

**Good** 
**Bradford District Care Trust**

# Adult community-based services

## Quality Report

BDCT Headquarters  
New Mill  
Victoria Road  
Saltaire  
Shipley  
West Yorkshire  
BD18 3LD  
Tel: 01274 228300  
Website: [www.bdct.nhs.uk](http://www.bdct.nhs.uk)

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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)
BDCT Headquarters, New Mill	TADHQ	Early intervention services (psychosis) Community mental health	BD7 1LG
BDCT Headquarters, New Mill	TADHQ	AireWharfe community mental health centre Community mental health team	BD21 4AD
BDCT Headquarters, New Mill	TADHQ	Assertive outreach team Horton Park Medical Centre	BD7 3EG
BDCT Headquarters, New Mill	TADHQ	South and west community mental health Community mental health team	BD7 1LG

# Summary of findings

BDCT Headquarters, New Mill	TADHQ	The Craven Centre Community mental health team	BD23 2RJ
BDCT Headquarters, New Mill	TADHQ	Somerset House Community mental health team	BD18 3BP

This report describes our judgement of the quality of care provided within this core service by Bradford District Care 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 Bradford District Care Trust and these are brought together to inform our overall judgement of Bradford District Care 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 Adult community mental health services

Good 

Are Adult community mental health services safe?

Good 

Are Adult community mental health services effective?

Good 

Are Adult community mental health services caring?

Good 

Are Adult community mental health services responsive?

Good 

Are Adult community mental health 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

Bradford District Care Trust provides a range of adult community-based mental health services, including the assertive outreach team, community mental health teams and the early intervention service.

Adult community-based services were safe. Staff received appropriate training and they understood safeguarding procedures. Risk was managed effectively and communicated promptly on a daily basis. Although the number of community caseloads had increased overall, good line management and effective caseload management systems meant that they were well managed.

People's care and treatment was planned and delivered effectively. Care was recovery-focused and people were supported to achieve positive outcomes. Assessments of people's needs were thorough, and person-centred care plans were developed in partnership with people who used the service. Staff were supported well by their team managers and there was a good mix of professional backgrounds and skills in the teams. Multidisciplinary working was embedded across community services and information about people was shared appropriately. Staff received regular training and supervision.

Staff delivered care and support with kindness and compassion, and treated people with dignity and respect.

People felt listened to and involved in decisions about their care, and their cultural needs were included in their care plans. People were also able to influence how the service was managed and developed.

Adult community-based services were responsive. The trust's follow-up of people after discharge had improved since last year, and people were being provided with the right care at the right time. In addition, we did not find any issues with appointments or waiting times. Services were planned and delivered in a way that took account of the different needs of local communities. The relevant community teams were involved before people were admitted to hospital, during their stay in hospital, and in planning and supporting their discharge back into the community. We also saw evidence of trust-wide learning from complaints and incidents, for example through updates from team managers and trust-wide emails. This information was also included and discussed at monthly team meetings.

We found that teams were well-led by their team managers and that staff were aware of the trust's vision and strategy. We found evidence of responsible governance, and that the trust had an oversight of key risk areas, as identified on their risk register.

# Summary of findings

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

### Are services safe?

The service had a good track record on safety and provided a safe service for adults in the community. Staff received appropriate training and they understood safeguarding procedures. Risk was managed effectively and communicated promptly on a daily basis. Although the number of community caseloads had increased overall, good line management and effective caseload management systems meant that they were well managed.

Good



### Are services effective?

People's care and treatment was planned and delivered effectively. Care was recovery-focused and people were supported to achieve positive outcomes. Assessments of people's needs were thorough, and person-centred care plans were developed in partnership with people who used the service. Staff were supported well by their team managers and there was a good mix of professional backgrounds and skills in the teams. Multidisciplinary working was embedded across community services and information about people was shared appropriately. Staff received regular training and supervision.

Good



### Are services caring?

Staff delivered care and support with kindness and compassion. They were sensitive to individual needs and respected people's privacy and dignity. Care provided was person-centred and people felt involved in decision-making. Care plans and interventions were recovery-focused, and staff involved people in writing their care plans, making sure that people's needs and preferences were incorporated. Self-care was promoted and people were supported to be as independent as possible.

Good



### Are services responsive to people's needs?

Adult community based services were responsive. There were clear care pathways in place and people were supported well when they moved between teams, and between inpatient services and the community. People were provided with the right care at the right time. We also saw that changes in needs, and requests for support, were dealt with quickly. Learning from incidents was shared across the trust emails and discussions at team meetings.

Good



### Are services well-led?

Staff were aware of the trust's vision and strategy. The governance structures in place also supported the delivery of care. Staff in adult community-based services felt that the team worked well together and that they were supported well by their team managers.

Good



# Summary of findings

## Background to the service

### Assertive outreach team

The assertive outreach team provides mental health services in Bradford. The team is recovery-oriented and provides more intensive and longer-term support for people aged 18 to 64. It offers tailored packages of care and a variety of care pathways for people experiencing serious and/or enduring mental health problems.

### Community mental health teams

The community mental health team's work with people aged 18 to 64, who have a wide range of mental health difficulties. They help people to cope with periods of mental illness and severe distress. The teams offer short-term support to people who have a GP, as well as those who require longer-term care who they support to stay out of hospital, where possible.

### Early intervention service

The early intervention in psychosis team supports people aged 14 to 35, who are experiencing their first episode of psychosis or have a previously untreated psychosis that lasted for less than one year. The service supports young people and their families through a range of services, including psychological therapies and social interventions that are designed to meet the individual needs of the young person, and help them recover at an important stage in their life. Early intervention reduces the length of time that psychosis is left untreated and provides people with a recovery-focused service in the three years following their first episode.

## Our inspection team

Our inspection team was led by:

**Chair:** Angela Greatley, Chair, The Tavistock and Portman NHS Foundation Trust

**Team Leader:** Jenny Wilkes, Head of Inspection – Hospitals Directorate (Mental Health), Care Quality Commission (CQC)

The team included CQC inspectors and a variety of specialists: a social worker, occupational therapists, an independent Mental Health Act advocate and a senior nurse.

## Why we carried out this inspection

We inspected this core service as part of our Wave 2 pilot mental health inspection programme.

## How we carried out this inspection

To get to the heart of people who use services' experience of care, 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 visiting, we reviewed a range of information we held about the core service and asked other organisations to share what they knew. We undertook site visits to the teams bases We carried out visits on the 17th, 18th and 19th June 2014. During the visit we held focus groups with a range of staff who worked within the service, such as nurses, doctors and therapists. We

# Summary of findings

observed how people were being cared for and reviewed care or treatment records of people who used services. We met and spoke with people who used services who shared their views and experiences of the core service.

We reviewed and inspected the community services being provided. We visited eight community mental health teams, one assertive outreach team and the early intervention service (Psychosis).

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

People told us that staff were professional and compassionate in their care they delivered. People told us they were involved in the planning and treatment of their care. They also said that they could agree to care and treatment, as well as discuss and agree treatment options with medical staff. People we spoke with were

very positive about the services they received and described staff as “professional”, “caring”, “compassionate” and “friendly”. We saw examples of how people were consulted on their care and treatment. In addition, outcomes of surveys about the services provided were displayed for staff to see.

## Good practice

- There were non-medical prescribing leads for assessment and treatment.
- Safeguarding practices were safe and staff were knew how to make appropriate referrals.
- There were service user development workers employed by the trust.

## Areas for improvement

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

- The trust should make sure that all community mental health teams adhere to safe working systems and the lone working policy. In community teams, we saw that there were safe systems in place, which were not consistently adhered to. While we saw that the managers had recognised lone working needed to be improved, and had introduced safer working practices, this should be consistent across all community mental health services.
- The trust should make sure that monitoring systems are in place for managing medicines. Although we found there were suitable systems in place for the receipt, storage, administration and recording of information, in two of the community mental health teams we found that fridge temperatures were not routinely checked and recorded.
- The trust should continue to make sure that the impact of major service redesign, including the development of a single point of access and administrative hubs, is properly monitored and managed. This is to make sure that care delivered continues to be responsive and caring

## Bradford District Care Trust

Adult community-based  
services

## Detailed findings

## Locations inspected

Name of service (e.g. ward/unit/team)	Name of CQC registered location
Early intervention services (psychosis) Community mental health	BDCT Headquarters, New Mill
Airewharfe community mental health centre Community mental health team	BDCT Headquarters, New Mill
Assertive outreach team Horton Park Medical Centre	BDCT Headquarters, New Mill
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The Craven Centre Community mental health team	BDCT Headquarters, New Mill
Somerset House Community mental health team	BDCT Headquarters, New Mill

## Mental Health Act responsibilities

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

We saw information about the MHA was available to people that used services. We saw an example when a person

subject to a community treatment order (CTO), information was not translated into the person's first language. However, we saw that interpreters had been arranged for meetings held with the person. We saw good evidence of

# Detailed findings

the teams adhering to the guiding principles of the MHA Code of Practice by staff working in partnership with people to prevent admission to hospital and develop creative care and treatment plans in the community.

## Mental Capacity Act and Deprivation of Liberty Safeguards

Staff were also aware of their responsibilities under the Mental Capacity Act 2005 and were able to demonstrate through some of the treatment records seen, how they recognised, responded and raised issues about mental capacity.

# 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

The service had a good track record on safety and provided a safe service for adults in the community. Staff received appropriate training and they understood safeguarding procedures. Risk was managed effectively and communicated promptly on a daily basis. Although the number of community caseloads had increased overall, good line management and effective caseload management systems meant that they were well managed.

## Our findings

### Community mental health and assertive outreach teams

#### Track record on safety

Staff were trained in safeguarding vulnerable adults and children. Staff we spoke with were knowledgeable about their responsibilities regarding safeguarding. They described the process for referring any identified potential or actual concerns to the relevant department. The trust's policies and procedures were accessible on the trust's intranet site. Some staff gave examples of safeguarding concerns they had reported and described the process for completing this. They told us concerns were discussed with line managers where appropriate in the first instance.

Social care staff were an integral part of the team and took the lead in safeguarding as well as contributing to the duty system. Staff told us they valued the input from their social care partners as this provided a balanced and cohesive working partnership.

Staff confirmed that the trust had an online reporting system to report and record incidents and near misses. We saw that staff had access to this system via password protected computers. The trust-wide evidence provided showed us that the trust were reporting concerns through the National Reporting and Learning System (NRLS). The levels of reporting were within expectations for a trust of this size.

### Learning from incidents and improving safety standards

The trust's serious incident data showed us that trust-wide learning from serious incidents had been reviewed through local and trust-wide governance processes and shared throughout the trust. The majority of staff confirmed this and reported that the lessons learned from incidents had been discussed within their specific team and disseminated through the trust. For example, we saw copies of the trust's online safety bulletins. This provided information and guidance for staff to follow. Most members of staff spoken with were aware of the safety bulletins and we were told they were discussed at larger team meetings. Further trust-wide learning was evidenced through the trust's email updates. This included updates and 'key messages' for staff. The evidence reviewed showed us that the trust had embedded learning from incidents within the organisation.

Staff confirmed that they had received risk assessment training and told us that they were supported by their immediate line manager following any safety incidents.

Staff told us, and we were shown, how they used the trust's, electronic incident reporting (EIR) system for reporting any incidents, concerns or near misses. Feedback from serious untoward incidents was fed back to the individuals involved and wider trust incidents distributed by email globally. Lessons learned from incidents relating to the team and in wider trust were included in the agenda for monthly team meetings. Managers told us action plans were developed from investigations and lessons learned circulated globally with feedback given to specific teams. Staff told us they were supported and debriefed by their team manager following any incidents that occurred when they felt unsafe. Team managers were described as supportive. Staff told us about the variable level of support available through middle management. One senior nurse told us they had received very good support from middle management when preparing for a coroner's inquest, while another said they were supported by their immediate manager but not the middle manager who did not ask them about an incident.

# Are services safe?

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## Reliable systems, processes and practices to keep people safe and safeguarded from abuse

We saw there was information displayed in team offices about the trust's safeguarding adult's policy. We also saw the online safeguarding policy and procedure and patient safeguarding information leaflets. The trust safeguarding adult's policy was dated 2012 and was to have been reviewed in 2013 but this had not yet been completed. This also applied to the trust's medicines' management policy.

Staff were aware of the trust's safeguarding and other policies. They told us that they knew how to raise any safeguarding concerns. This was demonstrated by some of those individual treatment records seen. These showed us that risk assessments had been completed and identified if people were at risk of exploitation or vulnerable due to their mental health needs. Staff were also aware of their responsibilities under the Mental Capacity Act 2005 and were able to demonstrate through some of the treatment records seen, how they recognised, responded and raised issues about mental capacity. Agency staff we spoke with confirmed they had been shown how to use the safeguarding adults reporting system and as part of team induction had to read the trust's online policies and procedures.

Staff were aware of the trust's whistleblowing policy and confirmed that they felt able to raise concerns with their direct line manager. We also witnessed a staff member being supported by their line manager when concerns were raised about the single point of access service. Some staff told us that they had raised concerns through their line manager. For example, in relation to the introduction of the case management system, which staff said was impacting on their capacity. Staff said as a result of increased administration and workloads they were working longer hours to keep up to date with administration and record keeping. Staff told us that though team managers did not encourage them to work additional hours neither was it discouraged by them. Staff said they were unsure if an equality or safety impact assessment had been completed by the trust. We advised staff to follow this up with the trust's human resources department.

We saw that medication was appropriately administered and securely stored. Medicines management was seen to be effective with yearly audits undertaken by pharmacy. We found that while there were suitable medicines management systems in place, the storage of medicines in

fridges in two of the teams we visited should improve as there were no consistent arrangements in place for defrosting and checking and recording the operational temperature of the fridges. This meant that there was a risk that some medicines were not stored safely at all times.

Records were kept electronically using the RIO system. The staff said they had good access to patient information and could record a detailed picture and background of individual risks to staff.

## Assessing and monitoring safety and risk

We observed handovers and meetings in some of the teams. These appeared well planned and organised. Each person currently receiving care was discussed, including any new referrals for follow up. Appropriate sharing of information to ensure continuity and safety of care was observed. We saw serious incidents were discussed to ensure learning was shared within the team and the shared team risks were discussed. Referrals were accepted through the recently formed single point of access team, which community mental health team staffed through a duty system. Staff reported teething problems with the single point of access and told us improvements had been introduced to support them to assess and respond to risk.

We reviewed seven electronic records overall. Safeguarding and abuse issues were considered within the assessment document. We saw that staff jointly worked with other agencies and across services to promote safety. Caseloads and capacity were monitored by the team manager through monthly supervision. These sessions included discussion around discharges which established capacity for new referrals. Levels of caseloads had agreed limits with the introduction of caseload management. We saw case loads of up to 40 people in some community mental health teams. The high caseload levels of the community mental health teams were reported on the corporate risk register.

## Understanding and management of foreseeable risks

We were able to visit nine people who used the service with their care coordinator or other designated staff member. We saw that assessments and care plans were completed with people. Electronic records seen showed us that people who had recently been assessed by the single point of access team had an initial risk assessment completed over the telephone to determine which service they would be directed to and the level of risk determined how quickly they could access services. When referred to the

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community mental health team, we saw evidence that people who had been triaged as needing to be seen in one to seven days were seen within 48 hours. Less urgent referrals were seen within the 14-day timescale for assessment.

Each community mental health team had a duty system in operation to support the duty worker based at the single point of access. We saw from our observations the duty worker was able to follow up on the less urgent referrals and could respond to less urgent matters.

In the assertive outreach and early intervention teams we saw these teams had their own duty system in place and did not provide staff to support the single point of access team in Bradford. These teams also received referrals via the single point of access.

Risk assessments seen included assessments of the person's physical health and their risks to self or others where appropriate. Evidence was seen of the active involvement of the person in assessing risks for themselves and the assessments were linked to people's discussions with their community mental health nurse, care co-ordinator or consultant psychiatrist. These identified risks formed an integral part of people's current care plan and contained important information about who was at risk.

We saw good examples of risk assessments and subsequent care plans linked to those community treatment orders (CTO) reviewed during our inspection.

Personal safety of staff was well established in some teams but not as well as in others. Some teams had recognised the risk to staff and the need to improve upon the adherence to the lone worker policy and introduce more effective safety monitoring systems, but this needed to be implemented consistently across all the Trust's community mental health teams.

## Early intervention service

### Assessing and monitoring safety and risk

Records we were shown included risk assessments. These considered the risks people presented to themselves, to others and from others. There was a process in place to work positively with people to enable them to recognise triggers and signs that would indicate they were at risk. We saw plans in place to describe what actions staff and the person could take if there were elevated risks. We saw that all risks were recorded and the plans in place to minimise and manage risks.

## Track record on safety

We found that the trust's safeguarding systems were robust and were understood by staff. Staff confirmed they received training in safeguarding children and vulnerable adults which was regularly updated. Staff we spoke with were knowledgeable about their responsibilities in regarding to safeguarding. They described the process for referring any identified potential or actual concerns. Trust policies and procedures were accessible on the trust own intranet site. Staff told us they used the trust's electronic incident reporting (EIR) for reporting any safety incidents, concerns or near misses.

## Learning from incidents and improving safety standards

Feedback regarding incidents was notified through the electronic incident reporting system and lessons learned shared in team meetings and through weekly emails on local and national incidents. The groups of staff we spoke with described a robust system for monitoring safety and learning from incidents, which we saw was embedded in the team. The team manager and duty officer showed us the duty system in place and how the use of a safety board had improved the information available to staff on the elevation of risk for people the team supported. For example, we saw a person was referred to another team and the reason for the referral being refused due to the individual's risk of illicit drug use. This information was available for staff to see on the safety board. Information about risk was changed in response to the level of risk increasing or reducing.

## Reliable systems, processes and practices to keep people safe and safeguarded from abuse

Safeguarding concerns were referred through the trust electronic RIO system to record referral details and investigation and outcome.

The trust's lone working policy was adhered to within the team. Staff knew how to access the policy via the trust's intranet site. Systems were in place for staff to be alerted to any concerns or risks regarding visits or contacts people.

## Assessing and monitoring safety and risk

Records we were shown included risk assessments which identified risk where people that used the service were a risk to themselves, staff or from other people. There was a process in place to work positively with the person to enable them to recognise triggers and signs that would indicate they were at risk. We visited a person using the

# Are services safe?

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service and spoke with two people and a carer who had attended outpatient appointments. People told us that staff encouraged them to identify if they felt unsafe and to seek help. One person said, “I could access help pretty quick. When I was in a bit of trouble they were here in 20-30 minutes.”

We saw care plans and risk assessments were in place to describe what actions staff and the person could take if there were elevated risks. We saw that all risks were recorded and the plans in place to minimise and manage risks.

We looked at three records and attended a handover and multidisciplinary meeting. We found risk assessments had been updated in a timely manner to reflect current risk as described in the progress notes. We saw during our visit that risk assessment and care planning involved the person and their family and we saw examples of good person centred information.

Staff described a good relationship with other teams with a clear understanding of how they could make referrals. The clinical lead showed us evidence that over 40% of people that were discharged were not referred to other services. Staff were aware of the recovery model in place and as part of the model worked in partnership with other teams to move people on safely from their service and people did not remain on the team caseload beyond the three years. One staff member told us, “The positive thing about the team is that using the recovery model we are working with

people for three years and not like AOT (assertive outreach team), where it can be time limited. You have to live the model with the client to understand their risk, it’s quite a commitment and a privilege.”

Caseloads and capacity were monitored by the team manager through monthly supervision. When we visited caseloads in the EIS team were around 14:1, which is within the national recommended caseload size for EIS, which is 15:1. The manager told us they discussed capacity and caseload management in supervision. Staff we spoke with said they had manageable caseloads and could approach the manager at any time if capacity compromised patient safety or care. Staff said at times their caseload could exceed the national recommendations.

## **Understanding and management of foreseeable risks**

Staff told us the team and clinical lead were receptive to any concerns raised. Any disruption to staffing levels incurred due to staff sickness were dealt with through cross cover among the cluster of teams to fill any gaps which limited any impact on people using services. The manager, clinical lead and staff told us about the peer support groups in place. These groups met monthly and offered staff the opportunity to meet and discuss individual cases and risk management within a safe environment. Meetings were structured by the clinical lead to offer support and guidance to staff.

# Are services effective?

Good 

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

## Summary of findings

People's care and treatment was planned and delivered effectively. Care was recovery-focused and people were supported to achieve positive outcomes. Assessments of people's needs were thorough, and person-centred care plans were developed in partnership with people who used the service. Staff were supported well by their team managers and there was a good mix of professional backgrounds and skills in the teams. Multidisciplinary working was embedded across community services and information about people was shared appropriately. Staff received regular training and supervision.

## Our findings

### Community mental health and assertive outreach teams

#### Assessment and delivery of care and treatment

We looked at records and saw that care plans were outcome-based and reflected progress in achieving aims. Progress notes were comprehensive and linked to the care plan in place. Records we were shown were person centred and demonstrated people's involvement. People told us they were aware of their care plans and they had been involved in their reviews. One patient told us, "AOT (assertive outreach team) is brilliant. I am involved in my care plan and risk assessment. I have an advanced plan that when I get depressed I present at hospital and am admitted for a few days while they adjust my medication. It's my bolthole, but keeps me from harming myself."

We saw evidence of comprehensive assessment by medical and nursing staff on initial contact and they had covered all aspects of care as part of a whole person assessment.

Teams offered a good range of evidence based psychological therapies. However patients and staff told us that there were long waiting lists to access psychological therapies. During our listening events and patient focus groups, patients told us that they had benefitted from psychological therapies but through more varied therapies could be offered through the community mental health services. One person told us:

"It's all psychological therapies or CBT (cognitive behavioural therapy). My friend wanted to access CBT, but they work full time and it's not available to them after work. There's also a six to nine month waiting list. I had art therapy in the past. We need more support services that encourage you to look after your physical health and that looks after your mental health as well."

The relative of a person using services told us, "Instead of psychology services what about other therapies, exercise groups or art therapy. These young people need help to keep fit with the medication they're prescribed they put on weight. That's just as important to their health." We advised these people to address their ideas and concerns to the trust and Clinical Commissioning Groups.

#### Outcomes for people using services

We saw a monthly audit tool completed by managers covering areas such as health and safety and records which was fed into the trust system. Feedback about performance was shared with managers for their action. Managers and staff within the various teams told us that more monitoring had been introduced around case management.

Community mental health team staff said that the case management system was positive but were concerned about the impact this was having on them with caseloads increasing as part of the service improvement plan. Community mental health teams were realigning around a cluster of GP practices that linked to a group of consultant psychiatrists. As a result of case management, we saw figures that consultant psychiatrist caseloads had been reduced. This meant that people had been transferred to other services or discharged to the care of their GP as appropriate. We spoke with several community mental health team managers, an assertive outreach manager and two advanced nurse practitioners. All said the case management system was positive, but had identified some risk which they had raised with their line manager. For example, with the arrangements for consultant psychiatrists being linked to a cluster of GP practices, patients had either been discharged or had to change their care coordinator or GP or both.

Managers assured us that this had been identified as a potential risk and where necessary the transfer of patients had been put on hold or the transfer period had been extended. Care coordinators we spoke with said people's

# Are services effective?

Good 

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

needs had been considered during the transfer. One care coordinator told us that two patients they supported had changes to their care coordinator and consultant psychiatrist. They told us:

"The distress to patients was recognised. For my two (patients) I had worked with them and planned for the transfer. One patient decided to be discharged back to her GP as she had been well for a long time and the other is being seen by both consultants during the transfer. The team managers have listened to our concerns".

We spoke with a group of consultant psychiatrists at a listening event and to three consultant psychiatrists at the team bases. They told us that their case loads had been reduced considerably and many patients had been discharged back to their GP. We were given an example by a consultant of their case load being reduced from 420 to 260 patients and when a consultant psychiatrist retired two posts were created which further reduced caseloads. We were told that when patients were being transferred to their GP the process could be slowed down to allow for the transfer process and to help the patient adjust. With reduced caseloads the consultant psychiatrists retained the responsibility for their patients when admitted to an inpatient psychiatric bed. Consultants said the discharge of patients back to their GP had been a 'whole team' decision and had been agreed with the individual patients. Consultants said that they worked within national institute for health and care excellence guidelines (NICE) when prescribing medication and this was discussed when transferring people back to their GP's.

## Staff, equipment and facilities

Staff told us they had received induction and training to prepare them for their role and were supported by their line manager. We spoke to agency staff employed within the community mental health teams. Staff confirmed they received supervision and training from the trust, but were not sure if they were expected to have completed the trust's induction programme. Staff told us the trust asked that staff working in teams on fixed-term contracts had to provide evidence by the recruitment agency that they had completed the relevant safeguarding children and adults training.

Staff members we spoke with told us that they received supervision and annual appraisals from their line manager as required. This meant that staff received the appropriate levels of support from their immediate manager. Agency

staff told us they were usually included in the supervision and appraisal system though we did receive comments from two staff that they had to request for supervision sessions to be arranged.

Staff confirmed that systems were in place to monitor staff sickness and that they had access to occupational health support. Most staff told us that they felt well supported by their team manager.

Staff told us they were supported to undertake training outside of mandatory training. We saw a robust supervision process in place. Staff received management supervision monthly. Performance issues and caseload capacity were embedded in this process. This included specialist supervision for approved mental health professionals (AMHP) and non-medical prescribers. Senior medical staff told us they had regular peer group supervision. Teams we visited had daily handover meetings, weekly clinical meeting for case discussion and also a monthly team meeting for more team related issues, which included information sharing.

## Multi-disciplinary working

Social workers, psychologists and occupational therapists were integrated into community mental health services and the assertive outreach team. Staff reported positive engagement and working with social work colleagues and said they were a necessary part of the team and supported the team's duty system. Consultant psychiatrists told us they had junior doctors to support them in in-patient and out-patient areas, though some consultants said that having to see patients could be time consuming when having to travel to the Lynfield Mount or Airedale sites when they were not based there.

Information on patients subject to the care programme approach was shared on the electronic system, which all the different professions could access.

Staff told us in all the teams we visited that capacity to meet demand was challenging but there was good team support from advanced nurse practitioners and team managers. Staff were aware of the introduction of the single point of access and case management system. Staff said the case management system and changes to the administration support in teams had meant that case loads had increased and the combination of changes was impacting upon their workload. Staff provided some examples of how this had impacted on multidisciplinary

# Are services effective?

Good 

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

working. For example, with administration hubs being set up, we were told that appointment letters had been sent out too late for people to be able to attend the appointment. A consultant psychiatrist said there had been problems with their electronic diaries being updated so appointments had been missed.

## **Mental Health Act (MHA)**

We saw information about the MHA was available to people that used services. We saw an example when a person subject to a community treatment order (CTO), information was not translated into the person's first language, but we saw that interpreters had been arranged for meetings held with the person. CTO care planning was comprehensive with evidence of people's involvement and multidisciplinary review. We saw good evidence of the teams adhering to the guiding principles of the MHA Code of Practice. We attended meetings and saw documentary evidence of the whole team understanding and adhering to the 'least restriction principle'. This was evidenced by staff working in partnership with people to prevent admission to hospital and develop creative care and treatment plans in the community.

## **Early intervention service**

### **Assessment and delivery of care and treatment**

Records we were shown contained outcome-based care plans. We saw that care plans were developed with people's involvement. In records we saw comprehensive assessment of need, which was completed over an initial period of up to three months in order to input important information about people's health, welfare and lifestyle.

A good range of evidence based psychological therapies were available to people using the service. The service involved people before making referrals to other services as well as providing assessment of carers. For example, we saw a person and their family member being offered to be referred for support from other services and support with accessing relevant benefits. Information was provided about the services being referred to and consent sought for the referrals to be made from both the person using the service and carer. The team had good links with other services for example Culture Fusion and Youth Space. People that used the service told us they were able to access this service with support from support workers based in the team as part of their care and treatment. Culture Fusion was the service through which the single point of access referred people to the team.

Staff were able to discuss issues around consent and capacity and how to undertake or organise an assessment for people as necessary. Mental Capacity Act and Deprivation of Liberty Safeguards were part of mandatory training programme.

## **Outcomes for people using services**

A range of evidence-based tools and education materials were used with people to establish understanding about their illness. Materials were used to help people recognise triggers and patterns to their symptoms. We saw examples of how people were encouraged to recognise relapse triggers as part of their staying well plan and use these as part of a relapse drill to help support and manage their mental health. The service provided two recovery support workers, which helped people access other services such as employment and education. One person told us about the support they had received to help them back into education and said, "They are always there to help, everything and anything. They focus care around me. I am doing a Princes Trust construction course, and am getting work experience. I could not have done this without the staff."

## **Staff, equipment and facilities**

Staff told us they were supported to undertake training outside of mandatory training. We saw a robust supervision process in place. Staff received management supervision monthly. Performance issues and caseload capacity were imbedded in this process. This included specialist supervision for staff providing psychological therapies and non-medical prescribers. Managers told us that specialist training for staff was actively encouraged and sought externally. Clinical meetings took place weekly and covered a range of issues including caseload issues, complex cases and discharge planning. Staff were also supported through the peer review process.

## **Multidisciplinary working**

We saw that the approach to assessing and coordinating care ensured that people's needs were understood and continued to be met over a period of time. Staff worked with people for up to three years as per national guidance. Referrals were made to other professionals through multidisciplinary case discussions where appropriate. Information on patients subject to the care programme approach was shared on the electronic system which all

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staff within the team had access to. The multidisciplinary team was made up of consultant psychiatrist, nurses, support workers, occupational therapists, psychiatrists and clinical psychologists.

## **Mental Health Act (MHA) 1983**

Staff told us that they had access to social workers and advanced mental health professionals (AMHPs) within the wider trust to provide guidance on the MHA to support compliance. We did not look at records that related to people subject to elements of the MHA.

# Are services caring?

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

## Summary of findings

Staff delivered care and support with kindness and compassion. They were sensitive to individual needs and respected people's privacy and dignity. Care provided was person-centred and people felt involved in decision-making. Care plans and interventions were recovery-focused, and staff involved people in writing their care plans, making sure that people's needs and preferences were incorporated. Self-care was promoted and people were supported to be as independent as possible.

## Our findings

### Community mental health and assertive outreach teams

#### Kindness, dignity and respect

We spoke with nine people who used services and two carers. People and their carers were very complimentary about the care and treatment they had received. One person told us, "The staff are nice and they respect me." Another said, "My care coordinator is easy to get hold of and if she isn't there I talk to another member of staff who knows me."

People told us they felt listened to and included in each stage of the care they received. We observed two assessments and a review between staff and people that used the service that covered areas of their health, wellbeing and lifestyle. The people were engaged with the staff who explained all their questions in detail so they understood the assessment process. The language used was anti-oppressive, friendly and staff took time to listen and explain any medical words to people.

In the assessments and records we looked at we saw people's cultural needs were discussed, which meant staff considered cultural or personal preferences as part of the assessment. Staff in the teams reflected the ethnic diversity in the area they worked.

### People using services involvement

We met people who used the services attending outpatient clinics or during our visits to their homes or assessment meetings at the team base. At the assessment meetings we observed the aims of the service were clearly explained and people were asked about their anticipated outcomes.

People we spoke with understood their medication, its use and described side effects. This demonstrated education around medication had been provided. However, at our listening events people raised issues about one of the community mental health teams who they felt lacked understanding about transgender people and as a result people felt they were not treated with respect. People that used services also said that community mental health staff in this team did not respond to telephone calls, or get messages and did not arrive for arranged appointments. Concerns were raised about the single point of access staff not being caring and that people had to speak to different people when they contacted this service. People said they had experience of being put on hold then speaking to a different person and having to share their information again. We fed this information back to the respective team managers during our inspection.

Staff were clear about how to secure advocacy services for people. However, we received mixed comments about the availability of advocacy services available to people and limited evidence of the trust liaising with external providers to rectify shortfalls. We were shown how people could be referred and access advocacy services. Advocacy services were provided by local mental health charities, for example Bradford and Airedale Health Advocacy Group (BAMHAG) and Cloverleaf Advocacy. Appropriate literature and information was seen in team bases about the advocacy services available. If people needed to access information in different languages there was an interpreting service available. Information was also made available in a variety of languages.

### Emotional support for care and treatment

We met and spoke with nine people and two carers who used the service and received many positive comments. Staff we met with told us that people's carers were involved in their assessment and care planning. In all the care plans we sampled there was evidence that carers were involved where possible.

The single point of access duty system offered people the option of speaking to the duty officer based in the team if

# Are services caring?

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

the duty officer at the single point of access passed this task to them. People could ask the duty officer based in the community team to contact their identified worker or the duty officer in the team. The assertive outreach service had made an arrangement with the single point of access staff to give people supported by the team the direct contact number if they needed emotional support. The administration and development manager for the single point of access team advised us that staff at the single point of access team had received training in customer care and that service improvements had been made. We observed the team when we visited and observed staff to be polite and professional when speaking to people. We also saw that non-medical prescribers based in teams were available to support people to visit their GP's and discuss issues about prescribing medication.

## Early intervention service

### Kindness, dignity and respect

We visited one person and met with two people and a carer at outpatient clinics relating to the early intervention service (EIS). We saw staff were friendly, professional and supportive of people. Staff listened to people's comments about the support they needed, their feelings, questions and concerns about their mental health needs and talked about personal risk with sensitivity and understanding. People that used services spoke positively about the staff that supported them. One person told us, "... (support worker) just telephoned about our session tomorrow. He's right funny, a good laugh we have a lot in common. . (support worker) Is alright as well. I couldn't have chosen better myself." Staff spoke passionately and positively about their work. The three records we saw demonstrated that people were involved in their care and their views about their health, welfare and lifestyle were acknowledged and respected.

### People using services involvement

Appropriate literature and information was seen that people were routinely provided with throughout their treatment. These were available as necessary in a variety of accessible formats. The trust's website provides people

with accessible information about the service available to them and the range of needs the service supports as well as how people can get involved in the various support groups within the areas and age ranges the trust covers.

In the early intervention service, former service users had been recruited into a variety of roles. This enabled these workers to use their own experience of recovery to help engage with people that used the service and to act as recovery role models. Their involvement in support work, therapeutic activity and coordination of activity and self-help groups meant people were supported by people who could relate to them. Service user development workers facilitated self-help groups, art therapy and other support groups.

This approach provided people the opportunity to influence service management and development. Service user development workers took active roles in developing service literature and information packs provided to people when they were referred to the service and their families. This also included induction information packs for new staff. We saw one of the projects that the service user development worker had been involved in called the 'recovery story' project. This project had engaged young people in reflecting on their recovery and what had supported this. Their stories were then captured using creative media and written stories. People who used the service also told us about the service user satisfaction questionnaire, which they used to provide feedback about the service they received. Though we were unable to see copies of these surveys we were shown the collected data on the electronic system.

### Emotional support for care and treatment

The three records we saw demonstrated that staff positively engaged family, friends and carers who supported people using their service. The 'staying well plan' included information about how family, friends and carers supported people as part of their recovery, and relapse prevention.

# 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

Adult community based services were responsive. There were clear care pathways in place and people were supported well when they moved between teams, and between inpatient services and the community. People were provided with the right care at the right time. We also saw that changes in needs, and requests for support, were dealt with quickly. Learning from incidents was shared across the trust emails and discussions at team meetings.

## Our findings

### Community mental health and assertive outreach teams

#### Planning and delivering services

The community mental health teams operated a duty system between 9am and 5pm. This linked into the duty officer for the team based at the single point of access. The duty officer at the single point of access initially responded to referrals to the team and then would triage and make decisions as to whether the referral was appropriate. If the contact to the duty officer at the single point of access was not urgent then these could be diverted to the duty officer based in the community mental health team. We sat in on several team meetings and handovers at the beginning of the day and observed work being prioritised according to risk.

Duty officers based in the community mental health teams were able to provide telephone support and in a crisis alert the intensive home treatment team or single point of access duty officer for support. This meant that appropriate systems to share information with other services were established. Assertive outreach staff were based in the same location as the community mental health teams and we observed positive working relationships.

We saw the trust had undertaken held a number of stakeholder engagement events over a three month period to develop the vision for transforming the community mental health teams. The improvement plan was shaped around the perceived local need and in negotiation with commissioners. The plan meant that community mental health team consultant psychiatrists were linked to a number of GP practices and their case loads reviewed. This

was seen as a positive development for services by staff, but we received comments that the timing and introduction of a number of changes had reduced the team's ability to be responsive in the future. One staff member said, "We were told our caseloads would be 30, mine's 31 and my manager said we could go to 35. With extra admin, I'm already working more hours than I'm paid for. If we go to 35 I won't have time to see all my clients." Other comments included, "Managers are constantly asking about case management and to fill in the returns. I think it's a good system, but could have been introduced later on as we're now doing our own administration and working in SPA (single point of access), that's a whole day away from working with patients or catching up on administration".

We saw that people were seen in their homes, community bases and clinics. Staff told us that if they felt issues in people's home situation were identified then they would respond to this with a home visit with additional support. This meant the services could be responsive and flexible to the issues relating to and impacting upon the person's well-being.

#### Right care at the right time

In the community mental health teams and assertive outreach teams, improvements were noted around the performance of community mental health teams for patients followed up within seven days of discharge from psychiatric inpatient care. Since January 2013 there has been a marked improvement in follow up appointments.

The trust governance committee in March 2014 reported a red rating against care programme approach (CPA) patient's not receiving follow-up within three days, which goes beyond the requirements of the national target of seven days. This was highlighted as a problem in that some patients were reluctant to have a follow-up within three days of discharge.

The trust responded by following up patients after discharge as part of the implementation of the adult mental health acute care pathway. The response has increased the number of CPA patients receiving follow-up contact within seven days of discharge, with the latest performance on seven-day follow-up reported as 98.5%. The trust was also responding to the local target for

# Are services responsive to people's needs?

Good 

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

following up CPA patients within three days, which goes beyond the requirements of the national target of seven days. The trust achieved 76% achievement against a stretch target of 95% by March 2014.

Appointments waiting times were not raised as a concern by people we spoke with or staff. Feedback from the duty team and staff members was that people were seen with 24 to 72 hours for more urgent matters and then within 14 days.

The numbers of the non-medical prescribers had increased within teams. We spoke with three of the non-medical prescribing staff. We saw two treatment plans for people being supported by these staff. Staff told us this role was to be functioning from June 2014 and there would be at least one non-medical prescriber in each team. Staff told us they had been supported to complete the required additional training and had been supervised through their personal development. We spoke with one consultant psychiatrist who was supervising a non-medical prescriber. They told us they thought this was a positive development and would provide a more flexible service to patients but the model had yet to be developed.

## Care Pathway

Staff told us that all members of the team were valued and respected regardless of discipline or level of seniority. We were able to observe teams working in collaboration and saw many examples of positive working relationships.

Staff were clear about the lines of accountability and who to escalate any concerns to. Staff were able to describe the other services involved in people's care pathways and how the community mental health and assertive outreach teams fitted into it.

The appropriate community teams were involved with people before hospital admission, during the admission itself and when planning and supporting discharge back to the community. Care pathways were clear and the various teams knew each other's roles and worked well together. This meant people's transition back into the community was not unnecessarily delayed. The trust had implemented the 'continuity model' across all services, which meant that people retained their consultant psychiatrist if they were admitted to hospital. People we spoke with were positive

about having consistency between treatment in the community and whilst an inpatient. People told us that the service accommodated requests to change their care coordinator.

Within teams initial triage was undertaken by the duty officer based in the single point of access team and a telephone referral would be taken. Referrals were then passed to the duty officer at the team who could decide in consultation upon the immediate plan of care and level of contact. This had a degree of flexibility and was subject to change as the single point of access team developed.

## Learning from concerns and complaints

Staff were aware of the trust's complaints policy. Complaints received directly were passed to the team manager or to the patient advice and liaison service (PALS). We saw information in reception areas used by people regarding how to make a complaint. Information leaflets about each service included complaints information. People we spoke with had not needed to make a complaint but were sure of how to take forward any issues they had. Investigations of complaints at a local level were initially dealt with by the team manager and people were directed to use the patient advice and liaison service (PALS) to support them with using the trust's complaints procedure.

We saw evidence of the trust listening to what people said about the services provided and reports of 'what you said', 'what we did'. This demonstrated the trust's willingness to engage with people that used services.

Evidence of trust-wide learning from complaints and incidents was demonstrated through the team manager sharing with staff and globally through updates via the trust email system. This information was included and discussed at monthly team meetings.

## Early intervention service

### Planning and delivering services

Staff in the early intervention service (EIS) told us that they prioritised work according to risk and identified need. We saw that people were seen in the community and people's homes. We saw that the trust had employed both male and female staff from different ethnic backgrounds. This ensured that staff were able to support people with their gender, cultural and personal preferences. Information was accessible on the trust's website which offered information

# Are services responsive to people's needs?

Good 

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about the purpose of the service and how to be referred into it. Referrals to this team were via the single point of access team. Referrals could also be picked up following acute crisis or during inpatient admission.

## Right care at the right time

No waiting lists were in operation. Cases were prioritised and discussed by the multidisciplinary team, with contact made by letter with details of how to access services as an interim measure. No examples were shared of treatment being cancelled or delayed due to capacity issues.

Managers described people being discharged after their first episode of psychosis without them requiring further contact with mental health services. The clinical lead provided data that this was in excess 40% of people discharged by the team.

People on the caseload and those with booked initial appointments were provided with the numbers to call if they needed an urgent response outside of working hours. EIS staff liaised with the crisis service regarding people who may present out of hours or at weekends due to deterioration in their mental health.

## Care pathway

Staff told us they worked cohesively with other teams and that all members were valued and respected regardless of discipline or level of seniority. Staff were able to give a clear overview of the care pathways within the team and this

involved collaborative working. Transfer of care between teams and shared care within teams was effectively managed. This enabled smooth transition between teams for the patient as part of their on going recovery.

People referred by in-patient staff who were ready for discharge were seen while still an inpatient to begin to build a rapport and relationship with the staff supporting them in the community. Relationships with other teams in the trust were described as good.

## Learning from concerns and complaints

Staff were aware of the trust's complaint's policy. Complaints received directly were passed to the team manager or to the patient advice and liaison service (PALS). Staff told us they were confident on how to advise people with a concern, complaint or compliment. We saw information in the team's reception and waiting areas used by people regarding how to make a complaint. Information leaflets about the service also contained complaints information. We also were shown the team's information page on the trust website which provided information about the service.

Evidence of trust-wide learning from complaints and incidents was demonstrated through the team manager sharing with staff and globally through updates via the trust's email system. This information was included and discussed monthly team meetings.

# 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

Staff were aware of the trust's vision and strategy. The governance structures in place also supported the delivery of care. Staff in adult community-based services felt that the team worked well together and that they were supported well by their team managers.

## Our findings

### Community mental health and assertive outreach teams

#### Vision and strategy

The majority of the staff we spoke with told us they felt well supported by their team managers. They all spoke positively about their role and demonstrated their dedication to providing quality patient care. They told us that the board engaged them, provided information and consulted with them in a variety of formats. Key messages about the trust were communicated to all managers at monthly senior management meetings and shared with the team.

We ran a number of focus groups as part of inspection and spoke to a wide number of staff groups. Consultant psychiatrists told us the trust had not listened to them about the concerns they had in regards to the introduction of a number of changes and tended to be reactive. They used the introduction of the 'continuity model' as an example. However, they were clear that the trust did listen and respond once the new system was experiencing some problems and that the dialogue and communication then improved.

Team managers said that there had been improvements over the last two years and they were positive about the trust's vision. However, team managers said that the trust approach to staff sickness was unsympathetic and did not focus on root causes. They felt that advice given to them by the trust focused too heavily on managing individual staff performance as opposed to providing necessary support and working on the underlying causes of work related stress and staff sickness.

We noted in teams that there was a lack of adherence to lone working policy across community mental health teams so local managers were not monitoring the arrangements and ensuring that staff were adhering to the trust policies in place for their own safety.

#### Responsible governance

Staff told us that they felt well supported by their line manager. Staff told us that they received clinical, managerial and peer group supervisions as required. Staff attended monthly team meetings. The trust vision was cascaded through the intranet and via update emails. Staff told us monthly business meeting were a source of feedback in regard to audits undertaken as the number of audits had increased, for example case management.

A trust-wide risk register was in place and managers told us this was an effective tool for capturing on going concerns. For example, staff in one team were advised by the team manager to report their concerns about the single point of access service through the electronic incident reporting system. Staff told us that they were aware of the trust's whistleblowing policy and that they felt able to report incidents and raise concerns and that they would be listened to. We saw an example of how a staff member reported their concerns about the single point of access and was supported to do so by their team manager.

Monthly monitoring of records were submitted to the locality service governance groups by managers and this in turn was reported to the trust's Service Governance Committee, providing assurance against relevant governance and risk standards. Team managers received performance monitoring reports in response to the information they provided. Audits of records about the standards of record keeping we saw were in-depth in regard to identifying outcomes for people and the standard of progress reporting in care plans and progress notes. Staff attendance on training was monitored by team managers and we saw evidence of high attendance rates for staff attending training. We saw the electronic staff records of staff from several teams. These recorded staff training for mandatory and role specific training, though staff reported the system did not accurately reflect the training they had undertaken.

#### Leadership and culture

We saw a supportive culture within teams. Staff had a broad understanding of the current and future needs of the organisation and a good understanding of how changes to

# Are services well-led?

Good 

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service provision was meant to improve the services provided. We saw that staff were passionate about their work and showed a genuine compassion for people. Staff told us that the chief executive had visited their teams and engaged with staff at all levels. Staff also said the executive team visited teams and sat in on staff and multidisciplinary meetings, as well as visiting people with care coordinators. Staff talked positively about the chief executive.

Patients and carers we spoke with said they were aware of who the chief executive was and they were asked for feedback about the services they received involved in.

Staff and service users reported some issues with the recent scale and pace of change in the organisation, and the transition to some of the new ways of working had caused some difficulties. This included for example, some service users having experienced problems getting hold of their care team when the administration systems had been changed. However, we saw there had been some recent improvements and a commitment to make these changes work including increasing trust board oversight and ownership of these issues.

## Engagement

People were asked about their views of the service via satisfaction surveys which related specifically to the team that cared for them. These asked them to rate the quality of the staff that supported them. These were provided to people on the trust intranet and available in the sites teams were based in. Teams also provided people with surveys about the service they received and we saw evidence of the results of surveys in team offices. This meant the trust actively sought people's opinion and participation in improving service delivery. We saw evidence of learning from complaints and the trust's intranet had the last three years reports about complaints made.

Staff were aware how to access advocacy services for people and leaflets given to people about the team also contained information about relevant local advocacy contacts, however there was a lack of local advocacy services and we could not see evidence of how the Trust was responding to this. Staff were aware of the whistleblowing policy and that they would feel confident to report and refer concerns if it was needed. The whistleblowing policy was available on the trust's intranet site for staff to refer to.

## Performance improvement

Staff we met with understood their aims and objectives in regard to performance and learning. Staff told us they valued the supervision they received. We saw that service developments were being monitored for risks, efficacy and with consideration of local needs. We saw that monthly team meetings focussed on team objectives and direction particularly through the implementation of new ways of working. For example with the introduction of case management.

The trust received 94 formal complaints between April 2013 and March 2014, a very slight increase from the previous year. There were five or more complaints about three community mental health teams accounting for approximately 20% of complaints received.

Common themes among the formal complaints included:

- Staff – attitude, lack of support for patients, poor communication.
- Care planning.
- Record keeping.
- Waiting for appointments.

These complaints corroborate some of the pressures on community mental health services and changes in the way of working for example through the admin hub and move to single point of access which the trust was attempting to actively manage.

We saw that learning had been drawn from complaints for service improvement; for example one complaint highlighted that there were unclear transfer arrangements and clinical oversight following the retirement of a community consultant psychiatrist and action drawn up to prevent this reoccurring. The complaint highlighted a more systemic issue beyond one individual complainant relating to a significant number of people. However, it was unclear why the systems within the trust were not in place to ensure that this did not occur in the first place to manage performance of teams during routine events such as a member of staff leaving the trust.

## Early intervention service

### Vision and strategy

Staff reported to us that morale in teams was high. Key messages about the trust were communicated to managers at monthly senior management meetings. Staff told us they felt well supported by their managers. They spoke passionately about the work they did and

# Are services well-led?

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demonstrated their dedication to providing quality patient care. They told us that senior managers and the board members engaged them, provided information and consulted with them in a variety of formats.

## Responsible governance

Staff received a variety of regular supervision, for example clinical, line management and professional. They told us these were well organised and meaningful. Team meetings were on a monthly basis and were used for sharing relevant information. The trust's vision was cascaded through the intranet and via update emails. Staff told us business meetings were good for feedback in regard to audits undertaken as the level of audits had increased. The manager told us that monthly business meeting were good for feedback in regard to audits undertaken. Staff confirmed that they had an understanding of governance issues.

Staff told us that they were aware of the trust's whistleblowing policy and that they felt able to report incidents and raise concerns and that they would be listened to. Staff reported that management were supportive and acted upon any concerns raised. Staff reported that sickness and absence was monitored and we saw information from the trust that long-term sickness absence is much lower than other trust service areas. Staff attendance on training was monitored by managers. A training grid was reviewed and this was updated and put up for staff to see. Fundamental training for the team was 93% and on an upward trend and above the trust average.

## Leadership and culture

We saw a supportive culture within teams with staff displaying a positive regard for each other. Staff had a broad understanding of the current and future needs and

goals for the organisation. Staff we met with were passionate about their work and showed a genuine compassion for people. We saw a sense of collective team responsibility with good levels of supervision, peer support and clinical discussion in place. Staff told us they were able to raise issues without fear in this team. The clinical lead told us about the psychology vacancy in the team and demonstrated how they were actively seeking to fill this.

Staff were aware of the whistleblowing policy. They told us that they had not needed to use it as they could speak open and honestly. A copy of the policy was available on the trusts intranet site.

## Engagement

The team actively sought people's feedback by asking people to complete satisfaction surveys. The service user development worker role was seen as an outstanding example of engaging with people that used the service. People that have had experience of using services and recovered from their individual mental health needs were employed to support people and lead on developing services through engagement.

## Performance improvement

We saw that the team invested time and resources into supporting staff. Staff we met with understood their aims and objectives in regard to improvement and learning, through regular formal and peer supervision. Staff told us they valued the supervision they received. We saw that monthly team meeting focussed on maintaining a high quality of service delivery and improving ways of working.

Team performance was monitored through key performance indicators and we saw that overall, EIS had been meeting the national targets where applicable.