Requires improvement

Black Country Partnership NHS Foundation Trust

Community-based mental health services for adults of working age

Quality Report

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Locations inspected

Location ID	Name of CQC registered location	Name of service (e.g. ward/ unit/team)	Postcode of service (ward/ unit/ team)
TAJHQ	Black Country Partnership NHS Foundation Trust	Sandwell Single Point of Referral Service	B69 2DG
TAJHQ	Black Country Partnership NHS Foundation Trust	Wolverhampton Complex Care North Team	WV10 9TH
TAJ52	Penn Hospital	Wolverhampton Complex Care South Team	WV4 5HN

This report describes our judgement of the quality of care provided within this core service by Black Country Partnership NHS Foundation Trust. Where relevant we provide detail of each location or area of service visited.

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

Summary of findings

Where applicable, we have reported on each core service provided by Black Country Partnership NHS Foundation Trust and these are brought together to inform our overall judgement of Black Country Partnership NHS Foundation Trust.

Summary of findings

Ratings

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

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

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

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

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

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

Summary of findings

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Summary of findings

Overall summary

We rated the community based mental health services for adults of working age as **requires improvement** because:

- Medication was not properly stored at Complex Care North. Fridge temperatures were not routinely checked. This could have led to harm to patients who used the services.
- There was no emergency equipment at Complex Care North.
- Measures for summoning assistance were not robust across all the teams. Single Point of Referral had systems that we found were ineffective.
- Single Point of Referral service had no contingency plan to deal with unexpected staff shortages. This could have meant patients who used services were waiting longer to be seen.
- High referrals and excessive waiting times were present in the Single Point of Referral team for people waiting to be assessed. This meant patients who used services waited long periods to be seen. There were no processes in place to monitor patients whilst they were waiting.

However:

- Staff received training, appraisals and supervision.
- Staff felt confident to raise any concerns.
- Crisis plans were detailed in the notes we viewed.
- Processes were in place to deal with sudden deteriorations in people's health, they would be referred to the Crisis team for urgent assessments.
- Urgent access to psychiatrists was possible.
- Incidents and complaints were reported and we saw that learning from these took place. Apologies were given to patients if things went wrong.
- Physical health monitoring occurred on an on-going basis.
- Good working relationships existed with other agencies. Shared protocols were in place with General Practitioners.
- Health of the Nation outcome scales (HONOS) were used. This was primarily to ascertain care clusters for individuals. HONOS ratings determined future care pathways and treatments.
- The environments were fit for purpose. Information leaflets were available. These covered areas such as how to complain, medications, what to expect. They were available in languages other than English. Interpreters were used.
- Trust vision and values translated to care provided. Staff knew who the senior managers were in the trust and felt supported.
- Staff knew how to safeguard people who used services.
- Administration staff supported the clinical staff. Clinical staff maximised the time spent providing care.
- Research and audits took place meaning the service was committed to improvements.

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:

- There was no emergency equipment at Complex Care North service. This could have put patients who used services at risk.
- Measures for summoning assistance were not robust across all the teams. Single Point of Referral had systems that we found were ineffective.
- Medication was not properly stored at Complex Care North. Fridge temperatures were not routinely checked. This could have led to harm to patients who used the services.
- Single Point of Referral had no contingency plan to deal with unexpected staff shortages. This could have meant patients who used services were waiting longer to be seen.
- There was only one registered nurse allocated to the clozapine clinic, in her absence there was no clear system in place to ensure the effective on-going monitoring of Clozapine clinics.

However:

- The environments were bright, clean and spacious.
- Staffing levels were adequate. Regular bank and agency staff were employed on short term contracts to manage staff shortages.
- Caseloads in Complex Care were in line with department of health guidance.
- Crisis plans were completed. Processes were in place to deal with sudden deteriorations in people's health. Patients were referred to the Crisis team for immediate assessments.
- There were processes for reporting incidents. We saw that learning from incidents occurred and evidence that apologies were made when things went wrong.
- Staff completed mandatory training. Staff had received training in safeguarding vulnerable adults and children.

Are services effective?

Good

We rated effective as **good** because:

- Staff received training to complete their roles. Training in psychological therapies was completed.

Summary of findings

- Physical health monitoring occurred on an on-going basis.
- Health of the Nation outcome scales (HONOS) were used. This was primarily to ascertain care clusters for individuals. HONOS ratings determined future care pathways and treatments.
- Good working relationships existed with other agencies. Shared protocols were in place with General Practitioners.
- Records were comprehensive, holistic and personalised.
- Administration staff supported the clinical staff. Clinical staff maximised the time spent providing care.

However:

- Each patient had two sets of care records. Information was also stored electronically. This could have led to staff missing vital information.
- Not all records contained the appropriate paperwork for patients subject to community treatment orders.
- Training in the Mental Health Act (MHA) and Mental Capacity Act (MCA) had not been available for the past three years. Staff knowledge was of the MHA & MCA was variable.

Are services caring?

Good

We rated caring as good because:

- People who used services were given support to live independently. They felt staff understood their individual needs. They described staff as helpful and understanding.
- We observed staff to be respectful, considerate and sensitive in their interactions. Good relationships existed.
- People were involved in their care planning. Copies of care plans were available to people who used services and their carers, if agreed.
- Staff discussed recovery goals during appointments.
- There were opportunities for people to give feedback on services. Suggestions, compliments and complaints boxes were present.

Are services responsive to people's needs?

Requires improvement

We rated responsive as requires improvement because:

• Waiting times to seen from referral to assessment were excessive in the Single Point of Referral team. This meant people who used

Summary of findings

services waited long periods to be seen. There were no clear processes in place to monitor people whilst they were waiting. We found high levels of referrals waiting for assessment assigned to each clinician.

However:

• Systems were in place to respond quickly to people who were accepted by the service if needed. Urgent access to psychiatrists was available and if required people would be referred to the Crisis team.

• There were robust procedures to assess people who failed to attend for appointments.

• Information leaflets were available. These covered areas such as how to complain, medications, what to expect. They were available in languages other than English. Interpreters were used.

• When complaints were received, actions were taken in response and we saw evidence of learning as a result.

- • Research and audits took place meaning the service was committed to improvements..

Are services well-led?

Requires improvement

We rated well-led as requires improvement because:

- There were no robust systems or methods to effectively monitor the safety and ongoing performance. The inspection team identified areas where improvements

were required in monitoring waiting lists and lack of emergency equipment.

However:

- Staff received training, appraisals and supervision. They felt confident to raise issues.
- Incidents and complaints were reported and learning took place. We saw evidence that apologies were given if things went wrong.
- Trust vision and values translated to care provided. Staff knew who the senior managers were and felt supported.
- Staff knew how to safeguard people who used services.

Summary of findings

Information about the service

The Black Country Partnership NHS Foundation Trust provides community-based mental health teams for adults of working age at eight registered locations.

The inspection team visited three teams. The community teams were available to people aged 18-65. They operate between 9:00am – 5:00pm Monday - Friday. The trust was currently in a transformation process, remodelling all of the community teams

- **Sandwell Single Point of Referral (SPOR)** service screened urgent and routine referrals to secondary mental health services and signposted to appropriate services. The team operated an allocation process on a daily basis. The clinicians in the team accepted registered and screened referrals.
- **Wolverhampton Complex Care North and South Teams** provided community support to people with severe and enduring mental health problems such as schizophrenia and bipolar disorder. The service promoted recovery through a stepped model of care by changing the level of a service user's care in response to their presenting need. The Complex Care Service linked with other specialist mental health services to ensure effective collaboration and co-working to support recovery. The team received referrals from other health professionals.

This was the first comprehensive inspection of the community teams.

Our inspection team

The comprehensive inspection of the Black Country Partnership NHS Foundation Trust was led by:

Chair: Dr Oliver Shanley, Deputy Chief Executive Officer, Hertfordshire Partnership University NHS Foundation Trust.

Head of Inspection: James Mullins, Head of Hospital inspections, CQC.

Team Leader: Kenrick Jackson, Inspection Manager, CQC.

The team that inspected the community-based mental health services for adults of working age in the trust were made up of eleven people including: two inspectors, two pharmacist inspectors, a psychiatrist, mental health act reviewer, mental health nurses, social workers and an expert by experience.

Why we carried out this inspection

We inspected this core service as part of our on-going comprehensive mental health inspection programme.

How we carried out this inspection

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

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

Before the inspection visit, we reviewed information we held about these services, asked a range of other organisations for information and sought feedback from carers and families of those who use services.

We carried out an announced visit from 16 - 20 November 2015. During the inspection visit, the inspection team:

- Looked at the quality of the environments

Summary of findings

- Visited three community teams and observed how staff were caring for patients
- Spoke with 35 people who were using the services
- Attended nine home visits
- Observed three outpatient reviews
- Spoke with the service managers and managers for each of the community teams visited
- Spoke with 43 other staff members; including doctors, support time recovery workers, administration workers, medical secretaries, mental health act administrators, community psychiatric nurses, a student nurse, psychologists and occupational therapists.
- Attended and observed a team meeting, a duty system, a depot clinic, a clozaril clinic, an outpatient's clinic and an assessment clinic.
- Looked at 41 patient care records
- Reviewed 16 prescription charts
- Carried out a specific check of 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

We spoke with 35 patients and eight relatives and carers. They were positive about their experience of care received by the Community Teams.

- Patients and carers reported they were happy with the service they received. They reported staff were helpful and understanding.
- Patients told us staff treated them with kindness, compassion and in a respectful manner. They were polite, non-judgemental and they spoke to them as if they were a person.
- Patients felt listened to and staff had an understanding of mental health.
- Patients told us they attended their review meetings and were encouraged to involve their relatives if they wished to. Relatives told us they felt included.

Good practice

- Wolverhampton has a large and established Asian community. A nurse who spoke four Asian languages had been recruited to the team. She acted as a lead in the team for black and minority ethnic (BME) communities. We heard the nurse speak with a person's mother in her native language. This was to seek her views and to share information. The patient who used services was present during this interaction and involved in the discussion.

Areas for improvement

Action the provider MUST take to improve

- The trust must ensure that emergency equipment is available and accessible at all locations.
- The trust must ensure that checks of temperatures of the medicines fridges are completed, recorded consistently and medicines stored at the required temperatures. This was an issue in the Complex Care North Team.

Action the provider SHOULD take to improve

- The trust should ensure that there are effective systems to monitor high referrals and waiting times in the Single Point of Referral team.
- The trust should ensure that the legal status of patients is recorded on prescription charts in line

with the code of practice requirements. Ensure that when appropriate the T2, T3, Form 4a or CTO12 capacity to consent to treatment forms are with the prescription charts.

- The trust should ensure that MHA paperwork copies are available in all patients' notes. To ensure clarity regarding the legalities of the CTO and its application.
- The trust should ensure that records are well organised and different team members can have easy access to patients' records when needed.

Care Quality Commission

Black Country Partnership NHS Foundation Trust

Community-based mental health services for adults of working age

Detailed findings

Locations inspected

Name of service (e.g. ward/unit/team)	Name of CQC registered location
Sandwell Single Point of Referral Service	Black Country Partnership NHS Foundation Trust
Wolverhampton Complex Care North Team	Black Country Partnership NHS Foundation Trust
Wolverhampton Complex Care South Team	Penn Hospital

Mental Health Act responsibilities

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

- People were advised of how to contact Independent Mental Health Advocates and the care quality commission (CQC). Information was on posters and patients confirmed staff that had given them information.
- People were made aware of their rights. Patients confirmed they had been kept informed and we saw evidence that this was recorded.
- Staff knowledge and awareness of the MHA varied across teams. Staff in the Complex Care (South) had a good working knowledge. Staff in Complex Care (North) had limited knowledge. Despite this, staff were able to tell us the requirements of community treatment orders. Staff would contact the MHA administrators if they needed advice.
- Complex Care North did not have capacity to consent to treatment forms with prescription cards.
- Training in the Mental Health Act was not available. The Trust had not provided any training in the last three years. Staff training records indicated that staff employed before this had completed the training. MHA updates had not been made available to staff.

Detailed findings

Mental Capacity Act and Deprivation of Liberty Safeguards

- The Trust had not provided any training in in the Mental Capacity Act (MCA) for the last three years. Staff training records indicated staff employed before this had completed the training.
- The trust has a policy on MCA that staff could refer. Staff were aware of this.
- Staff in Complex Care South had good knowledge of the MCA they were able to give an overview of the guiding principles of the MCA. Staff in the other teams had limited knowledge and were not able to give an overview of the principles.

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

Our findings

Safe and clean environment

- Complex Care North, South and the Sandwell Single Point of Referral service were bright areas and in a good state of repair. They were visibly clean and we observed cleaning schedules and cleaning taking place during our inspection.
- Not all the locations had access to panic alarms. The Sandwell Single Point of Referral team assessed patients at the General Practitioners surgery. Interview rooms were not fitted with panic alarms. Staff were aware of risk issues. If required, two staff would see patients. A security guard was reportedly on site to respond to any concerns. The afternoon we visited, we did not see any security guards. When asked about this staff did not know why they were not present. We were concerned that both staff and patients could be at risk in an emergency.
- At Complex Care South, staff had pinpoint alarm systems. We observed staff wearing alarms in clinical areas. Ward based staff would respond to emergencies as the need arose in order to keep people safe.
- No emergency equipment or drugs were present in the clinic room at the Complex Care North Team. There were no emergency bags, defibrillators or anaphylaxis kits. Complex Care South team's equipment were on the main hospital site, this was through one door. Staff were aware of where and how to access emergency equipment. We were concerned that emergency equipment was not readily available for either teams.
- Medicines were appropriately stored at Complex Care South. We reviewed records of medicines being booked in and out when dispensed. The fridge temperature had not been recorded at Complex Care North from 1 September until 18 November 2015 on 34 occasions. Temperatures above the maximum of 8 degrees celsius were recorded on 40 occasions. We did not see records of actions taken. We were concerned that medication was not appropriately stored and could have caused harm to people. Medication was disposed of during our visit due to being unsafe to use following advice from the trust pharmacist.
- Due to the nature of the service, there was no clinic room or medicines stored at Single Point of Referral team.

Safe staffing

- Staffing establishments were decided by the trust. Complex Care North and South Teams had 38 Substantive staff, made up of nurses, support time recovery workers (STR's), medical staff, psychologists, administration staff and an occupational therapist. There was one non medical prescriber in Complex Care team. Single Point of Referral team had 11 substantive staff made up of nurses.
- The services operated Monday to Friday 9am – 5pm. At the time of our inspection, we found there were adequate staffing levels with a small number of vacancies across the teams. Agency staff were employed on fixed term contracts to support deficits. Complex Care North team had one agency nurse working with them for a three-month period. The Single Point of Referral team used two familiar bank staff to cover the teams' long-term sickness in order to manage the number of referrals coming in. Not all teams had identified minimum staffing levels. Single Point of Referral team reported when staff were sick the team had no contingency and had to rescreen urgent patients over the telephone. This could have caused a delay in people receiving treatment.
- Complex Care team had vacancy rate of 20% over the previous 12 months. Recruitment was in progress for vacancies. Single Point of Referral team had three nursing vacancies out to recruitment.
- Complex Care teams had a rate of 4.7% for sickness. Sickness rates for the Single Point of Referral team records were unavailable. The trust reported their systems were not able to trace these figures.
- The average caseload across the Complex Care teams were manageable varying across the teams from 18 to

Requires improvement

Are services safe?

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

30 per individual. This was in line with the Department of Health guidance (2002). Complex Care teams discussed their caseloads in the multidisciplinary meetings and management supervision sessions.

Assessing and managing risk to patients and staff

- We found the risk assessments were comprehensive in the 24 records we looked at. Staff recorded and updated them regularly as well as identifying historical, current risk and contingency plans.
- Crisis plans were present in the notes reviewed within the Complex Care teams. We saw no evidence that advance decisions were discussed with people or recorded in their records.
- The Complex Care teams had processes in place to be able to respond to a sudden deterioration in a person's health. People we spoke with confirmed they had been able to access the services quickly. The nursing teams operated a duty worker system. People reported feeling confident they would be seen quickly if needed.
- Staff received training in safeguarding adults and children. Level two and level three training was completed with compliance at 100%.
- Complex Care teams had raised 20 safeguarding alerts and Single Point of Referral team six over a 12- month period. Staff were familiar with what would constitute a safeguarding concern and knew how to raise this. We observed an external meeting at a local school showing good practice and links with external agencies.
- Mandatory training was 100% compliant.
- Staff conducted appointments at patients' homes depending on individual needs and risk. Clear lone working protocols existed. Whilst on visits we observed staff adhering to safe working practices. Sign in and out books were used when staff left the team bases. Staff made sure team members were familiar with their whereabouts and had an expected time to return to the base.
- One member of staff was going over and beyond in the Complex Care North team by visiting a patient on a Saturday outside of working hours. However, the psychiatrist and management were not aware of this and this had not been risk assessed against their lone working policy. We were concerned this staff member was working outside their remit alone to meet patient needs.
- One member of staff was solely responsible for ensuring that blood results were reviewed for clozapine monitoring. It was unclear who would complete this vital role in her absence. There was a risk that people would not be appropriately monitored and may not receive their medication as a result.

Track record on safety

- The Complex Care Team had reported two serious incidents between 1 July 2014 and 30 June 2015; one of which had led to practice improvements.

Reporting incidents and learning from when things go wrong

- The trust used an electronic incident reporting system called Datix. Staff knew how to report incidents and the type that had to be reported. One hundred and twenty eight incidents were reported from November 2014 – November 2015. Teams used team meetings, MDTs and supervisions to discuss feedback from incidents and the lessons learnt. Staff provided examples of learning. We saw records of meetings, which included feedback from incidents both, team and trust wide.
- All teams had access to group psychology sessions for debrief and support following serious incidents. One staff member told us they had been supported by their line-manager and by a psychologist following an incident. They felt supported and valued being able to discuss their experience.

Are services effective?

Good

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

Our findings

Assessment of needs and planning of care

- We examined 41 care records across the service and case tracked two records.
- Each person who used services had a set of nursing notes and medical notes. Additional information was recorded electronically. We were concerned vital information could be missed given the complex nature of recording information. Staff were not sure where to find the information we requested.
- Comprehensive assessments were completed in a timely manner within the Complex Care teams. The records we reviewed showed holistic and personalised care.
- We found only one care plan was written with a clear recovery focus. This was in contrast to the interventions we observed which were recovery focussed. Of the six care plans we reviewed none were signed. There was an explanation present on two, patient declined to sign and too busy to sign.
- Care records were appropriately filed and stored. In Complex Care South outpatients, a tracking system operated to locate files. We asked for files on the day and they were supplied to us without delay. The medical secretaries had to sign notes in and out.

Best practice in treatment and care

- Medical staff were aware of national institute for health and care excellence (NICE) prescribing guidelines and they ensured people taking anti-psychotic medication had an annual physical health review. We saw records that demonstrated physical health reviews took place. A new nursing post had been dedicated to physical health monitoring in the Complex Care teams. The nurse was aware of the national audit of schizophrenia and no health without mental health guidelines, which supported their practice.
- A clinic had been established to monitor people taking depot medication and clozapine. Lithium monitoring was completed by primary care services. The Single Point of Referral team had shared care medication protocols in place with General Practitioners.
- A staff grade doctor (Complex Care North) had participated in two audits in the previous 12 months. In relation to patient satisfaction and to review emotionally unstable personality disorder and adherence to NICE guidance. The nurses in the Complex Care teams carried out depot clinic audits. There was an audit programme in the Single Point of Referral team. A checklist was in each of the patients' notes. This had not been completed in the 14 notes we looked at. We observed discussion of audits from the recovery group in their MDT meeting.
- The Complex Care team held various groups for patients, including recovery group, hearing voices and emotional groups. The occupational therapist in the team also held cooking groups weekly.
- Health of the Nation outcome scales (HONOS) were used. This was primarily to ascertain care clusters for individuals. HONOS ratings determined future care pathways and treatments.
- Wolverhampton has a large and established Asian community. A nurse who spoke four Asian languages had been recruited to the team. She acted as a lead in the team for black and minority ethnic (BME) communities. We heard the nurse speak with a person's mother in her native language. This was to seek her views and to share information. The patient who used services was present during this interaction and involved in the discussion.

Skilled staff to deliver care

- 100% of the medical staff had revalidated in the previous 12 months.
- Complex Care teams had nurses, medical staff, psychologists and recovery workers. They had a range of administration support staff (team leader, team secretary, occupational therapist, medical secretaries, support secretary, CPA facilitator, and health records clerk). Two staff members employed by the criminal justice team worked in the teams with a specific role and remit. The Single Point of Referral team consisted primarily of band six nursing staff, with a range of office based administration support staff.
- The staff were established in the teams and experienced at working in a community setting. A student nurse told us they had received an induction on joining the team,

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.

was shown around the building and the fire evacuation procedures. They felt their mentor supported them. They were offered learning opportunities to meet their objectives.

- Staff received training in cognitive behavioural therapy, dialectical behavioural therapy, solution focussed therapy, knowledge and understanding framework and skills based training on risk management (STORM) – suicide prevention training. This meant staff had the necessary training to complete their roles effectively.
- There were link nurses for dual diagnosis, and personality disorder in the Complex Care teams. They had adopted meditation and mindfulness each morning for the staff as a way to manage stress.

Multi-disciplinary and inter-agency team work

- Team meetings and multi-disciplinary meetings occurred weekly. We reviewed the minutes of these meetings and attended a meeting in the Complex Care team North. We observed evidence of multi-disciplinary discussions of each patient.
- Staff had good working relationships with the Home Treatment team who supported their patients if their need increased beyond what the team could meet. Good relationships existed with the approved mental health practitioner's team.
- Psychologists supported the team and offered monthly supervision.
- The Complex Care team had two criminal justice nurses. There were good links with the probation services.
- The hospital pharmacy team provided pharmacy input.
- There was evidence of good working links with the General Practitioners. They provided on-going monitoring of medication and physical health needs in the Single Point of Referral team. We saw evidence of collaborative working .Staff contacted General Practitioners to confirm medication to ensure appropriate dosages. We observed effective direct handover between teams. The Crisis Team staff were in the same duty office as the Single Point of Referral duty team. They were able to discuss the urgent referrals between the teams.
- Complex Care staff had knowledge of local resources and were aware of who to refer or signpost people to for additional support. We were given examples of housing providers, floating support providers and drug and alcohol services. We saw wider resources used to support and monitor an individual who had a history of disengagement with mental health services.
- Administration staff were available. This enabled clinical staff to maximise their time working with people who used the services. Administration staff were viewed as part of the teams. Single Point of Referral team had employed an admin worker for the data input for their assessments. This was to support the community psychiatric nurses pressures to input their data.

Adherence to the MHA and the MHA Code of Practice

- The medical staff told us they had received an overview of the new Code of Practice facilitated by their medical directors.
- In the previous four years, six out of 13 staff had completed MHA training in the Complex Care South Team. Staff had a working knowledge of the MHA. Training in the MHA was not available. The trust had not provided any training in the last three years. Staff training records indicated that staff employed before this had completed the training. MHA updates had not been available.
- Staff knowledge and awareness of MHA varied across teams. Staff in Complex Care (South) had a good working knowledge. Staff in Complex Care (North) had limited knowledge. They had no understanding of the new code of practice. Despite this, staff were able to tell us the requirements of community treatment orders. Staff would contact the MHA administrators if they needed advice.
- Complex Care teams had 13 patients on Community Treatment Orders (CTO). Paperwork was completed appropriately and care plans reflected relevant elements of the CTO. Records checked were in order. Renewals and hearings by hospital managers were held in a timely manner. Eligibility for section 117 aftercare was recorded. Staff we spoke with did not understand the full legal requirements of section 117. Out of the eleven CTO records viewed, four of them recorded Section 117 aftercare entitlement. Two records stated no section 117 despite the patients having this legal entitlement.

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.

- In the Complex Care North Team, we did not see legal status of patients recorded on prescription charts. There were no T2, T3, Form 4a or CTO12 capacity to consent to treatment forms with prescription charts. This did not meet the code of practice requirements. Complex Care (South) team had six patients subject (CTO). We checked the medical files of five patients. They contained evidence of a mental capacity assessment. People had consented to their treatments. We checked fourteen medicine cards. Three people were subject to CTO; we found appropriate paperwork was present on two of these only.
- We saw clear evidence of people being made aware of how to contact independent mental health advocates and the care quality commission (CQC).
- Care records indicated that people were made aware of their rights.
- MHA paperwork was kept in the medical notes only. Copies were not available in the nursing notes. This could have created a lack of clarity regarding the legalities of the CTO and its application.

Good practice in applying the MCA

- Training in the MCA was not available. The Trust had not provided any training in the last three years. Staff training records indicated staff employed before this had completed the training. Nine of the staff had completed MCA training in the previous four years; five staff had not in Complex Care South team.
- The trust has a policy on MCA that staff could refer to. Staff were aware of this policy.
- Capacity was assumed in the teams. There was no specific assessment of capacity in the initial assessments. Variation in knowledge was evident. Staff in Complex Care South were clear all decisions were specific. Staff in the other teams were not fully aware of the principles of the MCA.
- There was evidence of informed consent and assessment of mental capacity in the records we viewed.
- Support and advice about the MCA and DoLS was available in the trust.

Good

Are services caring?

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

Our findings

Kindness, dignity, respect and support

- We listened to triage calls at the Single Point of Referral team and the duty workers at the Complex Care teams. Their interactions were respectful and considerate. They were sensitive in their approach when discussing risk, medication and mental state.
- Patients expressed that staff were very helpful and assisted them to live in the community independently. Patients described staff as great, helpful and understanding. Patients highlighted they felt listened to and staff had an understanding of their needs. One person commented on the nurse (depot clinic), "only met her once, but she knew all about me and my name."
- Good relationships existed between staff and people who used services. Staff allowed people time to speak. They discussed options with people and gave them choices. They were very familiar with the individual needs of people. They were respectful of individual differences and adaptable in their approach towards people. A staff member when visiting a person's home, who was known to neglect himself or herself, sensitively checked there was adequate food available. Staff were greeted warmly when they arrived at people's homes.
- A relative told us staff were caring, helpful, attentive and listened to them. She had a copy of her son's plan and felt included in his treatment.
- Staff maintained confidentiality when discussing patients' care. We accompanied staff on home visits using public transport. Patients recognised them and staff maintained a professional manner.
- One member of staff in the Single Point of Referral team commented when staff were under pressure, some staff were rather abrupt.

The involvement of people in the care they receive

- Involvement in care was evident throughout the interactions we witnessed. Staff discussed options with people and allowed them to make choices.
- Patients reported they were involved in their care programme approach (CPA) meetings.
- Patients in the Complex Care teams spoke about how they discussed their early warning signs at their reviews with the consultant.
- Patients told us they had written copies of their care plans.
- During discussions, staff had a clear focus on helping people to identify and work towards personal goals. We saw staff sensitively helped people to keep their goals realistic and achievable demonstrating staff helped to support individual's personal recoveries.
- There was positive feedback from patients and their carers. They were involved following patient consent. Carers we spoke to had been offered a carer's assessment. If refused this was documented. One carer had received relevant written information. Staff spent time during their visits educating carers about mental health.
- Advocacy services were available. Leaflets highlighting the local service were available. Staff had good awareness of access to advocacy services. There was evidence of this in patient records. Patients told us they knew how to access advocacy.
- Suggestions, compliments and complaints boxes were available in waiting areas for people to give feedback. The teams received feedback from the friends and family test.

Are services responsive to people's needs?

Requires improvement

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

Our findings

Access and discharge

- Patients were able to access Complex Care and Single Point of Referral Teams between 9am and 5pm weekdays. Out of these hours, patients were encouraged to contact the Crisis team.
- The Single Point of Referral team was the first point of contact for people accessing mental health services. The team accepted referrals from healthcare professionals. Self-referrals were not accepted and patients were advised to see their general practitioner or emergency department in order to receive an initial assessment. Referrals were received by telephone, post, fax or using an electronic referral form from the trust website. Referrals were screened by a duty worker. If risks were evident, urgent referrals were forwarded to the Crisis team on the same day. Routine referrals would wait to be assessed by a Single Point of Referral worker. For routine referrals, a standard letter would be sent to the patient with the telephone number of the team. The patient could contact the team whilst waiting for an assessment. The waiting time for routine assessments was between 6 - 20 weeks whereas the service target time was 4 - 8 weeks. There were no systems in place for ongoing monitoring of patients on waiting lists in this team. Patients were encouraged to contact their General Practitioner or the duty team if the need arose whilst they were waiting to be seen. We found evidence of a patient who was referred in September 2015 and was still awaiting an appointment date for assessment 15 weeks since initial referral.
- Complex care teams operated a duty worker system. They would take telephone calls from patients and carers and offer initial support to callers. If a need for urgent intervention was identified this would be referred to the crisis teams who would respond within 24hours. Non-urgent interventions were met by the Complex Care teams within 48 hours. The team showed responsiveness to patients who had the highest needs and offered them appointment slots when other patients cancelled the appointments.
- There was rapid access to a psychiatrist across the teams. Complex Care teams had dedicated medical staff at their base. The Single Point of Referral team were nurse lead. They could refer to "clinic 40" based at Hallam Street outpatients. Clinic 40 was a service where psychiatrists would assess patients within seven days. Hallam Street had additional available appointments daily. Urgent assessments would go to the crisis team on the day of referral.
- The teams worked with individuals who fit into specific care clusters. Care Clusters are reference groups used to link patients according to their individual needs.
- Care co-ordinators managed individuals care. Allocations occurred weekly at the multi-disciplinary team meetings. Waiting lists were discussed in team meetings within the Complex Care teams. On the day of inspection, three individuals were awaiting allocation of a care co-ordinator at Complex Care North. They had been waiting less than seven days. Allocation occurred weekly at the MDT meeting
- There were no clear systems to monitor referral numbers in the Single Point of Referral team. Each clinician had over 100 patients waiting for assessment. One clinician had 190 people waiting. We saw higher figures when we looked into the systems on site although the manager told us this was not 100% accurate due to data errors. The trust were aware of the issues with referral numbers and monitored this via the risk register. The service had recently gone through a transformation and was continuing to expand creating further risk due to potential growth in referral numbers.
- The Single Point of Referral service had a system for failed visits or patients that did not attend (DNA). Staff could describe how they would risk assess a patient who had not attended for an appointment. If no significant risk was identified, they discharged back to the General Practitioner for follow-up. Single Point of Referral team had varied DNA figures each month for individual clinicians. An example of DNA's from April 2015 – October 2015, for one clinician, varied from 19 to 36, with an average of 30. As a way to reduce DNA's the Single Point of Referral team would call patients prior to their appointments to check they were attending. In Complex Care, team if a person failed to attend for an appointment this was followed up by staff. The duty worker would attempt to contact the person via phone. During the inspection, we heard telephone calls being made to patients who had missed appointments. If phone contact was not possible team members would

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Requires improvement

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try to contact people by visiting their homes. No patient was discharged from the Complex Care teams for missed appointments without a full discussion being held at the MDT meeting.

- Unplanned staff absence led to the cancellation of appointments. The teams collectively would try to meet appointments. If this were not possible, people would be contacted and alternative appointments arranged.
- Future community appointments were arranged during the assessments. We saw that outpatient appointments were arranged prior to the person leaving the premises. We saw one person ask to be reminded of their future appointment. The reception at Complex Care South made an electronic entry to remind her to ring the person.
- The appointments where we accompanied staff ran on time.
- The running of a depot injection clinic in Complex Care South had been changed following feedback regarding long waits from people who used the service. Previously, people had turned up without appointments and waited. Since the change to the provision, people were given time slots; on arrival, they took a numbered ticket. Waiting was kept to a minimum and people were seen in order of arrival. At Complex Care North, the system had not changed. Patients could be waiting more than an hour for their injection. We spoke to carers who expressed some frustration over this saying that they preferred appointment slots.
- Social workers were managed externally to the team as part of the trust's section 75 agreement with local authorities. This caused delays in people receiving timely MHA assessments by the approved Mental Health Professionals (AMHP).
- One staff member informed us community patients could not access beds when needed. Patients were remaining in hospital either awaiting a social work assessment or funding for a placement.
- Discharge letters went to relevant agencies.

The facilities promote recovery, comfort, dignity and confidentiality

- The interview rooms across the service had adequate sound proofing to ensure conversations were private. Rooms available were spacious, comfortably furnished and accessible. The Complex Care Team had adequate interview rooms to meet the needs of patients. The staff base was separate from the clinical area in the Complex Care South Team. The consulting and interview room doors had large glass oblong viewing panels. This could have affected people's privacy and dignity. Staff covered some panels with paper.
- Complex Care had a clinic room for the administration of depot injections and the monitoring of physical health, associated with the prescription of certain medications. At the Complex Care North Team, examination and weighing equipment could not accommodate overweight patients. The team were fully aware of this. This affected some patient's comfort and dignity. The team had raised it as an issue to the management no action had been taken.
- A large range of leaflets and information was available. We saw medication leaflets, information about PALS and how to complain. Advocacy services including specialist Mental Health Act leaflets were displayed. We also noted Health watch, financial inclusion services, and a spiritual care team leaflets.

Meeting the needs of all people who use the service

- The leaflets were informative and gave an overview of what people could expect. There was information about the services and roles performed. Including information on support time recovery workers, physical health checks, hearing voices groups, a recovery course, an emotional regulation group and the discharge process.
- Leaflets were available in languages other than English. We saw a large poster, which covered many languages advising people to point to their own language and let the receptionist know.
- Patients and their carers reported there had been reasonable adjustments made to the clinic at the Complex Care North Team. Complex Care South had identified an issue with the approach to the building for wheelchair users and reported this.
- The Single Point of Referral team were able to book interpreters. They raised an issue they did not have leaflets available in enough languages and senior managers were aware of this.

Are services responsive to people's needs?

Requires improvement

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

- Single Point of Referral team had one Nurse Prescriber, supporting the team and offering advice. The trust was developing these roles and reviewing its policy before non medical prescribing could commence.

Listening to and learning from concerns and complaints

- The services had received 14 complaints in the previous 12 months. Six were open, two complaints were upheld, another partially upheld. One complaint had been upheld by the health service ombudsman in the previous 12 months.
- The majority of patients we spoke with were aware of how to make a complaint and told us they would feel confident in raising issues. At the Complex Care teams, compliments and complaints boxes were present. Patients could raise issues and give feedback. The teams welcome packs provided contained information on how patients could complain.
- Staff were familiar in how to deal with complaints and how to escalate them if needed. They received feedback on investigations and complaints in the weekly MDT meeting. Some staff we spoke to reported they did not always get feedback from incidents logged. A previous complaint had altered how the depot clinic operated.
- At the Complex Care North Team, we saw a radio in the waiting area which had been a response to the "you said, we did" survey for patients.

Are services well-led?

Requires improvement

By well-led, we mean that the leadership, management and governance of the organisation assure the delivery of high-quality person-centred care, supports learning and innovation, and promotes an open and fair culture.

Our findings

Vision and values

- Staff were familiar with the trust values. Staff could describe how the values translated to care. There were posters displayed which highlighted the trust values at the sites visited.
- Team values supported those implemented by the trust.
- Staff knew who their senior managers were, however, there were mixed responses about them visiting the teams. Most staff confirmed they had met their new director of nursing and felt supported by them.
- Service and Team managers said they received good support from senior management. Staff spoke highly of their line managers and their service managers and they said they found them supportive and approachable.

Good governance

- Appraisals happened in each of the teams 97% staff had completed their appraisals. Staff had a choice of individual clinical supervisors. Staff development was planned and monitored through appraisal.
- Staff received monthly managerial one to one supervision and group supervision with a psychologist. They confirmed receiving it and found supervision useful. This meant staff were supported in their roles.
- Managers monitored performance of staff locally and addressed any issues in their appraisals and supervision. However, governance arrangements in the teams did not have robust systems and methods to effectively monitor quality, safety and ongoing performance. The inspection team identified areas where improvements were needed. The areas that were not monitored effectively were waiting lists in the Single Point of Referral team and lack of emergency equipment in the Complex Care teams. There was no action plan to mitigate risks to patients on waiting lists.
- The team manager had authority to adjust staffing levels and submit items to the trust risk register. There were no service specific risk registers in place.

Leadership, morale and staff engagement

- There were no current bullying and harassment cases in the team.
- Staff were aware of their whistleblowing policy and expressed they were happy to raise concerns without fear.
- Staff reported good relationships, committed staff and good morale in the teams. They felt their teams were supportive of each other and there was good team working.
- Disciplines worked alongside each other to meet people's needs. Team members felt valued for the contributions they made.
- Managers across the services also spoke highly of their team members stating that they were hard working, committed and caring.
- Complex Care Team managers told us they had an open door policy were staff were able to raise concerns informally.
- Staff were aware of their responsibilities in relation to the duty of candour. Following a prescribing error, the trust apologised to the patient in writing. This led to a change in practice. CPN's now checked the last medical letter and confirm the prescription when medications are changed.
- Staff said they were happy in their roles. They felt they were a good team who worked well together. They felt they were person centred and put people's needs at the centre of all they did.

Commitment to quality improvement and innovation

- Research projects were led by the medical team. Current research included 'prescribing Valporate for bipolar disorder' , cardio-metabolic health screen and intervention framework', 'psychosis network evaluation', 'clinical audit on documentation of clozapine related monitoring', and 'prescribing in personality disorders'. This meant the service was committed to development and learning to enhance the care provided.
- The trust does not participate in any specific accreditation schemes for adult community services.

This section is primarily information for the provider

Requirement notices

Action we have told the provider to take

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

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 15 HSCA (RA) Regulations 2014 Premises and equipment **Regulation 15 HSCA (RA) Regulations 2014. Premises and Equipment.** **Ensure emergency equipment is available and accessible at all locations.** **This was a breach of Regulation 15 (1)(f)**

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment **Regulation 12 HSCA (RA) Regulations 2014. Safe care and treatment.** **Ensure checks of temperatures of the medicines fridges are completed. Recorded consistently and medicines stored at the required temperatures.** **This was a breach of Regulation 12(2) (g).**

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Diagnostic and screening procedures	Regulation 17 HSCA (RA) Regulations 2014 Good governance

This section is primarily information for the provider

Requirement notices

Treatment of disease, disorder or injury

Regulation 17 HSCA (RA) Regulations 2014 Good governance.

Governance arrangements in the teams did not have robust systems and methods to effectively monitor quality, safety and ongoing performance. There was no action plan to mitigate risks to patients on waiting lists.

This was a breach of Regulation 17(2)(a)(b)