Good

Cheshire and Wirral 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)
RXARE	Trust Headquarters, Redesmere	Adult Mental Health Services Chester	CH2 1UL
RXARE	Trust Headquarters, Redesmere	Vale Royal Adult Mental Health Services	CH2 1UL
RXARE	Trust Headquarters, Redesmere	Ellesmere Port and Neston Adult Mental Health Services	CH2 1UL

Summary of findings

This report describes our judgement of the quality of care provided within this core service by Cheshire and Wirral 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 Cheshire and Wirral Partnership NHS Foundation Trust and these are brought together to inform our overall judgement of Cheshire and Wirral 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?	**Requires improvement** 
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 rated community-based services for adults of a working age overall as good because:

- Risks to people using the service were assessed, monitored and managed on a daily basis and staff recognised and responded appropriately to changes in risks to people.
- Staff understood their responsibilities to report on incidents and near misses and were supported when they do so.
- Adults and children were appropriately protected and staff took steps to report any incidents of safeguarding to the local authorities.
- All three teams reported low staffing vacancies, mainly due to maternity leave, secondment and advanced practitioner training; however, systems were in place to address the vacancies with staff being offered temporary contracts and vacant posts being filled to keep people safe.
- Staff received feedback from investigations and incidents. Actions from incidents and patient alerts were regularly discussed in team meetings to ensure lessons were learnt.
- People who used the service had comprehensive assessments of their needs which included consideration of their clinical needs, mental health, physical health and their well-being.
- Information about peoples' care and treatment and their outcomes were collected and monitored.
- The teams participated in local and national audits and front line staff were involved.
- Staff were qualified and skilled to deliver care and treatment to their people but there were some gaps in their mandatory training.
- Peoples' care and treatment was planned and delivered in line with current best practice and evidenced based guidance.
- Feedback from people who used the services was positive about the way staff treated them. People reported and we directly observed they were treated with respect, kindness and were involved in making decisions about their care and treatment
- People' social needs were understood and people were assisted to maintain and develop their social networks and community support where needed.
- Information about patient and carer experience was reported back to teams from information collated in relation to the friends and family test.
- There was an effective process in place to identify, monitor and address risk issues.
- Staff were open, transparent and were aware of their 'duty of candour' in relation to the NHS organisation they worked in.
- There was a strong focus on continued learning and improvements for staff within the teams they worked in.
- The number of staff who had completed mandatory training was below expected levels in some areas. This had the potential to put people who use the service and staff members at risk.
- Systems existed to monitor and manage risk. Escalation procedures for urgent referrals were in place. Assessments were carried out in a timely manner, reviewed and reflected in care plans. Safeguarding was embedded within the service. Staff displayed a good understanding of their roles and responsibilities in this regard.
- Feedback from people who use the service was positive. We observed people who use the service being treated in a respectful manner and with care and empathy. We saw evidence of involvement in their care and decisions over treatment. Where families and / or carers were involved their opinions and views were also reflected. People who use the service were routinely offered a copy of their care plan.
- The trust had a clear vision and a set of values and staff were aware of these.

Summary of findings

- The trust had a quality strategy, processes and systems were in place around governance.
- The teams had processes in place to manage team performance and the quality of care and treatment provided.
- Processes were in place to monitor performance. Regular governance meetings were held and performance data was on display in teams. There were key performance indicators (KPIs) in place for monitoring quality initiatives.
- Teams informed us they were positively supported and well managed locally and the service manager and general manager were visible and approachable.

However:

- Where people were subject to a community treatment order (CTO) under the Mental Health Act there was no evidence in the paper or electronic system care notes that people were being read their rights. Records reviewed informed us people did not have their rights explained to them routinely and there was no documented evidence from the care coordinator.
- Staff were not routinely assessing people's capacity to understand the risks and benefits of treatment offered to them.
- Complaints and concerns information was displayed in the waiting rooms used by people that used the service. However, the information about complaints was only displayed in English.

Summary of findings

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

Are services safe?

Good

We rated safe as good because:

- Risks to people using the service were assessed, monitored and managed on a daily basis.
- Staff recognised and responded appropriately to changes in risks to people who used services.
- Staff understood their responsibilities to report on incidents and near misses and were supported when they did so.
- All of the team bases where people were seen were safe and where risks to patient's safety had been identified the managers were escalating these concerns onto the locality risk register.
- Adults and children were appropriately protected and staff took steps to report any incidents of safeguarding to the local authorities.
- All three teams reported low staffing vacancies, mainly due to maternity leave, secondment and advanced practitioner training; however, systems were in place to address the vacancies with staff being offered temporary contracts and vacant posts being filled to keep people safe.
- There were effective handovers and meetings within teams to manage risks to people who used their services.
- Staff received feedback from investigations and incidents and actions from incidents and patient alerts were regularly discussed in team meetings to ensure lessons were learnt.

Are services effective?

Requires improvement

We rated effective as requires improvement because:

- Where people were subject to a community treatment order (CTO) under the Mental Health Act there was no evidence in the paper or electronic system care notes that people were being read their rights. Records reviewed informed us people did not have their rights explained to them routinely and there was no documented evidence from the care coordinator.
- Staff were not routinely assessing people's capacity to understand the risks and benefits of treatment offered to them.

However:

Summary of findings

- People receiving a service had comprehensive assessments of their needs which included consideration of their clinical, mental health, physical health and their well-being.
- Information about people' care and treatment and their outcomes were collected and monitored.
- The teams participated in local and national audits and front line staff were involved.
- Staff were qualified and skilled to deliver care and treatment to their people.
- Patient care and treatment was planned and delivered in line with current best practice and evidenced based guidance.
- Staff were supported to deliver effective care and treatment and received good support from their managers and peers.
- When people moved between services the necessary teams involved were kept up to date.

Are services caring?

Good

We rated caring the community-based services for adults of working age as good because:

- The feedback we received from people who used the service was positive. They and their carers reported they were happy with the service they received.
- Staff treated people who used the service with kindness, dignity, respect, and compassion. Staff were patient and took the time to listen to individuals and to understand their needs.
- People that used services were encouraged to act as peer supporters for other people and take a role in greeting and helping people attending the wellbeing groups.
- People who used the service were given space and encouragement to ask questions, express their opinions and withhold consent to treatment if they disagreed with it.
- Staff listened to, and acted upon, people's opinions.
- People reported they were involved and encouraged in making decisions about their recovery pathways.
- Carers we spoke to felt they were involved in decisions around treatment and care. Carers we spoke to felt supported.

Are services responsive to people's needs?

Good

We rated responsive as good because:

Summary of findings

- The services had processes in place to identify and escalate urgent referrals.
- Services were planned and delivered in a way that met the needs of the local population.
- Care and treatment was coordinated with other services.
- Waiting times were monitored by local teams and allocation and referral meetings were used to allocate people to the appropriate staff who kept them informed of any delays or cancellations.
- Services were responsive to any identified and increased risks to people.
- The service had access to translation services including face to face translation.
- Processes were in place to engage with individuals who found it difficult to engage with mental health services.
- Facilities and premises were appropriate for the services being delivered and where people who used the service visited. Buildings were clean and well maintained.
- People could access the right care at the right time and access to care was managed taking account of their needs and risks.

However:

- Complaints and concerns information was displayed in the waiting rooms used by people that used the service. However the information about complaints was only displayed in English.

Are services well-led?

Good

We rated well-led as good because:

- The trust had a clear vision and set of values and staff were aware of these.
- Structures, processes and systems were in place around governance and these fed upward from team to the trust board and were fed back down to teams.
- The teams had processes in place to manage team performance and the quality of care and treatment provided.
- Information about patient and carer experience was reported back to teams from information collated in relation to the friends and family test.

Summary of findings

- There was an effective process in place to identify, monitor and address risk issues.
- The leadership at the trust had been engaging at the teams we visited.
- The staff were open and transparent and were aware of their 'Duty of Candour' in relation to the NHS organisation they worked in.
- There was a strong focus on continued learning and improvements for staff within the teams they worked in.

Summary of findings

Information about the service

Cheshire and Wirral Partnership NHS Foundation Trust provides community adult mental health services to adults of a working age across East Cheshire, West Cheshire and the Wirral.

A range of mental health services are provided via community mental health teams including assessment, diagnosis, treatment and follow up to people with severe and complex mental health problems. Teams operate a recovery and review model and offer treatments such as talking therapies, social interventions, and education. Teams co-ordinate care and visit people that use services in their own homes, team base or satellite clinics. Teams aim to support people to remain independent, monitor medication and move onto independent living or back into work. Teams support people who use services to be less socially isolated. People's health needs are also monitored via the outpatient department. This includes blood monitoring clinics for people prescribed mood stabilising or antipsychotic medication and clinics for people prescribed intramuscular or 'depot' medication via injection.

Community mental health teams consist of a range of skilled staff including: team managers, consultant psychiatrists, arrange of other grades of psychiatrists, approved Mental Health Professionals, psychologists, social workers, occupational therapists, clinical leads, community mental health nurses, support workers, family support workers and administration staff.

We have not inspected Cheshire and Wirral Partnership NHS Foundation Trust's community mental health services for adults of working age before this inspection.

Our inspection team

Our inspection team was led by:

Chair: Bruce Calderwood, Director of Mental Health, Department of Health (retired)

Head of Inspection: Nick Smith, Care Quality Commission

Team Leaders: Sharon Marston, Inspection Manager (mental health), Care Quality Commission,

Simon Regan, Inspection Manager (community health services), Care Quality Commission.

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 people's 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 people at two focus groups. The inspection took place across a range of the community-based mental health services for adults of working age. We sample community

Summary of findings

mental health services as part of our new inspection processes. We therefore visited three community mental health teams for adult of working age, located at three different sites. The teams we visited were:

- Adult Mental Health Services Chester
- Vale Royal Adult Mental Health Services
- Ellesmere Port and Neston Adult Mental Health Services

During the inspection visit, the inspection team:

- looked at the quality of the environment including the interview and clinic rooms spoke with 16 people who were using the service of which seven we visited
- spoke with seven carers of people using the service by telephone
- spoke with the managers for each team
- spoke with 28 other staff members; including doctors, a pharmacist, psychologists, occupational therapists, nurses and social workers
- attended and observed two referral and allocation meetings, two wellbeing clinics, one depot clinic and two multi-disciplinary meetings.

We also:

- collected feedback from people using comment cards.
- looked at 35 treatment records of people, including the records and Mental Health Act documents of 11 people on a community treatment order.
- looked at the care pathway of 12 people in more detail
- carried out a specific check of the medication management on all three sites, looked at a range of policies, procedures and other documents relating to the running of the service

Seven comment cards were received about community mental health services for adults of working age. Of these, two were positive in nature and five were negative in nature. Of the five negative responses, the issues raised three were relating to staffing and capacity issues, one relating to service users not being listened to and the other relating to the process and structures within the trust. Positive comments related to the caring and professionalism of staff.

What people who use the provider's services say

We spoke with 16 people that use services and 7 carers.

- All people we spoke with were positive about their experience of care and treatment in the community mental health teams for adults of working age we visited.
- They told us that they found staff to be very caring, supportive, and they were involved in decisions about their care.
- Carers commented they were involved in the care of their family members or spouses, were offered carers assessments and were aware of how to contact services in a crisis.
- People told us they were positive about the way staff treated them and were treated with respect and kindness by staff. Recurrent comments from people were staff genuinely took an interest in their health and welfare, and staff supported them to have the best quality of life possible.
- People reported they were involved and encouraged in making decisions about their own recovery, treatment options and their privacy and confidentiality were respected.
- People reported that staff understood their social needs and assisted them to maintain and develop their social networks and community support where needed. For example in becoming peer support buddies when attending the wellbeing groups.

Summary of findings

Good practice

People told us they were encouraged to act as peer supporters for other people attending the wellbeing group and acted as a point of contact before the group, providing refreshment and welcoming group members.

Areas for improvement

Action the provider MUST take to improve

Action the provider MUST take to improve

- Ensure where people were subject to a community treatment order (CTO) under the Mental Health Act their rights are read to them as part of their care and treatment so they understand the conditions of the CTO and there is documentary evidence of their rights being read to them.

Action the provider SHOULD take to improve

Action the provider SHOULD take to improve

- Ensure peoples' capacity to understand the risks and benefits of treatment offered to them is understood so they could decide if they want to accept it.
- Ensure complaints and concerns information displayed in waiting rooms is displayed in other languages apart from the English language.

Cheshire and Wirral 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
Adult Mental Health Services Chester	Redesmere, Countess of Chester Health Park, Liverpool Road, Chester
Vale Royal Adult Mental Health Services	Redesmere, Countess of Chester Health Park, Liverpool Road, Chester
Ellesmere Port and Neston Adult Mental Health Services	Redesmere, Countess of Chester Health Park, Liverpool Road, Chester

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.

Teams had access to MHA training which was mandatory and did not meet the 85% trust target with only a 74% completion achieved.

We looked at eleven people's paper and electronic record regarding their Community Treatment Orders (CTO).

However:

- None of the managers or staff were sure of who was responsible for reading and re reading people' rights.
- There was no evidence in the paper or electronic system care notes that people were being read their rights. People did not have their rights explained to them routinely despite being subject to conditions placed on them whilst subject to the Mental Health Act.

Detailed findings

We saw examples of care plans and risk assessments in relation to people subject to CTOs. These had been reviewed every 3 to 6 months and were collaborative, appropriate and comprehensive. A breach of the people's conditions as stipulated within their CTO could mean that people could be recalled back to hospital, if the risks they pose justify it. Staff provided care and treatment to people who were subject to a CTO were aware of the conditions stipulated in the order when providing care and treatment.

Patients on a CTO could access the Independent Mental Health Act advocates (IMHA) via the Mental Health Act department based at Chester.

Mental Capacity Act and Deprivation of Liberty Safeguards

Staff had received training in the Mental Capacity Act (MCA) and Deprivation of Liberty Safeguards (DoLS) which was part of the trusts mandatory training requirements. However teams overall did not meet the 85% trust target with only a 74% completion achieved.

Staff were able to articulate the principles of the MCA and discussed how they assumed capacity of people unless this was identified during their care and treatment. In the patient records we reviewed we looked at mental capacity and found capacity was not considered during the assessment process and had not been recorded.

Staff were not routinely assessing people's capacity to understand the risks and benefits of treatment offered to them. For example, two people told us they had been offered clozaril treatment and had been asked to think about this. They said they understood there were side effects associated with clozaril but their care coordinator or consultant psychiatrist had not discussed if they understood the risks or benefits of this medication. They said this had meant they had not been able to reach a decision to agree to this treatment.

We saw staff were recording on medicine administration records and in care notes that people had consented to take the prescribed medication being administered to them. However, there was no assessment of capacity completed on care notes when people were allocated to the team. Staff said there was a document within care notes to record capacity; but we did not see evidence of this being used in practice.

Staff were aware of where to go for support and advice about the MCA and DoLS within the team and said they would usually ask a social worker or psychiatrist to support them to complete assessment of capacity if they had concerns. The trust had a policy in place and this was accessible via their intranet.

Good

Are services safe?

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

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

Summary of findings

Our findings

Safe and clean environment

People were seen by staff in all three of the community mental health teams (CMHTs) we visited. Interview rooms were available and personal alarms were also accessible when seeing people at the community bases. Staff told us they would also see people within their own homes or an alternative community setting. If there was a risk indicated, then staff visited in pairs.

Responders to the activation of the alarm system had been identified either by a buddy system or where the whole team responded. Local policies and environmental risk arrangements were in place to inform staff about the use of consulting rooms.

We spoke with reception staff at all three team bases and the business manager at the Vale Royal site. Reception staff were well informed about the security arrangements for the building. Staff told us the reception rooms were shared by different out-patient clinics and teams. Staff were aware of where personal alarms were kept and arrangements for staff seeing people. For example, when new people were being assessed at the team bases, an indicator would be put on care notes to alert all staff including reception staff if there was a risk regarding the individual. Reception staff described how they would discreetly monitor people if a risk was known to them.

The managers at the Ellesmere Port and Neston and Vale Royal teams had recognised there were some gaps in their environmental risk assessments. The concerns they had identified related to ligature points in toilets accessed by people using the service. Toilets hand wash basins had pedestal taps fitted to them and toilets could be locked from the inside and taps and the lock could act as ligature points. Staff were able to describe how they locally managed patients they had concerns about accessing the toilets. However this had not been incorporated into the local risk assessment. The managers said they were going to review the risk assessment and escalate the ligature points to the locality risk register. We found alarms were fitted in the waiting areas and in some interview rooms. Otherwise staff accessed personal alarms.

We checked the clinic rooms at the team bases and all were well equipped and had the necessary equipment needed to see people within community teams, such as blood pressure machines, portable scales and phlebotomy equipment. The safety tests of portable and fixed equipment had been completed.

Safe staffing

We looked at the staffing levels at each team we visited to ensure they met the needs of the people. We reviewed the staffing levels and saw that these were in line with the teams' agreed staffing establishment.

All of the three teams we inspected had nearly all the number and grade of staff required. Vacant posts were in the process of being or had been filled by staff on temporary contracts. For example, the social work vacancy in the Ellesmere Port and Neston team was re advertised because there had been no applicants. Information provided by the trust was as of 31 May 2015 there was an overall vacancy rate of 4% across the community mental health teams of adults of working age; the Chester team had a vacancy rate of 2%, the Ellesmere Port & Neston team had a vacancy rate of 14% and the Vale Royal team had a vacancy rate of 5% The vacancy rate within the Ellesmere Port and Neston team was due to a number of staff on secondment and acting up, however vacancies had been filled.

Team sickness rates for the three teams to 30 June 2015 were Chester team 7%, Ellesmere Port & Neston team 5% and Vale Royal team 13% with an overall figure of 8%.

The trusts expected target for mandatory training was 85%. Records showed that most staff was up-to-date with all statutory and mandatory training. Training included equality and diversity, fire, safeguarding children level 1, safeguarding adults, health & safety, information governance, infection control, Mental Capacity Act (MCA), Deprivation of Liberty Safeguards (DoLS) and Mental Health Act (MHA).

Good

Are services safe?

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Teams had buddying arrangements in place and caseload management was discussed at the weekly referral and allocation meetings. Caseloads were reviewed by the managers at the teams with staff involvement. The Department of Health 'Policy implementation guide' for CMHT's (2002) recommended caseloads of no more than 35. Team members reported caseloads of between 20 – 44 people. The Chester team manager and clinical lead reported the highest caseloads of 44 people for a full time staff member. They told us they recognised this was too high and planned to reduce this to 35, through case management, referring people back to their GP's, referring people to outpatients' clinics for monitoring and discharge and transfer.

Psychology waiting times were monitored locally by the team and locality managers. There were no reported waiting lists and psychologists were able to assess people and cover urgent work.

New staff were orientated to the team by attending the trust corporate induction and team based inductions with buddying arrangements in place for new staff. The trust 'supervision policy outlined guidance for the supervision of employees and detailed requirements for managerial, clinical, educational/training and professional supervision of clinical and non-clinical employees. We looked at the Ellesmere Port and Neston and Vale Royal teams' supervision records and saw these were complaint with the trust supervision targets of six supervisions within a 12 month period. We saw supervision records in the Ellesmere Port and Neston teams and these recorded staff were having above the minimum trust target of supervisions. Staff reported supervision times were monthly to six weekly and falling within the trust policy timescales.

Managers told us there were plans in place to manage patient safety when staff were absent. These included referral and allocation and multi-disciplinary team (MDT) meetings and buddying arrangements. Each team had a duty system that managed referrals and contact from people that used the service and other professionals. Urgent referrals were triaged by the duty officer and they or a colleague could arrange to visit the person concerned or arrange a visit to the team base.

There was adequate medical cover within the three teams we visited. Consultant psychiatrists were fully integrated into the teams and had a junior doctor or trainee to assist them. Team members reported medical staff were accessible.

Assessing and managing risk to people and staff

The teams used the clinical assessment of risk to self and other (**CARSO)** in the assessment of patient risk. This was the standardised tool within the electronic patient record system.

Risks to individuals were effectively assessed and managed on referral to the community teams. Referrals into services were either to the duty team member based in each team or to a single point of access. We observed two referral and allocation and two multi-disciplinary (MDT) meetings. These were held weekly to discuss and manage people and their risks.

Of the 35 records we reviewed there was a process for identifying and managing risks to the patient and others to minimise any risk of harm. Risk assessments had been reviewed and updated where necessary or where risks had changed.

Community teams used an electronic patient recording system Care Notes. This was used to store and update current and historical information about people including risk information. This system was a trust wide system accessible to and integrated within the community mental health and other mental health services.

The system provided risk alerts about people who had previously been in receipt of services as well as those on the current team caseload. This meant staff were immediately alerted to serious risk information they may need to consider when a person was re-referred or was already receiving a service from the community teams.

Records had accessible and updated patient risk information and community teams were able to review the content of information provided by other professionals within the trust.

The community teams were all aware of local safeguarding adults and children procedures and how to report any concerns.

We spoke with the lead pharmacist for community mental health services when visiting the Chester team and looked

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at the arrangements for ordering, receipt, administration and disposal of medicines at all three sites. Medicines were stored securely at the services we visited and fridge temperature were monitored daily and recorded. The lead pharmacist visited the service to check that medicine administration records for administering slow release antipsychotic by injection were re written every six months as per the trust policy.

The pharmacist and pharmacy technician checked medicine expiry dates and carried out stock checks to ensure levels of stock medicines were appropriate. We saw medicines requiring refrigeration were transported in a cold box and kept in a fridge until needed for administration. Staff actively asked the patients if they were happy to receive their medication prior to it being given.

People who collected their medicines when attending outpatient clozaril or lithium clinics signed to confirm they had taken these medicines themselves. We saw in the Ellesmere Port and Neston team where staff who took medicines to people's homes as part of home visits encouraged people to sign for receipt for their medicines. However this was not a standard practice across the other two teams.

The teams had piloted the wellbeing clinics to promote physical health monitoring of people within their locality by completing physical health checks within the drug monitoring clinics. At these wellbeing clinics, staff monitored people's physical health over time.

Crisis plans were in place for people that used the service and all people we spoke with or visited who had a crisis plan were aware of this and told us they had contributed to it. Care plans we reviewed contained information which informed people of who to contact in a crisis. People we spoke with told us they were aware of whom to contact in an emergency and had the crisis team contact information. They were also aware of who their care staff coordinators were and how to contact them.

Teams we visited were able to respond to sudden deterioration in peoples' health. Teams had staff identified to respond via a duty system. We saw close working links with the crisis teams and where reports about people' deteriorating mental health was highlighted then these were discussed within teams and appropriate action taken.

The three teams visited did not have a waiting list of people waiting to be allocated. People who did not need to be allocated until the next referral and allocation or MDT meeting were monitored through reviewing referral information.

Staff knew how to recognise safeguarding concerns and were aware of the trust's safeguarding policy. Safeguarding leads had been identified within the trust and staff knew who to contact. Safeguarding concerns were discussed within the teams meetings we visited. Team managers reported and team meeting minute's evidenced monthly reports on safeguarding training was shared with teams to monitor compliance. We saw staff had flow chart guiding them on how to make a safeguarding referral and staff showed us the safeguarding team e-mail.

The trust had a lone working policy in place. Teams had developed local procedures to ensure staff were safe when visiting people in the community. For example, the Ellesmere Port and Vale Royal teams used location boards so the duty officer, their deputy or team manager could monitor staff expected times of return. Team administration staff were aware of the systems in place and how to escalate concerns about staff not returning or calling in safe. Duty officers followed up staff that were late returning to the office or did not call in safe when not returning to the office following a visit. All staff were able to tell us about the processes and checks in place, including a code work to alert staff at the base if they needed assistance.

Track record on safety

The trust reported 129 serious incidents from 1 May 2014 to 30 April 2015 via the strategic executive information system (STEIS). The trust reported that a total of 104 serious incidents which required further investigation and occurred between 3 January and 22 December 2014. In relation to community services for adults of working age, the majority of serious incidents reported were unexpected or avoidable death or severe harm to one or more patients, staff or member of the public (87); with 53% (54) of all incidents occurred at the patient's home and 20% (21) occurring in a public place. As a result we asked for information from the trust on the numbers of deaths of people within the three teams we visited which had occurred between 3 January and 22 December 2014. Six deaths were reported during this time period, of which five had occurred in the patient's own home and one in a

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public place. Staff were aware of these incidents and the subsequent outcomes of the investigations. This indicated that the trust had appropriately reported incidents to external agencies as required.

Information reviewed identified the trust had completed post incident reviews into serious incidents.

Reporting incidents and learning from when things go wrong

There was an electronic incident reporting system in place (called datix). The trust used the datix system to report incidents. This was completed following any incident. Incidents were graded by severity A to E. Levels A to C were reviewed by the complaints and incidents team. This enabled team managers and senior managers to review and grade the severity of incidents. A 72 hour safety review process was introduced in February 2015 and to be reviewed in September 2015. The review process was used following report of level 1, 2 and 3 incidents. This replaced the peer review system.

Staff were aware of how to report and complete an incident reporting form and were aware of their responsibilities in relation to reporting incidents. Incidents were analysed by the service manager to identify any trends and appropriate action was taken in response to these. We looked at examples of ten reported incidents across the three teams. We saw learning from incidents was via team meetings. We saw the minutes of five team meetings and learning from incidents was a standing agenda. The minutes contained information about the type of incident and recommendations arising from the investigation report. Team meetings also offered staff an opportunity to discuss incidents and staff reported having individual debriefings after incidents had occurred. Incidents from other teams were shared via the locality team managers meetings and the trust communicated with staff via the trust email bulletin.

The trust had a policy in place to ensure staff were supported and debriefed after a serious untoward incident and access to support should staff need to access this.

Staff had a general awareness of the duty of candour requirements which required all health and social care providers to notify the relevant people of a suspected or actual reportable patient incident and ensured that services are transparent and open. Staff had received information from the trust to inform them of these new regulations which came into force in November 2014 for all NHS organisations.

Are services effective?

Requires improvement

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

Summary of findings

Our findings

Assessment of needs and planning of care

We looked at 35 care records across the service. Each person had a comprehensive assessment. Peoples' needs were assessed on allocation to the teams and care was delivered in line with their individual care plans. Records showed that physical health needs were identified and managed effectively.

Staff reported there were occasions when they had to complete additional assessment of need for assessments accepted through the single point of access teams to ensure the referral was appropriate. However this was not reported to be a systemic concern.

Care records we looked at contained either a CARSO risk assessment or other specific risk assessment tool and records were up to date. When people had been recently discharged from hospital, their seven day follow up visit had been recorded and summary discharge information had been sent to their GPs.

Records reviewed indicated recovery focused care plans were in place. Records also identified where people were on medication which required monitoring, for example clozapine and lithium. The three teams we visited had specific monitoring clinics where people' attended for blood monitoring.

Care plans were reviewed on a regular basis and updated or discontinued as appropriate. Care records contained relapse prevention plans. These provided specific details of interventions, services and workers people were to contact to promote peoples' mental health, prevent deterioration and relapse of their illness. People we spoke with provided examples of the plan they had in place.

Patient information was stored securely at all the teams we visited. Staff had access to a computerised electronic system called care notes. Some paper records were maintained. Mental Health Act records were held centrally at the Mental Health Act office in Chester where we were able to see paper copies of Community Treatment Orders (CTOs).

People did not have access to areas where records were stored as locks or keypads were used to restrict entry. When other teams were involved in patient pathways, they had access to current information using the computerised system.

Best practice in treatment and care

The National Institute for Health and Care Excellence (NICE) guidance was followed by clinical staff when prescribing medication.

Evidence demonstrated the teams had implemented best practice guidance within their teams. This included the promotion of psychological treatments accessible to people, and implementation of NICE guidelines in psychosis. For example the national audit of schizophrenia 2014 had the trust performing above the national average for monitoring of physical health factors, smoking, glucose control, lipids, blood pressure, alcohol consumption and substance misuse. Trust performance for interventions offered for identified health risks had the trust performing above the national average for interventions offered in smoking, BMI, glucose control, blood pressure, alcohol consumption and substance misuse.

Lithium and clozapine were being monitored where necessary by the teams involved. We found good examples of lithium and clozapine monitoring in community teams with dedicated staff.

We found if any concerns had been highlighted regarding patient blood levels, these were escalated and discussed weekly with the consultant psychiatrist and team. The patient's GP was informed where necessary. New people were provided with a Lithium booklet, alert card and blood result booklet.

Blood tests were monitored for the levels of lithium to prevent the effects of toxicity and for clozapine to ensure white blood cell counts were in normal ranges. At Chester CMHT the team tested blood on site. The Vale Royal, Ellesmere Port and Neston teams sent blood samples to a laboratory for analysis. When blood samples were indicated as high for clozapine, people were not given their medication until the levels were within the accepted clinical range. Seeing people on an outpatient basis allowed people flexibility in their care and treatment when they were monitored by the lithium or clozapine clinics.

Are services effective?

Requires improvement

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

The trust was in the process of introducing the recovery star outcome tool for people who were treated on the recovery and review process.

The service had introduced the NICE guidance on the assessment and management of bipolar disorder in adults, children and young people in primary and secondary care published in September 2014. As part of the implementation process, the Ellesmere Port and Neston and Vale Royal teams were auditing the eleven recommendations contained within the guidance. The consultant leading on the audit had produced guidance to benchmark the interventions, services and prescribing of medicines used by the CMHT's against NICE guidance.

The trust had local commissioning for quality and innovation (CQUIN) targets to support operational improvements in the quality of services. Information reviewed indicated the trust had completed local audits against various CQUIN targets. Some of these included the friends and family test, assessment and treatment of people with severe mental illness to improve their mental and physical health care.

Health of the Nation Outcome Scales (HoNOS) were used to assess people. This covered 12 health and social domains and enabled the clinicians to build up a picture over time of their people' responses to interventions.

The teams were using two assessment tools to support people to understand their mental health needs and treatment:

- The Liverpool University Neuroleptic Side Effect Rating Scale (LUNSERS) was used by people as a self-assessment tool for measuring the side-effects of antipsychotic medications
- The KGV, also known as the Manchester Symptom Severity Scale is an assessment tool developed by three psychiatrists (Krawiecka, Goldberg and Vaughn) as a standardised psychiatric assessment scale for rating chronic psychotic symptoms. This was used to help people to express and measure the severity of psychotic symptoms most commonly experienced by them, such as schizophrenia and bipolar affective disorder.

People had access to psychological therapies as recommended by NICE. Staff reported there were no waiting times for specific therapies for example a psychologist arranged to see a patient who was discharged from hospital following perinatal treatment (before or after birth) as this was assessed as urgent.

Community teams provided individual psychological therapies as well as other patient support groups including cognitive behavioural therapies.

We observed two wellbeing support groups during our inspection at the Chester and Vale Royal team bases. The role of the wellbeing groups was to address the health and social needs of people using the service. Initially set up five years ago as a depot and clozaril clinic, the wellbeing group was expanded and offers a more holistic approach to people's health. The groups offered advice on nicotine management; nicotine replacement therapy and carbon monoxide monitoring which supported people to understand the positive health benefits of stopping smoking. The wellbeing group promoted stopping smoking initiatives especially as smoking was not permitted in the hospital wards run by the trust. The group was co facilitated by a staff member that used services and a person using the service.

People attending the wellbeing group paid nominal amounts for refreshments and the monies made were used to pay for complimentary therapies such as Indian head massage. The group also had a weekly guest speaker. Examples of guest speakers included occupational therapists, substance misuse worker, psychologist, musician and a graffiti artist. The group had good links to the recovery college and people were encouraged to attend the recovery college courses after their initial involvement with the wellbeing group. People were also supported to reintegrate into the community and were supported to attend GP appointments. Comments from people using the service were they valued the wellbeing group, and staff were enthusiastic and caring. A recovery college offers people education about mental health recovery using people who have experienced mental health. The college supports people to take control of their lives, find new opportunities and see beyond their mental health diagnosis.

The teams we visited had social workers embedded in their teams and provided support and

interventions to people to address housing and benefit needs. Peoples' care plans identified where people had

Are services effective?

Requires improvement

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

been signposted to outside agencies. People could be supported in accessing local social care support. For example the Ellesmere Port and Neston team base had access to educational, cookery and woodwork sessions on site and the Vale Royal team was located next to a MIND drop in and information centre. People were provided with a range of information about the recovery college and local support groups and services which helped them to look at and address their goals and aspirations. This included learning new skills, undertaking training courses and looking at voluntary and or paid work. People were encouraged to access a local registered charity providing a range of disability-related services including advice, information, a community café, shop mobility and a volunteer scheme based in Chester and Ellesmere Port.

The trust recovery college was established in the last five years and links into the recovery and review role of the CMHTs. This provided a learning centre offering courses based on peoples personal recovery. Examples of courses provided were: understanding mental health, which included mindfulness based cognitive therapy, understanding depression and coping with anxiety, 'rebuilding your life' which included managing sleep problems, moving forward, confidence building and an introduction to and development of wellness action plans. The courses lasted on one or two hour workshops and courses over several weeks.

People's records had information about their individual healthcare needs. Some people were monitored via their local GPs. We found some good examples of how teams ensured that the physical healthcare needs of people were being met. For example ongoing physical monitoring was carried out at the clozapine, lithium and wellbeing clinics. This included annual monitoring of peoples cardiac health by electrocardiograms (ECGs). Other tests included body mass index (BMI) checks, smoking cessation, blood pressure and sexual health checks were offered and discussed.

Skilled staff to deliver care

The staff working in the community adult teams came from a range of professional backgrounds included nursing, medical, occupational therapy, psychology, healthcare support workers and social workers. The Chester and Ellesmere and Neston CMHT's had specific non-medical prescribers in training.

Locality review meetings were held monthly for the working age adult teams. These meetings showed that the trust had reviewed and discussed vacant staffing issues within the teams.

Managers had access to the electronic staff records (ESR) for their teams' mandatory training records and staff received alerts when training was overdue. Staff reported they had access to other training specific to their team and patient need. Some staff had received psychosocial and CBT training.

The teams operated within a multi-disciplinary team (MDT) framework. New staff had a period of induction with the teams they were employed in and completed the trust compulsory induction training.

Staff reported they had been appraised and supervised by their line managers and that they were

supported by them as well as by their peers and team meetings happened regularly.

Multi-disciplinary and inter-agency team work

Regular and effective multidisciplinary meetings were in place. We observed two MDT and referral and allocation meetings during our inspection. These meetings provided effective handovers within the teams we visited to keep staff updated about patient risks and to oversee and manage team and individual caseloads.

All teams had good working links with primary care services and effective patient handovers were in place with GPs. Teams had link workers with the primary care teams who attended MDT. When teams could not attend MDT meetings, for example the crisis team, they provided up to date written information about people they were working with and this information was discussed as MDT and care and risk plans updated accordingly.

Computerised electronic records systems allowed trust staff to have access to updated information. When people were discharged from inpatient services and back into their communities the computerised system prompted staff to complete a discharge summary to send to the people GPs.

Teams had social workers and approved mental health practitioners (AMHPs) within their teams.

These staff were employed by local authorities but formed part of the community teams.

Are services effective?

Requires improvement

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

Adherence to the MHA and the MHA Code of Practice

Teams had access to MHA training which was mandatory and did not meet the 85% trust target with only a 74% completion achieved.

We looked at eleven people's paper and electronic record regarding their Community Treatment Orders (CTO).

However:

- None of the managers or staff were sure of who was responsible for reading and re reading people' rights.
- There was no evidence in the paper or electronic system care notes that people were being read their rights. People did not have their rights explained to them routinely despite being subject to conditions placed on them whilst subject to the Mental Health Act.

We saw examples of care plans and risk assessments in relation to people subject to CTOs. These had been reviewed every 3 to 6 months and were collaborative, appropriate and comprehensive. A breach of the people's conditions as stipulated within their CTO could mean that people could be recalled back to hospital, if the risks they pose justify it. Staff provided care and treatment to people who were subject to a CTO were aware of the conditions stipulated in the order when providing care and treatment.

Patients on a CTO could access the Independent Mental Health Act advocates (IMHA) via the Mental Health Act department based at Chester. People were aware of whom the IMHA were and information about this service was displayed at team bases. Peoples' reviews of and extension of their CTO were done at the Ellesmere Port and Neston and Vale Royal team bases, while the Chester team were done at the main Upton Lea site.

Second Opinion Appointed Doctors (SOAD) saw people at the team bases to authorise treatment for mental disorder where people lacked capacity to make a decision. These visits were arranged by the mental health department. We found patient records were stored appropriately at all three sites.

Good practice in applying the MCA

Staff had received training in the Mental Capacity Act (MCA) and Deprivation of Liberty Safeguards (DoLS) which was part of the trusts mandatory training requirements. Overall teams did not meet the 85% trust target with only a 74% completion achieved.

Staff were able to articulate the principles of the MCA and discussed how they assumed capacity of people unless this was identified during their care and treatment.

We saw staff were recording on medicine administration records and in care notes that people had consented to take the prescribed medication being administered to them. However there was no assessment of capacity completed on care notes when people were allocated to the team. Staff said there was a document within care notes to record capacity but we did not see evidence of this being used in practice.

Staff were aware of where to go for support and advice about the MCA and DoLS within the team and said they would usually seek support from a social worker or psychiatrist to complete assessment of capacity if they had concern The trust had a policy in place and this was accessible via their intranet.

However, staff were not routinely assessing people's capacity to understand the risks and benefits of treatment offered to them. For example two of the seven people we spoke with told us their psychiatrist had offered them different medication to consider when they had attended their outpatients' appointment. They told us that they had received some information about possible side effects of this medication. However as their care coordinator and consultant psychiatrist had not discussed these risks and benefits consistently they had difficulty remembering the information. They said this had meant they had not been able to reach a decision to agree to this treatment as the medication they were currently prescribed reduced their capacity to remember and recall information.

Good

Are services caring?

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

Summary of findings

Our findings

Kindness, dignity, respect and support

People told us staff treated them with respect, took an interest in their health and wellbeing and were responsive to their needs. Staff spoke positively about the improvements they saw in peoples' wellbeing. Staff spoke to people in a respectful and dignified manner.

We observed all staff interacting with people in a caring and compassionate way and this was supported by the comments people that used the service made. Staff responded to people in a calm and respectful manner. Staff were interested and engaged in providing good quality care to people.

When staff spoke to us about people, they discussed them in a warm respectful manner and showed a good understanding of their individual needs. People told us that staff provided practical and emotional support and they felt confident in raising any issues with them. We received positive feedback from people and their carers about the way staff treated them. People told us about the care and treatment they received and the records we reviewed supported their comments. All the care records we reviewed contained up to date care plans and indicated that a copy had been provided to people that used the service. Where people had been discharged recently a 7 day follow up visited had been recorded. Care records contained relapse prevention plans.

The involvement of people in the care they receive

People told us they were involved in developing their care plans. Records we checked on their computerised system, identified people had been involved and their comments recorded. People we spoke with were generally aware of the content of their care plans and could identify their crisis plans and goals for attending outpatient clinics and the recovery college.

People told us they were encouraged to act as peer supporters for other people attending the wellbeing group and acted as a point of contact before the group, providing refreshment and welcoming group members.

People were aware of the different assessments staff used to help them understand their mental health needs. People commented on the use of the Liverpool University Neuroleptic Side Effect Rating Scale (LUNSERS) and how this helped them understand the side effects medication could have on their wellbeing.

Details of local advocacy services and local support groups were displayed in the team bases we visited. Information leaflets were available about the local services. We saw the trust provided information about a range of mental health needs and treatment options. There was a range of information sheets available regarding the various medicines that could be prescribed.

In the Ellesmere and Neston team base we saw the triangle of care displayed within the waiting area with comments from people who used the service about the service provided about how this had improved their mental health.

We saw people were encouraged to involve relatives and friends in their care if they wished. Support staff worked closely with individuals and their families. For example the Vale Royal team had a worker who supported people experiencing anxiety through desensitisation programmes in the community. For example reintroducing people to public transport and rebuilding their confidence when they lacked confidence or experienced anxiety. Teams completed a carer's assessments when necessary to ensure their needs were assessed and support was provided. Feedback from carers was they were involved in people's care decisions, carers assessments were offered and carers had staff direct dial numbers so could seek advice and support. Relatives of people on a community treatment order (CTO) commented they were aware of relatives' rights, were included in the care planning process, services were flexible and people had access to crisis services.

We found a few examples of people with advance decisions in place for how they would like to be supported if their mental health deteriorated.

We saw a 2015 mental health survey conducted by the trust displayed at the Vale Royal team base asking for views of people who used the service. We could not see any results from the survey as this had not been completed. In addition there was information available to carers about the local carer organisations.

The CQC community mental health patient experience survey 2014 informed us the trust scored better than the

Good

Are services caring?

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

England average overall, scoring better than average for 11 out of 33 survey questions answered by people. For example in being involved in the organisation and planning of their care and access to crisis services.

Are services responsive to people's needs?

Good

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

Summary of findings

Our findings

Access and discharge

Referrals into community adult teams were accepted through the single point of access to the duty worker, though some referrals were accepted via the telephone or e mail. The draft operational policy we saw stated a four week timescale from referral to service input and urgency. For example people identified as being high risk were to be seen within 4 hours, then 72 hours or a week for less urgent referrals. Routine referrals would be seen within 28 days. All referrals were made to the duty worker or manager and the level of urgency assessed. Managers and data provided by the trust confirmed teams did not have a waiting list.

Teams were able to respond urgently to referrals when needed and arrangements would be made to see people on the same day. If the duty worker could visit the person or allocate another worker to visit them at home they would arrange for them to be seen at the team base. Where people without a key worker needed out of hours intervention, this was arranged by the team with the crisis service as the CMHT's did not work extended hours.

The duty worker triaged referral information and made assessment appointments. Assessment appointments were used to gather further information from the person and other professionals involved in their care, including the person who made the referral. Teams had access to the crisis teams throughout the trust and joint visits were arranged accordingly in response to patient need.

The trust provided data between 1st January 2015 to 30th June 2015 for referral to triage, triage to assessment and assessment to allocation times. During this time 98-100% of referrals were accepted by the teams following referral and the first face to face contacts were completed by the consultant psychiatrist or CMHT staff. At the time of our visit a total of 55 people remained without a care coordinator allocated between the three teams. Of these, 41 were identified as discharged with a discharge letter and were in the process of being closed. Eight people were receiving interventions from the teams but did not have a team member documented on care notes but this was rectified at the time of the inspection. Of these eight people two were on standard care and required further follow up which was rectified at the time of the inspection.

The psychologist reported for psychological input from referral to assessment time was 1-2 weeks;

However, the psychologist and staff told us there were no targets set by the trust to monitor initial patient assessment to them being in receipt of psychological treatment.

We saw teams had systems in place to respond to people who telephoned into the service. This included liaison with their care coordinators, duty and buddy systems in place to respond to people if their allocated worker was absent.

Team key performance indicators showed that the proportion of people on the Care Programme Approach (CPA) receiving follow up within 7 days of discharge from psychiatric inpatient care remained above the England average from April 2014 to June 2015 at 95%. For the CPA of people having a formal review within 12 months, monthly and quarterly figures collected showed a target of 95% had been achieved. Quarterly figures for the completeness of CPAs were 97%, while identification of people's goals or outcomes was 50%. There were no targets for the number of people in contact with mental health services, number of people on CPA, percentage of people on CPA with HoNOS recorded in previous 12 months, percentage of people on CPA in settled accommodation, percentage of people on CPA in employment and electronic recording of number of patients on CPA who have been offered a copy of their care plan. However the trust collected monthly figures on these key performance indicators for commissioners as part of CQUIN reporting but did not provide data because there were no targets to meet.

The trust provided us with figures on completion and non completion figures for people accessing services. The figures related to assessment (including risk assessment using CARSO), care planning and review of patients for the last two quarters from June to December 2014 for the three teams we visited. Compliance monitoring covered carso compliance (CPA patients only), HoNOS compliance (all patients) and care plan compliance.

Are services responsive to people's needs?

Good

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

- CARSO compliance for the Chester and Ellesmere Port & Neston Team CMHT's increased from quarter 3 to quarter 4. The Vale Royal CMHT compliance reduced slightly between quarters 3 and 4 but had the least non completion rates for the three teams.
- Chester CMHT care plan compliance was the highest followed by Ellesmere Port & Neston Team then Vale Royal CMHT's. At the end of quarter 4 Chester CMHT had only 1 care plan pending completion, Ellesmere Port & Neston Team had 7 care plans pending completion and the Vale Royal team 9.
- < > compliance for the Chester and Vale Royal CMHT's increased from quarter 3 to quarter 4 while the Ellesmere Port & Neston Team CMHT's performance remained the same. The Vale Royal CMHT had the least non completion rates for the three teams.
  During quarters 3 and 4 we noted the trust continued to achieve national targets relating to CPA.

People who did not attend (DNA) their appointments or outpatient lithium, clozaril or depot clinics were followed up by the community teams. Do not attend rates for outpatient clinics were not routinely followed up by medical secretaries. A consultant psychiatrist raised a concern at a focus group that insufficient medical secretarial support was contributing toward follow up letters not being sent out to people, which was supported by medical secretaries we interviewed. Managers told us the monitoring of DNAs had recommenced in June 2015.

During our visits, team managers informed us there had been recent deaths of people in receipt of community services. We were told during the peer review process of the deaths by team managers an identified theme was the people did not attend outpatient appointments. We looked at the peer review reports of four deaths which occurred in the last five months. Learning from these deaths was included within the peer reviews. The concern about DNA of appointments was not identified as a contributing factor. One learning point was identified for the team to achieve compliance with the DNA policy. DNA's discussed at multi-disciplinary meetings and an appropriate course of action taken. The trust DNA policy was not always adhered to as not all DNA's, only people deemed high risk, were discussed due to time constraints.

Due to the distance and remoteness of some locations to the community teams, teams provided satellite clinics in local health centres for example in their local GPs surgery or a community facility.

The facilties promote recovery, comfort, dignity and confidentiality

In all of the teams we visited and where people were seen, the facilities were clean, comfortable and mostly well furnished. Some teams shared visiting rooms and these needed to be booked in advance. The interview rooms were adequately sound proofed to maintain people' privacy. Reception areas provided a range of information such as complaints information, local self-help groups, advocacy services and information about the teams and treatments provided.

Meeting the needs of all people who use the service

The teams had access to language translation through the trust and they could access interpretation services and access patient information in various languages.

However:

- The Ellesmere Port and Neston and Vale Royal teams reported there was a growing Eastern European population accessing services. The only information we saw available to people using the service in a multi lingual format was from the local authority on dealing with domestic violence. Information about the trust complaint procedure at all three bases was displayed in English only.

Listening to and learning from concerns and complaints

From the trust's inspection information submitted during the inspection, there were a total of seven complaints received in the last 6 months (November 2014 to April 2015) for the community adult mental health services we inspected. Of the seven complaints received, one was partially upheld. For this complaint, the trust looked at lessons learnt and concluded a referral was not completed to the primary care mental health team following discharge from secondary services to the GP. The clinician concerned reflected that their letter did not make it clear who was completing the referral. The clinician wrote an apology letter and made a fast-track referral to the primary care team. As a result the person concerned was seen by the primary care team.

Are services responsive to people's needs?

Good

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

Information on how to make a complaint was displayed in the teams we visited, as well as information on the patient advice and liaison service (PALS) and advocacy services.

People we spoke with told us they would initially raise issues with their identified staff member and felt comfortable doing so. Staff informed us they tried to address people concerns informally as they arose and would address them to the trust complaints procedure, if they couldn't resolve the complaint informally. Staff were aware of the trust's formal complaints process and knew how to signpost people as needed to PALS.

Patient complaints were fed back to staff in their team meetings and we saw evidence of this in team meeting minutes and locality data packs, where complaint information was recorded. This meant staff were kept informed of any complaints made against their team so that improvements were made and actions were implemented to improve their service to people.

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.

Summary of findings

Our findings

Vision and values

Staff were aware of the trusts vision and values. Staff were motivated and dedicated to give the best care and treatment they could to people in receipt of community mental health services. Staff were supportive of the changes to the model of care which had been implemented, for example the introduction of the recovery star.

Most staff were aware of senior managers within the trust. The chief executive was accessible to the teams we visited and had engaged with the community teams.

Staff reported they knew who their locality managers were and reported they visited their teams on a regular basis.

Good governance

Each team had a community team locality data pack. The data pack contained detailed information about individual team performance and how the teams contributed to the goals of the trust. Information was presented under the CQC five domains of safe, effective, caring, responsive and well led. The data pack formed part of the trust zero harm implementation plan. Data in the pack was drawn from published sources or the trust information systems, primarily datix and electronic staff records. Data packs contained locality background information. For example data packs for the three teams we visited (West locality) for May 2015 identified two risks. Non completion of carso risk assessment as per the trust policy and ligature and environmental risks (red) that would not be addressed via capital expenditure.

However the risks we identified regarding managers and staff being unsure of who was responsible for reading and re reading people subject to a CTO their rights and the lack of recording of this process was not identified on the risk register.

Lessons learnt from serious incidents in the last financial year included, ensuring patients understood the risk and benefits of medicines, communication between agencies, documentation and care planning and contingency planning. Data packs contained information about individual team performance on training, supervision and appraisal, serious untoward incidents, complaints and compliments. The data packs recorded between November 2014 and April 2015 no complaints had been received by any of the teams. In the same time period the Vale Royal team received 55 compliments, Chester CMHT 19 compliments and Ellesmere Port and Neston CMHT 3 compliments.

Teams were provided with governance information through community quality dashboards. We saw the November 2014 dashboard, which provided individual team performance information on areas of improvement, areas for improvement, accelerating service improvement and sustained improvement. For example all teams performed well for 7 day follow up and achieved compliance, sustaining strong scores in risk assessment and managing do not attend appointments with people that use services.

We found the services were well managed and had good governance structures in place. Staff had clear roles and a management structure that was understood by staff.

There was opportunity for staff to submit organisation/ team risks to the locality risk register. All staff reported they liked working at the trust and felt well supported by their managers.

Community team managers reported into specific governance teams monthly. We saw the minutes of governance meetings for January, March and May 2015. Agenda items included business continuity, friends and family test, smoke free issues, action plan response to coroner regulation 28 request, feedback form governance and quality and clinical management, safeguarding and service updates. The minutes reflected the information about vacancies within teams and staff who were seconded for training and were in acting up positions. The May 2015 meeting confirmed the final draft operational policy was going to the senior management team for ratification and agreement.

Most staff we spoke with told us they were not involved in clinical audits within their team but had an awareness of trust audits in place.

The Ellesmere Port and Neston and Vale Royal teams were auditing their service against National Institiue for Health and Care Excellence (NICE) guidance around the diagnosis and treatment of bipolar disorder.

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.

Data submitted indicated the services key performance indicators (KPIs) were met, seven day follow up for people on the CPA discharged form inpatient wards.

Leadership, morale and staff engagement

Most staff described strong leadership at team level and said they felt respected, valued and supported. The Ellesmere Port and Neston team had a temporary manager in post and staff reported positively about the manager being supportive, organised and approachable. Comments made by staff were that they would recommend the community services for adults of working age as a place to work and were supported and offered opportunities to develop their skills and knowledge.

Staff reported they were able to raise concerns without fear of victimisation and were aware of the trust whistleblowing policy.

Staff told us they had opportunities and were encouraged to undertake further education to support them in their job roles as well as being encouraged to attend outside conferences. Staff told us there was support for them to undertake a management qualification.

Commitment to quality improvement and innovation

The trust quality accounts for 2013/14 indicated the trust participated in the national audit of schizophrenia. The Ellesmere Port and Neston and Vale Royal teams were using an audit of NICE 185 Bipolar disorder: assessment and management to benchmark the services offered against the guidance. The consultant leading on the audit had produced guidance to benchmark the interventions, services and prescribing of medicines used by the CMHT's against NICE guidance.

This section is primarily information for the provider

Requirement notices

Action we have told the provider to take

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

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment Regulation 12(1)(2)(a) Health and Social care Act 2008 (regulated Activities) Regulations 2014. Providers must ensure where people were subject to a community treatment order (CTO) under the Mental Health Act their rights are read to them as part of their care and treatment so they understand the conditions of the CTO and there is documentary evidence of their rights being read to them.

This section is primarily information for the provider

Enforcement actions

Action we have told the provider to take

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