmacy department at good hope hospital. The resettlement and review team and carer's service care records showed that patient and carer's needs had been assessed in line with the Care Act 2014. This included consideration of outcomes as part of the adult eligibility threshold and wellbeing principles.

Skilled staff to deliver care

- A full range of mental health disciplines were available throughout community mental health teams to provide treatment and care for patients under the care of the community teams. This included support time recovery workers, occupational therapists, social workers, psychologists and community psychiatric nurses.
- The trust's human resources department monitored professional registration with the Nursing and Midwifery Council and the Health and Care Professions Council centrally. Managers our inspection team spoke with were able to describe the process used to ensure all qualified staff maintained their profession specific qualifications.
- Staff in all teams attended trust and local inductions to the workplace and this was documented within some personnel files and reviewed as part of managerial supervision. Staff at Growthpoint undertook a trust induction followed by four-week observations in the use of machinery. All unqualified staff completed the care certificate as part of their induction; some unqualified staff also completed a certificate in working in community care. City CMHT were in the process of piloting a new electronic information system which all staff could use and was useful for staff who were new to the service. The system contained personal staff information and all documents, policies and information that they would need for their role.
- Staff in CMHTs received supervision. Not all staff had received an appraisal; however, we saw significant improvement since our last inspection. The teams also organised group supervision and support for staff. Staff could access clinical supervision from a member of staff of their choice, should they wish to. Newcastle CMHT had organised an informal support group called "let's talk team" where staff could raise concerns and talk about team matters, this was specifically set up for the team to use as a forum to help stress levels and team functioning. There were regular team meetings in all teams we visited. Professional staff including social workers and psychologists were able to access profession specific clinical supervision and to attend professional forums with colleagues from other teams. Appraisal (annual personal development review) compliance within the community teams was 91%. Staff that we spoke to told us they had received an annual appraisal, we saw evidence of annual appraisals in personnel files and on the trust intranet. Some teams had lower levels of appraisals. In City CMHT 63% of staff had had an appraised, in Newcastle CMHT this was 80% and in Moorlands CMHT this was 85%. The approved mental health professionals and best interest assessment team had completed 78% of their appraisals. All CMHT managers demonstrated that they had booked in the outstanding appraisals to be completed. The average rate for staff that had received regular supervision in line with the trust policy across the community teams visited was 96%. Staff were being regularly supervised in all teams. Supervision documents included a thorough case management tool, which gave staff an opportunity to review their caseload in a systematic way, some teams used a system which identified as patients as red, amber or green. This helped staff to identify risks for patients and monitor patients' recovery progress.
- There were training and development roles available within community teams and our inspection team met with staff undertaking training to be social workers and psychologists, staff told us about specific training they had completed which was relevant to their role. Most staff that we spoke with said that they felt well supported by the trust, their colleagues and managers in community teams and valued the opportunities for professional development. However, some staff said there were not enough opportunities to develop in their

role. Each CMHT held team education sessions. They used these sessions to invite external speakers to talk to the team, feedback on audits or as an opportunity to explore learning about new approaches in mental health. The approved mental health professionals and best interest assessment team had developed effective links with Birmingham University who delivered training to staff. All approved mental health professionals undertook annual training in the Mental Health Act and Mental Capacity Act as part of their role. The best interest assessors were required to complete annual profession specific updates.

- There were no staff performance issues at the time of the inspection, however, we saw evidence in personnel files that managers had dealt with poor staff performance in the past and that they had used the trust's sickness and absence policy. The trust occupational health department had supported staff with poor attendance and we saw evidence that local team managers worked collaboratively with staff subject to sickness and attendance management. Where there had been stress at work identified as a cause of sickness staff were supported appropriately and sensitively.

Multi-disciplinary and inter-agency team work

- There was evidence that regular team meetings, team supervision and business meetings took place in all community teams and we reviewed minutes of these as part of our inspection activity. Items included on team meeting agendas included referrals and outcomes, reviewing patients who had missed appointments, current assessments in progress and patients waiting for discharge. The early intervention team reviewed patients on their caseload that were at risk due to their mental state and patients that were making the transition to services including CMHTs and to the care of their GP in the community. All CMHTs had weekly MDT meetings. We observed MDT meetings in City and Moorlands CMHTs. Both of these were structured, attended by a range of staff and demonstrated a robust approach to managing risk for the people that used their services. Each of the CMHTs had invited the employment support agency they worked with to their MDT. Moorlands CMHT worked in partnership with a local mental health charity who attended their weekly MDT meetings.
- All of the staff that our inspection team spoke with in the CMHTs, community day services teams, the approved mental health professionals and best interests team and Growthpoint described a culture of multi-disciplinary working and mutual support from their colleagues. Moorlands and City CMHTs had team meetings on a weekly basis where hand over and planning took place. Newcastle CMHT had a short daily meeting for handover and planning.
- CMHTs had introduced a link worker to work with the inpatient wards and the crisis team. Staff said that this had improved the handover of patients between teams and had helped to reduce risk for people who use services.
- There were effective working links with primary care and social services. Our inspection team spoke with social care staff that worked for the trust as part of a section 75 agreement with the local authority who reported that they felt supported by colleagues in both organisations. Staff in the best interest assessment team reported effective communication links with local GPs, care homes and hospitals. The resettlement and review team were responsible for the care co-ordination of patients within the Stoke-on-Trent area in funded nursing and residential placements. Staff described building effective communication links with local clinical commissioning groups, this assisted patients that were moving from secure inpatient settings to secure community settings. The community day services team delivered some services in partnership with brighter futures who also owned some of the community locations where staff delivered services, including the carers group and the "Jam Factory" music production studio. CMHTs worked in partnership and had good relationships with a range of organisations in the community including housing, employment and primary care services. There was also evidence of effective and beneficial interagency working with the fire service and police across all CMHTs. Moorlands CMHT had been working closely to deliver services in partnerships with a local mental health charity. We spoke to staff from the charity who said the experience was beneficial for people who used services.
- Staff at Growthpoint held an annual trip abroad funded by patients, who had achieved work through qualifications gained with the service. These included trips to Paris, Normandy and Belgium. The service had

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obtained funding to buy transport enabling them to undertake community and landscaping projects. Our inspection team met with patients engaged in skill gaining activities, including plumbing and brazing pipework, furniture restoration and horticulture.

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

- The Trust provided mental health law training for community staff including training on the Mental Health Act 1983 and the updated code of practice 2014. The average compliance rate of the community teams visited during our inspection was 90%. Most staff that we spoke to were able to demonstrate a satisfactory understanding of the Mental Health Act, the Code of Practice and the Guiding Principles.
- Twenty-three patients were subject to a community treatment order (CTO). We reviewed seven sets of CTO documentation. All patients had their S132 rights to read to them and staff routinely reviewed this. CTO documentation was up to date, staff had properly completed the correct paperwork and it was stored appropriately. However, in two of the records, documents recording assessment of capacity were not present. The deputy team manager at Moorlands CMHT followed this up immediately to locate the documentation to ensure that it was stored appropriately. All of the care plans that we reviewed in these files contained information about the CTO.
- Administrative support and legal advice on the use of the Mental Health Act and the code of practice was available for community staff from the Mental Health Act law team based at Harplands hospital.
- Regular audits of Mental Health Act documentation took place in the teams.
- The approved mental health professionals and best interest assessment team had developed a pathway providing guidance with Mental Health Act assessments. Details included the process from the referral to the access team, through the team involvement and outcomes following a Mental Health Act assessment being completed; this included admission, the use of Community Treatment Orders or further interventions by community services.
- Patients had access to the independent mental health advocacy service (IMHA) based at Harplands hospital. There was accessible information about advocacy at all services apart from City CMHT; staff here told us they had just ordered new leaflets. Staff understood the role of the IMHAs and knew how to refer patients to them.

Good practice in applying the Mental Capacity Act

- The Trust provided Mental Capacity Act training as part of the Mental Health law training for community staff. Ninety percent of staff had completed training in the MCA.
- There were variations in depth of knowledge about MCA. However, most staff could talk about the five principles and how the MCA is applied when working with patients. They were able to explain best interest decision-making and supporting patients to make decisions themselves wherever possible. Staff knew how to refer to advocacy services that provided independent mental capacity advocates.
- There was a trust policy on MCA and staff knew that they could access the policy on the trust intranet.
- Staff sought consent to treatment at initial assessment and could assess capacity if appropriate as part of the assessment process. Capacity assessments that the inspection team viewed were thorough and recorded appropriately. Staff assessed capacity in relation to specific decisions and ensured that these decisions were made in the best interests of patients. We reviewed capacity assessments that staff had completed at the deprivation of liberty and best interests assessment team and at CMHTs. We found that staff assessed and recorded capacity to consent appropriately. We saw evidence during a best interests assessment that a patient was given assistance to make a specific decision for themselves before they were assumed to lack the mental capacity to do so. Staff provided the patient with verbal and written information as part of a deprivation of liberty safeguards assessment, and they were provided with information about their right to appeal any decisions made and the role of an Independent Mental Capacity Advocacy service.
- Records reviewed from the approved mental health professionals and best interests assessment team demonstrated consistent involvement with the families, carers and support networks of the people using their

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service. We saw family and carer's views were sought and were reflected in the decision making process when considering Deprivation of Liberty Safeguards. We saw that staff considered the views of patients and those that cared for them, including families, health professionals and nursing home staff. These were documented in records as part of the best interest assessment process.

- Staff could access advice from the mental health act law team within the trust but also sought advice from colleagues with specialist skills. Throughout the directorate of community mental health, there were several staff who were trained as approved mental health professionals and as best interest assessors. Both of these roles involved specialist training in applying the MCA and these staff gave advice to colleagues across the service. Staff told us they were able to access the deprivation of liberty safeguards team and best interest assessment team if they needed advice on the use of the MCA.
- MCA paper work was reviewed and audited by the trust to ensure that staff were applying it properly in their work with patients.

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

- Throughout the inspection, our inspection team observed staff to be kind, respectful and compassionate. Our inspection team saw that staff were understanding and sensitive when interacting with patients. Staff supported patients with their emotional health and activities of daily living. We saw staff relaxed with patients in the reception area, making them feel welcome, supporting them with mobility issues and giving patients information leaflets.
- All patients that our inspection team spoke to said staff were positive, helpful and were there when they needed support. Patients described staff as caring and said they were polite and respectful. We met with a patient from the early intervention service who told us staff were brilliant and understanding. They felt they could talk to them about anything. Another patient we met with told us staff never gave up hope and their keyworker had been their lifesaver.
- Staff in all the community mental health teams demonstrated that they understood the individual needs of patients. They told us about the way they supported patients in their recovery and to improve their lives. Care plans reflected holistic and individualised care. All patients we met told us staff took the time to get to know them and had developed an understanding of their individual needs. Patients were supported to gain meaningful occupation and work. A range of patients had engaged in vocational and educational opportunities because of attending Growthpoint, all of whom told us the service had been a key factor in their recovery progress. One patient we met with told us that the service had offered them the opportunity to grow, whilst knowing they had support from staff they could rely on if needed.
- At all of the community mental health teams (CMHTs), our inspection team saw clear desks when staff were not using them. We also saw staff logging out of their computers when they had finished using them to ensure electronic care records and patient information was secure. Patients and carers we spoke with said they felt staff maintained confidentiality whilst working with them.

The involvement of people in the care they receive

- Care plans our inspection team reviewed demonstrated patients participated in their care. Our inspection team saw patient involvement in development of care plans and that staff offered a copy of the plan. Patients told us they had been directly involved in their care planning and most patients chose to have a copy of the care plan. Patients said they were involved in making choices; we saw evidence in notes that staff had recorded that a patient had disagreed with their care plan. We observed appointments that involved patients on their care and promoted choice. Staff members spoke about a recovery focus in treatment; we observed a nurse-prescribing clinic at City CMHT where the nurse actively empowered a patient to manage their health better through strength based care planning. At a consultant psychiatrist clinic at Newcastle CMHT, we observed that the consultant provided patients with a copy of their shared risk assessment and immediate care plan, which they were consulted on and had agreed.
- The Growthpoint service had developed an induction pack for patients using the service; this included a health and safety checklist, standards of what patients could expect from staff and promoted the service philosophy of working with patients to help them identify, value and develop their skills and talents. One patient at the early intervention team showed us a recovery journey portrait illustrating stages of their journey from being unwell to being in recovery. They attributed their success to support from their key worker and the team.
- The carer's team and carer's assessors based in Newcastle and Moorlands community mental health teams offered and facilitated carers' assessments. City CMHT referred carers into the carers' team for assessment. With patient consent, staff invited carers to care programme approach (CPA) meetings. Carers told us staff had always involved them in the care review process. Carers were able to attend meetings and both give and receive updates about the person they cared for. The carers' service had developed a comprehensive information pack for the carers of people using the service. This included a list of useful contacts, information about common conditions, the care programme approach, carers' assessments and what to expect if someone they cared for was admitted to

Good

Are services caring?

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hospital. They supported carers using direct payments and personal budgets accessed from the local authority to access gym memberships and complementary therapies. Our inspection team attended a carer's group at the Phoenix Centre and met with carers using the service. They described the service as a "little haven" and told us that staff offered support to them in a non-judgemental way, so that carers felt safe to discuss their concerns. carers that we spoke with said that staff were always willing to listen and went beyond what they would have expected in their efforts to help people using the service. When we visited the carers' team, a carers' support group was taking place and staff offered complementary therapies. The early intervention team ran a support group for the carers of young people experiencing psychosis, the aim of this was to provide people with the opportunity to ask questions and seek advice, meet others with similar experiences and build community support networks. Staff at the early intervention team had identified a need in service provision for patients who had a parental role and developed family oriented groups and outings as a result. This included social trips and Christmas parties; they recognised the need for increased support during school holidays.

- There was information about advocacy in the reception areas of Newcastle and Moorlands CMHT's. This was not visible in City CMHT but a volunteer who welcomed and supported patients in reception told us they had new advocacy leaflets. Staff were able to tell us how to access advocacy services. A patient told us that he had used advocacy services in the past.
- Patients that our inspection team spoke with across all the community teams told us they were able to give feedback on the services they received. Feedback forms were collated locally and through team satisfaction surveys. At a nurse practitioner clinic in Moorlands CMHT a nurse had designed her own feedback forms so that she could review and make potential improvements to her clinics. Team administrators send out feedback forms to patients and we saw evidence of this at Newcastle CMHT. Patients using the Growthpoint service had regular meetings with the project co-ordinator where they could plan upcoming events, including day trips. At these meetings, they provided and received feedback about the service. The early intervention team completed an annual patient satisfaction survey; feedback was extremely positive with some service users saying they had received help at a vital time in their life. Patients also provided feedback on the service through the North Staffordshire service user group. Patients were not involved in recruiting staff on interview panels but Moorlands CMHT were making plans to involve patients in the staff recruitment process. Newcastle and Moorlands CMHTs these took part in a friends and families feedback survey that provided positive feedback about services. We attended an assessment as part of the approved mental health professional and best interests assessment team and saw staff took time to discuss the purpose of the visit with the patient and their family, liaised with other professionals involved in their care and were patient centred and empathetic during the assessment process.

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 community mental health teams and early intervention team received referrals from a number of sources including healthy minds, GPs and other professionals. The majority of referrals came through the trust's access team who then referred these on to the early intervention team and CMHTs after they had completed a full assessment and a risk assessment. Patients or their GPs could make referrals directly to CMHTs if they had been in treatment with the CMHT within the last 12 months. The CMHTs referred into the support time recovery team and Growthpoint carers' service. The CMHTs and carers could refer into the carers' service. The approved mental health professional and best interest assessor team and the review and resettlement team received referrals for people who were in funded care placements.
- The community mental health teams and the early intervention team were meeting the national target times set for their services by NHS England. The CMHTs had an average waiting time from referral to assessment of nine days and from referral to first treatment of 35 days. The early intervention team was meeting the national access and waiting standard times. They were also meeting national institute for health and care excellence guidelines for the treatment of psychosis and schizophrenia in young people CG155, and adults CG178. The standard requires that from 01 April 2016, more than 50 % of people experiencing a first episode of psychosis should commence their package of care within two weeks of referral to the service. The team had met the national standard with an average of 75% of patients in the five months since its introduction and in the month prior to our inspection had exceeded the target by 35%.
- There were waiting times from referral to start of treatment for psychological therapies in the CMHTs. There were 168 patients waiting for psychological therapies and the average waiting time was 26 weeks. Of these patients103 were already engaged in treatment with the CMHTs. Psychology staff told us that the Newcastle CMHT waiting time had increased recently due to staff vacancies and leave, however a new psychologist was working with the team reduce the waiting time. The psychology teams were all working hard to manage their waiting lists and improve access and there was a directorate level plan for this. Staff identified that referrals had increased, as CMHTs had become more recovery focused. The patients on waiting lists for psychological therapies that were not already working with the wider teams had nearly all been referred by the healthy minds team and the CMHTs were working closely with the healthy minds team to manage these referrals effectively.
- The approved mental health professionals and best interests' assessment team had a waiting list of 520 Deprivation of Liberty Safeguarding assessments at the time of our inspection; this had increased from the end of the financial year 2015 to 2016 when there were 371 assessments waiting. The team was commissioned to undertake 900 assessments a year and had received 1,348 in the year 2015-2016. The manger had identified that waiting lists for Deprivation of Liberty safeguarding assessments were a national issue following the March 2014 supreme court judgement about what may constitute a Deprivation of Liberty. The service manager was taking action to reduce the team waiting list, this included securing extra funding from the local authority for staff to work bank shifts to reduce the backlog. The team case manager was monitoring the current waiting list and all referrals to the team received an automated response informing them of the waiting list and actions to be taken if they required an urgent assessment.
- Staff were able to respond to urgent referrals quickly if required. CMHT staff saw urgent referrals within four hours. Although waiting lists existed in the carer's service and the approved mental health professionals and best interests assessment team, these were monitored and there were sufficient staff to respond to urgent referrals.
- All of the staff that our inspection team spoke with across the community teams gave examples of the steps they would take to engage with people who found it difficult or were reluctant to engage with mental health services. This included offering flexible times and locations of appointments, using community resources and working beyond service hours if this met patient need. At multidisciplinary meetings in CMHTs, staff

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sought solutions to engage with people who did not engage with services. Staff told us they took a proactive approach wherever possible to make contact with people who used their service.

- All staff and managers were clear about the criteria for patients that they could offer a service to and considered carefully their referrals to ensure they were offering their service appropriately. The CMHTs worked closely with the trust's healthy minds team to make sure they were accepting appropriate referrals.
- CMHTs operated a duty response system so that staff could deal with phone calls promptly if care co-ordinators were unavailable. City CMHT had installed a second phone line to improve their response to phone calls. The early intervention team also operated a duty system to enable a member of staff review referrals and respond to any patients.
- Staff told us that they tried to be as flexible as possible when offering appointments, and always took into account patients' preferences about appointment times. However, it was not always possible to be as flexible when booking appointments with psychiatrists and psychologists.
- Carers and patients that our inspection team spoke to told us that appointments ran to time and they were confident the service would explain why delays happened if it was the case that they did. At Newcastle and City CMHTs, we saw appointments ran punctually. Managers and staff told us that appointments were only cancelled when necessary. However, a member of staff from Newcastle CMHT said when they needed to manage a crisis they sometimes had to cancel appointments and that this has happened regularly in recent months due to staff leaving.

The facilities promote recovery, comfort, dignity and confidentiality

- All community mental health teams (CMHTs) had a range of rooms including meeting rooms, reception, clinic room, interview rooms and a group room. Staff at City CMHT told us that sometimes they did not have enough rooms to see people. However, they managed this by seeing people at home wherever possible and they were able to use rooms in other trust buildings when required. Moorlands CMHT also had two other community venues that they saw patients at to improve access for patients who live in a large rural area. Newcastle CMHT ran medication clinics with direct access to blood test results. Carers and people who used CMHT services told us the environment was always clean. Carers that attended the Phoenix Centre told us that they found the environment was clean and beautifully decorated
- Interview rooms have adequate soundproofing to ensure confidentiality and we observed this to be the case.
- There was a range of accessible information across all services. All services displayed ratings of the previous CQC inspection. In CMHT receptions, there was information about how to make a complaint and comment boxes in each reception area. All teams had information about the North Staffordshire service user group. There was information about carer's support groups, mental health diagnosis and treatments available. At Newcastle CMHT and Moorlands CMHTs, there was information about advocacy in the reception area. There were a range of leaflets available at the carers' service, the Growthpoint service and in the reception at the Hope Centre, these included details for carer's contacts and support services. Leaflets were available across all services for families and cares; this included details on carer's and confidentiality in information sharing, working in partnership with mental health professionals and a guide for patients and carers about information to request during meetings with healthcare professionals. Information packs had been developed by the early intervention team to provide patient's families and carers with details of how to access services, which professionals were available to support them and details about the early intervention team.

Meeting the needs of all people who use the service

- All community mental health teams (CMHTs) were accessible to disabled people including wheel chair users. Toilets were accessible for wheel chair users. There was disabled parking available at the CMHTs our inspection team visited. The Hope Centre also had access for people with reduced mobility.

Are services responsive to people's needs?

Good

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

- Staff that our inspection team spoke with said they would be able to request information leaflets in different languages from the Trust via the intranet if required. We saw examples of community language leaflets in the reception of Moorlands CMHT.
- All teams accessed trust interpretation services when required. There was evidence within records at the early intervention team where staff had used interpreters during a care review to assist a person who did not speak English as their first language. Newcastle CMHT had developed deaf awareness, which they promoted across the trust; they have trained staff in British sign language (BSL) and have a register of staff so they can provide support to other teams. Newcastle CMHT reception staff can communicate with BSL. Two members of staff had completed a Deafness and Mental Health certificate. The team also had equipment people to use such as a deaf loop and iPad for communication purposes.

Listening to and learning from concerns and complaints

- Community mental health teams for adults of working age received 29 complaints over a12 month period from April 2015 to March 2016. Of the 29 complaints made, seven were upheld. There were no complaints referred to the parliamentary ombudsman. Nine of these complaints related to attitudes of staff and five related to clinical issues. Of these, three of complaints relating to staff were upheld and one complaint relating to clinical issues was upheld. Resolutions had been found or were in the process of being found for the upheld complaints when the data was published.
- The trust had information leaflets about how to raise a complaint in all waiting areas. All patients that our inspection team spoke to said they knew how to make a complaint. All staff our inspection team spoke to could explain the complaints procedure and talked about the role of the patient advice and liaison service (PALS) in supporting people who wanted to make a complaint. Managers told us they tried to resolve complaints locally before escalating them to the (PALS) team.
- Each of the community mental health team managers was open and transparent when explaining the actions they had taken to resolve complaints. All managers provided us with evidence of complaint resolution and of changes, they had made. We saw letters of apology and saw responsive compliments patients had made about the services they receive
- Staff received feedback from complaints in the form of emails and through multidisciplinary team meetings and governance meetings. We saw agenda items in relation to complaints in meeting minutes.

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 defined a vision to be an outstanding organisation providing safe, personalised, accessible and recovery focused support and services every time. The trust values were to be compassionate, approachable, responsible and excellent. Most of the staff that we spoke to in the community teams were able to describe these values and gave examples of how they were demonstrated them through the care they provided.
- Managers were able to demonstrate how they embedded these values in appraisals, away days and meetings. They described the compassionate work of their staff and how they were focusing on recovery for their patients.
- Staff our inspection team spoke with knew who the senior trust managers were including the manager for their directorate. The staff from community mental health teams (CMHTs) told us that the most senior members in the organisation had visited them. Some staff talked about the benefit of the listening into action scheme (LIA) and that this had improved communication with senior managers. There were photographs of the board members in all reception areas.

Good governance

- Most staff were up to date with their mandatory training and we saw that effective systems and processes were in place to monitor this.
- Most staff within the community teams had received an appraisal in the 12 months prior to our inspection. Staff our inspection team spoke with told us they received regular clinical and managerial supervision and we saw caseload management tools and room for reflective practice was part of this.
- All staff our inspection team spoke with said they felt able to maximise the time they spent on patient care. Managers were able to give examples of how they supported staff to do this.
- Staff told us they were aware of their responsibilities to report serious incidents and near misses and had access to the trust's intranet system to do so. The team discussed feedback from incidents at team meetings and the trust provided a monthly lessons learned bulletin to disseminate information from other services.
- Staff participated in clinical audits and used outcome measures to check the effectiveness of the interventions they were providing as part of patient care. We saw that the community teams used guidance from NHS England and the national institute for health and care excellence to ensure the care provided met with national standards for timeliness and range of interventions. This included the use of psychological therapies and family therapy for young people experiencing their first episode of psychosis.
- All team managers ensured that learning from incidents and complaints that had taken place both in their team and in the wider trust were shared with their teams. Service users and carers our inspection team spoke said that they felt staff and the wider trust respected and valued their views. We saw evidence of the proactive use of service user surveys; these were completed at the early intervention team and in CMHTs.
- Service managers had access to electronic systems to monitor key performance indicators. Some staff our inspection team spoke with told us the system was not always up to date and there were inconsistencies occasionally with the data received. Staff felt confident that these issues would be resolved by the planned introduction of the trust's new electronic record keeping system in 2017. The trust participated in the commissioning for quality and innovation framework for patient safety and the community teams had met the targets set by commissioners for the first quarter of 2016-2017. Good practice that had been developed within the trust included the use of patient safety boards in team offices. Training had also been introduced for staff in critical incident stress management following incidents.
- All team managers our inspection team spoke with told us they felt well supported by their administrative staff and felt they had the authority and autonomy to manage the teams locally with support from directorate leads when required.

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.

- The community mental health teams were able to place items of concern on the trust's risk register. All risks that were placed on the register contained a colour coded rating according to the level of risk and contained details of factors used to mitigate these risks.
- Staff understood and worked within the Mental Capacity Act and Mental Health Act, our inspection team saw evidence of this in care records. There were staff that provided specialist support for issues relating to Mental Capacity Act and Mental Health Act.
- All staff demonstrated they could identify safeguarding and most had completed safeguarding training. Team managers reported that they worked well with the local authorities.

Leadership, morale and staff engagement

- Managers were managing staff sickness and absence rates effectively; they used agency and bank staff occasionally to ensure that teams could operate safely. Staff personnel files contained information, which demonstrated that the teams followed the trust's sickness and absence policy.
- There were no reported incidents of bullying and harassment within the community teams and there were no grievance procedures pursued by staff at the time of our inspection.
- Staff were aware of the trust's whistleblowing policy and felt able to raise concerns using this if necessary without fear of victimisation. Staff also described the trust's "Dear Caroline" system where they could raise concerns directly with the chief executive. Staff gave us examples of when this had been used and they reported that it was effective.
- Morale within the community mental health teams for adults of working age was high. Staff told us that they felt supported by their team managers and we saw evidence of strong leadership. Staff our inspection team spoke with told us they enjoyed their jobs and felt that staff supported each other. In the Newcastle CMHT and City CMHT, most staff said morale was good and that they were supported by their managers, where staff felt there were issues with morale they reported that this was due to workload. They told us their managers did everything they could to help them and reported supportive teams that worked together well.
- The trust had a being open policy incorporating duty of candour. This had been approved in 2015 and was due for review in 2018. This provided guidance for staff on promoting a culture of openness to improve patient safety and the quality of care delivered. Staff we spoke with understood their responsibilities as part of this policy.
- There were opportunities for leadership development within the trust and we met with staff that were being supported to undertake formal qualifications as social workers and psychologists. We met staff whose managers had supported to take on a leadership role in both Moorlands and Newcastle CMHT; however some staff said there was not enough opportunity to develop in their professional roles, due to the grades and posts available in the team.
- Staff told us they felt listened to and their team mangers ensured there was sufficient supervision, team forums and meetings for staff to give feedback.

Commitment to quality improvement and innovation

- The early intervention team had developed a range of innovative ways to provide care and support for people using their service for the first time and those who cared for them. The team had developed their own website linked to the trust's home page with details about their purpose, the staff who worked there, information about psychosis and self-help advice including coping with paranoia, mania and voices. The team had also secured funding to produce information videos as part of their website. Actors had been used to portray the journey of a person experiencing a first episode of psychosis, the care available from the team for them and their family and the recovery process. Information packs had been developed by the team and provided patient's families and carers with details of how to access services, which professionals were available to support them and details about the early intervention team.
- The Early Intervention Team had participated in the Early Intervention Dual Diagnosis Engagement and Recovery Project during 2016. This was an 18-month project aimed at improving engagement and recovery outcomes for patients experiencing psychosis and co-existing substance use.
- Newcastle CMHT ran a hearing voices group at a local community venue and all patients across the service could access this. The group works to help patients who

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hear voices to live with them and find ways to manage them. Patients could self-refer to the group and it was run in a community building separate from the trust. The team had won an innovation award for this group. Moorlands CMHT were also runners up in the trust's spotlight on excellence awards.

- All CMHTs have been involved in recent research and development. Staff had participated in a range of studies looking a variety of topics including the effects of organisational change on CMHT staff, the views of both patients and staff about borderline and personality disorder diagnosis and attitudes of professionals about talking to people with psychosis about intimate relationships. Since January 2016, Newcastle CMHT has been involved in a feasibility study for six commercial clinical trials.
- The Growthpoint service was awarded recognition by the Trust for providing clinical placement for medical students training to be doctors during 2015-2016.

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 12 HSCA (RA) Regulations 2014 Safe care and treatment Safe care and treatment Staff were not checking fridge and room temperatures where medication was stored. Staff were not clearly defining patients' allergy status on medication prescription charts. This was a breach of regulation 12 (2) (g)

This section is primarily information for the provider

Enforcement actions

Action we have told the provider to take

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