Good

Rotherham Doncaster and South Humber NHS Foundation Trust

Community-based mental health services for older people

Quality Report

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Locations inspected

Location ID	Name of CQC registered location	Name of service (e.g. ward/ unit/team)	Postcode of service (ward/ unit/ team)
RXE00	Trust Headquarters - Doncaster	North Lincolnshire Community Mental Health Service for Older People	DN4 8QN
RXE00	Trust Headquarters - Doncaster	Rotherham Community Mental Health Service for Older People	S60 5BX
RXE00	Trust Headquarters - Doncaster	Doncaster Older People's Community Mental Health Service	DN15 7DQ

Summary of findings

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

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

Where applicable, we have reported on each core service provided by Rotherham Doncaster and South Humber NHS Foundation Trust and these are brought together to inform our overall judgement of Rotherham Doncaster and South Humber NHS Foundation Trust.

Summary of findings

Ratings

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

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

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

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

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

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

Summary of findings

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Summary of findings

Overall summary

We rated Rotherham Doncaster and South Humber NHS Foundation Trust as **good** because:

- The skill mix within the service was sufficient to ensure good quality care and treatment. This led to flexibility across the teams allowing staff to cover essential visits and clinics in the event of unexpected illness or holiday leave.
- Patient risk assessments were updated when new risks were identified and during patient reviews. Staff documented daily any increased risks if a patient's mental health deteriorated. The care records we reviewed all had up-to-date risk management plans. This meant staff could make changes to the care they gave their patients keeping them safe.
- Multidisciplinary teams managed the referral process, assessments, on-going treatment and care by discussing the best treatment and pathway options for each individual. This meant patients received care and treatment that suited their individual needs.
- Patients gave positive feedback and felt personally involved in the development of their care plans. Staff delivered care to patients and their carers in a compassionate and respectful manner. Support groups for carers were available and staff arranged for respite care when appropriate. Carers consistently told us that staff actively supported them and valued this service.
- Patients took part in national initiatives to raise awareness of the needs of people with young onset dementia. The day care facility attached to the young onset dementia service allowed patients to organise their own activities and therapies. It supported people to live active lives in their community and maintain their day-to-day skills, friendships, hobbies and interests. The memory services either had accreditation or were in the process of achieving accreditation with the Royal College of Psychiatrists' memory service national accreditation programme. The young onset dementia service in Doncaster was carrying out research in partnership with Sheffield Hallam University. Rotherham memory service was researching a cognitive stimulation therapy project. Staff from North Lincolnshire set up a choir for service users and carers. They were finalists at the recent Alzheimer's Society dementia friendly awards for best dementia friendly involvement initiative.

However:

- The community mental health teams held caseloads that exceeded Department of Health guidelines.
- Patients' care plans were not always personalised or holistic and the quality varied across the teams. Some care plans did not consider all aspect of the patient's wellbeing or support their recovery.

Summary of findings

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

Are services safe?

Good

We rated safe as **good** because**:**

- Flexibility within the teams comprising the CMHS ensured that patients received timely appointments for treatment.
- All staff had a good understanding of safeguarding processes and knew their responsibilities to protect patients from the possible risk of abuse and harm.
- Staff kept patients' risk assessments up-to-date. If a patient's mental health started to deteriorate, staff would document this increased risk in their case notes.
- Staff followed the trust's lone worker policy and developed local protocols to keep staff safe.
- The CMHS had systems in place for the reporting of incidents. Staff received feedback from investigations when appropriate. The trust reviewed working practice and made changes as part of lessons learned.

However:

- The community mental health teams held caseloads that exceeded Department of Health guidelines.

Are services effective?

Good

We rated effective as **good** because:

- Staff had the correct qualifications, skills, knowledge and experience to deliver care and treatment.
- Multidisciplinary teams managed the referral process, assessments, on-going treatment and care by discussing the best treatment and pathway options for each individual.
- Staff received support and professional development through clinical and management supervision, appraisal, handovers and training. This meant staff could carry out their duties effectively.

However:

- Patients' care plans were not always personalised or holistic and the quality varied across the teams. Some care plans were comprehensive and clear, but others did not consider all aspect of the patient's wellbeing or support their recovery.

Summary of findings

- Service managers relied on the yearly trust-wide performance and quality audit and the local six monthly audits. This could potentially lead to delays in responding to trends and making improvements

Are services caring?

Outstanding 

We rated caring as **outstanding** because:

- Staff members were responsive, respectful and offered appropriate emotional and practical support to patients and their carers.
- Staff had a good understanding of the individual needs of patients. Home visits were person centred, with patients fully involved in discussions about their care. Staff gave clear information regarding medicines and offered a choice of services were possible.
- Families and carers thought staff supported and involved them in patient reviews. Carers we spoke with consistently told us that staff kept them informed, shared care plans with them and made them aware of medication and treatments.
- There was a monthly support group for patients with Huntingdon's Disease and their carers.
- The young onset dementia service was proactive in raising awareness locally and nationally. Patients promoted national initiatives to raise awareness of the needs of people with young onset dementia.

Are services responsive to people's needs?

Good 

We rated responsive as **good** because:

- Staff followed the care pathways in a clear, well-planned way and responded to the needs of their patients.
- Staff contacted patients using the memory service and their carers to remind them about their appointments.
- Staff continued to offer support to carers after the death of a patient who had used the young onset dementia service.
- The young onset dementia service could be adapted to meet the changing and on-going needs of the patients.
- Staff gave carers, family members and patients information about how to make a complaint and explained the process to them.

Are services well-led?

Good 

We rated well led as **good** because:

Summary of findings

- The quality of care delivered to patients and their carers reflected staff awareness of the trust's vision and values.
- Staff felt supported by management and fellow team members. Morale was good and there was a low turnover of staff.
- Service managers followed the trust policy on duty of candour.
- The CMHS had a commitment to quality improvement and innovation and was involved in research projects and innovative practices.
- All memory services had accreditation or were currently awaiting approval from the memory service national accreditation programme.

Summary of findings

Information about the service

Rotherham Doncaster and South Humber NHS Foundation Trust provide community based mental health services for older people (CMHS) in Doncaster, Rotherham and North Lincolnshire.

The CMHS teams have staff from multiple healthcare disciplines, including community mental health nurses, community support workers, doctors, occupational therapists, physiotherapists, psychologists, and social workers. They operate from three locations. The CMHS teams provide mental health assessments and treatment both at home and in clinic settings for people aged 65 and over. The CMHS in Doncaster and Rotherham also provide a service for people under the age of 65 who have a diagnosis of young onset dementia. The CMHS included a memory service that assessed and diagnosed the nature of people's memory difficulties, monitored patients and provide interventions such as cognitive stimulation therapy.

- Doncaster older people's community mental health service operated from Cherry Tree Court based within the Tickhill Road site. The service included a community mental health team, a memory therapy service, day care facilities, a young onset dementia service and a community care home liaison.
- North Lincolnshire community mental health service for older people operated from Berkeley House. It included a community mental health team, memory therapy service, support therapy and re-ablement service, and a community care home liaison.
- Rotherham community mental health service for older people operated from Howarth House. The service comprised a community mental health team, community care home liaison, single point of access, young onset dementia service, dementia outreach treatment team and community memory service.

Different clinical commissioning groups commissioned all three teams. The Care Quality Commission previously inspected CMHS in October 2013 and found they were meeting all the standards.

Our inspection team

Our Inspection Team was led by:

Chair: Philip Confue, Chief Executive of Cornwall Partnership NHS Foundation Trust

Head of inspection: Jenny Wilkes, Care Quality Commission

Team Leader: Jonathan Hepworth, Care Quality Commission

The team that inspected community based mental health services for older people included: two CQC inspectors, two qualified mental health nurses, a psychiatrist and a social worker.

Why we carried out this inspection

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

How we carried out this inspection

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

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

Summary of findings

Before the inspection visit, we reviewed a range of information we hold about these services and asked other organisations to share what they knew.

During the inspection visit, the inspection team:

- Visited three community teams and looked at the quality of the office environment
- visited a young onset dementia service and day care
- spoke with six patients and eight carers
- spoke with the managers of each community team
- spoke with 16 other staff members; including doctors, nurses, social workers and support workers
- accompanied staff on 11 visits to patients at home and observed how they cared for them
- attended and observed two multidisciplinary team meetings
- attended a memory service clinic.
- looked at care and treatment records of 15 patients

looked at a range of policies, procedures and other documents relating to the running of the service.

What people who use the provider's services say

We spoke with six patients and eight carers, and accompanied nurses on 11 home visits. Our observation of staff interaction on these visits was positive. Staff engaged in a compassionate and respectful way, allowing patients time to respond to and ask questions about their treatment choices.

The feedback we received was complimentary about the staff, the level of care provided and the support available. Patients and their carers told us staff listened to their views and they felt involved in making decisions about their care. They said access to the CMHS was good and they could call the service to discuss concerns knowing staff would respond quickly.

Good practice

Young onset dementia day care offered carers respite and was designed to help keep patients engaged and in the community.

There was a support group for male carers.

There was a support group for patients with Huntingdon's Disease and their carers.

Areas for improvement

Action the provider SHOULD take to improve
The trust **should** ensure that:

- All care plans across the CMHS are personalised and recovery focused.
- Staffing levels and caseloads for community mental health teams follow the Department of Health guidance.

Rotherham Doncaster and South Humber NHS Foundation Trust

Community-based mental health services for older people

Detailed findings

Locations inspected

Name of service (e.g. ward/unit/team)	Name of CQC registered location
North Lincolnshire Community Mental Health Service for Older People	Trust Headquarters
Doncaster Older People's Community Mental Health Service	Trust Headquarters
Rotherham Community Mental Health Service for Older People	Trust Headquarters

Mental Health Act responsibilities

Mental Health Act training was not part of the core mandatory training for any of the community services we visited, including training on community treatment orders. However, records demonstrated that overall the services had effective systems in place to assess and monitor risks to individual patients previously detained under the Mental Health Act, including timely section 117 reviews. Under section 117 patients previously detained under section three of the Mental Health Act have a right to aftercare.

Patients told us about how they could access advocate services if they wanted assistance and we observed staff giving information about advocacy services. During visits, patients discussed consenting to their medication and understanding the side effects.

Detailed findings

Mental Capacity Act and Deprivation of Liberty Safeguards

Staff carried out capacity assessments on all patients consenting to informal admission to inpatient service. This was regardless of the nature of the patient's illness. If a patient was ill enough to merit a transfer from the Community Mental Health Team to inpatient services, it was sufficient to overturn a presumption of capacity and trigger an assessment. We found capacity assessments prior to inpatient admission in patients' records

Mental Capacity Act training forms part of the mandatory training and all services met the trust target for this. Staff had a good understanding of how to apply the principles of the Mental Capacity Act.

Good

Are services safe?

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

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

Our findings

Safe and clean environment

All teams had facilities on site for patients to attend clinics and groups. These settings were clean, well maintained and suitable for delivering care to older people. The design and spacious layout of the day care setting met the needs of patients attending. It was well maintained and safe.

The memory service clinic in North Lincolnshire was temporarily operating from an adapted interview room during refurbishment of the memory suite. This room was fitted with an alarm. In Rotherham, the memory clinic was on the ground floor. Staff carried personal alarms, as these rooms did not have alarm systems installed.

Staff routinely monitored and checked the medical equipment kept in the clinic rooms. We found that all medications and disposable medical equipment was in date. There was easy access to sharps bins, alcohol gel and gloves showing that an infection control system was in place. However, the fridge temperature setting in the clinic room in Rotherham was slightly out of range at the time of our inspection. We immediately brought to the attention of the service manager to remedy. Certain medications need to be stored in fridges that are set within a range of 2-8 degrees. This ensures the medication is unspoiled and safe to use.

Safe staffing

The CMHS had not based their staffing levels on a specific model. In Doncaster, managers had carried out a consultation exercise to ensure the staffing skill mix for each team meant patients received safe care and treatment. The North Lincolnshire service had based their staffing levels on adult service staffing levels. Rotherham had similar staffing levels and skill mix to Doncaster and North Lincolnshire but did not have social workers within their skills mix. This meant that staff had to refer patients to social services if they identified a need.

The service manager for the CMHS in Doncaster was currently recruiting for a qualified nurse vacancy in the community mental health team. The other community mental health teams did not have any qualified nurse or support worker vacancies. The CMHS had low staff turnover rates as any moves tended to be within the different teams. The community mental health teams had sickness levels below 3% in Doncaster and 4% in Rotherham. However, North Lincolnshire had a sickness level of 7% due to staff being on long term sick. The national NHS average is 4.7% by comparison. The manager for the North Lincolnshire service had assessed the impact of long-term sickness on the service and covered shifts using agency block booking and cross cover from other teams. All staff had experience and training in the skills needed for assessment, memory and community mental health enabling managers to cover absences using staff from across the service.

Patients' carers and family members did not report experiencing any cancelled groups or appointments. The service managers for Rotherham and North Lincolnshire could provide clinical support when unexpected appointments arose.

Across the service, community mental health teams had caseloads of approximately 50 cases per full time equivalent care coordinator. Staff did not see all their patients on a regular basis, as some patients did not need visiting as often as those with a higher complexity of need. However, The Department of Health, Mental Health Policy Implementation guide 2001, suggests a maximum caseload of 35 per whole time equivalent care coordinator.

Managers monitored staff caseloads during supervision to ensure staff provided a high quality service and received support with complex issues. The memory service in Rotherham currently had a caseload of approximately 1,500 patients. The young onset dementia service in Doncaster had an overall caseload of 102 patients.

Each community mental health team covered set areas. For example, Doncaster had four teams covering central, east, southwest and north west Doncaster and surrounding areas. Each team had rapid access to a psychiatrist when required. Doncaster had just recruited a new psychiatrist and employed a temporary psychiatrist. The trust had previously highlighted the shortage of permanent psychiatrists in Rotherham and Doncaster as a risk. Rotherham had three psychiatrists in post including a temporary psychiatrist. North Lincolnshire had two psychiatrists working across their team. Psychiatrists were contactable by telephone immediately and would see

Good

Are services safe?

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

patients within four hours depending on the urgency, if not sooner. Case notes showed that psychiatrists provided timely responses and could see and admit patients to inpatient facilities the same day if necessary.

There was a core programme for mandatory training which included equality and diversity, fire, infection control, safeguarding children, safeguarding adults, health and safety and information governance. Managers monitored mandatory training using an electronic database. The system identified when a staff member needed to update their mandatory training but did not provide an overview of the teams' compliance with mandatory training as a whole. However, the trust provided some training records that show the community mental health teams achieved an overall compliance rate of 78% for mandatory training. In Doncaster, 82% of the staff in the young onset dementia service had completed mandatory training while in Rotherham this figure was 69%. All of these training rates were below the trust overall target of 90% compliance to be achieved by 31 December 2015. Violence and aggression training and supervision training for supervisors had low compliance rates.

Assessing and managing risk to patients and staff

Each patient had a risk assessment and risk management plan in place. These took place at the start of the patient's involvement with the CMHS as part of the comprehensive assessment process. The risk assessment tool used was decision, inform, choice, explanation, and support. This was an evidence-based tool that identified the individual risks associated with each patient. Staff updated patients' risk assessments when necessary and during patient reviews. Staff documented daily any increased risks when a person's mental health deteriorated All of the 15 case records we reviewed had up to date risk management plans. Staff could raise alerts on the electronic recording system to show when patient risk had increased.

Patients had a crisis and contingency plan. Nurses developed this during the assessment process and added to it if necessary during subsequent visits.

Staff asked patients if they wished to have an advance directive in place as part of the admission process. An advance directive is a decision you can make to refuse a specific type of treatment at some time in the future should you be no longer able to make decisions because of illness or incapacity. North Lincolnshire was the only location that had a current advance directive in place for a patient.

All staff knew how to respond if there was a sudden deterioration in the health of a patient. They followed the appropriate referral pathway when risks increased. For example, in Rotherham either the dementia outreach team, community mental health team or care home liaison team would respond. The crisis team responded out of hours and during the weekend. Staff contacted medical emergency services for a physical health problem. Staff had a good understanding of safeguarding and knew their responsibilities to protect patients from the possible risk of abuse harm. We looked at safeguarding alerts for each location and reviewed the trust policy, which showed that the staff had followed procedure. The CMHS had safeguarding leads within the teams.

Each CMHS had different safeguarding procedures in place due to staffing arrangements with local authorities. Doncaster had social workers in their locality teams, who along with healthcare professionals, picked up the alerts, raised and investigated them. In Rotherham and North Lincolnshire, the local authority led with safeguarding referrals and investigations and training. All staff received basic level safeguarding training. Figures for completing mandatory level two safeguarding training varied. Doncaster community mental health team achieved 100% compliance, North Lincolnshire was unable to supply this information and Rotherham achieved 50%. Despite this, all staff understood the processes involved in reporting safeguarding concerns, and had experience of making referrals and raising alerts. Staff knew how follow up outcomes and record actions taken.

The trust had a lone worker policy in place. This looked at level of risk and deployed two staff on patient visits if necessary. All the CMHS had developed local protocols to ensure staff safety. Staff explained what actions they would take if they felt concerned about their safety.

Track record on safety

The CMHS had a process for de-briefing staff and investigating incidents. There had been two serious incidents in the last twelve months. The trust investigated both incidents leading to changes in working practice. The trust improved the safe storage of documentation and reviewed the communication pathway between GPs and community staff in relation to changing prescribed medication.

Good

Are services safe?

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

Reporting incidents and learning from when things go wrong

Staff felt confident in reporting incidents and concerns. They knew which incidents needed reporting and how to record them using the electronic reporting system. We looked at incident reporting in all locations and found this followed trust policy. Service managers discussed learning points arising from incidents with their staff.

Staff confirmed they received feedback from the investigation of incidents that occurred across the service either through the intranet (there were learning and quality sections on trust intranet), team meetings or supervision. Team meeting minutes showed staff received feedback and held discussions about lessons learned.

The CMHS was open and transparent and provided patients with an explanation when something went wrong. Service managers in Doncaster and North Lincolnshire had followed the trust's duty of candour process. In both instances, the service manager met with the patient and their carer to apologise and explain the events to them. Throughout the investigation in to the incident, staff kept the patient informed. Staff discussed the lessons learned at local team managers' meetings and individual team meetings.

Are services effective?

Good

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

Our findings

Assessment of needs and planning of care

The community mental health services completed comprehensive assessments of the needs of patients. These included their social, occupational, cultural, physical and psychological needs and preferences. The quality of care plans varied across the CMHS. Some care plans were comprehensive, clear and recovery-based. Recovery-based means focusing on helping patients to be in control of their lives and build their resilience to avoid admission to hospital.

We looked at 15 care and treatment records and found that the seven records we looked at in Rotherham contained comprehensive holistic care plans but two records were missing crisis plans. Four records in Doncaster showed good evidence of patient input and views and we observed a visit where a nurse developed a care plan with the patient. The four records reviewed in Scunthorpe lacked detail and did not address all the patients' individual needs.

We saw good evidence in the care records across all services that timely reviews were taking place, and staff members were able to inform us what would trigger a review.

Information was stored on the trust's database system. However, Scunthorpe and Doncaster also used paper-based files due to the difficulty in navigating the database system. We observed staff struggling to locate aspects of care records on the system. This led to lack confidence in the system and the need to run an additional paper based system.

Skilled staff to deliver care

The CMHS followed the National Institute for Health and Care Excellence (NICE) guidance CG42, Dementia: Supporting people with dementia and their carers in health and social.

In Doncaster, the memory therapy services followed the Newcastle Model. This model provides a framework and process in which to understand behaviour that challenges in terms of unmet needs. The model suggests a structure to develop effective interventions that keep people with dementia central to their care. The model only used medicines to manage behaviour as a last resort.

Although care plans did not refer to any guidance, staff members could tell us about guidance they followed, including NICE dementia quality standard 30 and NICE guidance on Parkinson's disease (CG35). We observed one nurse following the NICE guidance on medication adherence, although they could not say what guidance they were following.

The services used goal attainment scaling in rehabilitation (GAS). GAS is a method of scoring the extent to which patient's achieved individual goals during the course of intervention. Care records examined showed this was taking place.

The teams completed a physical health screen at the point of referral and if required patients were signposted to the appropriate service. The teams linked in with GP practices over physical health needs.

All three services had good record keeping systems in place to ensure accurate monitoring of lithium and antipsychotic medication. Staff members were able to describe what monitoring needed to take place including routine bloods and electrocardiography (ECG). ECG is a simple test that records the rhythm and electrical activity of the heart. Staff arranged ECG appointments in a timely fashion including cross service agreements with hospitals within the trust.

Multi-disciplinary and inter-agency team work

Services worked together to plan on-going care and treatment in a timely way through the multi –disciplinary meetings and handover structures. Care was coordinated between teams and services from referral through to discharge or transition to another service.

Multidisciplinary team meetings collaboratively managed referrals, risks, treatment and appropriate care pathways options. We observed a multidisciplinary referral and review meeting in Rotherham. The team discussed all referrals in depth apart from urgent referrals. Staff responded to urgent referrals immediately. The trust target was to see routine referrals within 10 days. However, this did not account for when the weekly meeting took place, so in theory this meant some referrals could take 16 days. The Rotherham service was the only CMHS that did not have social workers as part of the integrated team. If patients needed input from social services, staff made a referral for the patient. This meant that patients had to wait for a social services appointment to address some of their needs.

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.

In Doncaster, we saw excellent team working between nurses and social workers. These social workers had direct access to social care budget, making multidisciplinary team working effective and timely.

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

Mental Health Act (MHA) training is not part of the core mandatory training for any of the community services we visited, including training on community treatment orders. However, records demonstrated that overall the services had effective systems in place to assess and monitor risks to individual patients who previously detained under the MHA, including timely section 117 reviews.

Patients told us about how they could access advocate services if they wanted assistance. We saw a nurse giving patient information on advocacy services during a home visit. Patients discussed consenting to their medication and understanding the side effects.

Good practice in applying the Mental Capacity Act

Staff carried out capacity assessments on all patients consenting to informal admission to inpatient service. This was regardless of the nature of the patient's illness. If a patient was ill enough to merit a transfer from the Community Mental Health Team to inpatient services, it was sufficient to overturn a presumption of capacity and trigger an assessment. The capacity assessment was an inpatient service requirement before admission could take place. Capacity assessments prior to admission were evident in patient records.

Mental Capacity Act training forms part of the mandatory training and all services met the trust target for this. Staff we spoke with had a good understanding of how to apply the basic principles of the act. The service had displayed aide memoires in key areas to remind staff about the basic principles.

Outstanding ☆

Are services caring?

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

Our findings

Kindness, dignity, respect and support

We attended 11 home visits with staff and observed appointments at clinical review meetings. Throughout staff responded to the emotional, health and social needs of their patients and offered practical support.

Staff showed a good understanding of the individual needs of patients. Home visits were person centred, with patients fully involved in discussions. The nurse gave clear information regarding medicines and the choice of treatments available. They clarified support needs, physical health issues and any other concerns.

Patients gave extremely positive reports regarding the support offered by staff. This included comment cards, direct feedback, family and friends results, and compliment cards and letters. Consistent themes fed back to us were:

- The prompt responses by the service
- The helpfulness of individual nurses and clinicians
- Clinicians cared about all aspects of their patients' lives
- Carers felt listened to and supported by professional

The involvement of people in the care they receive

Staff empowered patients to become involved in their care. Discussions between clinicians and service users included choices of treatments and treatment plans. Staff documented their patients' individual preferences and needs in care plans. Patients confirmed they had received a copy of their care plan.

Staff supported families and carers and involved them in patients' assessments and reviews. Carers we spoke with consistently told us that nurses kept them up-to-date with the medicines and treatments and understood the care plan. We observed an initial memory assessment meeting in which the nurse took suitable time to explain outcomes and procedures. Patients had ample time for questions and offered further information and support. The nurse provided further information leaflets to carers about the assessment process and on activities of daily living.

A support group for carers met every fortnight and there was a separate group for those with a diagnosis of young onset dementia (YOD) that enabled carers to come together and share experiences.

Staff motivation was high and they provided support that went over and above their remit. In Doncaster, the YOD service offered emotional and practical support to patients and families following the death of their loved one. They also provided a male only carers group, supporting the specific needs of men whose partners were receiving treatment. Staff had identified this as a previously unmet need. In North Lincolnshire the nurse specialising in Huntingdon's disease ran a monthly support group for her patients and their carers.

A carer told us that they had filled out a neuropsychiatry inventory questionnaire and was offered time to see a nurse on their own. This allowed them time to listen and discuss their family members' dementia and other practical matters including information on advocacy. Staff monitored how carers were coping and offered respite when appropriate.

The YOD service in Doncaster promoted awareness of young onset dementia both locally and nationally. Staff supported them in this. For example, patients raised money and awareness by staging an event called 'the garden party'. The trust reinvested all the money raised in the YOD service.

The service users had received positive media support, along with nationally recognised awards for their contributions to dementia care in Doncaster, such as an MBE.

Staff in North Lincolnshire had set up a choir one evening a week for people who used the memory service. This took place outside of normal working hours. 'The Togetherness Choir' had performed at local charity functions. Staff received acknowledgment for their initiative by becoming finalist in the Alzheimer's society Dementia Friendly Awards, October 2015.

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 CMHS focused on assisting people to remain in the community and reducing admission into hospital where possible. The trust set target times for referral to triage/ assessment and assessment to treatment. The single point of access received and triaged all referrals. Where necessary, a doctor would see a patient within four hours if they were acutely unwell or at risk. The community mental health teams responded to less urgent referrals within 48 hours and routine referrals within 10 days following a multidisciplinary team review meeting.

We observed an initial assessment take place within five days of referral to the community mental health team. If a service did not meet the target referral times, they reported it as a breach for investigation. This helped the CMHS identify and remedy delays. The CMHS achieved a 96% compliance rate against the trust target of 95% for referral to treatment times over a six-month period. The diagnosis and development of a care package for the memory service took place within 18 weeks from referral. The memory services achieved 97% compliance rate against the trust target of 92%.

The CMHS had clear pathways into treatment for functional and organic mental disorder. Organic illnesses, included conditions associated with memory loss and cognitive impairment, like dementia. Functional illnesses include depression, anxiety, bipolar disorder and schizophrenia. The CMHS accepted all referrals; however, some would only involve an initial visit followed by signposting or referring on to another service.

In Doncaster and Rotherham, patients who used the young onset dementia service remained with the service once they reached the age of 65 for better continuity of care.

Staff sought consent from patients and carers to include carer information during the initial assessment. This helped staff arrange convenient appointments times for patients and carers. Nurses made appointments for follow up visits during the current appointment or over the phone. Staff sent patients reminder letters if an individual did not keep their appointment. Patients engaging with the memory service received telephone call reminding them of their appointments. If necessary, a home visit took place. For example, patients could have a course of cognitive stimulation therapy at home. This therapy helps with thinking, concentration and memory. CMHS would only discharge a person who was not attending appointments if they had made it clear they did not want the service.

The facilities promote recovery, comfort, dignity and confidentiality

In Doncaster, the memory therapy service could meet the changing and on-going needs of the patient. As well as home visits, there was a day care facility in the grounds of Tickhill Road hospital managed by the Memory Therapy Services. This facility was warm, welcoming, furnished and decorated in styles from previous decades. Day care had several reminiscence areas with associated activities including a relaxation pod, cookery area, hairdressing salon, gardening, a bus stop, a car and SONAS groups. SONAS promotes multi-sensory stimulation utilising communication and interactive skills using movement, song, smell, taste and hearing.

The user led day care facility helps support patients to live active lives in their community and maintain their day-to-day skills, friendships, hobbies and interests.

The memory service clinic at North Lincolnshire was on the first floor and accessed by lift or stairs. The waiting room was on the ground floor. Staff told us they would meet patients on arrival and accompany them safely to the clinic. The clinic usually consisted of 3 rooms but all were at different stages of decoration and soundproofing.

During this period of refurbishment, the clinic took place in a temporary interview room on the ground floor.

A wide array of information was on display at different locations about treatments, medication and side effects, local support services and the services that made up the CMHS. Staff gave patients using the memory services a standard information pack. However, the community mental health teams had more individualised information available for their patients.

Meeting the needs of all people who use the service

The memory service clinics and day care facilities all had access ramps and disability bathrooms for patients and carers with mobility difficulties.

The service could arrange for information leaflets in large print or braille if the need arose. Rotherham CMHS had noted that there was not much call for information in

Are services responsive to people's needs?

Good

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

different languages. They had been advised by Rotherham Ethnic Minority Association that large numbers of their patrons may be fluent in a spoken language rather than the written form. The service could access interpretation service if needed.

Staff recognised that male carers for patients with young onset dementia needed different support to female carers and had provided an appropriate male support group to meet this need.

Listening to and learning from concerns and complaints

The CMHS had received four formal complaints in the last 12 months, with one complaint upheld. A senior manager was currently investigating a complaint spanning a few years about diagnosis and engagement with the different teams making up CMHS. As a result, the investigator was reviewing practice and considering feedback to staff to improve service delivery.

All the carers and family members we spoke with said they had received information about how to make a complaint.

We observed a nurse making a patient and carer aware of the complaints procedure during an initial assessment visit and provide information about the process. Managers dealt with informal complaints. Staff would signpost any person wanting to make a formal complaint to PALS.

The trust encouraged patients and carers to give feedback about the service they received in the following ways:

- using 'your opinion counts' forms
- family and friends survey
- during patient and carer feedback week
- general feedback from thank you cards and letters

Staff discussed feedback from complaints and compliments in team meetings, along with lessons learned. The older people's mental health service received 173 compliments between January and June 2015 from patients and their carer's, this included inpatients. Weekly review meetings took place as well as reflective practice meetings where staff discussed various experiences to share knowledge and to improve care.

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 positively promoted its commitment to 'leading the way with care' with trust wide emails, posters, booklets and the health bus, which visited sites away from the main hospitals.

Staff embraced the ethos of the trust's vision and values and felt proud of the services they offered.

Staff knew who members of the senior executive team were. The chief executive had visited one of the teams based in Rotherham in response to an email invitation from staff. In North Lincolnshire, staff had emailed a member of the board and received a positive response.

Good governance

Staff could to describe the systems and processes in place to ensure they received suitable training to do their jobs. The trust used a central electronic information system to monitor mandatory training. This system did not allow service managers to accurately monitor overall compliance with mandatory training and identify gaps in staff training. Staff had a lack of confidence with the database systems and experienced difficulties finding information on the system.

Service managers undertook regular appraisals of staff performance through annual appraisal and supervision. They discussed feedback and learning from incidents, complaints and compliments with staff during supervision if appropriate.

Skill mix was sufficient to ensure good quality care and treatment. There was flexibility across the teams allowing staff to cover essential visits and clinics in the event of unexpected illness or holiday leave.

Staff had a good understanding of the types of incidents and events that required reporting. The team meeting structure was well-organised and covered appropriate governance issues relevant to the service and included organisational learning from incidents and complaints.

Staff had a good understanding of safeguarding procedures, the MHA and the Mental Capacity Act 2005.

The service managers had a clear understanding about the key performance indicators (KPIs) for their services. They monitored KPIs such as referral times, falls and risk assessments through the yearly performance and quality audit. Service managers would put in place an action plan if any issues needed tackling. Minutes from the team managers' meetings showed discussion of performance level indicators and actions agreed. Senior healthcare professionals assessed each other's teams within the service, carrying out local clinical audits every six months.

CMHS managers had sufficient authority to manage and improve service delivery although a review of the Rotherham service put off any planned changes the manager had for the service. In Rotherham, the trust was considering amalgamating adult services with CMHS to provide an all age service.

The older peoples' mental health business division held the risk registers. Service managers felt able to submit items to the register via senior management. Doncaster and Rotherham had an item on the risk register in relation to lack of permanent psychiatrists and Rotherham had an on-going issue with vandalism due to location of the service.

Leadership, morale and staff engagement

All staff we spoke with felt respected, valued and well supported by their managers and peers. Half of the nurses described their team as being happy and having good morale. The Doncaster community mental health team appreciated having an integrated team and enjoyed working in the community.

Staff had the opportunity for leadership and development within the service. For example, some nurses trained as nurse prescribers.

The CMHS had a low turnover of staff. When staff did leave, it was often to transfer to another team within the service. Sickness rates were usually low across the CMHS. However, one of the locations currently had staff on long term sick and this increased their sickness rates.

Staff knew how to use the whistleblowing process and felt comfortable raising concerns with their managers and through staff meetings and supervision sessions. Managers confirmed they had an open door policy.

Service managers had a good understanding of duty of candour and knew how to implement trust policy and procedures. Staff knew what actions and steps taken when things went wrong and understood the need to be open and honest with patients when this happened.

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.

Commitment to quality improvement and innovation

Rotherham and Doncaster memory services were both accredited as excellent as part of the Royal College of Psychiatrists' memory service national accreditation programme. North Lincolnshire was awaiting the peer review process for accreditation. Accreditation assures staff, patients and their carers, commissioners and regulators of the quality of the service provided.

The young onset dementia service in Doncaster was carrying out research in partnership with Sheffield Hallam University on the rate of diagnosis and prescribing for people with early onset dementia. Young onset dementia day care was involved in a schools project to raise the awareness and promote dementia friendly primary schools.

In North Lincolnshire, a member of staff received a runner up award from the trust for patient and carer experience. Staff from the service were finalists at the Alzheimer's Society dementia friendly awards for their work with the memory service 'togetherness choir'.