Requires Improvement

Worcestershire Health and Care NHS Trust

Community-based mental health services for adults of working age

Quality Report

Worcestershire Health and Care NHS Trust
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Locations inspected

Name of CQC registered location	Location ID	Name of service (e.g. ward/ unit/team)	Postcode of service (ward/ unit/ team)
Trust Headquarters	R1ADJ	Redditch (Community Mental Health Team) CMHT	B98 7DP
Trust Headquarters	R1ADJ	Bromsgrove CMHT	B61 0BB
Trust Headquarters	R1ADJ	Wychavon CMHT	WR9 8QU
Trust Headquarters	R1ADJ	Droitwich CMHT	WR11 1JT
Trust Headquarters	R1ADJ	Wyre Forest CMHT	DY11 6RY
Trust Headquarters	R1ADJ	Worcester CMHT	WR1 2AE
Trust Headquarters	R1ADJ	North Worcestershire Early Intervention Service (EIS)	B61 0BB
Trust Headquarters	R1ADJ	South Worcestershire Early Intervention Service (EIS)	WR1 2AE

Summary of findings

This report describes our judgement of the quality of care provided within this core service by Worcestershire Health and Care NHS Trust. Where relevant we provide detail of each location or area of service visited.

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

Where applicable, we have reported on each core service provided by Worcestershire Health and Care NHS Trust and these are brought together to inform our overall judgement of Worcestershire Health and Care NHS Trust.

Summary of findings

Ratings

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

Overall rating for Community-based mental health services for adults of working age	Requires Improvement 
Are Community-based mental health services for adults of working age safe?	**Requires Improvement** 
Are Community-based mental health services for adults of working age effective?	**Requires Improvement** 
Are Community-based mental health services for adults of working age caring?	**Good** 
Are Community-based mental health services for adults of working age responsive?	**Requires Improvement** 
Are Community-based mental health services for adults of working age well-led?	**Good** 

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

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

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

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

Summary of findings

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Summary of findings

Overall summary

We gave an overall rating for the community mental health teams for working age adults and early intervention services of **Requires Improvement** because:

- The staffing establishment in the Droitwich team was on the service's risk register due to the number of agency staff used. Several agency staff were due to leave and we were informed that the funding to recruit agency staff would cease April 2015. It was not clear what the plans for staffing following this period would be.
- The referral system variable across the teams. There was a large amount of inconsistency across teams in respect of waiting times for urgent and non-urgent referrals. There was a risk that people requiring timely access to the team may be missed because the referral system was not always working effectively.
- There was no clearly defined role of the 'duty worker'.
- There was a risk that information about people's care across the community teams could be missed. There were different electronic and paper based systems in use and staff within teams were not always working to the most up to date system. This had been identified as a trust and local level risk.
- In the Redditch team the medical staff and medical notes were not based within the same building.
- Training in the Mental Capacity Act 2005 (MCA) was not mandatory in the trust. Across the teams an overview of the completion of this training was not monitored for all staff.
- There were no agreed waiting times for urgent and non-urgent referrals across teams. This did not promote equity for people waiting to be allocated a named worker and commence the treatment process.
- There were long waiting lists and times for psychological interventions.

However, we found that:

Staff were compassionate and supportive and recognised people's individual needs.

There was strong leadership at a local level across all of the teams that addressed issues of culture within teams where this was identified.

Summary of findings

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

Are services safe?

Requires Improvement

We rated safe as **Requires Improvement** because:

- The lone working system for staff was not embedded across teams and there was a variance in how the panic alarm system was operating. This meant that if there was an incident other staff in the team would not be alerted to this or be able to offer effective support and assistance.
- The staffing establishment in the Droitwich team was on the service's risk register due to the number of agency staff used. Several agency staff were due to leave we were informed that the funding to recruit agency staff was due to cease in April 2015. It was not clear what the plans for staffing following this period would be.

Incident reporting and learning from incidents was apparent across teams.

Staff had been trained and knew how to make safeguarding alerts

Are services effective?

Requires Improvement

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

- The referral system variable across the teams. There was a large amount of inconsistency across teams in respect of waiting times for urgent and non-urgent referrals. There was a risk that people requiring timely access to the team may be missed because the referral system was not always working effectively.
- There was no clearly defined role of the 'duty worker'.
- There was a risk that information about people's care across the community teams could be missed. There were different electronic and paper based systems in use and staff within teams were not always working to the most up to date system. This had been identified as a trust and local level risk.
- In the Redditch team the medical staff and medical notes were not based within the same building. This had been identified as a risk in the service.
- There was no monitoring of staff trained in the Mental Capacity Act 2005 (MCA).

The early intervention lead for the trust led on a physical health project called SHAPE through joint working with the local university. The aim was to support young people experiencing a first early psychosis through a physical health and wellbeing intervention programme. There was internal recognition of good practice as staff had been involved in research published trials.

Summary of findings

The recovery model showed this had been filtered down into staff's clinical work. Assessments across the teams were multidisciplinary in approach.

Are services caring?

Good

We rated caring as **good** because:

- Staff were compassionate and supportive and recognised people's individual needs.
- People were involved in developing and reviewing their care plan and were encouraged to involve relatives and others if they wished to.
- People felt listened to and supported by staff.

Are services responsive to people's needs?

Requires Improvement

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

- There were no agreed waiting times for urgent and non-urgent referrals across teams. This did not promote equity for people waiting to be allocated a named worker and commence the treatment process.
- There were long waiting lists and times for psychological interventions.
- Pathways were used where appropriate to refer to the drug alcohol team who carry out assessments where needed. Some staff expressed difficulties in accessing specialist services across the county when needed.
- Staff said that urgent outpatient appointment waiting times would vary depending on which consultant people were allocated to. There had been a number of cancelled outpatient appointments since July 2014. We were told appointments were rebooked. For non-urgent appointment people using the service could experience a long waiting time between appointments.

Teams took a proactive approach to re-engaging with people who did not attend scheduled appointments which had been found to be higher than expected in some teams. Staff described the protocol to follow if people did not attend appointments. There were high levels of completion rates across teams for equality and diversity training. This formed part of the trust's mandatory programme of training.

Are services well-led?

Good

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

Summary of findings

- There was strong leadership at a local level across all of the teams that addressed issues of culture within teams where this was identified.
- We saw a number of changes had taken place since 2014. Regular meetings were now taking place between the lead for community mental health services and team managers. This allowed for practice across teams to become more aligned. Furthermore it enabled sharing of good practice and improved ways of working.
- Staff across teams said they felt well supported by management and enjoyed working in the trust.

Summary of findings

Background to the service

Community mental health services are delivered through integrated health and social care teams are provided by Worcestershire Health and Care NHS Trust.

Worcestershire Health and Care NHS Trust has seven community mental teams (CMHT) and two early intervention services (EIS). We inspected six of the seven CMHTs and the two EIS teams.

Our inspection team

Our Inspection team was led by:

Chair: Dr Ros Tolcher, Chief Executive Harrogate and District NHS Foundation Trust.

Team Leader: Pauline Carpenter, Head of Hospital Inspection, Care Quality Commission.

The team that inspected the community teams included two inspectors, nurses, an occupational therapist, a mental health act reviewer (MHAR) and an expert by experience.

Why we carried out this inspection

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

How we carried out this inspection

To get to the heart of 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 and asked a range of other organisations for information to share what they knew.

During the inspection visit, the inspection team:

- Visited six of the community mental health teams and the two early intervention teams in the County.
- Spoke with people who were using the service.
- Spoke with the managers or acting managers for each of the services.
- Spoke with other staff members; including doctors, nurses, occupational therapists and social workers.
- Interviewed the community lead who held responsibility for these services.
- Attended and observed multi-disciplinary meetings and a discharge meeting.

We also:

- Looked at care records for people.
- Carried out checks of the medication management.
- Looked at a range of policies, procedures and other documents relating to the running of the service.

What people who use the provider's services say

People we spoke with were positive about the support they received from staff and access to doctors. Most described being involved in developing their care plans

Summary of findings

and people were encouraged to involve relatives or others in their care if they wished to. Some patients told us they had been given copies of their care plans. They described having time to talk with staff and felt listened to.

Good practice

Staff were aware of the importance of working to the recovery model in mental health. Staff demonstrated this through their commitment to ensuring people received robust care by being proactive and committed to people using the service despite the challenges they faced.

The early intervention lead for the trust led on a physical health project SHAPE through joint working with a local university. The aim was to support young people experiencing a first early psychosis through a physical health and wellbeing intervention programme. There was internal recognition of good practice as staff had been involved in research published trials.

In the Wyre Forest team a pilot initiative was identified to reduce referrals from GP to secondary services. A CPN was located in GP surgery to assess and screen all referrals. They were involved in counselling people or referring people on to primary care to receive cognitive behavioural therapy. This had proved to be successful with a reported reduction of referrals from 19% to 10% over a two year period. This had been supported by the clinical commissioning group (CCG) and GPs.

Staff told us that early intervention teams had been successful in discharging 70% of people on their books back to primary care.

Staff and people we spoke with found the re-ablement worker post to be invaluable as this role signposted to the appropriate services in the community.

Areas for improvement

Action the provider MUST or SHOULD take to improve

Action the provider SHOULD take to improve

- The trust should ensure that access to psychological interventions are improved.
- Waiting times for referrals should be monitored and addressed.
- The service should ensure that the lone working policy and use of panic alarms are embedded across the service.
- The trust should ensure there are clear plans for staffing within the Droitwich team as it was not clear what the plans were for staffing following April 2015.
- The trust should clarify the role and responsibilities of the duty worker.
- The trust should ensure the system for referrals are improved across the service.
- The trust should monitor the training that both substantive and agency staff are in relation to the MCA.
- The trust should review the current IT and paper records system.
- The trust should look at ways of improving access to medical records and clinical records in the Redditch team.
- The trust should improve communication with staff on the rationale and potential impact of changes across the services.

Action the provider COULD take to improve

Worcestershire Health and Care NHS Trust

Community-based mental health services for adults of working age

Detailed findings

Locations inspected

Name of service (e.g. ward/unit/team)	Name of CQC registered location
Redditch (Community Mental Health Team) CMHT	Worcestershire Health and Care NHS Trust
Bromsgrove CMHT	Worcestershire Health and Care NHS Trust
Wychavon CMHT	Worcestershire Health and Care NHS Trust
Droitwich CMHT	Worcestershire Health and Care NHS Trust
Wyre Forest CMHT	Worcestershire Health and Care NHS Trust
Worcester CMHT	Worcestershire Health and Care NHS Trust
North Worcestershire Early Intervention Service (EIS)	Worcestershire Health and Care NHS Trust
South Worcestershire Early Intervention Service (EIS)	Worcestershire Health and Care NHS Trust

Mental Health Act responsibilities

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

Staff were trained in and had a good understanding of the MHA, the Code of Practice and the guiding principles.

The use of the MHA was mostly good across the teams. We reviewed documentation for people who were under a community treatment order (CTO). Records were generally compliant with the MHA and the Code of Practice. The

relevant assessments were reviewed and updated on time and documented that people were informed of their rights under the MHA. Capacity to consent to treatment forms were completed.

Mental Capacity Act and Deprivation of Liberty Safeguards

Training in the Mental Capacity Act 2005 (MCA) is not mandatory in the trust. Across the teams an overview of the completion of the training was not monitored for all staff. Some staff told us they had received training in the use of the MCA. Additionally it was not clear whether agency staff had received MCA training as records for completion of this training was not kept.

However staff we spoke with demonstrated good knowledge on the application the legislation appropriately when a person was deemed to lack the capacity to make a specific decision. We saw examples across the teams and had discussions with staff about complex scenarios when a person has fluctuating capacity. MCA assessments were discussed in multi-disciplinary meetings as a team.

Requires improvement

Are services safe?

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

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

Summary of findings

We rated safe as **Requires Improvement** because:

- The lone working system for staff was not embedded across teams and there was a variance in how the panic alarm system was operating. This meant that if there was an incident other staff in the team would not be alerted to this or be able to offer effective support and assistance.
- The staffing establishment in the Droitwich team was on the service's risk register due to the number of agency staff used. Several agency staff were due to leave we were informed that the funding to recruit agency staff was due to cease in April 2015. It was not clear what the plans for staffing following this period would be.

Incident reporting and learning from incidents was apparent across teams. Staff had been trained and knew how to make safeguarding alerts.

Our findings

Teams visited: Redditch CMHT, Bromsgrove CMHT, Worcester CMHT, Wychavon CMHT, Droitwich CMHT, Wyre Forest CMHT, Worcestershire Early Intervention Service (EIS) – North and Worcestershire EIS - South.

Safe environment

- The majority of clinic rooms were well equipped with the appropriate facilities. People were offered a choice on whether they wished to be treated at home or at the centre. If they choose to receive their injections at the centre, this was care planned for each individual.
- An audit had been completed for the Redditch team and a number of issues had been identified in the environment. The team manager proposed placing the state of the building on the risk register. For example, staff on the reception desk were left exposed and vulnerable in the event of an incident. Measures had been discussed including the option to move to new premises.
- The lone working system for staff worked well in some teams but was not embedded across all of the teams. The system had been implemented in various forms which meant it was not always working effectively. In one team staff were not checking in with each other following visits to people in the community. We were given examples where staff had been in compromising situations, which meant that if there was an incident other staff in the team would not be alerted to this or be able to offer effective support or take steps to ensure staff safety in a timely manner.
- There was a variance in how the panic alarm system was operating across the teams. Panic alarms were available in most of the meeting rooms. However in some teams, for example where rooms were being used for meeting with people, these were not fitted with panic alarms and staff were not routinely wearing personal alarms. This increased the risk that if an incident occurred staff within the building would not be alerted and therefore be able to respond in a timely manner.
- Staff regularly checked the emergency resuscitation equipment and it was kept in a place where it was readily accessible.

Safe staffing

- A consultation was underway for the service redesign of CMHTs therefore a few outstanding vacancies across teams had been 'frozen'. We were told that there would be no vacancies but that existing caseloads would be managed by existing staff.
- High levels of staff vacancy in the team resulted in a significant use of agency staff to maintain standards of quality and safety for people using the service. The team had been struggling to recruit staff to the team. To preserve the continuity of care for people using the service, long term agency staff that were familiar to the service had been used and some staff from the Wyre Forest team had taken on a caseload of people from Droitwich. There were outstanding vacancies and staff who were due to leave the team shortly. At the time of the inspection we were told that the funding to recruit

Requires improvement

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agency staff was due to run out in April 2015 and it was not clear what the plans for staffing would be following this period. Subsequently we were told plans are in place for reconfiguration of community teams.

- One Droitwich consultant raised concerns about their high caseload and not having sufficient resource to manage the caseload effectively. We wrote to the trust to request how this high caseload was being managed. We were informed that two of the consultants in across different teams had inherited very high caseloads and that these had been significantly reduced during their time in post. We were informed that management in the trust, including the clinical director and associate medical director were aware of the pressures in the Evesham locality and were providing support to the consultant and staff grade doctor to manage local expectations. However they felt the medical configuration was considered to be adequate. The amount of consultant cover had been increased last year to full-time cover to help deal with case management issues. We were told these issues were being addressed within the service delivery unit (SDU). Medical staffing was not on the service delivery unit risk register but staffing in general was on the SDU risk register.
- If staff were off on long-term sick or there were ad hoc levels of sickness absence, temporary or bank staff were used to cover the shortfall. Where possible team managers attempted to contact staff familiar to the service where possible.

Assessing and managing risk to patients and staff

- The majority of staff had received training in safeguarding adults and children. Staff we spoke with knew who to inform if they had safeguarding concerns. They had a good understanding of the trust's safeguarding protocols and procedures. There was a safeguarding lead within each of the teams. Information about contacts for local safeguarding departments within the local authority were on display so that people could access them. Staff of across teams and of all levels provided examples of safeguarding referrals that had been made.
- Safeguarding discussions with staff also took place during supervision, to ensure staff had sufficient awareness and understanding of safeguarding procedures.
- We looked at the medicines management systems. Medicines were stored safely in locked clinic rooms. In the Bromsgrove team we found 19 depot injection cards to be out of date during our visit. The doctor had not recorded that they had reviewed these and it was not updated on the prescription card that the medication had been administered. This was raised with staff. Following the visit we were informed that this had been actioned and the medication cards had been updated to demonstrate that the medication had been administered. Following the Wyre Forest internal peer-review inspection in May 2014, it was found that medication clinics lacked an overall clinic lead with overarching responsibility for the day to day operation of medicines management. Actions were put in place to address this by a specified date.
- Staff could access pharmacy support in the trust when required.

Track record on safety

- Internal investigations would automatically follow an unexpected death in the community. This was to inform and improve learning around the incident. In one team, following an unexpected death, learning points had been identified to improve processes around staff communication when people using the service missed appointments.
- We asked whether incidents were reported within the trust's reporting timeframe of 48 hours. We saw the incident log for all adult community and early intervention teams since January 2014. Incident reporting was 69% for adult teams and 66% for the early intervention teams. The trust target was for 90%of all incidents to be reported within 48 hours. During a quality meeting in June 2014 results from a survey distributed to staff discussed delays in reporting and recommendations were made to address the main issues. For example team managers were expected to discuss incident reporting in team meetings and supervision. This was now happening across teams.

Reporting incidents and learning from when things go wrong

Requires improvement

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- All staff in the team were expected to take responsibility for reporting incidents. The community lead said the incident reporting had increased since the introduction of the electronic reporting system Ulysees.
- The community lead maintained an overview of all incidents. Incidents were discussed in team meetings and were a standard item for discussion at team meetings. The reporting system ensured all staff received feedback from an incident they had reported.
- In the early intervention teams incidents were discussed in weekly clinical team meetings and in monthly business meetings.

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

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

- The referral system was working variable across the teams in line with the three CCGs within Worcester. There was a large amount of inconsistency across teams in respect of waiting times for urgent and non-urgent referrals. There was a risk that people requiring timely access to the team may be missed because the referral system was not always working effectively.
- There was no clearly defined role of the 'duty worker'.
- There was a risk that information about people's care across the community teams could be missed. There were different electronic and paper based systems in use and staff within teams were not always working to the most up to date system. This had been identified as a trust and local level risk.
- In the Redditch team the medical staff and medical notes were not based within the same building. This had been identified as a risk in the service.
- There was no monitoring of staff trained in the Mental Capacity Act 2005 (MCA).

Our findings

Teams visited: Redditch CMHT, Bromsgrove CMHT, Worcester CMHT, Wychavon CMHT, Droitwich CMHT, Wyre Forest CMHT, Worcestershire Early Intervention Service (EIS) – North and Worcestershire EIS - South.

Assessment of needs and planning of care

- The referral system was working variably across the teams. There was a large amount of inconsistency across teams in respect of waiting times for urgent and non-urgent referrals. People accessing the team in a timely manner would depend on what team they were allocated to.
- For the teams in the South Worcestershire area referrals were triaged through the single point of access (SPA) system and forwarded onto the team. If there were gaps in information referrals the SPA staff acted as the gatekeeper and followed up the information. Staff felt the quality of referrals were higher and ensured a smoother transition process for people being referred onto the teams than if referrals were being received direct into the teams to triage.
- Where teams did not work to a single point of access system, referrals were triaged by a 'duty' member staff who ensured that people's needs were established through an initial meeting and assessment process. Urgent referrals were identified and prioritised for assessment.
- Staff we spoke with described the inefficiencies of not having a gatekeeper for referrals in teams that did not operate on the SPA model. It was discussed that referrals may be less detailed and the overall system of processing referrals coming direct to the team from a number of sources led to a system that was less robust that the SPA model.
- In the Redditch team there had been a recent incident involving a missed referral and on another occasion the referral was not missed but appointments were not offered in a timely manner. This meant there was a risk that some people who required timely access to the team may be missed because the system did not always work adequately.
- The community lead said there were plans to look at bringing in the SPA model to the teams that were not already using this system. The referral system was being looked at county wide.
- The role of the duty worker was not widely understood. There were plans to audit the duty worker's role in order to understand the demands. However there was no plan attached to when this would be completed. To promote clarity for this role meant it would reduce the risk of inconsistent decision making and support staff to perform consistently across the teams in respect of the decisions about referrals being made.
- In one team we were told by a staff member that the 'duty' meetings were not minuted and there was no record of the decisions made about the duty system. They said that no one manager had oversight of the system or responsibility for its smooth running.
- Staff from individual teams had been working directly with GP surgeries to improve the type and quality of referrals received. The community lead felt this was

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slowly becoming embedded. In Redditch and Bromsgrove we were told there had been resistance from the local CCG to support the system of making electronic referrals.

- There were different electronic and paper based systems in use and staff within teams were not always working to the most up to date system. There was a risk that information about a people's care could be missed. There was no systematic way of sharing information across teams and outside of teams. There was a risk of information about people's care not being shared in a timely manner particularly outside of office hours. This had been identified as a trust and local level risk.
- In the Redditch team the medical staff and medical notes were not based within the same building. The medical and clinical notes were therefore kept separately. Reported delays took place if other staff within the team required access to the medical notes.
- There was a risk that if a person had a medical appointment off site and then came into the team the next day staff may not be informed of changes in the person's care. Staff gave us examples where they knew that work had been carried out but that this had not been updated in the medical records. This had been identified as a risk in the service and actions were being taken to move the medical records onsite. Actions had been taken to improve the interface in the interim period. However there was no timeframe for when this work will be complete.
- Some teams had developed a workaround to proactively address the issues of sharing information with relevant parties and ensuring that different members of the MDT had access to the relevant.
- In the Droitwich team issues were raised about the computers not working and difficulties with the wireless connection. These issues had been acted on but remained a concern.
- We reviewed a sample of care records across teams. Overall the care records were personalised and holistic. Most were recovery and included discharge plans with the exception of one. Risks had been identified and there were clear risk management plans in place. Specialist input was obtained where required and documented. We were told for example that staff in the early intervention teams, responsible for completing risk assessments, was trained in STORM.

Best practice in treatment and care

- The community and early intervention teams used a number of measures to monitor the effectiveness of the services provided. They conducted a range of audits on a regular basis. In one example a clinical audit report from October 2014 based on data from July 2014 looked at 10 sets of patient records from across services including all of the CMHTs and EI services. Areas of good practice and areas for improvements were highlighted. One area for improvement identified that all patient records are to contain a risk assessment. Actions were drawn up to demonstrate how this was going to happen, by when and an allocated staff member was allocated to deliver this.
- The staff assessed patients using the Health of the Nation Outcome Scales (HoNOS). These covered 12 health and social domains and enabled the clinicians to build up a picture over time of their patients' responses to interventions. This was used to inform that the right clustering of people were coming into the team. There was still some work underway to ensure that people were discharged back to primary care if they were on a lower clustering.
- The recovery model showed this had been filtered down into staff's clinical work. There were clear examples of positive risk taking in care records. Good crisis care plans which included what family should do, information they needed to know to ensure safety and out of hours support. It showed people's involvement in care plans and goal attainment.
- The early intervention lead for the trust led on a physical health project called Supporting Health and Promoting Exercise (SHAPE) through joint working with the local university. The aim was to support young people experiencing a first early psychosis through a physical health and wellbeing intervention programme. There was internal recognition of good practice as staff had been involved in research published trials. People using the service were offered a SHAPE referral and this covered for example, smoke cessation and the development of a health passport.
- Regular physical health checks were completed and this was confirmed by staff and people we spoke with and in the care records we looked at. We saw physical health

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audit results for one early intervention team. 37 entries were looked at and all were within the British National Formulary (BNF) limits. Most annual physical health checks had also been recorded as complete.

Skilled staff to deliver care

- Staff working across the teams were from a range of professional backgrounds including, social work, nursing, psychology and medical. Nursing student placements were supported across the teams. In the Worcester team specialisms had been developed within roles. For examples there was a CAMHS transition worker and a worker who had a caseload of people with forensic placements only. There was a high risk and forensic specialist nurse in the trust that could be contacted for support and advice on forensic areas. The CAMHS transition worker attended meetings in the community to promote continuity for people who were transitioning from CAMHS to an adult team.
- Substantive staff received appropriate training, supervision and professional development. Staff told us they had undertaken training relevant to their role including infection control, moving and handling and information governance. Records showed that most staff were up-to-date with statutory and mandatory training.
- Staff received training essential to their role. We were told that staff in the early intervention teams were trained in the duration of untreated psychosis (DUP). Nurse prescribers completed their training at Worcester University.
- New staff received an induction before being included in the staff numbers. We spoke with an agency social worker who had been in post since last 2014. There were supported with an induction in house and had spent time with the SPA team to support their induction.
- Most staff told us they received monthly supervision where they were able to reflect on their practice and discuss cases. We saw from electronic records that performance, continual professional development and the diagnosis of people using the service was also discussed.
- We were given examples of where staff that had performed poorly were managed out of the organisation in line with human resource procedures.
- Induction and mandatory training for agency staff were not recorded on electronic staff records. Many of the teams we visited did not have an overview of what training staff had completed and when they last completed it. In addition long term agency staff were not offered appraisals or receive regular supervision. This meant there were not suitable arrangements in place to ensure agency staff were appropriately supported in their responsibilities to deliver care to people safely.

Multi-disciplinary and inter-agency team work

- Assessments across the teams were multidisciplinary in approach. Discussions which took place in multi-disciplinary MDT meetings showed that there was effective MDT working taking place. Care records included advice and input from different professionals. People we spoke with confirmed they were supported by a number of different professionals in the teams. There was strong access to family therapy within the early intervention teams
- There were regular team meetings and most staff felt well supported by their manager and colleagues on the ward. Many staff mentioned multi-disciplinary working as one of he positive features about their teams. One community psychiatric nurse who was new in post in Worcester described their experiences of being new to the team. They felt staff had been welcoming and had allowed them to settle in in a paced way. They had received an induction, mandatory training and 1:1 support from staff. They felt their ideas were listened to: one example being the service had brought in plans for lone working.
- We observed meetings held to discuss complex patients, referral meetings, and multi-disciplinary meetings and found these were effective in sharing information about people and reviewing their progress. Safeguarding concerns or physical health issues were also discussed. Different professionals worked together effectively to assess and plan people's care and treatment. Specialist input was obtained outside of the teams when required. For example in Redditch for people with alcohol issues the drug and alcohol team were accessed.

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.

- Staff attended inter-agency meetings. For example staff attended meetings on inpatient wards as part of patients admitted pathway to the team and discharge planning.
- In Worcester team the CAMHS transition worker worked with 16 – 18 years olds who were not in full time education. Joint assessments were carried out with staff from CAMHS so that at the age of 17 ½ years of age the transition to the adult community teams were smooth.
- Staff reported that the relationships with GP surgeries varied across the teams. They felt this was an issue leading to inappropriate referrals to the teams.
- The early intervention teams work closely with crisis and the home treatment team. They carried out joint visits together if needed. There was also cross working with the adult community teams which usually took six months in advance to ensure a smooth transition.

Adherence to the MHA and the MHA Code of Practice

- Staff were trained in and had a good understanding of the MHA, the Code of Practice and the guiding principles.
- The use of the MHA was mostly good across the teams. We reviewed documentation for people who were under a community treatment order (CTO). Records were generally compliant with the MHA and the Code of Practice. The relevant assessments were reviewed and updated on time with clear documentation that people were informed of their rights under the MHA. Capacity to consent to treatment forms were completed.

Good practice in applying the MCA

- Training in the Mental Capacity Act 2005 (MCA) is not mandatory in the trust. Across the teams an overview of the completion of the training was not monitored for all staff. Some staff told us they had received training in the use of the MCA. Additionally it was not clear whether agency staff had received MCA training as records for completion of this training was not kept.
- However staff we spoke with demonstrated good knowledge on the application the legislation appropriately when a person was deemed to lack the capacity to make a specific decision. We saw examples across the teams and had discussions with staff about complex scenarios when a person has fluctuating capacity. MCA assessments were discussed in multi-disciplinary meetings as a team.
- There was a contact in the trust for advice on the MCA and staff we spoke with discussed who this was.

Good

Are services caring?

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

Summary of findings

We rated caring as **good** because:

Staff were compassionate and supportive and recognised people's individual needs. People were involved in developing and reviewing their care plan and were encouraged to involve relatives and others if they wished to. People felt listened to and supported by staff.

Our findings

Teams visited: Redditch CMHT, Bromsgrove CMHT, Worcester CMHT, Wychavon CMHT, Droitwich CMHT, Wyre Forest CMHT, Worcestershire Early Intervention Service (EIS) – North and Worcestershire EIS – South.

Kindness, dignity, respect and compassion

- Staff we spoke with showed they knew people who use services well. They demonstrated compassion and genuine feeling about the people they supported. We saw examples of extra support being offered to people who were becoming very unwell.
- When staff spoke to us about people, they showed a good understanding of their individual needs. We observed MDT meetings and found that across teams staff reflected the wishes / views of the people they were discussing. This was supported from feedback we received from people.
- We observed a discharge meeting in the community with a person who was accompanied by their CPN. Interaction between staff and patients was positive, therapeutic and encouraging. Patients discussed how great his care had been. In another team one person who was not yet on the team's caseload was awaiting an outpatient clinic appointment were given the number for the team to ring for advice whilst they were waiting for their appointment.

The involvement of people in the care they receive

- People we spoke with were positive about the support they received from staff and access to doctors. Most described being involved in developing their care plans and people were encouraged to involve relatives or others in their care if they wished to. Some told us they had been given copies of their care plans. They described having time to talk with staff and felt listened to. They discussed physical health checks they had received and some told us they were given choice and information around their medication. They described activities that had been organised in the community and individual activities that had been beneficial for them, such as gym sessions. Some told us of the support they received around housing, benefits and employment. One person said that at the end of the session the CPN hands over their notes to the person to comment on the accuracy and whether they agree/ disagree and will make changes if necessary.
- Some people discussed having access to the outside of hours crisis team for support. However one person felt that if they were in a crisis and required support their family would deal with this. They felt their care had been based around their medication rather than a holistic view of their needs.
- We found a good example of care delivery. One staff member discussed a person who had a history of not attending their appointments. A recovery care plan was developed to address their non-attendance and self-harm. As there was no DBT being offered, the CPN assessed the person with a DBT trained therapist who was able to assist with coping strategies when it came to engagement with education. The care plan was written in the person's voice with direct quotes from the person on their likes and dislikes and what made them frustrated.

Are services responsive to people's needs?

Requires Improvement

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

Summary of findings

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

- There were no agreed waiting times for urgent and non-urgent referrals in Redditch and Bromsgrove. Waiting times were agreed and in place in South Worcestershire and Wyre Forrest. This did not promote equity for people waiting to be allocated a named worker and commence the treatment process.
- There were long waiting lists and times for psychological interventions.
- Pathways were used where appropriate to refer to the drug alcohol team who carry out assessments where needed. Some staff expressed difficulties in accessing specialist services across the county when needed.
- Staff said that urgent outpatient appointment waiting times would vary depending on which consultant people were allocated to. There had been a number of cancelled outpatient appointments since July 2014. We were told appointments were rebooked. For non-urgent appointment people using the service could experience a long waiting time between appointments.

Teams took a proactive approach to re-engaging with people who did not attend scheduled appointments which had been found to be higher than expected in some teams. Staff described the protocol to follow if people did not attend appointments. There were high levels of completion rates across teams for equality and diversity training. This formed part of the trust's mandatory programme of training.

Our findings

Teams visited: Redditch CMHT, Bromsgrove CMHT, Worcester CMHT, Wychavon CMHT, Droitwich CMHT, Wyre Forest CMHT, Worcestershire Early Intervention Service (EIS) – North and Worcestershire EIS – South.

Access, discharge and transfer

- There were no agreed waiting times for urgent and non-urgent referrals across teams. This did not promote equity for people waiting to be allocated a named worker and commence the treatment process. It was confirmed by the community lead and managers across the team that waiting times were not being monitored to ensure that people were seen with a timely manner.
- Waiting lists and times for psychological interventions were long across the adult community teams. At the time of the inspection there were 139 people on the waiting list. For example, in the Redditch, Malvern, Worcester and Wyre Forest teams' staff said waiting times for psychological interventions were in excess of 12 months. In Wychavon we were told the waiting times to psychology ranged from 9 - 12 months and this was due to in part to the psychologist being away on maternity leave. There were was no local psychology service that the team could tap into and in most teams there were no groups for people running. Staff could signpost to other services such as a counselling service.
- People with complex needs who had been identified as requiring psychological treatment, for example, dialectical behaviour therapy (DBT), were not able to formally access this talking therapy as waiting lists for DBT across teams had been closed. By not offering people psychological interventions in a timely way, there was a risk that the planning and delivery of care was not meeting the people's individual needs and ensuring their welfare and safety.
- Interim measures had been sought to provide people with a basic level of psychology support. We were told that staff trained in DBT skills would use these skills to work with people on a day to day basis. Staff were also working to reduce lists by referring people back to Improving access to psychological therapies (IAPT) through primary care where appropriate.
- We spoke to lead psychologist who informed us that a team of staff across the trust had been trained in DBT. The plan was for this team of staff to deliver DBT to people. A draft policy had been developed to ensure that staff trained up to deliver psychological treatment were given ring fenced time to carry this out before waiting lists could be opened again. However policy had not been ratified at the time of the inspection.
- Staff told us that early intervention teams had been successful in discharging 70% of people back to primary care. Staff had the time and resource to carry out carry

Are services responsive to people's needs?

Requires Improvement

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

out effective work with people to ensure they got better. There were reported considerable reductions of discharges of patients on caseload across teams. In Wychavon staff were supporting or providing advice to people who were not currently on their books to ensure people could access timely support.

- People were signposted to groups in the community. We spoke to a re-ablement worker in trust who was responsible for finding links in the community to sign post people to groups, courses that were running and form employment links. Staff and people we spoke with found this role to be invaluable.
- Pathways were used where appropriate to refer to the drug alcohol team who carry out assessments where needed. Some staff expressed difficulties in accessing specialist services across the county. Some examples given were links for dual diagnosis. It was also raised by staff that there were no specialist services for personality disorders, deliberate self-harm and eating disorders.
- Teams took a proactive approach to re-engaging with people who did not attend scheduled appointments which had been found to be higher than expected in some teams. Staff described the protocol to follow if people did not attend appointments.
- Staff said that if urgent, outpatient appointment waiting times would vary depending on which consultant people were allocated to. Some of the urgent outpatient appointments were described as being at the discretion of the consultant so there was a reliance on the good will of the consultant rather than embedded waiting time targets to ensure urgent referrals were seen within a timely manner.
- Outpatient clinics in the Worcester team had been cancelled in the week of the inspection due to a locum consultant leaving the service.
- We requested information on outpatient clinics cancelled by the trust from 1 July 2014 – 31 December 2014 as there had been a period of difficulty in gaining consultant cover. 17 patients had two appointments cancelled over this period and one person had four of 10 appointments cancelled in this period. In total 37 of 87 appointments were cancelled by the service during this period. We were told appointments were rebooked. For non-urgent appointment people using the service could experience a long waiting time between appointments.

The facilities promote recovery, dignity and confidentiality

- Across the teams interview rooms had adequate sound proofing. However rooms within the Redditch team had inadequate sound proofing and people's conversations with could be overheard. This had been identified in action plan for service back in 2014. Staff sometimes played low level music in order to get around this. It was not clear what the long term plan was for the building.
- All teams had access to meeting rooms where people could meet with staff in private. Most rooms were well-maintained and appropriately furnished.
- There was sufficient provision of accessible information on treatments, local services and people's rights on how to complain in the reception areas in all of the teams visited. In one team staff said they were could get information leaflets in different languages or have these translated.

Meeting the needs of all people who use the service

- There were high levels of completion rates across teams for equality and diversity training. This formed part of the trust's mandatory programme of training.
- We saw that staff put their equality and diversity training into practice. Staff discussed with us the different communities they served and where it was challenging to engage certain groups at times. Staff worked with people from a range of backgrounds, including the travelling community and Asian and Polish communities. Staff linked into a group in community to access support for individuals if required.
- Interpreters were available to staff and were used to help assess people's needs and explain their rights, as well as their care and treatment. Access to sign language services was advertised. In one of the early intervention teams we saw information on the service, illness and psychosis available in different languages e.g. Urdu, Bengali and Punjabi.

Are services responsive to people's needs?

Requires Improvement

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

- The early intervention teams said they would accommodate people's preferences for male / female workers.
- People also had access to a local independent advocacy service and information about this service and we saw staff discussed access to advocacy in MDT meetings we observed.
- Only people identified as requiring crisis support outside of office hours were assessed and referred onto the crisis team. Others were reliant on out of hour's GP support in a mental health crisis or whatever else was contracted in the area. This meant that there was a risk that a person or someone with a cognitive impairment may not have access to support for their mental health needs out of regular office hours.

Listening to and learning from concerns and complaints

- Most people we spoke with knew how to raise concerns and how to make a complaint. Most felt they would be able to raise a concern should they have one and believed that staff would listen to them. We saw PALS leaflets on how to raise a complaint in the reception areas of teams.
- Staff said that learning from complaints was discussed within team / quality meetings. For example, in one team there had been a number of complaints about medical staffing and people having to see different consultants in the service. As a result strategies were employed to mitigate the lack of consistency for people using the service by working with locums to stay for a longer period of time whilst they recruited consultant vacancies. Or if people wanted a change of a CPN in one team they described how this was supported and if issues were about a staff member this would be fed back to them to learn from lessons.

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

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

There was strong leadership at a local level across all of the teams that addressed issues of culture within teams where this was identified. We saw a number of changes had taken place since 2014. Regular meetings were now taking place between the lead for community mental health services and team managers. This allowed for practice across teams to become more aligned. Furthermore it enabled sharing of good practice and improved ways of working. Staff across teams said they felt well supported by management and enjoyed working in the trust.

Our findings

Teams visited: Redditch CMHT, Bromsgrove CMHT, Worcester CMHT, Wychavon CMHT, Droitwich CMHT, Wyre Forest CMHT, Worcestershire Early Intervention Service (EIS) – North and Worcestershire EIS – South.

Vision and values

- Staff were aware of the importance of working to the recovery model in mental health. Staff demonstrated this through their commitment to ensuring people received robust care by being proactive and committed to people using the service, despite the challenges they faced at times with limited access to psychology in the trust or access to specialist services.
- Overall, staff were aware that community teams were currently under consultation and changes were pending depending on the outcome of the service redesign and reconfiguration of geographical locations. There were savings to be made. Some posts had been frozen and there were no plans to recruit to these posts. However not all staff understood the rational of the current and prospective changes and the impact this may have on teams. Additionally given the prospective changes this had impacted on stalling changes within the service, such as the building work in the Redditch team and not knowing what would happen when the agency staffing funding ran out in the Evesham locality after April 2015.
- Some of the consultants we spoke with felt that the vision from the trust did not always match the resources available. They felt they were supported by the medical and clinical director. They reported feeling listened to by manager at trust level but did not feel their concerns would necessarily be actioned on. They felt the pending changes were being communicated but not the rationale being the change taking place. Other staff from the MDT we spoke with said it was sometimes hard to keep up with the changes and the impact of these changes in the trust.

Good governance

- There were strong quality assurance layers in place to ensure learning from serious incidents and complaints were shared. We told that team manager's peer-reviewed each other's incidents and checked that action plans had been met.
- All adult community teams had received internal comprehensive peer-reviews in 2014. Staff were aware of the issues and had clear plans in place to address these. There was a generative culture within most of the teams and overall staff had embraced the changes.
- We saw a number of changes had taken place since 2014. Regular meetings were now taking place between the lead for community and team managers. This allowed for practise across teams to become more aligned. Furthermore this enabled sharing of good practice and improved ways of working.

Leadership, morale and staff engagement

- There was strong leadership at a local level across all of the teams to lead on the required changes and address issues of culture within teams where this was identified. There was evidence of clear leadership at a local level.
- While there were a few areas identified for improvement, the teams had access to systems of governance that enabled them to monitor and manage identified issues in the service. However there were a number of systems that were not yet embedded.
- The community lead said they felt much supported by middle management. They said there were clear processes around the consultation which HR have been heavily involved in.
- Staff across teams said they felt well supported by management and enjoyed working in the trust.

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.

- Staff were aware of the whistleblowing process if they needed to use it. There were 'Speak out Safely' posters on display in reception areas. This was part of a trust initiative for staff to raise concerns about patient safety concerns within the trust at the earliest opportunity.
- There were good opportunities for staff development. We came across examples where nurse prescribers had been funded by Trust to undertake a university course, people who had used services in the past had been promoted in teams to a band 4 level and the medical director / consultant in one team was on a leadership programme. One team manager told about how the trust invested in skills based training for staff and described dialectic and suicide awareness as part of the training staff had attended.

Commitment to quality improvement and innovation

- There were a number of changes that had already taken place to streamline services across all of the teams. There were a number of draft policies in place which were not yet operational. However we were told that staff had had the opportunity to feed into the policies and these were amended to reflect feedback. Staff gave us examples of where their ideas had been taken on board.
- In the Wyre Forest team a pilot initiative was identified to reduce referrals from GP to secondary services. A CPN was located in GP surgery to see assess and screen all referrals going out. Additionally they were involved in counselling people or referring people on to primary care to receive cognitive behavioural therapy. This had proved to be successful with a reported reduction of referrals from 19 down to 10 per cent over nearly a two year period. This had been supported by the CCG and GPs.
- Staff were not routinely capturing feedback across services which would allow performance to be compared across other teams and alert the individual teams of the themes that indicate what is working well and what requires improvement. A draft policy had been drafted to for service user feedback have been drafted but was not yet operational. Given the teams were operating differently across the patch this would enable teams to be more streamlined in their way of working. Understanding the needs and views of people using the service to ensure high quality care is delivered.