

Good 

# 5 Boroughs Partnership NHS Foundation 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)
RTV04	Wigan	Wigan and Leigh home treatment team	WN7 1HS
RTV04	Wigan	Wigan and Leigh assessment team	WN3 4NW
RTV02	St Helens	St Helens & Knowsley home treatment team	WA9 3DE
RTV51	Knowsley	Knowsley and St Helens assessment team	L35 5DR

# Summary of findings

RTV06	Warrington	Warrington and Halton home treatment team	WA2 8WA
RTV06	Warrington	Warrington and Halton assessment team	WA5 1GH
RTV06	Warrington	Warrington recovery team	WA5 1GH
RTV04	Wigan	Recovery team North Wigan	WN3 4NW
RTV02	St Helens	St Helens recovery team	WA9 3DA

This report describes our judgement of the quality of care provided within this core service by 5 Boroughs Partnership 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 5 Boroughs Partnership NHS Foundation Trust and these are brought together to inform our overall judgement of 5 Boroughs Partnership NHS Foundation Trust.

# Summary of findings

## Ratings

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

### Overall rating for the service

Good 

Are services safe?

Good 

Are services effective?

Good 

Are services caring?

Good 

Are services responsive?

Good 

Are services well-led?

Good 

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

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

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

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

# Summary of findings

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# Summary of findings

## Overall summary

We gave an overall rating for community based mental health teams for adults of working age as **good** because:

- The teams assessed, monitored and managed patient risks on a day-to-day basis. There were effective handovers and shift changes, to ensure staff can manage risks to people that use services. Staff took steps to prevent abuse from occurring and responded appropriately to any allegations of abuse.
- Staff, patients and carers were able to escalate concerns if a patient's condition deteriorated to the appropriate teams ensuring risks to people who use services were managed effectively. Staff worked collaboratively to understand and meet the needs of their patients.
- Staffing levels were managed and routinely reviewed by the managers and the trust. This ensured the services had the staff they needed with the right skill mix.
- Staff demonstrated a good understanding of the Mental Health Act (MHA) and Mental Capacity Act (MCA) and applied these in the protection of patients' rights.
- There was participation in relevant local and national audits within the community mental health teams to monitor their services.
- Staff were caring and compassionate to patients' needs, treated patients with dignity, respect and compassion, and recognised their individual needs. There were mechanisms in place to capture feedback from patients and carers who used the service. Staff helped patients to maintain and develop their social networks and community and, where possible, were enabled to manage their own health and care.
- The trust had complaints processes in place. Staff told us they were able to speak openly about issues and incidents, and felt this was positive for making improvements to the service.
- The trust had a clear statement of their vision and values, and staff were aware of these. There were

governance arrangements in place to monitor performance, quality and risk. The trust proactively engaged with staff and provided systems to seek feedback from them to improve their services.

However,

- The trust should ensure that the lone working policy is fully embedded and reviewed throughout the community teams and specifies who is required to check staff safety following visits and to improve the regularity of the checks.
- The trust should review and monitor their community bases where staff work alone and see patients in visiting rooms or within the community against the trust's associated policies and procedures for lone working to ensure staff and patients are safe.
- Clinical supervision and appraisals were not fully implemented in all of the teams we visited.
- The trust should continue to review and monitor patients who are subject to the Care Programme Approach to ensure patients receive planned reviewed and coordinated care they need.
- The trust should ensure that each team's operational guidance is updated to reflect the services provided by mental health services for adults of working age in the community.
- The trust should ensure staff receive clinical supervision and appraisals.
- The trust should provide the Care Quality Commission's contact details alongside the MHA patient information, so that patients know where to make a complaint regarding the application of the MHA.
- The trust should ensure that the Warrington and Halton home treatment team review the use of their medicines cabinet to ensure their medicine storage facility is fit for purpose.

# Summary of findings

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

### Are services safe?

#### We rated safe as good because:

- Risk assessments and plans were in place to keep patients and staff safe.
- The teams assessed, monitored and managed patient risks on a day-to-day basis.
- Clinical staff completed comprehensive patient risk assessments as needed in a timely manner.
- There were effective handovers and shift changes, to ensure staff managed risks to people that used services.
- Staff took steps to prevent abuse from occurring, responded appropriately to any allegations of abuse. Staff had received training in safeguarding adults and children.
- Staff, patients and carers were able to escalate concerns if a patient's condition deteriorated.
- Staffing levels and skill mix amongst the teams were managed and reviewed.
- Incidents and lessons learnt were reported and had been disseminated to staff.

However,

- The trust should ensure that the lone working policy is fully embedded and reviewed throughout the community teams and specifies who is required to check staff safety following visits and to improve the regularity of the checks.
- The trust should review and monitor their community bases where staff work alone and see patients in visiting rooms or within the community against the trust's associated policies and procedures for lone working to ensure staff and patients are safe.
- Implementation of individual clinical supervision was not fully embedded within all of the teams.
- The trust should continue to review and monitor patients who are subject to the Care Programme Approach to ensure patients receive planned reviewed and coordinated care they need.
- The trust should ensure that the Warrington and Halton home treatment team review the use of their medicines cabinet to ensure their medicine storage facility is fit for purpose.

Good



### Are services effective?

#### We rated effective as good because:

Good



# Summary of findings

- Teams from across the trust worked well together and this could be clearly seen in how patient care was coordinated.
- Staff demonstrated a good understanding of the Mental Health Act (MHA) and Mental Capacity Act (MCA) and applied these in the protection of patients' rights.
- Staff were qualified and had the skills they needed to carry out their roles effectively.
- Staff were able to access information they needed to assess, plan and deliver care to patients in a timely way and patients were provided with information about their care and treatment.
- Care records contained comprehensive assessments of needs, with individual goals and interventions.
- Information about patient care and treatment was routinely collected and monitored.
- There was participation in local and national audits within the community mental health teams.
- There was good multidisciplinary working within the teams.
- Staff were caring and committed staff to providing high-quality care; they showed a person-centred approach.
- Staff received peer and team supervision.

However,

- The trust should ensure staff receives clinical supervision and appraisals.

## Are services caring?

### We rated caring as good because:

- Staff were caring and compassionate to patients' needs and treated patients with dignity, respect and compassion.
- The feedback we received from people who used the service and their carers was positive. They told us staff were polite, caring and supportive and said they were happy with the service they received.
- We observed staff took the time to listen to patients and to understand their needs.
- Carers we spoke to felt they were involved in decisions around treatment and care of their relative. They felt supported and could access support and care when needed.
- There were mechanisms in place to capture feedback from patients and carers who used the service.
- People told us they were supported to maintain and develop their social networks and community and were enabled to manage their own health and care where they could.
- Staff were caring and committed staff to providing high-quality care; they showed a person-centred approach.

Good



# Summary of findings

## Are services responsive to people's needs?

### We rated responsive as good because:

- Following their referral, 92% of patients were seen within 24 hours, within the targets set by the trust. The service managers actively monitored this to ensure continued good practice.
- Care records contained comprehensive assessments of needs, with individual goals and interventions.
- The trust planned their services to meet the needs of the local population.
- Care was coordinated with other providers including primary and secondary care and treatment services.
- Reasonable adjustments were made for the needs of people with a physical mobility issue and access to premises had been considered. Three examples of this were accessible lifts and access to assistive toilets in the buildings we visited and information was available in different formats and languages.
- Patients could access the right care at the right time taking account of patients' urgent needs.
- The trust monitored waiting times and cancellations of appointments to understand the needs of the population and to plan services.
- Patients were aware of how to make a complaint about the service.

However,

- The trust should provide the Care Quality Commission's contact details alongside the MHA patient information, so that patients know where to make a complaint regarding the application of the MHA.

Good



## Are services well-led?

### We rated well-led as good because:

- Staff were able to speak openly about issues and incidents, and felt this was positive for making improvements to the service.
- The trust had a clear statement of their vision and values and staff were aware of these.
- There were monthly governance meetings and evidence of ongoing monitoring of performance.
- Staff felt supported at a local level by their managers and team members.
- There was evidence of changes to practice following lessons learnt from adverse incidents. An example of this was that improvements to staff safety were reviewed and amended to protect staff when they saw patients alone in the recovery team bases.

Good





# Summary of findings

- Staff told us they felt there was effective team working across professional groups in the community service and we observed good multidisciplinary work taking place.
- The service held monthly quality and risk meetings to oversee and manage clinical governance and risk issues within community services. Quality issues were discussed, such as complaints, incidents, audits and good practice guidance.
- The trust proactively engaged with staff and provided systems to seek feedback from them to improve their services.
- Staff were supported and encouraged to develop their learning and was provided with opportunities to be seconded to other teams to learn from their practices.
- Managers and leaders of the trust met with other organisations involved in patients care.

However,

- The trust should ensure that each team's operational guidance is updated to reflect the services provided by mental health services for adults of working age in the community.

# Summary of findings

## Information about the service

The trust provides a range of community based mental health services across the five boroughs of Halton, Knowsley, St. Helens, Warrington and Wigan. These include early intervention, assessment, home treatment and recovery teams, as well as psychological therapy services, primary care mental health teams, accident and emergency (A&E) liaison and a rapid assessment and discharge team. In addition, there are four criminal justice liaison teams. They offer patients with mental health problems a range of community based treatments, psychological support, medication and advice.

We inspected nine of the community teams during the inspection: three home treatment teams (HTTs), three assessment teams and three recovery teams. HTTs are intended for patients who have moderate to severe symptoms of mental illness and are seen as an alternative to hospital admission. The teams work closely with community services to help patients stay well and at home. When a hospital stay best suits their needs, the goal is to offer patients the treatment and support they need to return home as soon as possible and continued support at home. Referrals to the HTTs are made by community or in-patient services within the trust. We inspected:

- Wigan and Leigh HTT
- St Helens & Knowsley HTT
- Warrington and Halton HTT

The assessment teams work with adults who have moderate to severe symptoms of mental illness. They

provide a single point of access into secondary services through a specialist mental health assessment, advice and signposting team. The service operates 24 hours a day, 365 days a year. Referrals to the assessment teams can be made by the person themselves, or by another professional involved in their care, such as their GP. We inspected:

- Wigan assessment team
- St Helens and Knowsley assessment team
- Warrington and Halton assessment team

The recovery teams work with adults who have moderate to severe mental health needs to provide a recovery focused approach. The team are multidisciplinary and offer treatment. The community mental health teams changed in December 2012 to form the recovery teams. The services operate Monday to Friday 9am to 5pm; however, appointments can be made outside of these hours if required.

The recovery teams consist of six teams throughout the boroughs. We inspected three of these:

- St Helens
- Warrington
- Wigan North
- St Helens
- Warrington
- Wigan North

The Care Quality Commission had not previously inspected these teams.

## Our inspection team

Our inspection team comprised of:

**Chair:** Kevin Cleary, medical director and director for quality and performance, East London NHS Foundation Trust

**Head of Inspection** – Nicholas Smith, Care Quality Commission

**Team leaders:** Sarah Dunnett, inspection manager, Care Quality Commission

Patti Boden, inspection manager, Care Quality Commission

The team that inspected the community based mental health services for adult of working age consisted of nine people:

- Three CQC inspectors;
- A Mental Health Act reviewer;
- A consultant psychiatrist;
- Four specialist advisers who were nurses.

# Summary of findings

## Why we carried out this inspection

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

## How we carried out this inspection

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

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

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

During the inspection visits, the inspection team:

- Visited three home treatment teams, three assessment teams and three recovery teams.
- Carried out an announced visit between 21 and 23 July 2015 and completed an unannounced visit on 30 July 2015;

- Visited four patients in their homes and observed seven patient interviews to determine how staff were caring for people who use the services. This was with the approval of the person who used the service;
- Spoke with 24 patients who were using the services and eight relatives;
- Spoke with the managers for each of the services;
- Spoke with 59 other staff members, including nurses, psychiatrists and occupational therapists, psychologists, students, support workers and pharmacists;
- Attended three multidisciplinary team (MDT) meetings and three handover meetings;
- Looked at 43 patient care records;
- Looked at a range of policies, procedures, meeting minutes and other documents relating to the running of the services.

## What people who use the provider's services say

During this inspection, we spoke with 24 people who use services and eight carers or relatives. We also observed eleven clinical engagements.

The majority of feedback from patients who use services was positive. Patients were complimentary towards staff and considered them caring and supportive.

Patients reported that staff understood their social needs and assisted them to maintain and develop their social networks and community support where needed.

People who used the service and their carers reported they were happy with the service they received and had the necessary information they needed to access services and support in times of crisis.

Carers that we spoke to all felt they had been involved and listened to in the care and treatment of their relative. They knew who to contact in an emergency.

## Good practice

- The Warrington and Halton home treatment team had recruited a volunteer to conduct telephone interviews

# Summary of findings

with patients who use their services to gain feedback. We saw this feedback being shared through team meetings and actions being developed to improve the service patients receive.

## Areas for improvement

### Action the provider **SHOULD** take to improve

- The trust should ensure that the lone working policy is fully embedded and reviewed throughout the community teams and specifies who is required to check staff safety following visits and to improve the regularity of the checks.
- The trust should review and monitor their community bases where staff work alone and see patients in visiting rooms or within the community against the trust's associated policies and procedures for lone working to ensure staff and patients are safe.
- The trust should continue to review and monitor patients who are subject to the Care Programme Approach to ensure patients receive planned reviewed and coordinated care they need.
- The trust should ensure that each team's operational guidance is updated to reflect the services provided by mental health services for adults of working age in the community.
- The trust should ensure staff receive clinical supervision and appraisals.
- The trust should provide the Care Quality Commission's contact details alongside the MHA patient information, so that patients know where to make a complaint regarding the application of the MHA.
- The trust should ensure that the Warrington and Halton home treatment team review the use of their medicines cabinet to ensure their medicine storage facility is fit for purpose.

# 5 Boroughs Partnership NHS Foundation Trust

## Community-based mental health services for adults of working age

### Detailed findings

#### Locations inspected

Name of service (e.g. ward/unit/team)	Name of CQC registered location
Wigan and Leigh home treatment team	Wigan
Wigan and Leigh assessment team	Wigan
St Helens & Knowsley home treatment team	St Helens
St Helens and Knowsley assessment team	Knowsley
Warrington and Halton home treatment team	Warrington
Warrington and Halton assessment team	Warrington
Warrington recovery team	Warrington
Recovery team North Wigan	Wigan
St Helens recovery team	St Helens

#### Mental Health Act responsibilities

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

Regular audits were carried out to ensure the Mental Health Act (MHA) was being implemented correctly. Staff received MHA training as part of their mandatory training requirements and had a good understanding of the Act. Records indicated that 88% of staff had received MHA

# Detailed findings

training in the Warrington/Halton assessment team (the highest level of compliance), while 55% of staff in the St Helens/Knowsley home treatment team (HTT) had received MHA training (the lowest level).

Information was given to detained patients who were subject to community treatment orders (CTOs). The information included an explanation of their rights and recorded if the patient had been given information about independent mental health advocates.

Effective processes were in place to monitor and review patients who were subject to a CTO. In the recovery teams we visited, we saw clear identification of patients subject to CTOs. In the care records we reviewed, we found appropriate risk assessments and care plans in relation to CTOs. Systems were in place to record and monitor that patients had their rights explained to them. Information was also available to inform patients about their CTOs. We saw the information did not contain the Care Quality Commission's contact number, but referred to the patient making a complaint to an independent commission with no details included.

Administrative support was available within the trust to assist staff with implementation of the Mental Health Act (MHA).

There were no CTOs in place for people using services in any of the assessment or HTTs we visited. We saw that some people in the recovery teams who had a CTO were monitored and visited, with good systems in place to monitor patients. We found information was available to explain to patients why they had been placed on this type of order. The information also included a record of review dates. The person subject to the CTO and a member of staff signed the record to show it had been given and that they understood their rights.

St Helens recovery team had information available for people using the service to inform them about access to independent mental health advocates. This also included information about who could make a referral to this service.

## Mental Capacity Act and Deprivation of Liberty Safeguards

Staff said they had received training in the use of the Mental Capacity Act 2005 (MCA) and described how they would check if a person understood or was having difficulty. All staff said they could seek advice if needed and the trust had a policy on the MCA, which was available on their trust internal website.

Trust data for compliance with MCA training across the teams, including consent ranged from 86% at Warrington and Halton home treatment team (HTT) this being the highest and 77% at St Helens and Knowsley HTT and Wigan and Leigh HTT these being the lowest.

Most care records included frequent reference to capacity issues.

# 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

People were seen in all nine of the community bases we visited. Interview rooms were available and most bases had various alarm systems and /or call bells with differing response protocols in place. Personal alarms were available in some of the bases where room alarms had not been fitted.

Warrington and Halton team had an interview room, which was used regularly. This room did not have an alarm nor did staff have access to personal alarms, which meant there was a potential risk to staff.

The recovery team North had a well-equipped clinic room where physical examinations and depot injections were administered. The home treatment teams (HTTs) completed physical assessments at the patient's home using portable equipment.

All of the teams had clean and tidy work areas, which were well maintained. Patient and waiting areas were also clean and tidy. Information about hand washing was displayed in toilet areas accessible to patients and staff. The environment and facilities were suitable for patients with mobility issues.

### Safe staffing

Staffing numbers and grades had been established as part of the development of the acute care pathway. Managers told us that the staffing establishment had been identified prior to them taking up post. Managers informed us they had been able to make amendments to their teams based on the needs of the service.

Wigan and Leigh HTT had a total number of 27 substantive staff with one staff leaver in the last 12 months and a vacancy rate of 7% and 9% of permanent staff sickness.

Wigan and Leigh assessment team had a total number of 30 substantive staff with 4 staff leavers in the last 12 months, and 7% vacancy rate and 5% sickness.

St Helens & Knowsley HTT had a total number of 25 substantive staff with three staff leavers in the last 12 months and a vacancy rate of 14% and 9% sickness.

St Helens and Knowsley assessment team had a total number of 24 substantive staff with one staff leaver in the last 12 months and a vacancy rate of 7.5% and 13% sickness.

Warrington and Halton HTT had a total number of 27 substantive staff with no staff leavers in the last 12 months and a vacancy rate of 4.5% and 8.5% sickness.

Warrington and Halton assessment team had a total number of 31 substantive staff with two staff leavers in the last 12 months and a vacancy rate of 2% and 5% sickness.

Warrington recovery team had a total number of 46 substantive staff with four staff leavers in the last 12 months and a vacancy rate of 5% and 4% sickness.

Recovery team North had a total number of 37 substantive staff with no staff leavers in the last 12 months and a vacancy rate of 12% and 9.6% sickness.

St Helens recovery team had a total number of 46 substantive staff with two staff leavers in the last 12 months and a vacancy rate of 0.6% and 3.7% sickness.

There were cover arrangements in place for staff sickness but the high sickness in the HTTs had impacted on capacity to keep appointments. Most teams we visited had a duty system in place; they provided cover for staff sickness, leave and vacant posts.

Where there were clinical staffing shortages the teams tried to access bank staff. The Wigan and Leigh HTT had recruited two agency workers to cover staff vacancies until newly recruited staff was in post and had been inducted into the trust. Known agency workers were also used, who had demonstrated competency in the role. Most of the assessment and recovery teams we visited had minimal staff sickness and when staff were off sick the managers did not routinely access bank or agency staff.

Caseload sizes of the whole HTTs ranged from mid-50's to over 120 with the average length of treatment being 6-8 weeks. The recovery teams had between 25-35 patients who were on the care programme approach. Some teams used a coloured traffic light system during supervision to identify complexity and intensity on their caseloads, red

# Are services safe?

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

being complex case work and green being minimal support and intervention. Caseloads were managed and reassessed in supervision, team meetings and weekly multidisciplinary team meetings the staff attended.

At first point of contact the Columbia suicide screening tool was in use, followed by a more detailed risk assessment during the team's first face-to-face contact with the patients. The assessment and screening tools in use varied across the teams. The St Helens and Knowsley assessment team had piloted a mental health screening assessment, which was to be rolled out to the other two assessment teams. No date was provided.

Patients in the community who were subject to the Care Programme Approach (CPA) were managed by the recovery teams. Patients who were subject to a CPA were not always allocated a care coordinator, which is not in line with good practice guidance. The clinical commissioning groups (CCGs) were monitoring this. Figures identified within Wigan showed the percentage of patients in contact with services who were on CPA was 45% in April 2015, in May 49% and in June approximately 49%. This was being reviewed by the trust and the CCG at the contract meetings held to agree an action plan. Mersey and Warrington CCGs were also monitoring these with Mersey borough services showing 50% in April 2015, 49% in May and June 49%.

All teams had access to a psychiatrist as part of their establishment, which resulted in rapid access to treatment when needed. Teams told us that when the psychiatrist was out on visits they were usually accessible by phone. Out of hours staff contacted the on call doctor and all staff interviewed reported no major problems with receiving a speedy response.

Staff were monitored on their compliance with mandatory training, which was linked to pay progression. Staff reported they were up to date with their mandatory training and where they were not they were aware which training they needed to book on to. Records requested following the inspection identified the HTT and assessment teams we visited had between 79% and 87% of their staff had completed the trust's statutory training. This training included infection control, fire, safeguarding children level one and moving and handling. The trust's target for mandatory training was 85%.

## Assessing and managing risk to patients and staff

The first point of contact into mental health services was usually via the assessment teams. The records we reviewed confirmed an initial triage/assessment was completed. Staff used the Columbia suicide screening tool to identify suicidal patient risk, followed by a more detailed risk assessment on the patient's first face-to-face contact.

The assessment and screening tools in use varied across the teams, and the St Helens and Knowsley assessment team had piloted a mental health screening assessment, which was to be rolled out to the other two assessment teams.

We reviewed 24 care records at the HTTs and most showed a clear rationale for the teams' involvement with clear risk assessments in place which were regularly reviewed.

Nineteen patient records were reviewed across the assessment and recovery teams we visited and all but one had a completed risk assessment in place. The electronic records allowed staff to place a marker on a record to alert other staff of any potential risk issues before patients were seen.

The assessment teams completed an outcome plan for patients following their assessment. The plans were completed by the staff member and included a summary of the intervention with the person using the service and any future plans. They included emergency contact numbers and information contact numbers of national organisations as well as an explanation of any referral pathways. A copy of this was given to the individual, their GP and the teams kept a copy.

The teams had a duty person or team identified to respond promptly to any sudden deterioration in a patient's mental health. The assessment teams also had close links with the local A&E services as well as the street triage teams.

Duty workers monitored people who were on their waiting lists. Duty workers contacted patients and arranged to visit them in their own homes if necessary. They also liaised with other professionals who may be involved in their care and treatment. Multidisciplinary team meetings were in place to discuss 'increased level of risk as well as discussions with the duty workers, their teams and with managers.

Staff had received training in safeguarding vulnerable adults and children and staff knew how to recognise a



# Are services safe?

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

safeguarding concern. They knew who to inform if they had safeguarding concerns. We observed safeguarding issues documented in care records, and liaison and attendance at strategy meetings. Between 1 January and 30 June 2015, the HTTs and assessment teams made 11 referrals to adult safeguarding and 190 safeguarding children referrals were made.

We reviewed St Helens and Knowsley assessment team's lone working procedure following our visit and this stated that staff would complete a full risk assessment before seeing an urgent assessment alone as well as notifying the wards and out of hour's coordinator to ensure they were safe. We did not review this in practice during our inspection.

During our inspection, we found Wigan assessment team had made changes to their lone working team protocol and we observed an email that had been sent to all team members reminding them to contact the team to inform them they were safe following a visit, as per their lone working policy.

Patients were seen in both the offices we visited and their own homes. We found the trust lone working policy had a review date October 2014. Full risk assessments had not been completed for staff working alone in buildings. We requested information following our inspection and the trust provided us with local team procedures for lone working. These identified the local procedures for lone working as well as stipulating adherence to the lone working policy.

We reviewed datix incident data for Warrington recovery team following our inspection. This highlighted two incidents where patients had become violent and aggressive toward staff whilst staff were alone with the patients. The trust reviewed both of the incidents and provided debriefing to staff where needed. The security representative visited the team to discuss specific plans to keep staff safe and the manager reviewed the current safety and security measure including the environment. Meetings were held with relevant professionals on the team but we did not see that this had been cascaded to other teams. This meant that although local procedures were in place any lessons learnt had not been cascaded with other community teams.

We saw team meeting minutes for the HTTs, which highlighted the importance for staff to ensure they

complied with the lone working procedure. We were told that the trust's local security management specialist was in the process of setting up a trial of two lone worker devices in the assessment and HTTs.

Where medication was stored on site, storage was appropriate with regular checks made by the pharmacist. The Warrington and Halton HTT kept their medicine cabinet in a room, which resembled a cupboard. This room did not have hand washing facilities and maintaining temperature in the room had been a problem. Daily recording of the room temperature was being overseen and the pharmacist was monitoring the situation.

## Track record on safety

We reviewed a governance report dated July 2015 for the HTT and assessment teams. It identified that, from 1 January to 30 June 2015, 67 incidents (1% of all trust incidents) had been reported by the HTT and assessment teams (six teams). Halton and Warrington reported 21 incidents whilst Wigan and Leigh reported four incidents. These figures represent the highest and lowest number of reported incidents.

Over the same period, the HTTs and assessment teams reported 15 serious untoward incidents (SUIs). One of the reported incidents from the HTTs was an example of the team following the trust's duty of candour policy.

Between 1 May 2014 and 30 April 2015, there were 28 serious incidents reported by the assessment and HTTs. 26 of these concerned unexpected deaths. We reviewed information supplied by the trust and this identified that managers had reviewed the incidents and completed post incident reviews into serious incidents.

The trust had implemented a new system to inform staff of patient safety alerts from June 2015. These alerts had been generated from learning from serious untoward incidents (SUIs) reported. The information identified who the alerts were applicable to and who was responsible for acting on them, with specific actions to be taken immediately and other actions within a specified period of time.

## Reporting incidents and learning from when things go wrong

The service had systems in place for reporting incidents and serious untoward incidents, investigation and feedback of any lessons learnt. Staff we spoke with understood their responsibilities in reporting incidents.

# Are services safe?

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

All staff interviewed knew what and how to report incidents using the datix incident reporting system. Staff reported that they received debriefing and support following any serious incidents. Some staff felt this mainly came from their immediate line manager and team colleagues, they felt support from higher management was not always evident.

We saw evidence in team meeting minutes of particular serious incidents or complaints being discussed and shared with team members. We saw evidence of this in some supervision notes also within the HTTs.

Staff told us that when something significant had happened they had received debriefing and the learning had been shared amongst team members and this was confirmed in some of the datix incident reports we reviewed. Staff were less clear if they could recall incident information from other teams and boroughs being shared.

The manager in the St Helens and Knowsley HTT had implemented a practice whereby two workers attend all

first assessment meetings, which was a result of the learning from an investigation into an incident in that team. We did not see that this had been implemented within the other two HTTs visited.

Staff were open and transparent and gave examples of how they would apologise and inform a patient if things went wrong. The trust had provided a flow chart for the duty of candour and the datix system was being used to trigger incidents that would fall under the duty of candour requirements. Not all staff we spoke with was aware of what duties of candour meant but were able to tell us of how they would escalate concerns to their manager. We saw communications had been sent to staff via the trust 'core brief' in May 2015 to inform them of how to raise a concern and the duty of candour.

Staff received an electronic newsletter called 'in view'. This detailed initiatives and lessons learnt across the trust. Managers told us that they contributed to local quality initiatives and attended quality and safety meetings. A core brief was received monthly and lessons learnt were cascaded to their teams through supervision and 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

We examined 43 care records during our inspection of the nine teams.

The trust has a policy in place (review date July 2014), which applied to all patients in contact with 5 Boroughs Partnership NHS Trust services, regardless of age and whether they were treated in a hospital or community based setting. The aim was to work closely with individual patients, their families and other healthcare professionals across the spectrum, in order to adequately meet each individual's holistic healthcare needs, focussing on three levels:

- Engaging in healthy lifestyles;
- Promoting health-seeking behaviours;
- Responding to physical deterioration.

Records showed that the teams did not always undertake full physical health examinations; instead, they would liaise with local GP services for physical health checks. All HTTs had a dedicated assistant practitioner whose remit was to provide physical health support by taking blood samples, monitoring blood pressure and undertaking tests such as ECG. This was confirmed in care records, which demonstrated consideration and monitoring of patients' physical healthcare needs.

24 HTT records were reviewed. Records showed that patients' needs were holistically assessed and care was delivered in line with their individual care plans.

Records showed risks to physical health were identified and managed effectively, with the teams' psychiatrists actively liaising with GPs. However, the standard of record keeping was not consistent across all teams. We saw some care records that were unclear regarding what the aims and interventions for the patient were.

In the Wigan and Leigh HTT, we examined eight records; in one, the care plan and risk assessment were incomplete. One record stated the patient was receiving daily visits, but also showed a two-day gap in the record without a visit or telephone call to them. Another record stated that the

patient had not received their scheduled visit and the practitioner had contacted them the next day to apologise. This might have endangered patient care if the visits they were scheduled for and were not completed.

Staff across all teams used an electronic case management system to record and secure patient information. There were also paper records stored securely in areas that were restricted by doors with locks or keypads.

### Best practice in treatment and care

Medical staff followed NICE guidance; some staff said that they were informed of new guidance through the core brief (a newsletter sent to all staff) and the intranet.

Patients requiring psychological therapies were referred to the improving access to psychological therapies service or were provided with psychological support by the assessment and recovery teams.

Patients in the recovery teams had access to various intervention courses and groups, to enable them to benefit from support from other group members. Staff members attended some of these courses. Carers were also invited to some of the groups. These included wellness planning, managing emotions, hearing voices group course, mental health awareness for carers, and training for family and carers of patients diagnosed with a personality disorder, as well as an anxiety management toolkit for patients. The wellness planning provided individual patients with different methods to aid their recovery and manage a crisis.

The St Helens recovery team also provided a well-established gardening group (known as 'project orchard') and recovery teams provided walking groups and social activities for patients to access throughout their recovery.

Staff assessed patients using the Health of the Nation Outcome Scales. These covered 12 health and social domains and enabled the clinicians to build up a picture over time of a person's responses to interventions.

Some managers we spoke with carried out regular audits of care records. The results of these were fed back to team members during team meetings or individual supervision sessions. We saw evidence of this in supervision and team meeting minutes. Other audits which either took place or were planned to take place across the next 12 month period included:

- Infection control;
- Audit of care plans, crisis plans and contingency plans;

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- CPA compliance;
- Assessment team audit of emergency and urgent referrals against local guidelines;
- Use of contraception with psychotropic medication;
- Audit to assess the quality of consultant assessment team clinic letters to GPs;
- Discharge letter audit.

The Knowsley and St Helens HTT were working towards the Home Treatment Accreditation Scheme. This was to assure and improve the quality of the HTTs by providing standards to work towards.

The assessment teams were audited to review their response to an 'urgent' or 'emergency' referral, to confirm that the service user was contacted within the appropriate timeframe. They were also assessed against the NICE quality standard 14 – service user experience in adult mental health (Quality Statement No. 9). The trust was also re-auditing their compliance against NICE schizophrenia guidelines to benchmark the trust nationally and to give assurance of improvements noted in the previous audit.

The trust had audits to check their compliance with aspects of the quality of care provided to patients with a diagnosis of schizophrenia or a schizoaffective disorder (NICE CG178, 2014). Audits of care plans, crisis plans and contingency plans assessing compliance with the NICE – quality standard 14 had also been completed.

Patients who used the assessment and recovery services received employment, housing and benefits support from social work teams across the boroughs. Referrals were made mostly via telephone. Some social work teams were based in the recovery teams we visited and close working links were maintained.

The patient's physical healthcare was considered during the initial assessment and was then managed in collaboration with GPs. Shared care protocols were in place for the management of patients on lithium. Pan Mersey lithium guidance was used across Pan Mersey and was beyond their review date. However, a revised document has been developed by the Pan Mersey sub-group and had been circulated for stakeholder consultation. The trust informed us there had been a number of updated versions following consultation resulting in delays to the ratification process. As of July 2015, the document was awaiting final

ratification at the area prescribing committee. A shared-care local agreement was in place between 5 Boroughs and Wigan Borough clinical commissioning group – to implement the lithium shared care protocol.

Monthly records of patients discharged from the service were maintained by the HTTs. They also monitored risk assessments and diagnosis, psychosocial interventions and management after risk assessments, referral to other services, and other data. The assessment teams reported on activities with patients and carers, as well as face-to-face contacts and patient discharges.

## Skilled staff to deliver care

The assessment teams consisted primarily of band six nursing staff, with two out of three teams having band three support time and recovery (STR) workers. The recovery teams also had STR workers available. All of the HTTs we visited had access to and input from an occupational therapist, psychologist and pharmacist.

The teams we visited included a full range of mental health disciplines. These included qualified nurses, consultant psychiatrists, occupational therapists, senior mental health practitioners, assistant practitioners, STR workers and, on some teams, psychologists. The street triage team attached to St Helens and Knowsley assessment team included a senior nurse practitioner a social worker and a police constable. All teams we visited had access to administrative support and could access a pharmacist if needed.

Staff told us they had undertaken training relevant to their roles. When the HTTs were re organised in 2012, all staff had received training in the acute care pathway and in basic cognitive behavioural therapy. Some of the HTT staff had undertaken further training such as psychosocial interventions.

Staff also received core training on conflict resolution, equality and diversity, safeguarding adults, basic life support, information governance, and health and safety. Figures provided identified 78% to 85% of staff had completed training in these areas. Across the various teams, 60% to 74% of staff have received conflict resolution training. Within the HTT and assessment teams, between 55% and 66% of staff have also received additional specialist core training.

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New staff had a period of induction to welcome them into the teams, in addition to the trust-wide induction. Staff received a mix of trust-wide and role-specific training, followed by a period of shadowing more experienced staff members in their team.

Clinical supervision for staff ranged from 0% to 29% for the HTTs and assessment teams. This allows staff to discuss their patients and to learn from their experiences at work to ensure good patient care. The trust's clinical supervision policy stated that this should be delivered to staff on a quarterly basis and could be provided as one-to-one, peer group, multidisciplinary group, and unplanned/ad-hoc or inpatient clinical supervision.

The management supervision policy (July 2015) outlined guidance for the supervision of all trust employees and detailed requirements for managerial, clinical, educational/training and professional supervision of clinical and non-clinical employees. All of the teams we visited had access to regular team meetings and some had daily handovers, which provided staff with peer support for clinical cases.

We saw minutes of leadership meetings that had taken place on 18 June 2015. These included medicines management updates, risk management, attention deficit hyperactivity disorder training information, personal development reviews, admissions and bed status, core brief and complaints.

The regular team meetings provided staff with an opportunity to raise concerns and share information. We reviewed team meeting minutes for the Knowsley and St Helens assessment team, and observed various meetings held with other professionals and teams. These meetings highlighted issues about assessment and performance, and raised concerns regarding patients who did not attend their appointments and the waiting times between their second appointments being offered. This meant the teams had systems in place to discuss and make changes to their local service provision.

We also looked at the mental health forum minutes from June 2015 where section 136 of the MHA, advance mental health practitioners, the MHA, the Mental Capacity Act 2005 and access to hospital beds were discussed.

## Multi-disciplinary and inter-agency team work

Regular and effective multidisciplinary team (MDT) meetings were in place. An MDT meeting involves the group of professionals from one or more clinical disciplines who

together make decisions regarding the recommended treatment of individual patients. We observed one MDT meeting during our inspection. The meeting was effective and provided staff with opportunities to discuss patient care and treatment.

At the Wigan assessment team, we observed a gap in the daily communications meeting. The purpose of the daily communications meeting was to ensure patients were contacted within 24 hours of non-attendance. We found that patients who did not attend appointments on a Friday at a satellite base away from the main office and could have up to four days where they were not followed up. We discussed this with the acting manager who immediately emailed all staff to inform them that should this happen then information was to be faxed to the assessment team offices so that the patient could be contacted dependent on any risk factors at the time.

There were effective handovers between the trust's community teams and the inpatient services. The recovery teams and ward staff attended handover meetings and MDT meetings to discuss patients planned discharge and admission to the wards.

We observed a twice daily teleconference call to discuss bed management between staff on the acute wards, the duty worker at the HTT and the bed management and business manager who had the authority to allocate resources and authorise referrals to external providers. Staff in the HTT and acute wards discussed patients who needed inpatient care, as well as the bed state across the trust including out of area beds. Staff in the HTTs reported that the pressure on beds had noticeably increased within the past 18 months and felt this was a problem. When a patient required an inpatient bed and one was not available, staff in the HTT sat with them until one became available. This could often be for several hours, which took up valuable resources and was difficult for the person awaiting admission.

We saw there were good working links between primary care and social services. Staff made referrals and liaised with these services to ensure patients received the right services for their needs.

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

Regular audits were carried out to ensure the MHA was being implemented correctly. Staff received MHA training



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as part of their mandatory training requirements and had a good understanding of the Act. Records indicated that 88% of staff had received MHA training in the Warrington/Halton assessment team, these being the highest figures and the lowest being 55% at St Helens/Knowsley HTT.

Information was given to detained patients who were subject to community treatment orders. This included information about the explanation of their rights and recorded if the patient had been given information about independent mental health advocates.

We saw effective processes were in place to monitor and review patients who were subject to community treatment orders (CTOs). In the recovery teams we visited, we saw clear identification of patients. In the care records we reviewed, we found appropriate risk assessments and care plans in relation to CTOs. Records indicated that patients were having their rights explained. Information was also available to inform patients about their CTOs. However, this did not contain the Care Quality Commission's contact number and instead referred to the patient making a complaint to an independent commission with no details included.

There were no CTOs for patients in any of the assessment teams or HTTs we visited. Some patients in the recovery teams had a CTO. These patients were monitored and visited and good systems were in place to monitor patients. Information was available to explain to patients why they had been placed on this type of order. The information also included a record of review dates; it recorded if the patient had understood their rights providing a section where the staff and patient signed.

Administrative support was available for implementation of the MHA within the trust.

The St Helens recovery team had information available for patients to inform them about access to IMHAs, including information about who could make a referral to this service.

## **Good practice in applying the Mental Capacity Act**

Staff had received training in the use of the Mental Capacity Act and described how they would check if a person understood or was having difficulty in understanding the information staff were giving them. All staff said they could seek advice if needed and the trust had a policy on the MCA, which was available on their intranet.

Trust data for compliance with MCA training across the teams, including consent, ranged from 86% at Warrington and Halton HTT (the highest) to 77% at St Helens and Knowsley and Wigan and Leigh HTTs (the lowest).

Between 77% to 86% of staff had completed the Mental Capacity Act 2005 (MCA) and Deprivation of Liberty safeguards (DoLS) training. Figures also showed between 55% to 87% MHA training however clinical risk assessment identified a low compliance rate for these teams with figures ranging from 17% to 50%. This meant that some of the compliance figures for the HTT and assessment teams were low and this could place staff at risk especially in areas where lone working in the community and in bases took place.

# 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 accompanied practitioners on home visits and/or clinic appointments and observed staff displaying a caring attitude and engaging with patients and their relatives / carers. We observed appropriate practical and emotional support during these visits. We attended multidisciplinary team and handover meetings and saw that staff had a good understanding of the patients they were providing care and treatment to. Our observations of staff interaction with people who used the service were positive. Staff engaged with patients who used services in a respectful manner allowing patients and carers to express their opinions. We observed staff interacting with patients in a caring and compassionate way.

Following the inspection, we contacted two patients and two carers from Wigan North recovery team. One patient and carer had also received services from the HTT. They had told us that staff treated them with respect and were kind. One carer said they had been “absolutely brilliant” and had received a carer’s assessment, which identified the help they needed. All of the patients and carers told us they had received a good service and were pleased with the care and support they received. Patients described how they felt listened to and had been provided with information about services they could access locally including local groups, college and psychological services and local support networks.

We also contacted two patients from St Helens recovery team following the inspection. Their comments included, ‘I find the staff great’, and ‘they are very friendly and accessible’. ‘I think they do more than tick boxes’, ‘I think they take an interest’.

“Oh yes they are fantastic, they are absolutely interested in me, I have a care plan we did quite a bit of it together, they encourage me to make choices my care coordinator mentioned advocacy but never needed it. I have been asked for feedback, If I wanted to give feedback would speak to care co-ordinator, and if that didn’t work go to PALS”.

We conducted telephone interviews with patients currently on the HTTs’ caseload or those recently discharged. Staff were described as “lovely”, “polite”, “listen to me”, “interested in me” and “respectful”. Patients frequently said

they “felt safe”. We also contacted patients in the assessment teams who provided positive comments in relation to access to the service; they all said staff were helpful, respectful and listened to them. They told us that they all had contact numbers if they needed to contact someone in an emergency.

The patients and carers told us they had information and contact numbers of who to contact if there was an emergency or if their mental health was deteriorating. Warrington and Halton HTT had recruited a volunteer to gain feedback from patients who used services regarding their experience so they could further improve the service provided.

One person said they had received “phenomenal benefit from their help and feels more in control” another said “got out of bed and had a wash knowing they were coming and getting me back on track”.

Patients described some staff as exceptional. Most knew how to make a complaint. One carer told us they had called the team who were overseeing their family member’s care and staff on reception had told them the worker was not there. However, when they described the urgency of the call the worker was contacted and responded to the call.

At all of the nine teams we visited, we found evidence that confidentiality was well maintained. Records were maintained electronically and on paper. Both were kept secure. We saw staff locked their screens when walking away from their computers to ensure confidentiality was maintained.

### The involvement of people in the care that they receive

Patients who accessed the services told us that they were involved in decisions about their care and treatment.

Patients told us they were provided with written information about the team and informed of how to contact them. We saw leaflets that practitioners had given to patients and they had information relating to illnesses such as depression.

The Wigan assessment team did not provide care plans to the patient. The team’s manager had identified this as an area in need of development and a care plan document had been ratified and was to be introduced. The St Helens and Knowsley assessment team used a care plan, which listed the identified interventions to be delivered to the

# Are services caring?

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patient, and the patient was able to take away a carbon copy of the plan. The care plans at the HTT teams addressed patients' needs and most records showed that patients who used the service and carers were involved in care planning.

Patients were involved in their care and records including carers support and assessments were seen to support this. Some patients we interviewed by telephone confirmed they had been fully involved in developing their care plan and had received a copy. Not all patients could recall being given choices about their care or receiving a care plan.

Most patients that accessed the HTTs reported seeing several different people in the same role. Managers were aware of this through patient feedback. Of those spoken with, the majority said they had not minded that it was different staff visiting them as they were usually told "up front" that this might happen. The manager from the St Helens and Knowsley HTT was attempting to respond to this feedback and had made changes in the team to try to enable the same practitioner to continue with the patient throughout their treatment.

Referrals to advocacy in patients care records were seen as well as referral to IMHA. Advocacy leaflets were available in the bases we visited.

Carers stated that they felt involved in their care and were involved in decisions around treatment as appropriate. Carers were positive about the service they received.

The trust provided training educational support for carers. This was a skills based education course for families and carers to teach them about problem solving techniques whilst caring for patients with severe and enduring mental illness. Carers support groups were available throughout the trust and information. When staff visited patients and carers, they were given this information and it included local groups and services available.

Details of local advocacy services were readily available to inform patients about the support services available to them.

The views of patients who had used the services were gathered using the friends and family test. St Helens recovery team had 68 patient responses in May 2015 with 85% extremely likely or likely to recommend the service to friends and family if they needed similar care or treatment and 58 responses in June with 81% extremely likely or likely to recommend our service to friends and family if they needed similar care or treatment.

Wigan North recovery team had 31 responses in May with 100% extremely likely or likely to recommend the service to friends and family if they needed similar care or treatment. In June, they had seven responses with all extremely likely or likely to recommend the service to friends and family if they needed similar care or treatment. This meant the trust was seeking feedback from patients that used their service. The friends and family test included space for comments. Responses to this were fed back to staff at team meetings, to enable them to make changes where needed.



# 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

Patients were able to access assessment team services 24hrs a day and the home treatment teams between 8am and 8pm (9am and 9pm for St Helen's and Knowsley home treatment team).

The assessment teams we visited provided cover over 24 hours with reduced staffing levels throughout the night. These teams had only one staff member in place during the night. The assessment teams were responsible for attending the 136 suites. These are a place of safety where patients can be taken from a public place whilst awaiting assessment of their mental health, as well as attending A&E liaison where needed.

The assessment teams offered a single point of access into mental health services throughout the trust and could have patients on their caseload for up to 12 weeks. This meant a full assessment of patients need was completed and then patients were moved on to a more appropriate service if needed. We found high levels of referrals into the assessment teams. Knowsley and St Helens assessment team had 848 open cases some of which had been active for over a year. Staff reported problems in discharging patients from their services into other service pathways. We saw recent interventions had taken place with staff to discharge patients from their caseloads.

The total number of referrals for the assessment teams for Q1 was 3527 with a breakdown of:

- emergencies 304
- urgent 443
- routine 2384
- not eligible 396

The assessment teams had targets set by the trust in place to see patients. They had to see patients with an emergency within 24 hours, urgent referrals within 72 hours and routine appointments within 10 days. Wigan assessment team saw 96% of patients within their set targets. In April to June 2015 an average of 92% of emergency referrals were seen within the 24-hour target and 79% of urgent referrals within three days.

Where patients needed a more intensive service prior and post discharge from the acute hospitals the HTTs provided

a more intensive service to support patients and to prevent a readmission where possible. Processes were in place to follow up patients post discharge and this usually happened within 72 hours.

The HTTs monitored days between referral into the service and face-to-face contact. In April 2015 at

Halton and Warrington HTT 53 out of 99 patients were seen on the same day and 30 patients within one day of referral. In May 2015, they saw 110 patients with 50 seen on the same day and 34 being seen within one day of referral.

St Helens and Knowsley HTT for the same period had 88 referrals in April, 31 patients were seen on the same day, and 34 were seen within one day. In May 2015, 106 referrals were made with 37 patients seen on the same day and 39 seen within one day of referral.

Wigan and Leigh HTT had 102 referrals in April 2015 with 32 patients seen on the same day and 33 patients within one day. May 2015, 97 patients were referred with 27 patients seen on the same day and 41 within one day.

The teams we visited were able to see patients quickly as an urgent referral. They had systems in place to facilitate this by providing a duty system and single points of access into the services. The assessment teams provided urgent referral appointments each day. Recovery teams had procedures in place to identify and accelerate urgent referrals.

Patients who were in crisis were directed to a duty team/worker when they contacted the recovery and assessment teams. Responsive systems were in place to update and inform staff of any patient who made contact throughout the day. Duty workers within the assessment teams decided on the priority of response needed and where a referral was needed to another mental health team then this was actioned.

The home treatment, assessment teams and the recovery teams all had operational guidance in place with service pathways. We found the operational guidance was not always reflective of the service being offered. However, the teams provided a single point of access within their borough mental health services to patients who needed signposting to more appropriate services either in a primary care services or within specialist mental health

# Are services responsive to people's needs?

Good 

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

community teams. These meant patients were not excluded and those patients that needed treatment benefited from their service provision or were directed to care that is more appropriate or treatment.

Data informed us that the proportion of patients on the CPA were followed up within seven days of discharge from psychiatric inpatient care and remained above the England average.

Processes were in place to encourage patients who were reluctant to engage with mental health services to access the services offered. These included contact with the individuals, contact with referrer to seek further information, follow up appointments were made, home visits were escalated and dependent on the risk assessment escalation to emergency services or arrangements for a MHA assessment were made. The teams had regular team meetings in place to discuss these patients as well as access to a MDT meeting weekly where patients with complex needs and difficult to engage patients were discussed, to agree a plan of action.

Patients were provided with some flexibility of appointment times and where appropriate they were rearranged if a patient was unable to attend. Patients who used services told us that they could access the services quickly by telephone and that staff had dealt with them promptly.

Some appointments had been cancelled with patients due to staff sickness, but only when absolutely necessary. We found duty workers within the teams would reallocate an appointment, or other team members would rearrange to see the patient.

The trust monitored the discharge of patients back into primary health services and discharge information was provided to the patient and their GPs.

Knowsley and St Helens, and Warrington and Halton assessment teams had incorporated a street triage team, which Warrington and Halton team reported an 89% reduction in patients being arrested under section 136 of the MHA or being taken unnecessary to hospital for treatment. Knowsley and St Helens also reported a reduction in the use of their 136 suite. These teams provided a mental health nurse to support the police on emergency call outs when a person might have mental health issues. They helped to co-ordinate the least restrictive but most appropriate treatment for patients. The

police street triage team who worked alongside St Helens and Knowsley recorded the use of 136 suite, the number of presentations in A&E and the police mode of transport, North west ambulance service (NWAS) time at scene, length of time police were on patrol in response to a s136 MHA.

## **The facilities promote recovery, comfort, dignity and confidentiality**

Buildings used by staff and patients who used the services were well maintained, clean and had appropriate furniture. Some teams had access to rooms for individual consultations as well as some larger rooms used for multidisciplinary meetings and group therapy. Clinic rooms were kept clean and tidy and were appropriately equipped with equipment checked regularly. Interview rooms we visited had adequate sound-proofing.

## **Meeting the needs of all people who use the service**

Patients who had mobility issues could access the offices and facilities were accessible to them.

Information leaflets were available for staff and patients to access them as required. In most teams, these were accessible to patients. There was a full range of information available in the reception and waiting areas, which provided information about local services, groups and information about how to make a complaint.

The trust had access to information in accessible formats and staff were aware of how to request these as well as access to interpretation services.

Child and adolescent mental health services (CAMHS) liaised with the access and recovery teams to plan care and intervention. The CAMHS team provided a transition link person who met three monthly or routinely as required to discuss and make a referral into appropriate mental health community teams. The transition to adult services was made when the child was 18. Wigan recovery North team informed us that a staff member had been seconded for ten months into a CAMHS team. This meant staff were provided with opportunities to work on a temporary basis in another part of the organisation to review and learn from different parts of their organisation.

## **Listening to and learning from concerns and complaints**

The total number of complaints in last 12 months relating to the community adult teams was 79.

# Are services responsive to people's needs?

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Total number complaints upheld were 25.

Total number complaints referred to The Ombudsman in last 12 months were two.

43% of all mental health (MH) complaints related to community based MH services for adults.

Patients knew how to make a complaint although some patients and their carers were not aware of the formal procedure. These patients and carers told us they would raise any issue with their worker and/or their manager. Managers described how they would handle any

complaints and how the process was managed. Staff knew how to respond to anyone wishing to complain and the managers demonstrated how positive and negative feedback was used to improve services.

Staff were aware of the trust's complaints procedure and knew how this could be accessed. We saw information about complaints was displayed in the teams we visited.

Feedback on complaints and complements were feedback to staff through team meetings and/or at supervision.

# 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

Some staff, but not all, knew who the chief executive and director of nursing were. Some staff reported a “disconnect” with higher senior management and said the executive team was not visible. Team managers said they received good support from their senior managers. We saw staff had the opportunity to pose their questions to the chief executive via their internal computerised system.

Staff were aware of the term used by the trust about ‘Future fit’ which looked at re modelling of the services and where improvements could be made in the delivery of care.

The trust’s vision and values were displayed on all staff home screens on their computers and within their team bases.

### Good governance

Information submitted by the trust showed that clinical supervision for staff ranged from 0% - 29% for the HTT and assessment teams. Wigan and Leigh assessment team being the lowest. These figures could have an effect on patient care, as support for staff in practice should enable practitioners to maintain and promote standards of care by receiving clinical supervision.

There were effective systems in place for incidents to be reported, and quality and risk meetings took place on a monthly basis to review and monitor identified risks. Systems were in place to alert staff to learning from events. Recovery steering groups were in place within the three of the five boroughs

The trust disseminated ‘Core Brief’ newsletters to managers and team leaders. These identified key information to be shared with all team members. It also provided managers with a system to confirm they had fed the information back to their teams, as well as being able to submit feedback and/or ask questions. The information also directed staff to newly approved policies and any NICE guidance that had been published.

Data and key performance indicators had been collated. These were available for the teams to review and monitor their performance.

National clinical audits were in place. These included prescribing for people with a personality disorder,

prescribing for attention deficit hyperactivity disorder in children, adolescents and adults. As well as an audit of the quality of care provided to patients with a diagnosis of schizophrenia or a schizoaffective disorder and the use of contraception with psychotropic medication. An audit of care plans, crisis plans and contingency plans had also been completed. These allowed national comparisons with other trusts to enable them to deliver better and improved care for their patients.

Care records and record keeping audits had also been implemented.

Staff used the electronic datix system to report incidents. All staff were aware of the system and knew how to access it. Staff were aware of the trust’s complaints procedure. Minutes of team meetings showed that the results of serious untoward incidents and complaints were fed back to the team. Safeguarding, MHA and MCA procedures were followed.

### Leadership, morale and staff engagement

The teams we visited were well led. There was evidence of leadership at a local level and the managers were aware of who their senior managers were. The team managers were accessible and available to oversee the management and provide support to staff.

Sickness and absence rates for the teams we inspected ranged from 4% at Warrington recovery team to 13% at St Helens and Knowsley assessment team.

Total staff vacancies for these teams excluding seconded staff ranged from less than 1% at St Helens recovery team to 14% at St Helens and Knowsley HTT.

Staff knew how to access the whistleblowing procedure if needed and mostly felt confident that they could use this if needed. There was high morale among staff teams. Staff supported each other with good support from their managers. Staff were open and transparent and explained the situation to patients when something went wrong.

Staff were offered the opportunity to give feedback on services and input into service development. ‘In view’ and ‘core brief’ provided staff with information about the trusts development as well as informing staff about leadership opportunities. The trust had employee and team awards where staff could nominate and recognise a job well done by nominating colleagues.

# 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.

Each of the three Boroughs had monthly leadership meetings in place for adult mental health services. These provided opportunities for managers of services to review, monitor and action identified key areas for improvements in their directorates.

## **Commitment to quality improvement and innovation**

The Knowsley and St Helens HTT was working towards the accreditation by the Royal college of psychiatrists, Home Treatment Accreditation Scheme.

The trust had identified in the staff 'in view' update June 2015 that in the most recent national audit for

Schizophrenia (2014) the trust reported low rates of offering cognitive behavioural therapy (CBT) to their patients (18% when the national average is 39%) and family intervention (1% when the national average is 19%). The trust had arranged a workshop for staff to help them understand the culture and expectations regarding psychosocial interventions within the recovery and early intervention teams to improve their performance. The trust provided an update to all teams about NICE guidance on psychosocial interventions in schizophrenia, including CBT and family interventions.