York & Selby Early Intervention Service

Quality Report

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This report describes our judgement of the quality of care at this location. It is based on a combination of what we found when we inspected and a review of all information available to CQC including information given to us from patients, the public and other organisations

Ratings

Overall rating for this location	**Requires improvement**
Are services safe?	**Requires improvement**
Are services effective?	**Requires improvement**
Are services caring?	**Good**
Are services responsive?	**Good**
Are services well-led?	**Requires improvement**

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

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

Summary of findings

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

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

Overall summary

We rated this service as requires improvement because:

- Staff training did not include basic life support, breakaway techniques to avoid conflict, the Mental Capacity Act (2005) and the Mental Health Act (1983). This meant that staff could not provide effective care if, for example, patients needed emergency first aid.
- Staff did not always record that they had assessed patients' capacity, when there was an indication (such as a learning disability) that they lacked capacity to make specific decisions, for example, agreeing to their care and treatment.
- People with mobility difficulties could not access all parts of the building, the service was provided in a building over three floors with no lift.
- Patients' safety, dignity and comfort was compromised because the waiting area was also used as the staff kitchen. Also, the building had only one toilet that was used by staff, patients and other visitors. There were some areas of the building, such as the kitchen and toilet, that put patients at risk because they contained dangerous items such as sharps (knives and forks) and boiling water. The service had not included these in the risk register to highlight the need for action.
- Arrangements for managing the service were complex between Community Links and the NHS trust, which contracted it. Senior managers across both providers did not communicate with each other effectively.
- The service had no arrangements for checking and auditing medication kept on site, and keeping it at the right temperature. This increases the risk that staff might administer medication incorrectly.
- The service was not investigating serious incidents so enable staff to learn lessons and improve practice.

However:

- The service was managed well on a local level, despite issues at provider level. Staff saw patients within two weeks of referral and there was no waiting list.
- The service was focused on development, and making use of innovative practice and new models of working.
- We saw excellent examples of compassionate and responsive care. Patients and carers that we spoke with made positive comments about their experience of the service.

Summary of findings

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Summary of this inspection

Background to York & Selby Early Intervention Service

The York and Selby Early Intervention Service is an independent mental health community service, based in York, North Yorkshire. The provider of the service is Community Links Northern Ltd. a voluntary sector organisation, as a sub contract of an NHS Trust.

The service provides community mental health support to people aged 14 to 35 experiencing their first episode of psychosis, or those thought to be at risk of developing psychosis. The service works intensively with patients for up to three years working towards reducing the need for other care services at point of discharge. The service takes on the role of care-coordination for the people they work with. It provides support to people living in York, Tadcaster, Selby and Easingwold, and has a maximum caseload capacity of 105 people.

This service has been registered since 2012 to carry out the following regulated activity:

- Treatment of disorder, disease or injury.

The service has a registered manager. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

We last inspected this service using our previous inspection standards in January 2014 and we found the service to be meeting all the standards inspected.

They included :

- consent to care and treatment
- care and welfare for people who use services.
- safeguarding people who use services from abuse.
- safety and suitability of premises.
- staffing
- complaints.

Our inspection team

Team leader: Gemma Berry, Inspector, Care Quality Commission.

The team that inspected the service comprised two Care Quality Commission inspectors and two specialist advisers who were qualified nurses specialising in adult and child mental health.

Why we carried out this inspection

We inspected this 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?

Before the inspection visit, we reviewed information that we held about the location, asked other organisations for information and sought feedback from carers at a focus group meeting.

During the inspection visit, the inspection team:

Summary of this inspection

- spoke with four patients who were using the service
- observed three home visits
- looked at 10 care and treatment records of patients
- held a staff focus group, and patient focus group meetings
- spoke with carers of people who use the service in a focus group meeting
- spoke with the registered manager, operational manager, chief executive and managers commissioning the service
- spoke with nine other staff members; including doctors, nurses, occupational therapist, psychologist, psychiatrist and social worker
- attended four meetings about patient care and treatment
- looked at 10 care and treatment records of patients
- carried out a specific check of the medication management within the service
- looked at policies, procedures and other documents relating to the running of the service
- visited the service, and looked at the quality of the therapy, waiting and meeting rooms.

What people who use the service say

During this inspection, we spoke with carers and patients who use this service. Every person we spoke with was positive about the service.

Carers said they felt involved, supported and informed at what was an incredibly difficult time for their family.

Patients said that staff were caring, kind and had time to listen, and offered them choice in how their care was delivered.

Staff supported patients to recover and move to obtaining employment, education and new relationships.

Summary of this inspection

The five questions we ask about services and what we found

We always ask the following five questions of services.

Are services safe?

Requires improvement

We rated safe as **requires improvement** because:

- Staff did not audit medication kept on site, and we found out of date medication during our visit. Staff could not ensure that medication was being stored below 25 degrees Celsius, as there were no recording instruments. Medication might not work correctly or become harmful if not kept at the correct temperature causing a risk of ill health to patients.
- The service was not aware of risks in the physical environment, which patients could use to harm themselves or others. For example, patients had access to cutlery and boiling water in the waiting area because this was shared as a staff kitchen. There were ligature points (places such as pipework, where someone intent on self-harm could tie something in order to strangle themselves) in the building. This meant that staff could not assess the risk to patients using the building and reduce these risks by providing additional support when they visited. The service had not put these risks on the risk register.
- There were no call points in therapy rooms so staff could not call for help in an emergency. Neither of these concerns were included in the risk register.
- The service did not train staff who worked alone with vulnerable patients in basic life support. This meant they could not give emergency support to patients.
- Staff had not received training in managing conflict, such as breakaway techniques. This meant that staff and other patients were at risk of harm.
- The service did not have a robust process of investigating serious incidents, as they were reliant on the NHS trust to undertake investigation when things went wrong. This meant that learning from incidents could not be shared with staff in a timely way.
- Staff recorded their appointments when they worked alone at patients' homes on the computer system. However, this did not always work. This meant that the service could not keep staff safe when out on visits.

However:

- Staffing levels were safe and in line with National Institute for Health and Care Excellence good practice guidance for this service.
- Staff carried out detailed risk assessments with all patients.

Summary of this inspection

- Staff knowledge of safeguarding patients from abuse was good and when required they made referrals quickly and appropriately to the correct services, such as the police and adult and children's social care departments.

Are services effective?

Requires improvement

We rated effective as **requires improvement because**

- Community Links did not have a Mental Health Act and Mental Capacity Act policies in place for staff to follow.
- Staff were not making referrals to independent mental health advocates and independent mental capacity advocates.
- Staff were not undertaking assessments of Gillick competence for patients under 16.
- Staff had not received training in the Mental Capacity Act (2005) and Mental Health Act (1983). However, the impact on patients was reduced because staff had a basic knowledge from previous training and employment.

However:

- Staff assessed patients' needs in detail, including all areas of their lives and involved them in the process.
- The service used National Institute for Health and Care Excellence guidance throughout their work.
- Staff held effective handover meetings and regular multidisciplinary meetings involving different kinds of staff involved in caring for patients to share information about changing patient needs.
- Staff received regular managerial supervision and appraisal of their work performance.

Are services caring?

Good

We rated caring as **good** because:

- Feedback from patients and those who were close to them was wholly positive about the way that staff treated people.
- Staff ensured that patients were active partners in their care, and were involved in their assessments and planning of their care.
- Staff were respectful when they talked to people.
- Staff involved families and carers in care and offered support via family therapy and carers' support groups.

Are services responsive?

Good

We rated responsive as **good** because:

Summary of this inspection

- The service was assessing patients within two weeks of referral, meaning that there was no waiting list for assessment or treatment.
- The service ensured that staff supported patients who did not attend appointments; they did this by using creative ways of contacting them.
- Patients and carers told us that the service always supported them if a crisis occurred and offered practical and emotional support.

Are services well-led?

Requires improvement

We rated well led as requires improvement because:

- Staff felt that they were managed by two organisations (Community Links and the NHS trust), there appeared to be a lack of agreement regarding who was responsible, and staff found this confusing. Senior managers from Community Links did not meet regularly with senior managers from the NHS trust with whom they were contracting, and this had an impact on day-to-day practice.
- Policy and procedures were outdated, and policies relating to important issues, such as Mental Health Act (1983) and Mental Capacity Act (2005), were not in place. This means that staff could not perform their roles adequately, as they had limited knowledge of what actions they should take.
- The service had not updated the local risk register with known risks such as issues regarding building safety.
- Community Links were not investigating incidents and providing lessons learnt to the staff team, the service was reliant on the NHS trust to perform this role.
- Records were not accessible, because the computer system was complex and staff could not access historical information quickly.

However :

- Staff were passionate about their work, and supportive of each other, there was a strong feeling of teamwork and mutual support.
- Staff were happy with management systems in place at a local level and felt supported in day-to-day practice by the multidisciplinary team.
- The service manager carried out caseload supervision on a regular basis to ensure staff were performing their duties and not overworked.

Summary of this inspection

- We saw innovative practice such as the drama therapy work and 'model lines'

Detailed findings from this inspection

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.

The service did not provide inpatient care, but used the Act when working with patients who were subject to a Community Treatment Order. The service also worked with patients detained in hospital and those who were at risk of being detained.

Training in the Mental Health Act was not mandatory for staff. In addition, the service did not have a Mental Health Act policy, which would act to provide guidance and instruction to staff. Staff should be able to provide support, understanding and explanation as required to patients and their families. Lack of training in this legislation and the associated code of practice, may place patients at risk as the staff may not be aware of the guiding principles of the act and how to manage complex cases.

However, where patients had Community Treatment Orders in place, staff explained their rights to them as required.

Mental Capacity Act and Deprivation of Liberty Safeguards

Training in the Mental Capacity Act (2005) was not mandatory for staff. In addition, the service did not have a Mental Capacity Act policy, which could provide guidance and instruction to staff.

Patients under 16 were not having Gillick competency assessments undertaken.

However, we found that the staff had a basic knowledge of the Act, and knew who to refer to should they require support. We found evidence in all of the files that staff discussed and assessed consent to treatment and sharing of information with every patient.

One service user record had an advance decision in place. This tells staff and carers what this person would or would not like to happen to them in the event they become unwell.

Overview of ratings

Our ratings for this location are:

	Safe	Effective	Caring	Responsive	Well-led	Overall
Community-based mental health services for adults of working age	Requires improvement	Requires improvement	Good	Good	Requires improvement	Requires improvement
Overall	Requires improvement	Requires improvement	Good	Good	Requires improvement	Requires improvement

Requires improvement

Community-based mental health services for adults of working age

Safe	Requires improvement
Effective	Requires improvement
Caring	Good
Responsive	Good
Well-led	Requires improvement

Are community-based mental health services for adults of working age safe?

Requires improvement

Safe and clean environment

The York and Selby Early Intervention Service was located in the centre of York. The building was used as staff offices, and had therapy and meeting rooms where patients could meet with staff.

The building was not safe. For example, there were no call points in areas where staff worked alone with patients. Staff did not carry personal alarms that they could use should they feel at risk, or should a patient require emergency assistance. Patients who the service did not know visited the building, increasing the need for alarms, because staff were not aware of potential risks from patients they did not know.

The service was not aware of risks in the physical environment, which patients could use to harm themselves or others. For example, patients had access to cutlery and boiling water in the waiting area because this was shared as a staff kitchen. We saw risk assessments for patients who were at risk of using sharps to harm themselves or other people.

The toilet on the ground floor contained ligature points; these were things that patients could use to tie something to in order to harm themselves. We looked at the risk assessments of people using the building and found that several patients had ligaturing discussed as a risk on their assessment. There were no ligature cutters held within the building. Staff told us that because the service was not an inpatient area, they had not considered these environmental risks and the service had not done a ligature risk assessment in the building, these risks were not on the service risk register. This meant that staff were not aware of risks and could not support patients to use the building safely when they visited. The risk was increased when patients visited for therapy appointments which may cause their emotions to heighten during their visit.

The building had three interview or therapy rooms, all rooms were clean, furniture contained within them was in good condition. However, these rooms also contained ligature risks; staff told us they never left patients alone in these rooms. All windows in the therapy rooms had the amount they could open restricted.

In the reception area, there was one door out of the waiting area (staff kitchen) with a keypad lock; the receptionist was responsible for opening the door to let patients through for appointments. The only toilet in the building was located through this door. When patients accessed the toilet, they also had free access to other parts of the building. Staff could not always monitor patients' access to the toilet, which meant that patients could access staff offices which may contain confidential patient information.

The premises did not have a clinic room. Staff told us that they held a physical health clinic once each month for patients who did not wish to attend their GP surgery. The service held this clinic at a nearby NHS site, in a purpose built clinic room.

The building was clean. However, the cleaner for the service, who visited daily was not employed by Community Links. This service was provided by NHS services. The service advised that the NHS carried out audits and inspections of cleaning on a regular basis, these records

were held by the NHS trust and not Community Links and were therefore not available to view on inspection. We did find that areas of the staff office were dusty and the cleaner had not cleaned the toilet or emptied the bins during our visit.

Safe staffing

York and Selby Early Intervention Service had 12 whole time equivalent staff. This included; a psychiatrist sub-contracted from the NHS for two and a half days a week, a full time service manager, a full time psychologist and a full time deputy manager, who was also a care co-ordinator. In addition to this, the service had six care co-ordinators, two support workers, a full time administrator and a part time drama therapist. A care co-ordinator was a member of staff assigned to a patient who has overall responsibility for their care. The manager told us that the service was fully staffed; patients and carers told us that there were currently no issues with low staffing. However, there had been four staff leave the service in the last 12 months which carers told us had affected continuity of care for their relative.

The manager calculated staffing levels by dividing the caseload of the service by fifteen. This meant that the service should have seven care co-ordinators for a caseload of 105, which it did. Best practice guidance from National Institute for Health and Care Excellence (implementing the early intervention in psychosis access and waiting time standard, April 2016) says that the caseload per care coordinator at the service was in line with good practice. However, we saw evidence in supervision notes, caseload management, and on the provider's electronic system that caseloads for individual workers were sometimes above this level. The manager acknowledged that this was due to short staffing in previous months and showed us evidence of these caseloads beginning to reduce. The service manager monitored caseloads in supervision every three weeks. They used a weighting tool to assess staff's current workload. We saw evidence that this took place regularly with all care coordinators and support workers.

The service did not have a waiting list. The service manager explained that they never used bank and agency workers. This was because of the complex computer system, which ran on Community Links and NHS programmes, and was difficult for new staff to learn quickly. This was also because of the nature of the patient group, who found changes in staff difficult. If staff called in sick, or were attending training or on annual leave other team members managed this by prioritising their workloads to ensure actions continued for patients. Staff agreed workloads at their daily meetings and wrote on a visual display board for staff to refer to. The sickness rate for the service was low at 1.8% during 1 April 2015 and 31 March 2016.

The psychiatrist worked at the service two and a half days per week and was located with other staff in a shared office. Staff, patients and carers told us that the psychiatrist was accessible and responsive. All staff had their mobile telephone number and felt able to contact them at any time for advice or to explain a change in patient needs or condition; this was also the arrangement on the weekdays that the psychiatrist was not in the service. The service operated in office hours only, outside this time a patient would access a psychiatrist via the crisis service as required.

Staff completed mandatory training to meet the requirements for the service and some additional training which was a requirement of the NHS trust they subcontracted with.

Community Links required all staff to undertake mandatory training. Topics included information governance, fire safety, safeguarding children, safeguarding adults, health and safety, professional boundaries, patient involvement, organisational awareness, fire, and equality and diversity. In addition to this, staff did clinical risk assessment training and care programme approach training with the NHS trust. Compliance with mandatory training was above 91% except in care programme approach training, which had 55% compliance for care co-ordinators. The organisation's training target was 90%.

The manager told us that Mental Health Act (1983) and Mental Capacity Act (2005) training were not mandatory. Both training courses had 45% compliance across the service. The manager explained that training in basic or intermediate life support was not mandatory for staff, even though some staff administered injections to patients on site and at their homes, and staff met with vulnerable patients in the community. This could place patients at risk because staff would be unable to provide the appropriate support in first aid or resuscitation in the event of an emergency. Staff worked alone with vulnerable patients in the community, increasing the risk of them being unable to support them in an emergency.

Only one staff member had undertaken medicines management training, despite staff administering injections and managing medication stored on site.

Assessing and managing risk to patients and staff

We looked at the records of 10 patients using the service - six adults and four young people. All records contained an updated risk assessment. Staff completed and recorded risk assessments using the 'safety assessment management plan' tool on the electronic system. All risk assessments contained assessment of current risks, and a risk history. Staff also used 'health of the nation outcome scales' scoring to determine risk levels. One patient did not have a risk assessment in place, the manager told us that this was because this was a new referral and that the service were having difficulty engaging with this patient.

All but one of the records we looked at contained a crisis plan, which explained to the patient and those caring for them, what they could do and who they might contact should their needs increase. One service user record had an advance decision in place. This tells staff and carers what this person would or would not like to happen to them in the event they become unwell.

The service did not hold a waiting list; the manager allocated all cases within two weeks of referral. The referrer would manage the service user's needs for example the GP or community mental health team until the service started work with the patient.

We found that the day-to-day management of risk was good. Each morning the day began with a whole team referral and risk meeting to manage referrals, identify patients who may be at high risk and any actions. The team then split into two 'cells' which were smaller groups of staff and were led by a band 6 cell lead where they discussed patients, actions and needs in more detail with clear plans being documented. Any actions or interventions from the previous day were reviewed in line with best practice for recovery guidelines. Staff placed any actions from this onto a visual board in the staff office and a staff member was responsible for each action. Staff then followed this up the next day.

Cases that were high risk or that staff needed support with, they passed to the 'supercell' this was a weekly meeting of the management team, including the psychiatrist and psychologist. They also made action plans and followed up progress meetings the following day.

The service made three safeguarding alerts to the Care Quality Commission in the last twelve months. Of these, the service made one referral two months after the incident, which was an oversight by staff who had sent it to the local authority on time. The service had a safeguarding lead, and had recently created a safeguarding tracker to ensure they followed up referrals made to the local authority and took action. Staff had good knowledge of safeguarding procedures, and how to report concerns.

York and Selby Early Intervention Service had a lone working policy in place that protected staff during community visits. Two staff visited patients thought to be high risk, or visits took place in the office. Each patient file had a lone working risk assessment completed. The service also ran a duty system whereby one member of staff was the 'five o'clock person'; it was the responsibility of all staff to inform this person of their whereabouts at the end of each day. The service held a personal record for each staff member, which the manager could easily access to make contact they think that staff were at risk whilst out in the community. Staff were expected to keep their electronic calendar updated so that other staff could confirm their whereabouts. However, staff told us that the computer system often broke down meaning that other staff cannot check their calendar. They reduced risk by sharing their whereabouts with colleagues verbally.

We looked at the management of medicines. Staff told us that the only medication stored on site was depot medication. This was medication given to patients via an injection to support them to manage their mental health. Medication was stored securely in a locked cupboard, the key to which was secure. However, we found two packs of medication, which were out of date; one expired in June 2016 and one in March 2016. The service said that these had not been given to -patients. The service removed these medications during our visit, and responded by immediately creating a protocol for checking medication stored within the service. There was no such protocol already in place. The service had an agreement with a pharmacist from an NHS trust. The service said that pharmacist did not visit the service unless specifically requested to see a patient about choice of medication or side effects. This meant that the service could not be sure what medication was stored in the building. The staff also told us that the pharmacist was able to deliver training to staff; however, the service had not recorded this because this was informal training.

Requires improvement

Community-based mental health services for adults of working age

The psychiatrist prescribed all depot injections and the NHS trust pharmacy delivered them to the service for storage. There was no medication fridge in the building. The service used a medication the guidance for which states that it should be stored in a refrigerator or below 25C if a refrigerator was not available. There was not a thermometer in the medication cabinet, which could record the temperature at which the service kept medication. This meant that the service could not be sure medication given was fit for purpose, as they had not followed guidelines for storage.

The pharmacist reviewed all medication charts on a six monthly basis. Staff recorded allergies visibly at the top of the chart. Charts were clear and legible and did not identify any medication errors. Nurses administering injections were alternating injection sites as per good practice to reduce the risk of infection.

Track record on safety

The service had reported two serious incidents in the last 12 months. Both incidents were under investigation and the coroner was assessing one. One incident related to self-harm, and one related to suicide. Both incidents happened in the community and neither occurred whilst in the care of any Community Links staff. The NHS trust rather than Community Links undertook investigation in both incidents. Community Links were not taking an active role in incident investigation until the NHS trust had completed reports, meaning that there was a reduced ability for staff to learn lessons from incidents. One investigation had resulted in an action plan for the service to enable staff to learn lessons reduce the risk of reoccurrence.

Reporting incidents and learning from when things go wrong

The process of recording incidents was complex and time consuming for the service. The manager explained that the service reported serious incidents to Community Links, the NHS trust they contract to, and to the Care Quality Commission. The NHS trust then investigated these and gave action plans to the service.

The most recent serious incident had resulted in de-briefs to the staff team, and to the individual practitioner involved. When the incident was reported, the manager de-briefed staff after the initial fact finding exercise. The investigation report had only recently been completed. However, the manager planned to de-brief the staff and explain the action plan. Learning from incidents was reduced because Community Links were not involved in the investigation of these, and therefore opportunities for learning were reduced and delayed.

Staff knew how to report incidents, usually going to the most senior member of staff available and reporting via the appropriate systems.

Staff had a good understanding of duty of candour and its importance, and a policy was in place. Duty of candour is when a service apologises to patients and carers when something has gone wrong. It is important to make sure services are open and transparent. However, the service advised that they have not used this because there had been no mistakes in patient care, which have led to significant harm. They advised that the two serious incidents did not require the use of Duty of Candour.

However, during our visit, we saw evidence that the service had written to a family following a patient death, and offered support and an appointment along with their condolences. We found this to be caring, open and approachable.

Are community-based mental health services for adults of working age effective?

(for example, treatment is effective)

Requires improvement

Assessment of needs and planning of care

We looked at the assessments of ten patients, and found that all had a comprehensive assessment of needs and care plan. These were assessments, which included a patient's whole life, rather than only their mental health needs. The service used the assessment tool called comprehensive assessment of at risk mental states, which was a nationally recognised assessment tool. However, we found that the assessment was difficult for patients to understand and was more of a clinical tool rather than one that patients could take part in. Assessments and care plans were not child centred meaning that young people may be less likely to engage with them.

Patients referred to the service followed one of two pathways. The first pathway was 'first episode psychosis'

this was used with patients who have been diagnosed as experiencing their initial episode of psychosis. The second pathway was called 'at risk mental state' and was for patients who were showing early signs of the onset of psychosis. The idea of this pathway was to delay the onset of psychosis, or even stop the experience of a first episode of psychosis altogether. Staff allocated patients to the appropriate pathway; staff knew the pathways well and applied them to their day-to-day practice.

Staff accessed care records in two ways, either via a paper-based record or via the electronic system. Care records were difficult to navigate and information was stored in different places. The service manager explained that the service transferred to a new computer system in April, and staff could not retrieve all information from the old system. Therefore some records were paper, some electronic, and some needed to be ordered from patient records service to be viewed. The manager advised that the risk of missing information regarding patients was reduced as some staff had access to both the old and new system and that medical records responded quickly when information was required. The service using the NHS system was helpful to out of hours and crisis services, which used the same system and could view information.

During our inspection, we experienced the issues staff had with the computer system, as the Community Links server failed, and there was no way of re-connecting the system. This meant that the service manager and staff were unable to locate information they required, and which we were requesting to inform our inspection. Staff told us that this happens often and can be stressful. This concern was not included on the risk register for the service. However, the manager was able to evidence that they had raised the concern several times with Community Links.

Best practice in treatment and care

We saw good examples of best practice in treatment and care. Staff followed the eight part quality standards for psychosis and schizophrenia in adults, and in children and young people (February 2015); set by the National Institute of Health and Care Excellence, these were

- treatment within two weeks of referral
- family therapy
- the use of psychological intervention, such as cognitive behavioural therapy
- treatment with clozapine
- supported employment
- physical health assessment and monitoring
- promoting a healthy lifestyle and smoking cessation
- carer focussed education and support

The service was working towards meeting all of the above quality standards. Where they were unable to provide care directly they liaised with other appropriate professionals to support the patient. For example, to ensure physical health checks were completed, staff had written to the patient's GP, and held their own monthly health clinic for those who did not want to see their GP. The service had trained the majority of the staff group in family therapy. The psychologist had their own pathway for patients that included cognitive behaviour therapy, behavioural family therapy and drama therapy.

In addition to one to one meetings, the service held friends and family groups, and a hearing voices group. The service also had a monthly activities schedule sent to all patients to encourage involvement in activities such as yoga, football, and a healthy body group. The service was involved with community activities such as volunteering with groups of patients doing conservation work.

Alongside following National Institute for Health and Care Excellence guidance, the service was using a process called 'model lines'. The NHS Trust had written the use of this model into the service contract. Staff were embracing this new model of working. The aim of this model was to ensure the service tailored every mental health intervention to the patient's identified recovery goals, and benefit to their experience throughout the care pathway.

Skilled staff to deliver care

Staff working at the service were skilled, with a wide range of expertise in social work, occupational therapy, nursing, psychology, psychiatry and support work. The service employed staff as care co-ordinators rather than in a specific professional role. Staff brought their wide range of skills together to enhance the service.

Staff completed a comprehensive four-week induction programme. The induction programme was thorough and explained the service in detail. It gave time to new staff to explore the service and observe practice of more experienced colleagues. However, we found that the induction policy did not include the duty of candour policy.

Requires improvement

Community-based mental health services for adults of working age

We found good evidence of a wide range of staff supervision. This took the form of caseload management supervision, this was where the manager discussed caseload levels, and ensured tasks were completed. This allowed the staff member and the manager to focus on caseloads being manageable and on achieving outcomes. In addition to this, all staff received clinical supervision, and we saw evidence that this took place on a regular basis in line with Community Links policy. All staff had received a performance development review within the last 12 months and group supervision sessions took place to support staff with more complex cases.

However, we found that supervision arrangements for the service manager were complicated. Both the NHS trust contract manager and the Community Links area manager supervised the service manager. However, both managers gave the service conflicting information, tasks and priorities as the group did not meet together in a three way meeting.

Multi-disciplinary and inter-agency team work

The service had an effective multi-disciplinary team, made up of social workers, occupational therapists, nurses, and psychiatry, psychology and support workers. We found good examples of multi-disciplinary team working; the team met each day to conduct a handover, discuss complex cases and had open access to the doctor, psychologist and service manager as required. We saw evidence that when cases were complex the care co-ordinator called multi-disciplinary team meetings and invited professionals from other teams and services involved with the patient. We also saw evidence that the team made referrals to adult and child safeguarding teams as required.

However, patients and carers told us that they experienced problems with communication between services. For example, the GP's understanding of the patient's condition, prescription, and the crisis team understanding diagnosis and crisis plans. The service was not meeting with other agencies on a regular basis to reduce the impact of cross agency care. This was a factor discussed in the recent serious incident investigation, which stated that the service did not give an effective handover to other services working with the same person. We did see evidence that the service was trying to make these links, for example, the psychiatrist explained that in order to reduce complications, they faxed a patient's prescription and diagnosis to the GP surgery to reduce delays in letters reaching the GP.

Adherence to the MHA and the MHA Code of Practice

The service did not provide inpatient care, but used the Mental Health Act when working with patients subject to a Community Treatment Order. The service also worked with patients detained in hospital and those who were at risk of being detained.

Training in the Mental Health Act was not mandatory for staff. Therefore, only five staff (45%) had completed the training. In addition, the service did not have a Mental Health Act policy, which would act to provide guidance and instruction to staff. There was no evidence that training had taken place regarding the updated Mental Health Act Code of practice, published in 2015. Lack of training in the Act and the associated code of practice, may place patients at risk as the staff may not be aware of the guiding principles of the Act and how to manage complex cases.

However, where patients had Community Treatment Orders in place, their rights staff explained their rights to them as required. Staff had a good basic knowledge of the Act due to previous training and employment. Staff also explained that they would seek out the support of the psychiatrist who had detailed knowledge regarding the act.

Good practice in applying the MCA

Training in the Mental Capacity Act (2005) was not mandatory for staff. Therefore, only five staff (45%) had undertaken this training. In addition, the service did not have a Mental Capacity Act policy, which could provide guidance and instruction to staff.

We did not see evidence of assessments of Gillick competence being undertaken with patients aged under 16.Gillick competence is a term used to decide whether a child under 16 is able to consent to his or her own medical treatment, without the need for parental permission or knowledge.

However, staff had a basic knowledge of the Act, and knew who to refer to should they require support. We found evidence in all of the files that staff discussed and assessed consent to treatment and sharing of information with every patient.

One service user record had an advance decision in place. This tells staff and carers what this person would or would not like to happen to them in the event they become unwell.

Requires improvement

Community-based mental health services for adults of working age

Are community-based mental health services for adults of working age caring?

Good

Kindness, dignity, respect and support

We observed interactions between patients, carers and staff including; three home visits, a care programme approach meeting and had a one to one meeting with a patient. We also held a patient focus group. We found staff were caring, and spoke to patients with kindness and dignity. Staff offered patients choice in how they would like meetings to be held, and what treatment and medication plans they would like to choose.

Carers told us that staff visiting their homes were polite and respectful, and never caused families to feel uncomfortable. A patient described positive outcomes following their time with the service, describing it as being the reason for their recovery.

Staff had a good knowledge of the patients they were working with. Staff told us that this was because they discuss patients in morning 'cell' meetings, meaning that all staff in a team knows that patient, not just the allocated worker. This meant that when staff were absent, the team did not delay tasks and patients had continuity of care. Carers told us that they could speak to any worker in the service and they all knew the patient.

The service kept patient files securely in locked cabinets or on the electronic system. Staff labelled files with codes for patients enabling staff to maintain confidentiality. We looked at 10 records and found that each file contained an assessment, which asked who patients would like staff to share information with, to ensure confidentiality was maintained for the patient.

The involvement of people in the care they receive

Patient involvement ran at the heart of all interactions and care. The service held patient and carers forums in order to get feedback and offer support.

We observed a care programme approach meeting whereby staff asked a patient if they would like to chair the meeting. They did so, and chose the order in which professionals gave feedback. We saw evidence during this same meeting of the patient discussing their care plan and being actively encouraged to make decisions independently regarding care, treatment and medication. Staff told us that the psychiatrist offers patients choice in medication and gives information about each choice prior to making out any prescription.

We viewed 10 care plans and found that all care plans were person centred; they involved statements about what the patient would do to support each need and how the service and carers would be involved. However, we did not see that patients had made comments on their care plans, as this was not possible on the electronic system. Some assessment tools used were not designed to engage with younger people.

Patients were involved in recruitment of all Community Links staff at all levels, and attended training to develop the skills required.

The service asked patients for feedback about their care in a variety of different ways. The service took part in the friends and family survey. The results of this were positive, the service received excellent scores (100%) in giving choice to patients, developing care plans and recommending the service to others. Scores in being given a choice of where a patient's appointment was held, whether patients felt supported by their key worker, and whether a key worker helped a patient to take control of their life where rated 'fair' at 50%.

As part of the performance development review process, the service manager contacted patients directly to ask about their care co-ordinator and experience of the service, which the manager fed back to the worker.

The use of advocacy within the service was low; patients we spoke to said they had not heard of advocates and none of the patients we spoke with had an advocate. Staff told us that they could refer to advocates, but were not able to explain the meaning of an independent mental capacity advocate and an independent mental health advocate. The Care Act (2014) explains that the service has a statutory responsibility to ensure patients were offered access to advocacy and referrals are made. We saw no referrals to advocacy in the patient files we looked at.

Are community-based mental health services for adults of working age responsive to people's needs?

Requires improvement

Community-based mental health services for adults of working age

(for example, to feedback?)

Good

Access and discharge

The service offered patients referred to the service an initial appointment within two weeks of referral. The service provided performance data for May 2016. This detailed that there were eleven new referrals in the month of March two of these were inappropriate referrals. Of the nine remaining patients, staff saw 56% within two weeks of referral and the remaining 44% had scheduled appointments within two weeks. The service met the target of 100% of referrals seen within two weeks.

The service used the care programme approach, and had a target that 95% of patients have a review of their care every six months. The service achieved 100% of care programmes reviewed in May 2016 and April 2016.

The expected length of involvement with the service was three years for patients with first episode psychosis and six months for those on the 'at risk' pathway. The service discharged eleven patients in March, two in May, and seven in April. Low level of discharges in comparison to higher levels of referral to the service, meant that it was often working above its capacity. The manager told us that this was because it was difficult to arrange discharges to other teams for those on the 'at risk' pathway. The service was unable to provide information regarding the average length of time they worked with patients, however at the time of inspection there was only one person who had remained with the service past the three year pathway target.

Staff discussed patients at morning cell meetings regarding the urgency of their referral and the service responded as quickly as was required. However, the service was only open between the hours of nine am and five pm Monday to Friday. This meant that patients could not access emergency support from the team outside office hours and during evenings, weekends and bank holidays. At these times, the patients and their families needed to access the mental health support line and crisis team, who they found to have less experience of their situation.

The service information leaflet stated that it takes referrals from GP's or a mental health professional. The service obtained most referrals from the single point of access in York. Referrals into the service were for patients experiencing first episode psychosis, or who had an at risk mental state.

Patients remained with the service, even when they no longer met service criteria until staff found an alternate appropriate service and a transition could take place. This was positive and reduced risk to patients of having no support.

The service currently excluded access to anyone over the age of 35. The local community mental health team currently works with these patients. The trust that contracted with the service, would have liked them to become an ageless service to match current National Institute for Health and Care Excellence guidance, and this was being discussed. The trust discussed this with us during the visit.

The service had a policy for non-engagement. This is where patients did not reply to appointment letters and offers of support. The service worked with these patients and took steps to ensure they arranged contact as soon as possible. The non-engagement policy stated that it was not standard practice for early intervention services to discharge a patient from the service due to non-engagement. Instead, staff took steps such as choosing different ways of engagement for example using text, email, and communicating with other professionals. If the service had concerns about the person's welfare, they requested a welfare check by the police to ensure the health of the patient. The service carried out this practice as it stated that the early phase of psychosis was a critical phase, which determined the longer-term outcomes for the service user.

The service provided support to people living in their own homes, staff also met with patients in the offices. The service leased the building from NHS property services, and it was not purpose built for use by a community mental health team. The building was over three floors and did not have a lift; there was no disabled access into the building. The building was not compliant with the Equality Act (2010) and would not be accessible to people who were not mobile. The service had not made any reasonable adjustments to the building to enable patients with

mobility problems to access the service. However, staff told us that they would meet with patients with mobility problems elsewhere and not invite them to the building for appointments.

The waiting room was on the ground floor of the service, it was a small area, which staff also used as the staff kitchen. Staff came into the waiting area to make drinks and heat up food whilst patients were waiting for appointments. This made the waiting area appear untidy, chaotic and cramped and staff and patients told us that this area was likely to increase the anxieties of people waiting for appointments. However, we spoke with one carer who told us that they like the waiting area because it appears homely and enables them to see staff on a more informal basis, rather than in a hospital like waiting area.

Staff were flexible in offering planned appointments. For example, they saw university students during breaks from lectures and completed family work and support groups outside nine to five office hours. The staff told us that they often work past office hours to ensure flexibility for the patient group they support. However, we spoke with one carer who told us that each time their family member went away to university they had to be re-referred to the service when they came home out of term time. We did not think that this was responsive and created additional stress for the patient and their family.

The service did not keep record of appointments, which staff had cancelled, however the service manager told us that staff only cancelled appointments if a crisis had occurred, and if so staff would rearrange immediately. The manager explained that if a care co-ordinator were unexpectedly unable to attend, another worker would attend in his or her place.

The facilities promote recovery, comfort, dignity and confidentiality

The building the service ran from did not promote recovery, comfort, or dignity, and it was not fit for the purpose it was being used, and not accessible to all patients. However, the three therapy rooms available were spacious, and comfortable and soundproofing was adequate for these rooms.

Staff maintained confidentiality by locking display screen equipment when leaving their desks and noted when they had opened doors and windows. Staff used patient initials when they felt they might be heard discussing confidential information.

The waiting area contained lots of information for patients regarding their care, treatment and medication. There was a complaints and compliments box in reception. However, there was not a poster relating to contacting the Care Quality Commission and the information regarding the local advocacy service and health watch was not clear.

Meeting the needs of all people who use the service

There was no lift in the building and no access for patients who have mobility difficulties into the therapy rooms once inside. Staff told us that they would meet patients with mobility difficulties in another building at the local outpatients department. The service had not made reasonable adjustments to the building to improve accessibility such as installing ramps, or grab handles. The service manager told us that NHS services had carried out an assessment, and they told the service that it was not possible to adjust the building. The NHS trust had made plans for the service to move to a new location in 2017; there was not a plan to manage this in the interim.

We found that leaflets used were not child or learning disability friendly, for example, the service did not provide them in an easy read format, and they were not readily available in different languages and large print.

However, staff told us that they used a telephone interpreting service as needed and could access leaflets according to individual patient needs.

Listening to and learning from concerns and complaints

In the last twelve months, the service reported that it has not received any complaints. However, we found that staff knew how to manage complaints and would refer these to their senior manager as required. Community Links had a complaints policy in place and patients could contact the service using their website to make complaints.

Are community-based mental health services for adults of working age well-led?

Requires improvement

Community-based mental health services for adults of working age

Requires improvement

Vision and values

Community Links' mission statement was that it 'exists to provide excellent, client focussed mental health services which value diversity, instil hope and improve quality of life through recovery'. The values of Community Links were to be client centred, instilling hope, creating opportunity for all and achieving excellence. Staff were aware of these values but said they felt like they were managed by Community Links and by the NHS trust they contracted to. They told us that they felt confused about their priorities for the future. However, we found that the staff team were performing within the values of the organisation; we found that their work was client centred and each care pathway worked towards a positive recovery.

Staff were able to tell us who the most senior managers were within Community Links. However, they told us that these managers did not visit the service on a regular basis. The area manager had not met with the managers from the trust who provided the contract for the service until the day of our inspection. However, all new starters met with the chief executive to discuss their new role and the organisation's vision and values and the chief executive attended induction training. Staff said that most Community Links services were in Leeds and sometimes they felt that Community Links left them out of organisational activities due to their location.

Good governance

We saw governance structures in place, which were not effective and appeared to reduce the performance of the service. There were two governance structures running through the service. Staff found this confusing, for example, we found that the service was operating two different lists of training staff had to complete. We also found that the manager needed to report safeguarding and serious incidents to three organisations, and reported on different performance targets for each organisation.

Staff attended mandatory training and met the provider's compliance target. Staff had received little training in the Mental Health Act (1983) or Mental Capacity Act (2005) despite caring for patients subject to these laws being their main activity. Community Links did not have policies or guidance on either law despite staff having a statutory duty to perform their roles within the scope of both.

The whistleblowing policy was dated 2013 and did not contain a review date. The policy did not provide contact details for the Care Quality Commission. Staff should be clear on the role of the Care Quality Commission and how to contact us should they wish to raise a concern.

The service had written a duty of candour policy in June 2016. The duty of candour sets out the responsibilities for organisations to be transparent, open and honest. It sets requirements for organisations to acknowledge wrongdoing and provide apologies to patients and their families when things have gone wrong. Although this policy was in place, it was new and was not included in the induction training for staff. However, we found that staff and the service manager understood the process and were able to give examples of how they should use the duty of candour. The service could not give examples of when they used it, as they had not made mistakes in patient care, which had caused significant harm.

The service had not recognised risks in the building and added these to the risk register to ensure they were aware of risks and could protect patients, such as ligature risks, and the loss of access to historical patient records.

The safeguarding policies did not provide correct information in relation to the service's duty to inform the Care Quality Commission of any safeguarding issues or alerts. The service had not updated the children's safeguarding policy since March 2014.However, we found that at a local level, staff reported safeguarding in a timely manner and the manager informed us via notifications of any safeguarding concerns or alerts.

The supervision policy was dated 2011 with no review date or update since this time. However, the service manager was completing clinical and caseload supervision every four weeks and to a high standard.

We raised these concerns during the inspection and the provider told us that they were working to improve their governance structure at provider level. This involved the restructure of sub-committees, they explained that following a review they now have three sub- committees which report to their management committee:

- people and safety
- quality and performance
- finance and new business.

The provider also explained that Community Links new website was soon to launch and this would include proper version control of policies and procedures. The provider was aware of these issues and had plans to rectify the breakdown in the governance structure.

Staff were not always able to maximise their shift-time on direct care due to issues around the online electronic system. The staff used a Community Links system and the trust system. Staff told us that both computer systems crashed and reporting was repetitive. This created a risk that staff could miss important information. It also removed staff time from working face to face with patients.

However, we found that management used quarterly key performance indicators to measure how the service was performing and took action to manage this. Staff took part in audits, and took on lead roles for certain areas within the team, such as a lead for safeguarding. Community Links were able to provide us with personnel information, which evidenced that staff, the registered manager and the lead psychiatrist and psychologist were appropriately registered and all employment checks had been undertaken.

Administration support was available for the team; however, there was only one administration worker. Carers we spoke with told us that when the admin worker was away, they struggled to contact the service by telephone and had to leave messages on the answer machine. The service manager explained that when administration support was not available, the clinical team had to perform this role.

Leadership, morale and staff engagement

York and Selby Early Intervention Service had a low sickness rate at 2%, we found that the staff team had a high level of morale and they told us how much they enjoyed their job. Staff told us about the team being supportive of each other, and all the staff we spoke with told us that they had not experienced any form of bullying or harassment at work. When we interviewed staff, we were able to sense the compassion they had for the people they were working with.

Staff spoke highly of the management team at a local level, they told us that there was no hierarchy in the service and that all of the management team would speak to them at any time to support them with a complex case or a practice issue.

Patients and carers had been unaffected by the level of change in the organisation. Staff and the management team had managed this difficult period without allowing it to spill into day-to-day practice. The service manager was effectively managing and supporting the service to continue with its day-to-day business whilst using a complex governance structure.

Staff were encouraged to develop professional skills and were attending additional training courses in cognitive behavioural therapy and family therapy for example. Staff had regular caseload and clinical supervision. The service had given this high importance to ensure it supported staff and patients received high quality care. Staff raised issues and concerns in these sessions and the manager responded to these and followed them up at Community Links governance meetings.

Commitment to quality improvement and innovation

The service was beginning to embed a new model of working 'model lines'. The manager and the staff team were enjoying the experience of using this innovative approach. The team had attended training and commented on how effective the new model of working has been in improving the service. However, this innovative practice had been encouraged by a stipulation of the use of this model in the contract with the local NHS trust, rather than within Community Links.

The service was not involved in any peer quality review schemes. However, they met regularly with the Leeds Early Intervention Service and arranged joint Early Intervention Development Forums taking place in Leeds and York alternatively. The psychiatrist and service manager attended the early intervention network meetings. However, the service manager told us that they were restricted from attending the early intervention forums the subcontract trust held due to sharing of confidential information.

Outstanding practice and areas for improvement

Outstanding practice

An area of outstanding practice was the 'drama therapy' sessions taking place each week. The service received the funding for this work via the Big Lottery. Community links piloted the service for three years and the results were above the service expectations.

Drama therapy or 'wordless therapy' enabled patients to express themselves without using their voice. Providing this alternative method of communication and expression has been powerful for patients and carers. Many of the patients struggled to articulate themselves due to their mental health, confidence, and other issues. Patients and staff praised these sessions as having a significant impact on their recovery.

Areas for improvement

Action the provider MUST take to improve

Action the provider MUST take to improve

- The provider must ensure that staff receive the level of training appropriate to their role, such as basic life support, breakaway training to avoid conflict, and the Mental Capacity Act (2005) and Mental Health Act (1983).
- The provider must ensure that staff have access to a system for calling for assistance in an emergency.
- The provider must ensure the service has a dedicated, safe and dignified waiting area for patients, which is comfortable and not shared with staff.
- The provider must ensure that health and safety audits are carried out.
- The provider must have an effective governance structure to ensure risks are captured and managed, and that the service direction and requirements are clear to staff
- The provider must ensure that policies are updated and regularly reviewed, and in line with the Mental Health Act (1983) Code of Practice (2015) to provide guidance to staff to carry out their duties.
- The provider must monitor all medication stored on site and ensure there are regular audits. This includes monitoring medication temperatures to ensure they are safe for use according to the manufacturer's instructions.
- The provider must ensure that it investigates incidents alongside the NHS trust and ensures that lessons learnt from these staff incorporated into daily practice.
- The provider must ensure that they maintain all records in a single contemporaneous manner.

Action the provider SHOULD take to improve

- The provider should have stronger links with the local advocacy service and ensure that information regarding this is available to patients.
- The provider should undertake a ligature audit in the building and ensure that risks are reduced or eliminated.
- The provider should ensure that it writes assessments and care plans in a format young people can understand.
- The provider should keep records of cleaning taking place.
- The provider should ensure that training regarding duty of candour is included in the staff induction.
- The provider should ensure that information regarding how to contact the Care Quality Commission is accessible to staff and patients.
- The provider should ensure that it has clear and effective environments, which are accessible to the needs of all patients.

This section is primarily information for the provider

Requirement notices

Action we have told the provider to take

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

Regulated activity	Regulation
Treatment of disease, disorder or injury	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment How the regulation was not being met Staff were not monitoring what medications they kept on site, and auditing their safe use and the temperature of medication to ensure it was being kept below 25 degrees Celsius. The service had not identified environmental building risks to patients, such as ligature risks, and could not ensure they could be kept safe when using the building. This was a breach of regulation 12 (2) (d) and (g)

Regulated activity	Regulation
Treatment of disease, disorder or injury	Regulation 15 HSCA (RA) Regulations 2014 Premises and equipment How the regulation was not being met There was only one toilet in the building for staff and patients. People could access the building from the toilet without staff monitoring them, and could enter staff offices where confidential patient information could be found. The health and safety manual was dated 2014 with no review date. There were no call systems available. This means that staff cannot call for help in the event of an emergency. The service has not recognised these risks or mitigated them. This was a breach of regulation 15 (1) (c)

This section is primarily information for the provider

Requirement notices

Regulated activity	Regulation
Treatment of disease, disorder or injury	Regulation 17 HSCA (RA) Regulations 2014 Good governance How the regulation was not being met The provider's governance systems were not effective. Two governance systems were leading the service, which were not joined up and this caused confusion for the staff. Community Links did not have a robust system, joined up with the NHS trust for investigating incidents of harm or risk of harm to patients and staff to learn lessons from them and prevent them happening again. Policies were outdated and were not reviewed regularly in line with recent best practice or national guidance and were not compliant with the Mental Health Act (1983) Code of Practice (2005) The provider did not maintain records in a single contemporaneous record for each patient. This was a breach of regulation 17 (2) (a) (b) (c)

Regulated activity	Regulation
Treatment of disease, disorder or injury	Regulation 18 HSCA (RA) Regulations 2014 Staffing How the regulation is not being met Training in breakaway techniques for avoiding conflict, basic life support, Mental Capacity Act (2005) and Mental Health Act (1983) were not taking place. Significant gaps in training were influencing safe care and treatment, such as staff being unable to offer emergency first aid. This training was necessary to carry out the duties of the service. This was a breach of regulation 18 (2) (a)