Inadequate

Plymouth Community Healthcare CIC

# Community-based mental health services for adults of working age

## Quality Report

Local Care Centre
Mount Gould Hospital
Plymouth
Devon
PL4 7PY
Tel: 08451 558100
Website: www.livewellsouthwest.co.uk

Date of inspection visit: 21 - 24 & 28 June 2016
Date of publication: 19/10/2016

## Locations inspected

| Location ID | Name of CQC registered location | Name of service (e.g. ward/ unit/team) | Postcode of service (ward/ unit/ team) |
|---|---|---|---|
| 1-297622270 | Local Care Centre Mount Gould Hospital Local Care Centre Mount Gould Hospital | East community mental health team | PL7 2AU |
| 1-297622270 | Local Care Centre Mount Gould Hospital | West community mental health team | PL7 4QD |
| 1-297622270 | Local Care Centre Mount Gould Hospital | South community mental health team | PL7 4QD |

This report describes our judgement of the quality of care provided within this core service by Plymouth Community Healthcare CIC, also known as Livewell Southwest. Where relevant we provide detail of each location or area of service visited.

# Summary of findings

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 Plymouth Community Healthcare and these are brought together to inform our overall judgement of Plymouth Community Healthcare.

# 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 | Inadequate  |
| Are services safe? | **Inadequate**  |
| Are services effective? | **Requires improvement**  |
| Are services caring? | **Good**  |
| Are services responsive? | **Inadequate**  |
| Are services well-led? | **Inadequate**  |

**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 carried out an unannounced focussed inspection on 17 October 2016 to see if the provider had met the concerns we raised in a section 29 warning notice following our comprehensive inspection of the provider in June 2016.**

**We found evidence that Plymouth Community Healthcare CIC had made progress and improvements. At this time we will not be taking any further enforcement action but will continue to monitor the provider's compliance with the warning notice, this is because:**

- Between 21 and 23 June 2016 we inspected the services delivered by the community mental health teams for adults with mental health as part of the comprehensive inspection. During the inspection we found that the provider was not meeting the standards expected in this service as it did not have appropriate processes in place to monitor and prevent avoidable harm, or the risk of avoidable to harm to patients using the service.
- We found that the provider was in breach of Regulation 12 (1)(2)(a)(b)(c)(g) safe care and treatment, Regulation 17 (1)(2)(a)(b) good governance and Regulation 18 (1)(2)(a) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. We issued a warning notice on 15 July 2016. We told the provider to achieve compliance with the above regulations by the 19 August 2016. The provider sent us a comprehensive response and evidence demonstrating their compliance to all the concerns raised in the warning notice.
- We carried out an unannounced, focussed inspection of the South and West teams on 17 October 2016 to assess if the provider had addressed the concerns and to check the progress that had been made. During our inspection we spoke with 12 staff, including the South and West locality managers and reviewed six care notes.
- The provider had implemented processes to regularly monitor and assess the risk of patients on the waiting list and prioritise them in order of risk. All six records we sampled had been reviewed, had details of each client's key risks and contained a crisis and contingency plans with identified triggers and early warning signs. However, we still found that the South and West teams had over 50 patients on their waiting lists. At the time of inspection the longest a patient had been waiting was 26 weeks.
- We found that the provider's medicines management had improved. Audits showed that staff were taking action to address the high fridge and room temperature in the South team's clinic room. The clinic room was clean and all medicines were in date.
- The provider had recruited more band six nurses; the South and West teams were less reliant on agency staff. However, at the time of inspection the teams were still carrying eight vacancies.
- Data provided by Plymouth CIC showed that all staff had received recent supervision. Staff we spoke to told us that supervision was now happening and they were receiving better management.
- As a result of actions taken by the provider staff told us they that a safer service was being delivered to patients, although they still felt stressed by the pressures from vacant posts and waiting lists.
- Overall, we found evidence of progress and improvements being made across all the concerns raised in the warning notice although this was not enough to remove the warning notice. The provider had put in place several positive changes that were improving the safety of the service delivered. However, the provider had not addressed all concerns relating to waiting lists and vacancies. At this time we will not be taking any further enforcement action but will continue to monitor the providers' compliance with the warning notice.

**During our comprehensive inspection of the provider in June 2016 we rated community-based mental health services for adults of working age as inadequate because:**

- The service had substantial difficulties with recruitment and retention of staff. This included doctors, nurses, and allied health professionals such as social workers, psychologists and occupational therapists. Difficulties with staffing had been known to the service for at least 12 months prior to our inspection. There was very high use of agency and locum staff in the south and west teams, and teams

had difficulty covering for sickness, leave or vacant posts. Two serious incident investigations had highlighted concerns about safe staffing. Staff in the south and west teams were stressed and morale was low.

- Waiting lists for allocation of a care co-ordinator and lack of staffing were impacting on effective handover between teams within the organisation and some of the community mental health teams. Patients told us that they saw lots of different doctors, that there was high use of agency staff and that they did not always know who they were going to see. Staff told us that appointments were cancelled due to staff shortages. 2,444 appointments had been cancelled by the west, south and east teams between 1 June 2015 and 31 May 2016.
- All teams had waiting lists for patients waiting for allocation of a care co-ordinator. Although waiting lists were reducing, referrals into the service remained higher than the numbers of patients being discharged. Three patients had been waiting between 31 and 35 weeks. This was in breach of 18 week targets, and two people who had been waiting since October 2015 were potentially high risk. Although there was some monitoring of patients on the waiting lists, this was not sufficiently robust. Risk assessments that were carried out at first assessment were too basic and did not provide sufficient information to give staff a baseline risk against which to monitor, there was no waiting list monitoring tool to ensure consistent review of people waiting for a care coordinator, and waiting lists were not rated by severity of risk. One-third of risk assessment were not up to date.
- We had concerns about clinic and medication management in two of the three teams. This included clinic room and fridge temperatures not being recorded, out of date medications and an unlabelled medication in the medication cupboards. The wrong depot medication had been administered by another community mental health team in June 2015, and poor medication management increased the risk of medication errors.
- Staff had not been trained in STORM suicide risk assessment training, despite the need for this being highlighted in a serious incident investigation, and the action having been signed off as completed. No agency staff had received STORM training. One agency worker had not received duty training before working as the duty worker and had been involved in a serious incident whilst on duty.
- The quality of care plans varied and not all were personalised, holistic or recovery orientated. Staff were not trained to provide psychological therapies and there was a one year waiting list for cognitive behavioural therapy and a five month wait for psychotherapy. The provider was not meeting targets for improving physical health for people with severe mental illness, and the providers own audit showed that only 11% of patients in the south had not received annual physical health checks. Referral to assessment and treatment data was only available for the 18 week target and therefore the provider could not demonstrate that it was seeing urgent patients in a timely manner.
- Information about advocacy was not made widely available and patients and patients and carers had limited ability to contribute to the running of the service.
- Governance and leadership were inadequate. The provider had not undertaken a thorough analysis of the service in order to fully understand the root causes of the difficulties in employing and retaining substantive staff. There was no workforce strategy for community mental health teams despite issues with recruitment and retention having been ongoing for at least 12 months.
- The provider did not have a clear plan to reduce the waiting lists, maintain reduced waiting lists, or ensure those on the waiting list were effectively monitored for deterioration in their mental health.
- Staff had to access a number of different documents, some of which were draft copies and contradicted each other, in order to ascertain guidance on operational procedures. There was a draft operational policy for adult community mental health teams. The service specification was also a draft. Guidelines for prioritisation of referrals did not relate to the draft service specification and aims and objectives of the service were not defined.
- Systems to monitor supervision and training of staff were not effective, lessons and recommendations from internal investigations of incidents were not always implemented and some serious incident investigations took too long. This meant that the there

# Summary of findings

was a risk of similar incidents happening again. Some actions that the provider had taken as a result of complaints were unlikely to effectively reduce complaints as we found that contributory factors such as staff shortages, waiting lists and use of locum doctors were still present. This meant that patients were still likely to have cause for complaint.

However:

- Staff tried to ensure that essential tasks to ensure patient safety were undertaken, psychiatrists were available when needed and patients had numbers to contact if needed.
- Staff were aware of the problems in the service and wanted it to improve. Patients told us that staff were kind, respectful and friendly.
- Team managers ensured staff received induction and were trying to improve access to supervision by using supervision groups. Staff told us that they felt supported by team managers and locality managers.

# Summary of findings

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

**Are services safe?**

Inadequate

**We rated safe as inadequate because**:

- The service had substantial difficulties filling vacancies and retaining staff in the south and west teams.
- There were waiting lists for care coordination in all teams. Patients on the waiting list for care coordination were not safely monitored.
- Teams were not always able to make arrangements to cover for sickness, leave or vacant posts.
- Two serious incident investigations had highlighted concerns about safe staffing.
- There was very high use of agency and locum staff due to unfilled vacancies in establishment staffing levels.
- One-third of risk assessments that we reviewed were not up to date. High risk patients were not discussed in the daily huddle meetings.
- The south team used two staff activity boards plus an in/out board in reception, none of which were consistently completed. This meant there was not a safe system for managing where staff were working and when they were returning.
- We were concerned about medicines management in two out of the three teams that we inspected.
- A serious incident investigation recommended the use of the STORM suicide risk assessment and that a check should be undertaken to ensure all staff had completed this training. This action was signed off as completed on 31 January 2016. We looked at 19 staff records for the south and west community mental health team. Only two out of the 11 records in the west team showed staff had undertaken STORM training and one out of eight in the south team. No agency staff had received STORM training.

However:

- Staff had access to portable alarms.
- Staff tried to ensure that essential tasks to ensure patient safety were undertaken, such as administering depot medication.
- Despite the recruitment difficulties, staff and patients told us they were able to access a psychiatrist rapidly when required.
- Risk was discussed for all new patient assessments and of known patients who were a cause for concern due to potential escalating risk in the west team's multi-disciplinary team (MDT) meetings. Plans were made to manage the risk in each case by the MDT.

# Summary of findings

- Patients were made aware that they could contact duty if their health deteriorated.
- Oversight of the clinic and medication management in the west team was very good.

**Are services effective?**

**Requires improvement**

**We rated effective as inadequate because:**

- The majority of care plans in the west and south teams were not personalised, holistic or recovery orientated.
- The majority of patients had not received annual physical health checks. The provider's own audit showed that only 30% of patient in the west team, 18% of patients in the east team, and 11% of patients in the south had received an annual physical health check.
- Medical cover relied on locums. A substantive speciality doctor provided two sessions per week to the west team but all other medical cover was provided by locums and there had been five different locum doctors in the south team since January 2016.
- Social work staff had been re-integrated into the provider organisation over a year prior to our inspection. However only one of the three teams a social worker within it.
- There was a lack of continuity and experience amongst mangers and qualified frontline staff. Three out of the four locality managers did not have any mental health experience and two out of the three team managers had been in post for less than six months. Over 80% of band 5 staff in the west team were agency with the longest being in post four months.
- Some staff, including agency workers, were not receiving regular supervision.
- Lack of staffing and waiting lists for care coordination were impacting on effective handover between teams within the organisation and some of the community mental health teams.
- One agency worker had not received duty training before undertaking duty work and had been involved in a serious incident.
- None of the teams had reviewed all patients on care programme approach (CPA) in the last 12 months. All teams were less than 95 % compliant with this target, with the lowest being 88% of CPA patients in the south team.
- Staff were not routinely participating in clinical audit.

However:

# Summary of findings

- The provider used health of the nation outcome scales (HoNOS). The use of HoNOS is recommended by the English national service framework for mental health as an outcome indicator for severe mental illness. 100% of east team patients had completed HoNOS assessments.
- Staff attended corporate and local team inductions. There was a handbook for staff containing information relevant to the community mental health teams.
- All teams attempted to recruit a range of disciplines to their vacant posts.
- Management of sickness and poor performance issues were well managed with evidence of regular meetings and reviews.
- The south and west teams had morning "huddle" meetings, to prioritise tasks for the day.

**Are services caring?** Good

**We rated caring as good because:**

- We observed that staff spoke respectfully about patients in the multi-disciplinary meeting that we attended and observed respectful and kind responses to patients when staff spoke to them on the telephone.
- Feedback was generally very positive about staff and patients said they were treated with kindness and respect and that staff were friendly.
- Staff we spoke to told us they wanted to deliver the best care they could and were aware that the difficulty of recruiting and retaining staff had a negative impact on the care patients received.
- All patients we spoke to who should have had a care plan did have a copy and said they had felt involved in writing it.

However:

- Patients said they saw lots of different doctors. All three patients we spoke to from the south team told us about lots of changes of staff, high use of agency staff and not always knowing who they were going to see.
- We did not see any advocacy information in waiting areas. Patients that we spoke to said that they had not been made aware of advocacy services.
- None of the teams had peer workers and patients were not involved in recruiting staff.

**Are services responsive to people's needs?** Inadequate

**We rated responsive as inadequate because**:

# Summary of findings

- The provider advised us that the target was that staff should assess people referred as an emergency within one day. However staff were unclear about the emergency referral targets. The service specification document and operational policy, which would have provided a definite reference for staff, were still in draft, which contributed to the lack of clarity.
- All teams had waiting lists for allocation of a care coordinator, with the longest wait being 35 weeks. Some people who were waiting were potentially high risk.
- The service was not monitoring referral to assessment times, except for the 18 week target. This meant that the provider was not able to demonstrate whether it was providing assessment and treatment in a timely way for people who had been referred urgently.
- There was a one year waiting list for cognitive behavioural therapy and a five month wait for psychotherapy. Staff were not trained to provide psychological therapies such as cognitive behavioural therapy
- Inclusion and exclusion criteria were not clearly defined and there was a lack of clarity about the roles of the teams and which timescales to work towards.
- 2,444 appointments had been cancelled by the west, south and east teams between 1 June 2015 and 31 May 2016. Staff told us that appointments were often cancelled due to staff shortages.
- The east team were using a meeting room to administer a depot injection for a patient. This was an unsuitable space and did not protect patients' dignity.
- Between February 2014 and January 2015, 45 complaints against community mental health team were upheld.

However:

- There was a single point of access contact centre. Referrals were either triaged by the duty worker or by a member of permanent staff at band 6 or above.
- All teams had a qualified member of staff on duty each day to take calls from people who 'phoned in.
- The south team had received four compliments

**Are services well-led?**

**Inadequate**

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

- Senior managers had been aware of staffing concerns since at least September 2015. However, the provider had not

undertaken a thorough analysis of the service in order to fully understand the root cause in employing and retaining substantive staff. There was no workforce strategy for community mental health teams.

- Waiting lists for care co-ordination had operated for at least one year. However, the provider did not have a clear plan to reduce the waiting lists, maintain reduced waiting lists, or ensure patients who were waiting were effectively monitored for deterioration in their mental health. There was a lack of sufficiently robust systems to ensure that the provider was fully aware of any fluctuations in risk of patients on the waiting list.
- There was no service-wide auditing tool to ensure consistency of standards of auditing case records.
- Staff had to access a number of different documents, some of which were draft copies and contradicted each other, in order to ascertain guidance on operational procedures.
- The provider was not monitoring referral to assessment times, except for the 18 week target. This meant that the provider was not able to demonstrate whether it was providing assessment and treatment in a timely way for people who had been referred urgently.
- The provider did not have effective system in place to ensure they could monitor the supervision and training of staff.
- The provider had not ensured that all lessons had been learnt and recommendations implemented from internal investigations. Some investigations took too long. This meant that the there was a risk of similar incidents happening again.
- We were told that action had been taken as a result of complaints about appointments which had been due to staff shortages and waiting lists. However, we found that factors such as staff shortages, waiting lists and use of locum doctors there were still present. This meant that patients were still likely to have cause for complaint.
- Some staff were clearly stressed and felt under too much pressure. Staff morale was low in the south and west teams and it was not evident from our conversations with senior managers that they had undertaken meaningful consultation with staff or taken account of their views.

However:

- Most staff spoke positively about the team managers and operational managers

# Summary of findings

- Managers could access reports which showed information about care programme approach, clustering, number of visits and staff performance and a “managers toolbox” for staff performance management, training, grievance sickness and absence.
- A modern matron post was being advertised when we inspected. The modern matron role included operational oversight of the community mental health teams.

# Summary of findings

## Information about the service

Community mental health teams for adults of working age provided by Plymouth Community Healthcare CIC were separated into four teams under a locality model. The four localities were north, south, east and west, and each locality had agreed GP practices from which they accepted referrals.

The teams offered assessment and, where appropriate, treatment for a range of mental health conditions. There were also city-wide specialist community services, which included an assertive outreach team, asylum seeker team and community forensic teams. We did not inspect the citywide teams.

We inspected the east community team, based in east locality at Ridgeview Plympton Clinic, the west community team, based in the west locality at Avon House, and the south team, based in the south locality which also worked from a base at Avon House.

Plymouth Community Healthcare CIC's community mental health teams for adults of working age had not been inspected previously.

## Our inspection team

Our inspection team was led by:

**Chair**: Andy Brogan, executive director of nursing, South Essex Partnership Trust

**Head of Hospital Inspections**: Pauline Carpenter, Care Quality Commission

**Inspection manager**: Nigel Timmins

The team that inspected this core service comprised three CQC inspectors and two specialist advisors who had experience of working in adult mental health services.

## Why we carried out this inspection

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

## How we carried out this inspection

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

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

Before the inspection visit, we reviewed information that we held about these services, asked a range of other organisations for information and sought feedback from patients at three focus groups.

During the inspection visit, the inspection team:

- visited three out of the four community mental health teams for working age adults
- spoke with ten patients who were using the service and one carer and collected feedback from four patients using comment cards
- spoke with the managers for each of the teams
- spoke with 16 staff members including doctors, nurses and psychologists
- interviewed the deputy director of operations with responsibility for these services
- spoke with one locality manager and one deputy locality manager

# Summary of findings

- attended and observed two “huddle” meetings and a multi-disciplinary meeting
- observed one outpatient appointment.
- looked at 19 treatment records of patients and two records of patients on community treatment orders
- carried out a specific check of the medication management on four wards, including looking at 45 depot medication charts
- looked at 19 staff files
- looked at a range of policies, procedures and other documents relating to the running of the service
- We did not accompany staff on any home visits.

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

We spoke to seven patients and one carer. Feedback was generally very positive about the staff and patients said they were treated with kindness and respect.

However, some patients said they saw lots of different doctors. One west team patient told us that their doctor had left and they did not know who was taking over and that appointments were cancelled without them being informed. Another patient said they had seen five different doctors in three years. All three patients we spoke to from the south team told us about lots of changes of staff, high use of agency staff and not always knowing who they were going to see. One person said that they felt staff were not doing much to help them recover. None of the east team patients told us that they had experienced changes of doctors or other staff, although one patient felt it took a long time to get an initial appointment.

We received four feedback cards, one was about the assertive outreach service, one about the personality disorder service and two cards did not name the team they were referring to. The feedback was very positive about staff for all four comment cards.

## Areas for improvement

### Action the provider MUST take to improve

We issued a Section 29 warning notice on 15 July 2016 which told the provider they must make significant improvements to the following areas:

- The provider must ensure that care and treatment is provided in a safe way for patients.
- The provider must ensure that they assess the risks to the health and safety of patients receiving care or treatment.
- The provider must ensure that they do all that is reasonably practicable to mitigate any such risks.
- The provider must ensure that persons providing care or treatment to patients have the qualifications, competence, skills and experience to do so safely.
- The provider must ensure the proper and safe management of medicines.
- The provider must ensure that systems or processes are established and operated effectively to assess, monitor and improve the quality and safety of the services provided in the carrying on of the regulated activity (including the quality of the experience of patients in receiving those services).
- The provider must ensure that systems or processes are established and operated effectively to assess, monitor and mitigate the risks relating to the health, safety and welfare of patients and others who may be at risk which arise from the carrying on of the regulated activity.
- The provider must ensure that sufficient numbers of suitably qualified, competent, skilled and experienced persons are deployed.
- The provider must ensure that persons employed by the service provider receive such appropriate support, training, professional development, supervision and appraisal as is necessary to enable them to carry out the duties they are employed to perform.

### Action the provider SHOULD take to improve

- The provider should ensure that information about advocacy is easily accessible for all service users.
- The provider should ensure that they encourage patient and carer participation in developing and improving the service.

Plymouth Community Healthcare CIC

# 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 |
|---|---|
| East community mental health team | Local Care Centre Mount Gould Hospital |
| West community mental health team | Local Care Centre Mount Gould Hospital |
| South community mental health team | Local Care Centre Mount Gould 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.

Staff had recently undertaken training in the Mental Health Act Code of Practice. Independent mental health advocacy services were provided by Support Empower Advocate Promote.

Approved mental health practitioners were not based in the teams, but were accessed via the social work hubs.

Three patients were under community treatment orders (CTO). We looked at medication records for these patients and found that one patient did not have a consent form attached to their record. We did not review other CTO paperwork as part of this inspection.

CTO patients and patients receiving section 117 aftercare were not on the standard agenda for discussion as part of the regular multi-disciplinary team meetings. Section 117 is a section of the Mental Health Act which imposes a duty on health and social services to provide aftercare to certain patients who have been detained under the Mental Health

Act. Due to the turnover of staff in some teams, regular discussion of these patients could have been a useful prompt to ensure their needs were being met and their rights under the Mental Health Act were being adhered to.

## Mental Capacity Act and Deprivation of Liberty Safeguards

Most staff had received mandatory Mental Capacity Act (MCA) training. This training was up to date for 13 out of 14 staff in the west team, 11 out of 12 in the east team and all eligible staff in the south team. The staff we spoke to could demonstrate a basic working knowledge.

We saw assessments of capacity in the care records of patients who may have had impaired capacity. However, we could not be confident that there was sufficient oversight to ensure that mental capacity was always being addressed effectively because there was inconsistent consultant cover.

Independent mental capacity advocacy (IMCA) was provided by Support Empower Advocate Promote (SEAP). Leaflets for this service were not on display in waiting areas.

Inadequate

# 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

- All interview rooms were clean and in good repair. None of the interview rooms had fixed alarms systems, but staff had access to portable alarms. There were different systems to ensure these alarms were fully charged so that they operated if needed. In the east team, individual staff were responsible for ensuring the alarms were charged, but at Avon house there was a more robust system where this was the responsibility of administrative staff. None of the teams had access to interview rooms that were specifically designed as safe interview rooms for use with potentially aggressive or agitated patients, for example, rooms with two exits or furniture that could not be used as a missile.
- The west and south teams shared a clinic room. In the east team's service, the examination couch had failed infection control standards as it was ripped, however it had not been removed from the room. The east team clinic room was very hot, and there was no room thermometer so it could not be checked. The team said that they did not use the room with patients because of the heat and they found it was too cramped to use with patients who might be agitated.

### Safe staffing

- The service had substantial difficulties filling vacancies and retaining staff in the south and west teams. The provider provided data for sickness and staff turnover from 1 February 2015 to 31 January 2016. This showed that the west team had a 33% vacancy rate, 10% sickness, and 48% staff turnover. The south team had a 15% vacancy rate, 6% sickness, and 20 % turnover. These difficulties in recruitment and retention were not experienced by the other community mental health teams across community mental health service and staffing in the east team was stable for all staff except doctors. Team managers were given permission to use agency staff to fill gaps. A locality manager told us that concern about staffing was their biggest worry for the team. The provider was aware of the staffing difficulties and it featured on its corporate risk register. However, despite this, the provider had not undertaken a thorough analysis of staffing in order to understand the root causes of the difficulties or the reasons that some teams were affected more than others. The provider did not have a specific strategy in place for the community mental health teams to address these issues. However, they had carried out recruitment work which included recruiting four preceptors (newly registered staff) who would come into post in September 2016, internal staff moves, attendance at recruitment fairs, interviews for social workers to fill vacancies, a rolling advert for community mental health team staff and use of internal bank staff. The deputy director of operations informed us that a review of the overall community mental health team role and a "capacity and demand" exercise to look at staffing was underway. However, the provider did not provide us with information to support this. This meant that we did not have evidence that this work was at a stage where it was likely to have a meaningful impact within the near future.
- Caseloads for care co-ordinators were low and averaged 20 patients per full-time worker. The Department of Health Mental Health Policy Information Guide, 2001 recommends care coordinators should have a maximum of 35 cases. Despite low caseloads, there were waiting lists for care coordination. The south team reported that there were 41 people on the waiting list for care coordination on 6 June 2016. This was a reduction from 70 waiting in May 2016. The south team manager showed us that their team had 44 people on the waiting list. This was a decrease from the previous month when there were 66 waiting. Three patients had been waiting between 31 and 35 weeks.
- Teams were not always able to make arrangements to cover for sickness, leave or vacant posts. Staff tried to ensure that essential tasks to ensure patient safety were undertaken. For example, we observed a morning "huddle" meeting" in the south team where the manager checked that administration of all patients' depot medications were allocated. We observed a multi-disciplinary team meeting for the south team were they had difficulty planning cover duty for the week due to unexpected staff sickness.
- Serious incident investigations highlighted staffing shortages. For example, an investigation into a serious incident in September 2015 identified that low levels of

staffing led to a lone worker assessing a patient who was referred urgently. It was best practice for two workers to assess patients. Another serious incident in March 2016, which was still under investigation at the time of our inspection, involved a lone worker who visited a GP surgery to assess a patient who had been referred urgently. An incident in January 2016 also highlighted the use of agency staff and difficulties recruiting to vacancies as a concern although not directly contributing to the particular incident.

- Between 1 June 2015 and 31 May 2016, 2,444 visits and appointments were cancelled by the service. The reasons for these cancellations were not recorded, but staff told us that appointments were often cancelled due to lack of staff.
- There was very high use of agency and locum staff due to unfilled vacancies in establishment staffing levels. Bank or agency staff covered 228 shifts in the south team between 1 November 2015 and 31 January 2016, with 64 shifts not filled. The west team used bank or agency to fill 193 shifts with 31 unfilled during the same period. In contrast, the east team only covered 28 shifts with agency nursing staff, and no shifts were unfilled. The south team used five different locum psychiatrists since January 2016. When we inspected, the south team had one full-time permanent doctor and two locums although one locum was leaving the following week. The manager told us that there had been no consultant cover for three weeks over December 2015 to January 2016. Five out of nine band 5 staff were agency and all had been working in the team for less than three months and there had been five "care taker" managers prior to the current manager starting. In the west team, 5 full-time equivalent band 5 posts were filled by agency, out of an establishment of 5.8. None of the agency staff had worked more than four months in the team. Medical cover in the west team was provided by two locum consultants and two sessions from a substantive speciality grade doctor.
- The only vacancy in the east team was for a speciality grade doctor. This post was being filled by a locum, who was due to leave. Attempts were made to recruit to this post unsuccessfully. The locum had 189 patients on his caseload and no plans had been made to mitigate against his post being vacated.
- Despite the recruitment difficulties, staff and patients told us they were able to access a psychiatrist rapidly when required.
- Mandatory training included adult safeguarding, an emergency mandatory day, corporate mandatory training, manual handling, and safeguarding children up to level three. The provider's data showed compliance for emergency mandatory training was at 71% for staff in the adult community mental health teams and 75% for safeguarding children level 3, and 86% of staff were compliant overall for mandatory training. Agency staff completed mandatory training with their agency. However, additional data provided by the organisation showed that 11 out of 14 staff in the east team were up-to-date with annual mandatory training, eight out of 14 in the west and 11 out of 17 in the south. This meant that 67% of permanent staff were up-to-date with mandatory training.

### Assessing and managing risk to patients and staff

- Risk assessments that were undertaken at initial assessment were mainly tick boxes with optional free-text boxes. We looked at 19 electronic patient care records across east, south and west community mental health teams. The free-text sections were not completed in the vast majority of records. Thirty-three per cent of risk assessment were not up to date. Two out of five risk assessments were out of date in the south team. One patient in the west team had been referred in April 2016 and did not have a risk assessment at the time of our inspection. Four out of five risk assessments in the east team were too basic to demonstrate a thorough understanding of risk. High risk patients were not discussed in the daily huddle meetings that we observed. Crisis and contingency plans were not always present, and where they were, they were mostly limited to giving contact numbers. Although we reviewed one crisis and contingency plan which detailed early warning signs and relaxation techniques, most crisis and contingency plans did not include early warning signs, relapse indicators or self-help strategies. A serious incident in December 2015 had highlighted the issue of risk management plans which were not clearly formulated and that the risk assessment tool on the electronic records only having options available to indicated yes or no rather than rating low, medium or high. No action had been taken as a result of this. However, we saw good practice in the use of multi-agency risk meetings which took place when appropriate and were well attended. Risk was discussed for all new patient assessments and of known patients

Inadequate

# Are services safe?

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

who were a cause for concern due to potential escalating risk in the west team's multi-disciplinary team (MDT) meetings. Plans were made to manage the risk in each case by the MDT.

- Patients were made aware that they could contact duty if their health deteriorated. There was a home treatment team that patients could be referred to if appropriate.
- Patients who were waiting for assessment were deemed to be the responsibility of the referring GP and therefore the teams did not monitor any of these patients.
- Patients on the waiting list for care coordination were not safely monitored. There was some monitoring, however the system was not sufficiently robust. Monitoring that was undertaken included outpatients appointments and contact every two weeks for a "supportive phone call". However, there was a high turnover of doctors and patients often saw different locum doctors. There was no formal guidance for staff about reviewing risk for people on the waiting list and no monitoring tool was used to ensure consistency. Arrangements for monitoring fluctuations in needs of patients varied across the teams. For example, in the east team, the band 6 duty worker undertook this role, but in the west team it was done by an unqualified worker. Patients who had been waiting over the 18 week target were not routinely seen face-to-face to review their risk or identify any deterioration. Waiting lists were supposed to be discussed in weekly multi-disciplinary team meetings, but we observed a west team meeting where this did not take place. We found that the risk assessments for people on the waiting list were very basic, and were usually a simple yes or no tickbox. This meant that it would be difficult to reliably monitor risk during fortnightly telephone contacts as the initial risks had not been identified in sufficient detail for staff to follow up, and that staff were reliant on patients or their carers identifying that their health had deteriorated. Waiting list documentation was organised by length of wait and did not risk rate patients, so there was no easy way of identifying those people on the list who were considered to be higher risk.
- The south teams risk register dated 16 June 2016 stated that approximately 90 patients who required follow up had not been discussed at the multidisciplinary team meeting or allocated. The severity and risk to the individuals was not known as they had not been reviewed. The team mitigation for this was to undertake a telephone triage to determine initial risk and patients would be given the duty number to escalate any concerns whilst waiting for an appointment if required.
- Staff showed a good understanding of safeguarding. We observed the south team huddle meeting discuss a safeguarding issue related to patient at risk of financial abuse. This had been addressed appropriately. The local authority safeguarding team had not responded to the referral so the staff member followed this up a second time to ensure it was being dealt with. However the patient's risk assessment had not been updated to reflect the all the risks.
- We saw some good lone working practices in place. All staff had global positioning system (GPS) monitoring systems attached to their staff identity card. Staff had mobile phones and an agreed code to alert the office if they needed help. White boards were used to record staff locations and expected time of return. However, the south team used two staff activity boards plus an in/out board in reception, none of which were consistently completed. This meant there was not a safe system for managing where staff were working and when they were returning.
- We were concerned about medication management in two out of the three teams that we inspected. The west and south teams shared a clinic room but had separate storage of medication and operated different systems of medication management. Oversight of the clinic and medication on the west team was very good. In the south team's clinic, the room and fridge temperatures were not being recorded, four medications were found to be out of date in the medication cupboard (one of which was 11 months out of date), and on 15 occasions when medication had been administered it had not been signed by two members of staff (double signing). Double signing had been introduced by the west team as a learning point from an incident. Four depot injections of antipsychotic medication in the east team's clinic room had been prescribed six months previously, and were for patients who had since been discharged. The cupboard was full and no further medication could be stored in it. There was no process in place for collection of unused medication. One depot was in a box that did not have a prescribing sticker, so it was not possible to tell who it had been prescribed for and therefore could have been administered to the wrong patient by mistake.

Inadequate

# Are services safe?

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- Although there had not been any reported medication errors for the south or east team, the wrong depot medication had been administered by another community mental health team in June 2015, and poor medication management increased the risk of medication errors.
- The clinic room fridge temperature log in the east team clinic room showed that temperatures were not being checked daily. In the previous month it had not been checked for up to five successive working days, and there were other gaps of one and two days. This meant that medication that was being stored in the fridge because it needed to be kept below a certain temperature may have lost its efficacy. There was no room temperature thermometer, which meant that the room temperature could not be checked and the room was very hot. Staff told us they were unable to use the room to administer patient's medication because it was too hot to work in. They were using a meeting room to administer a patient's depot medication because the patient was at risk of assaulting staff and the clinic room was not sufficiently large to safely manage the risks.
- The examination couch in the east team clinic room was ripped and had failed the provider's infection control standards but had not been removed from the clinic.
- The south team had two staff activity boards plus an in/out board in reception, none of which were consistently completed. This meant there was no safe system for monitoring where staff were working and when they expected to return.

### Track record on safety

- There had been seven serious incidents involving the community mental health teams. These included deaths by suicide, self-harm resulting in life changing injuries and administration of the wrong depot medication.

### Reporting incidents and learning from when things go wrong

- We reviewed root cause analysis investigations for six serious incidents. Learning to prevent further incidents of a similar nature was not happening in a timely way. Time taken to initiate investigations and to complete them varied. One investigation did not start until three months after the incident took place and was not completed until seven months after the event. One took more than five months from the incident date until the completion of the investigation and one did not give start and completion dates.
- Incident reports included a section for duty of candour, and these were completed in all the reports we reviewed, and showed that duty of candour had been adhered to. Clinical incidents were a standing agenda on multi-disciplinary team meeting minutes.
- Incidents were reported on an electronic clinical incident form, and copies were sent to the team manager and the risk department. Low risk incidents were reviewed by the team manager. Incidents were not always reported when they should be. From a review of patients notes in the south team we observed that staff had appropriately alerted local authority safeguarding about the patient, but had not followed this up with an indent report. We raised this with the team manager and a report was submitted.
- Information was provided to team mangers at monthly operational meetings. Team managers were responsible for feeding back the learning from incidents to their teams The provider did not provide staff updates or newsletters to inform them of serious incidents. This would have increased the opportunity for learning from incidents that had occurred in other teams and services.
- We saw some evidence of learning from incidents as a result of investigations. For example all trained nursing staff in the west team had been assessed for their competency to administer medication as a result of a medication error in another team.
- However, one investigation recommended that the use of the STORM suicide risk assessment and that a check should be undertaken to ensure all staff had completed this training. This action was signed off as completed on 31 January 2016. We looked at 19 staff records for the south and west community mental health team. Only two out of the 11 records in west team showed staff had undertaken STORM training and one out of eight in the south team. No agency staff had received STORM training.
- Two serious incident investigations had highlighted concerns about safe staffing. An incident on 14 September 2015 involved an urgent assessment that was carried out by a lone worker. This patient received a serious, life-changing injury as a result of a suicide attempt. The investigation stated that staffing availability affected the decision to assess singly. An

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investigation into a serious incident that occurred in January 2016 had highlighted that staffing levels were a concern within community mental health team and a reliance on agency and locum staff may be a contributory factor to the lack of robust communication and documentation. A serious incident was reported to the Care Quality Commission on 11 March 16 and was still under investigation at the time of our inspection This was also related to a lone worker attending an urgent assessment.

- Staff were offered debriefings after incidents. One staff member in the east team spoke very positively of the support received after a serious incident.

# Are services effective?

**Requires improvement**

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

## Our findings

### Assessment of needs and planning of care

- We looked at care plans in 15 electronic patient records. The quality of these varied. All five patients' records for the east team had care plans. Three out of the five records in the west team did not have care plans. The majority of care plans in the west and south teams were not personalised, holistic or recovery orientated. Although we saw some detailed, good quality care plans, in many cases these were for patients who were also receiving support from the home treatment team and had not been written solely by community mental health team staff. However, patients we spoke to told us that they had copies of their care plan and felt involved in writing them.
- The provider used a secure electronic patient record.

### Best practice in treatment and care

- Consultant psychiatrists had regular meetings which included discussion about The National Institute for Health and Care Excellence (NICE) guidance and these were highlighted to team managers at monthly operational meetings. Doctors told us that they referred to NICE guidance for prescribing medication.
- The east team had recruited a psychologist in the previous six months, who was offering team supervision to aid psychologically-minded approaches. The team were considering psychological interventions for patients, including compassion focussed therapy. We attended a multi-disciplinary team meeting in the west team which included reference to a patient being referred for psychotherapy due to childhood trauma. The west team's psychologist had been providing some training sessions and team supervision, but was due to leave and a replacement had not been identified. This staff member had a waiting list of 16 patients who would all need alternative treatment options to be identified. Staff in the community mental health teams for adults of working age were not trained to provide psychological therapies such as cognitive behavioural therapy. No agency staff received training of this type from their agency or the provider.
- The teams could refer patients to a range of agencies in the area which provided services to support patients with social needs. Community support workers provided some assistance to support these needs but care plans showed limited interventions for support with employment, housing or benefits. An occupational therapist had written a proposal to increase group work interventions and occupational therapy focussed work within the community mental health teams. Social work staff had been re-integrated into the provider organisation over a year prior to our inspection, however only one of the three teams had a social worker. This social worker commenced in post in the week of our visit. Staff told us that they could refer to the social work team if required. Although it was not possible to make a direct link between the lack of integrated social work within the community mental health teams and the limited evidence of care planning for social care needs of patients, it was likely to be a contributory factor.
- Physical health checks were undertaken by GPs. This included patients who were receiving lithium or antipsychotic medication, and patients who were having depot medication administered by community mental health team staff. There was no formal protocol with GPs although we were told that the community mental health team had a process to update the GPs when a check was due and would facilitate the appointments if appropriate. The provider had undertaken an audit of patient's records in order to ascertain progress against commissioning for quality and innovation targets for improving physical health for people with severe mental illness. The audit had found that only 30% of patient in the west team, 18% of patients in the east team, and 11% of patients in the south had received an annual physical health check. The audit had recommended commencing a scoping project in 2016/17 on the role of the community pharmacy in order to target those with mental health needs and ensure interventions were offered when a person did not see their GP.
- The provider used health of the nation outcome scales (HoNOS) although monitoring data showed that this was not done in all cases. The use of HoNOS is recommended by the English national service framework for mental health as an outcome indicator for severe mental illness. 100% of east team patients had completed HoNOS assessments, but only 96% of patients in the west team and 95% in the south team. No other outcome measures were routinely used by

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staff. HoNOS was also used for mental health clustering. Although we saw that HoNOS was reviewed regularly, it was not clear that these measures were being used to inform treatment outcomes.

- The service had been involved in the national audit of schizophrenia in 2013/14, but staff were not routinely participating in clinical audit.

### Skilled staff to deliver care

- All three community mental health teams consisted mainly of nurses, doctors and community support workers. Only one team had a social worker, who was new in post. The west team had a part time occupational therapist who was on maternity leave, and a psychologist who was due to leave their post. The east team had an occupational therapist and a psychologist. All teams attempted to recruit a range of disciplines to their vacant posts, and had experienced difficulty filling vacant posts and retaining staff for at least a year.
- There was a range of experienced professionals in the teams including some staff who had worked for the provider for many years. However, three out of the four locality managers, who each had operational responsibility for the community mental health team for their locality, did not have any mental health experience and two out of the three team managers had been in post for less than six months. Medical cover relied on locums. The east team consultant was a substantive member of staff who had been in post for a year. The team also had a locum speciality doctor, but they were due to leave and the service had been unsuccessful in recruiting a permanent replacement. This post was to be replaced with another locum. A substantive speciality doctor provided two sessions per week to the west team but all other medical cover was provided by locums. There had been five different locum doctors in the south team since January 2016 and five temporary team managers prior to the recently appointed manager commencing in post. Qualified staff were mainly band 5. The south team had two permanent full time band 6 staff. Five out of nine (55%) of band 5 staff in the south team were agency and none had worked longer than two and a half months. The west team had 2.4 whole time equivalent band 6 staff, although one was on maternity leave. Over 80 % of band 5 staff in the west (4.8 out of 5.8) were agency with the longest being in post four months. This meant that there was a lack of continuity and experience at a senior leadership level as well as amongst the qualified frontline staff. South and west teams were particularly affected. The organisation was advertising for a modern matron to take on a leadership role across all four community mental health teams.
- Staff attended corporate and local team inductions. There was a handbook for staff containing information relevant to the community mental health teams. Staff in the west team were given a minimum of a week to familiarise themselves with the contents of the handbook and had to sign to say they had read it. The handbook had been introduced to assist staff to quickly familiarise themselves with key information due to the high turnover of staff. A band 6 nurse in the east team was a STORM suicide risk assessment trainer.
- We looked at 19 staff records for the south and west community mental health teams. Community mental health team guidance stated that line management supervision should take place every four to six weeks. In the south team, staff records showed that two out of four agency staff had not received regular line management supervision. The other two had received one written supervision. A band 3 worker had no evidence of supervision for over a year; another band 3 worker who had been in post since 2013 only had a record of joint peer supervision in April 2016. A bank staff member's file had no record of regular supervision. The file contained a letter of concern dated 5 June 2016 from the staff member to their bank staff manager highlighting risks in the team and stating that they were stressed. However, the south and west teams had recently set up supervision groups to increase the access to supervision for staff. This was a new process which was not yet embedded, but showed that the teams were attempting to increase opportunities for staff supervision.
- Data provided by the organisation stated that 100% of staff had been appraised. Staff records in the west team showed evidence of recent appraisals with most of the permanent staff records reviewed. However, in the south team there was a band 6 who had not had an appraisal since 2013. Agency staff did not receive appraisals.
- One agency worker had not received duty training before working on the duty team and had been involved in a serious incident. There was evidence of debrief and

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support but no evidence of additional training offered despite the agency worker's staff file showing that they had directly asked for more training in relation to working in the duty desk following the incident.
- No staff had undertaken non-medical prescribers training and limited professional development training was undertaken.
- There had been a number of issues with staff performance, particularly with performance of agency staff. We looked at staff records which showed that management of sickness and poor performance issues were well managed with evidence of regular meetings and reviews.

### Multi-disciplinary and inter-agency team work

- Multi-disciplinary team meetings took place weekly in all teams and included discussion about new referrals, feedback from new assessments and patients who did not attend. Other regular items for discussion included waiting lists, out of area placements, inpatients and patients who were being seen by the home treatment team. There was also a time slot for any other business. Patients who were on community treatment orders were not discussed. The number of patients to discuss was very high, and from our observation of a multi-disciplinary meeting we saw that this led to information being fed back from one team worker to the rest of the team rather than leading to robust discussion. Waiting lists were not discussed at the meeting we observed as there was insufficient time to cover all areas on the agenda despite this being one of the mechanisms the organisation was using to ensure that waiting lists were monitored.
- The south and west teams had morning "huddle" meetings, to prioritise tasks for the day. We observed the west team's huddle meeting. This was used to clarify tasks for the day, for example, who was covering duty, and to ensure that any patients who required a medication that day were receiving a visit to administer it. Whilst this ensured that important tasks were undertaken, it was noticeable that a large amount of staff time in the south team involved home visits to administer depot medication. The west team's huddle was minuted and the notes were put on the wall for staff to refer to. The south team did not minute their huddle meeting.
- Social workers had been integrated into the provider organisation from social services for one year. However, of the three teams, only one had a social worker and this staff member was new in post. Staff told us that there had been no difference in accessing social work support or joint working since integration took place.
- Lack of staffing and waiting lists were impacting on effective handover between teams within the organisation and some of the community mental health teams. All community mental health teams had patients who were being transferred between different localities under the same provider. This was usually due to patients changing GPs. Teams found it difficult to transfer cases to the west and south teams because of their waiting lists. The home treatment team reported that they held patients on their caseload when they should have been discharged back to the community teams because some community mental health teams did not have capacity to take these referrals. There were also concerns raised by the children and adolescent mental health teams (CAMHS) that the adult community mental health services did not have the capacity to be involved if they needed to plan the transition of young person's care to the adult community services.
- Link working with GP surgeries had stopped, due to competing demands on staff time. Staff could refer to a range of services, including services for veterans and a range of voluntary sector providers.
- The organisation commissioned an out of hours telephone support helpline which was provided by Mental Health Matters. The service was based in the north east of the UK and staffed by qualified counsellors. The service was for people in receipt of secondary mental health services and had clear inclusion and exclusion criteria. It was monitored by regular telephone conferences and monthly reports. We saw that patients were given the number for the mental health line as part of crisis and contingency plans.

### Adherence to the Mental Health Act and the Mental Health Act Code of Practice

- Staff had undertaken training in the Mental Health Act Code of Practice.
- The west team had 103 patients on their caseload who were receiving section117 aftercare. Section 117 is a section of the Mental Health Act which imposes a duty on health and social services to provide aftercare to

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certain patients who have been detained under the Mental Health Act. There was low use of community treatment orders (CTO). Only two patients in the west team and one in the south team were under CTO.

- We did not review CTO paperwork as part of this inspection, but did look at medication records. One CTO patient did not have a consent form attached to their medication record.
- CTO patients and patients receiving s117 aftercare were not discussed as part of the regular multi-disciplinary team meeting agenda. Due to the turnover of staff in some teams, regular discussion of these patients could have been a useful prompt to ensure their needs were being met and their rights under the Mental Health Act were being adhered to.
- Approved mental health practitioners (AMHPs) were not based in the teams, but could be accessed via the AMHP hub. We were told that the mental health act manager provided training for staff which was well attended.
- Independent mental health advocacy (IMHA) services were provided by Support Empower Advocate Promote (known as SEAP) Information about IMHA services was not on display in in public waiting areas.

### Good practice in applying the Mental Capacity Act

- Most staff had received mandatory Mental Capacity Act (MCA) training. This training was up to date for 13 out of 14 staff in the west team, 11 out of 12 in the east team and all eligible staff in the south team. The staff we spoke to could demonstrate a basic working knowledge.
- We saw assessments of capacity in the care records of patients who may have had impaired capacity, however, we could not be confident that there was sufficient oversight to ensure that mental capacity was always being addressed effectively because there was inconsistent consultant cover.
- Independent mental capacity advocacy was provided by SEAP. Leaflets for this service were not on display in waiting areas.

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 observed that staff spoke respectfully about patients in the multi-disciplinary meeting that we attended. We observed respectful and kind responses to patients when staff spoke to them on the telephone. Staff we spoke to told us they wanted to deliver the best care they could and were aware that the difficulty of recruiting and retaining staff had a negative impact on the care patients received. From electronic care notes we saw that one patient's care coordinator had changed three times in six months.
- We spoke to ten patients and one carer. Feedback was generally very positive about staff and patients said they were treated with kindness and respect and that staff were friendly. However, some patients said they saw lots of different doctors. One person said that they felt staff were not doing much to help them recover. We received four feedback cards, one was about the assertive outreach service, one about the personality disorder service and two cards did not name the team they were referring to. The feedback was very positive about staff for all four comment cards. None of the east team patients told us that they had experienced changes of doctors or other staff, although one patient felt it took a long time to get an initial appointment.
- We observed that duty telephone calls continued to be taken while a huddle meeting took place in the south team. Throughout the meeting patients were calling into the office duty line for advice and to arrange appointments. The staff team continued to review their case loads for the day, discussing patient names and details. Although we were told that the huddle meeting usually took place in another room, on this occasion it meant that there was a risk that people on the telephone could overhear confidential information, and that staff had not considered this.
- All patients we spoke to who should have had a care plan did have a copy and said they had felt involved in writing it. All patients had contact numbers to use in an emergency.
- Staff involved carers if patients consented. Families and carers were able to attend appointments if the patients permitted this.
- Advocacy was available through Support Empower Advocate Promote (known as SEAP). We did not see any advocacy information in waiting areas. Patients that we spoke to said that they had not been made aware of advocacy services.
- Patient feedback forms were available in the waiting area of the east team. Teams had hand held electronic devices that they could take to patient's homes to collect feedback from patients and carers. However, it was not clear that all teams used this feedback to inform service provision.
- Staff gave an example of a patient who attended the east team site for a depot and they administered this in the team meeting room because the clinic room was not suitable. The meeting room was full of tables, chairs and had a computer in it, and was not an

### The involvement of people in the care that they receive

- One west team patient told us that their doctor had left and they did not know who was taking over and that appointments got cancelled without them being informed. Another patient said they had seen five different doctors in three years. All three patients we spoke to from the south team told us about lots of changes of staff, high use of agency staff and not always knowing who they were going to see
- There was a carers' and patients' forum for mental health services which met four times a year. None of the teams had peer workers and patients were not involved in recruiting staff. There was a lack of proactive encouragement and facilitation of patients and carer involvement to shape the community mental health teams for adults of working age.

# Are services responsive to people's needs?

Inadequate

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

## Our findings

### Access and discharge

- Most referrals came through the Devon referral support service (DRSS), which was a single point of access contact centre that provided services for the county of Devon. This was a purely administrative service. GPs contacted teams directly to make urgent referrals. Referrals were either triaged by the duty worker or by a member of permanent staff at band 6 or above. Referrals were triaged on the same day. Routine assessments would be booked by DRSS. Teams kept urgent assessment slots and would book urgent appointments themselves.
- Targets for referral to assessment and treatment were seven days for urgent referrals and 18 weeks for routine referrals. The provider advised us that the target for emergency referrals was one day. However, staff were unclear about the emergency referral targets. The service specification document and operational policy, which would have provided a definite reference for staff, were still in draft, which contributed to the lack of clarity. Staff told us that the duty worker would attempt to see very urgent referrals on the same day, but that emergency referrals would be seen by the home treatment team or hospital liaison, which had a four hour target for this.
- However, all teams tried to see people in less than seven days if clinical need indicated this, and attempted to see people with more urgent needs within one day. We asked the provider for information about compliance with waiting time targets but they were only able to provide information about the 18 week target. The south team had achieved less than 95% of patients being seen within the 18 week target in four out of 12 months. For two consecutive months they had seen 87% or fewer patients within target. The best performing team was the east, which was 100% compliant for nine out of 12 months with its lowest compliance rate being 96%. None of the teams had reviewed all patients on care programme approach (CPA) in the last 12 months, and all teams were less than 95 % compliant with this target, with the lowest being 88% of CPA patients in the south team.
- South, west and east community mental health teams had waiting lists for patients who had been through the initial assessment process and were waiting for a care coordinator to be allocated. The west team had 56 patients on the waiting list, including 15 who had been waiting for more than 18 weeks. This was in breach of targets for referral to assessment and treatment. We saw that one patient had waited for 31 weeks. The east team had seven people on the waiting list on 14 June 2016, of which one had been waiting since 13 October 2015 (35 weeks) and another since 20 October 2015 (34 weeks). Another patient had been waiting for 19 weeks. The south team had 41 patients waiting for allocation of a care coordinator; this included two people who had been waiting since October 2015 and who were potentially high risk. One patient waiting since October 2015 had a diagnosis of recurrent depressive disorder with psychotic features, and was reported to have possible safeguarding concerns. Another patient waiting since October 2015 had a diagnosis of emotionally unstable personality disorder and there were child protection issues. A pregnant patient with a diagnosis of depression and post-traumatic stress disorder had been on the waiting list since March 2016. Waiting lists increased the risk of deterioration in a patient's health and difficulties would be harder to treat by the time the patient was seen.
- All teams had higher numbers of admissions into the service than discharges which meant that teams did not have sufficient flow through the service and team caseloads grew beyond capacity. Link working roles with GP surgeries had existed, but were no longer taking place, which meant that regular communication was not taking place with locality GPs to ensure that referrals were being made appropriately and to assist GPs to identify more suitable alternative for patients who did not require secondary mental health care. The east team manager hoped to reintroduce the link role.
- We requested referral to assessment and treatment monitoring data. The service was not monitoring referral to assessment times, except for the 18 week target. This meant that the provider was not able to demonstrate whether it was providing assessment and treatment in a timely way for people who had been referred urgently.
- All teams had a qualified member of staff on duty each day to take calls from people who phoned in. People on the waiting list were given the duty number to contact.
- The provider did not have an operational policy or up-to-date service specification. Both were in draft format and dated December 2015. Inclusion and exclusion criteria were not clearly defined. Staff had to access a

# Are services responsive to people's needs?

Inadequate

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

number of different documents, some of which were draft copies and contradicted each other, in order to ascertain guidance on operational procedures. As a result, there was a lack of clarity the roles of the teams and which timescales to work towards.

- The provider collected data about patients who did not attend their appointments, which showed that 5% of appointments were not attended. Patients who did not attend appointments were discussed at weekly multi-disciplinary team meetings. We observed a discussion to decide appropriate actions following failed attempts to contact a known patient. However, electronic notes did not always show that agreed plans to follow up patients who had not attended or were hard to engage were followed up.
- A total of 2,444 appointments were cancelled by the west, south and east teams between 1 June 2015 and 31 May 2016. Reasons for cancellation were not specified in the data provided, although a patient we spoke to said their appointments were often cancelled and staff told us that appointments were cancelled due to staff shortages.

### The facilities promote recovery, comfort, dignity and confidentiality

- The east team were using a meeting room to administer a depot injection for a patient. This was because the clinic room was uncomfortably hot and they felt it was too cramped to use with patients who were at risk of becoming agitated or assaultive to staff. This was an unsuitable space and did not protect patients' dignity.
- Interview rooms at Avon House did not have adequate sound proofing. This meant that patients' confidentiality could not be guaranteed.
- Staff accessed information for patients from the intranet. There was limited information available in waiting areas about treatments, local services or patients' rights.

### Meeting the needs of all people who use the service

- All three teams were based in buildings that were accessible for people with disabilities. Interview rooms were on the ground floor on both sites.
- The local population was predominantly white British with a 7% black and minority ethnic population. We did not see information in languages other than English in the public waiting areas. There was no information provided for different cultures within the service however we were informed that in the event of this being required the organisation would be able to provide this although it had never been requested.

### Listening to and learning from concerns and complaints

- Between 1 February 2015 and 31 January 2016, the south team had received four compliments.
- Between the same time period 45 complaints against community mental health team were upheld. The most common themes of complaints were communication, attitude of staff and issues with appointments.
- The provider told us that due to complaints about values and behaviours of staff and communication, a review by the Patient Association had taken place and led to an action plan to provide improved customer care training to all staff including clinical staff. This was due to begin July 2016. It was planned that the training would continue indefinitely as it had been accepted that communication was a major influence in patient complaints. A customer services training video was being developed which would be shown to all staff as part of the organisation's mandatory training programme. This video was due to be completed and in use before October 2016, and ad hoc training would be provided to staff within localities on a team basis when requested. Action the provider had taken was the implementation of customer service training and inclusion of updated customer service training as part of the annual mandatory training programme.
- Complaints about appointments were thought to be due to changes in localities and staff shortages. The provider was aware that some patients preferred to be seen by alternative consultants as they did not wish to be seen by locums, and that this caused delays. Some patients had complained because they preferred to be seen by female doctors, which was not always possible. The provider told us that they had taken action as a result of these complaints, which included attempts to recruit female doctors., offering patients a female chaperone in the interim, reducing waiting times by recruiting more staff and that there was ongoing work to ensure that consultants are recruited whenever possible to ensure they had permanent doctors in place.

# Are services responsive to people's needs?

Inadequate

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

However, our inspection showed that there were still long waiting lists and patients waiting over 18 weeks target times, in addition to a substantial proportion of locum doctors covering vacant posts.

# Are services well-led?

**Inadequate**

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

- While staff were clearly trying to provide a good service, we observed that teams were struggling to reflect some of the organisations aims due to the impact of staff shortages, turnover and pressures from waiting lists.
- Staff knew who their locality managers were and found them supportive. However, staff did not feel supported by senior managers.

### Good governance

- Managers could access reports which showed information about care programme approach, clustering, number of visits and staff performance and a "managers toolbox" for staff performance management, training, grievance sickness and absence.
- There were monthly meetings for team managers across the adult community mental health services, and managers attended monthly operational meetings with the deputy director of operations, who had overall responsibility for adult community mental health teams. Managers found their locality managers supportive, although three out of the four locality managers did not have mental health experience.
- The locality structure meant that each of the four community mental health teams had a separate line management structure despite working within a small geographic location. The south and west teams were based in the same building but under different locality managers. Teams were not always supporting or learning from each other. For example, the south and west team shared clinic facilities. The west team had a very high standard of medication management, but we found significant problems with the way medication was stored in the south team.
- Staffing issues were reported to the deputy director of operations at monthly community mental health operational meetings. We reviewed 12 months of community mental health team operational meeting minutes which showed that senior managers were aware of the concerns since at least September 2015. Minutes showed that the west team reported seven band 5 vacancies on 23 September 2015 and a total of 11.8 band 5 vacancies across the community mental health teams. However, despite ongoing difficulties with recruitment and high use of agency and locum staff, the provider had not undertaken a thorough analysis of the service in order to fully understand the root cause in employing and retaining substantive staff. There was no workforce strategy for community mental health teams despite issues with recruitment and retention having been ongoing for at least 12 months.
- A modern matron post was being advertised when we inspected. The modern matron role included operational oversight of the community mental health teams. It was planned that once filled, the post holder would address many of the issues that were affecting their teams' performance. However, despite their service having experienced difficulties recruiting to a wide range of posts, there was no contingency plan if the provider was unable to recruit a suitably qualified and experienced modern matron.
- Waiting lists were also reported to the deputy director of operations at the monthly community mental health team operational meetings. Minutes of the meeting held on 22 July 2015 showed a waiting list of 70 patients for the west area, and on 17 September 2015 it showed the waiting lists had increased to 86. This showed that waiting lists had operated for at least one year. However, the provider did not have a clear plan to reduce the waiting lists, maintain reduced waiting lists, or ensure those waiting were effectively monitored for deterioration in their mental health. Systems or processes did not operate effectively to assess, monitor and mitigate the risks relating to the health, safety and welfare of service users and others. This included a lack of sufficiently robust systems to ensure that they were fully aware of any fluctuations in risk of patients on the waiting list.
- There was no operational policy for adult community mental health teams. The provider had a draft version but this was far from complete. The deputy operational manager, who had overall operational oversight, told us that the staff used the service specification and staff handbook in lieu of an operational policy. However, the service specification was also a draft dated December 2015. The aims and objectives of the service, as defined by the service specification, contained comments to the text that suggested that it was still a work in progress. Guidelines for prioritisation of referrals were included in the staff handbook. Although this guidance was clearly defined in terms of clinical need, the timescales did not relate to the draft service specification. The guidelines appeared to refer to the home treatment team and

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primary care liaison services and were not specified for use by the community mental health teams. Aims and objectives of the service were not defined. Overall, this meant that staff had to access a number of different documents, in order to gain guidance op operational procedures, some of which were draft copies and contradicted each other. As a result, there was a lack of clarity in the roles of the teams and which timescales to work towards.

- There was no service-wide auditing tool to ensure consistency of standards of auditing case records. Electronic records were audited by team managers and were discussed in supervision meetings with staff. A quarterly audit of care plans, risk assessments and care programme approach reviews was carried out, but this process was not always effective in ensuring records were of good quality. However, the east team manager had identified that care plans needed to improve as a result of these audits and was working with staff to improve these.
- The provider was not monitoring referral to assessment times, except for the 18 week target. This meant that the provider was not able to demonstrate whether it was providing assessment and treatment in a timely way for people who had been referred urgently.
- Staff were undertaking mandatory training in safeguarding children level 3 however compliance was below 75%. One-third of permanent staff were not up-to-date with annual mandatory training.
- We looked at 19 staff records. The provider did not have effective systems in place to ensure they could monitor supervision and training of staff. Guidance stated that a record of line management was kept in the staff's records, held by their managers. The provider's policy stated that supervision should take place every three months. We looked at 19 staff records for the south and west community mental health teams In the south team, staff records showed that two out of four agency staff had not received regular line management supervision. The other two had received one written supervision. A band 3 worker had no evidence of supervision for over a year; another band 3 worker who had been in post since 2013 only had a record of joint peer supervision in April 2016. One agency worker had not received duty training before working on the duty team and had been involved in a serious incident.
- STORM suicide risk training was required for all clinical staff who undertook assessments. Managers told us that their staff had received this training but only two out of the 11 staff records in the west team showed they had STORM training and one out of eight in the south team. No agency staff had received STORM training. The deputy director of operations was unaware of this when we raised this on 28 June 2016, and arranged for all staff to be booked onto training. An agency worker in the west team had not received duty training before working on the duty team and had been involved in serious incident on 11 March 2016. The staff member's records showed evidence of debrief and support but no evidence of any training offered following this.
- Staff records showed that performance management of sickness and poor performance issues were well managed with evidence of regular meetings and reviews. Contracts with agency staff had been terminated when their work performance had not been satisfactory. No grievance or disciplinary procedures were taking place at the time of our inspection.
- We observed that staff maximised time with patients, however there was a prevailing belief held by staff that the organisation expected them to undertake four home visits each day. We could not find any reference to this in the organisation's policies. This meant that contacts with patients had the potential to be task focussed rather than based on individual needs and that staff were not always supported to make professional decisions regarding best use of their time.
- Although teams had learnt lessons from serious incidents, and changed practice as a result, the provider had not ensured that all lessons had been learnt and recommendations implemented from internal investigations. Some investigations took too long. This meant that the there was a risk of similar incidents happening again.
- The provider told us that they had taken action as a result of complaints about appointments which had been due to staff shortages and waiting lists. However, we found that factors such as staff shortages, waiting lists and use of locum doctors there were still present. This meant that patients were still likely to have cause for complaint.
- Each team had a risk register which managers could contribute to.

### Leadership, morale and staff engagement

- From our observations and discussions with staff, some were clearly stressed and felt under too much pressure.

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**Inadequate**

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This was particularly evident in teams that had high proportions of agency and locum staff. Permanent band 6 staff in this team had a particularly high work load. In addition to clinical work with patients, they also had responsibilities for supervising band 5 staff, most of whom were agency and had been in the team for a short amount of time, and deputising for some of the day to day running of the team if the team manager was not available. Some staff had reported they were stressed to their managers.

- Staff morale was low in the south and west teams. Staff told us they were "fire fighting", and this was related to staff turnover due to staff "burning out". The staff felt that the organisationfocused on recruitment rather than retention of already existing staff.
- Most staff spoke positively about the team managers and operational managers but felt distanced from senior leaders in the organisation.
- The provider provided data which showed that the west team had a 33% vacancy rate, 10% sickness and 48% staff turnover. The south team had a 15% vacancy rate, 6% sickness and 20% turnover rate. Vacancies for medical staff across adult community mental health were 26%. The providers average sickness rate was 5%.
- We were not made aware of any bullying or harassment concerns.
- Staff within teams were supportive of each other. However, there was limited opportunity for staff from other teams across the community mental health teams to meet and learn from each other or for different teams to work together to support each other, despite being based in a small geographical area.
- Duty of candour was evident from incident reports.
- All staff we spoke to within the community mental health team wanted to be able to provide a better service. Some staff we spoke to were able to identify many of the problems with the service, and were concerned that they were not providing a high quality service to patients. They had ideas about how the service could be improved and the factors that contributed to some of the difficulties experienced by individual teams. Others told us they could not see how the problems could be resolved. However it was not evident from our conversations with senior managers that they had undertaken meaningful consultation with staff or taken account of their views.

### Commitment to quality improvement and innovation

- None of the teams were engaged in quality improvement programmes. None of the teams were involved in innovative practice of in research.

This section is primarily information for the provider

# Enforcement actions

## Action we have told the provider to take

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

| Regulated activity | Regulation |
|---|---|
| Assessment or medical treatment for persons detained under the Mental Health Act 1983<br><br>Treatment of disease, disorder or injury | Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment<br>Care and treatment was not provided in a safe way for service users to:<br><br>- assess the risks to the health and safety of service users of receiving the care or treatment<br><br>- do all that is reasonably practicable to mitigate any such risks<br><br>- ensure that persons providing care or treatment to service users have the qualifications, competence, skills and experience to do so safely.<br><br>There was not proper and safe management of medication<br><br>**This is a breach of Regulation 12 (1)&(2) (a)(b)(c)&(g), of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 Safe care and treatment** |

| Regulated activity | Regulation |
|---|---|
| Assessment or medical treatment for persons detained under the Mental Health Act 1983<br><br>Treatment of disease, disorder or injury | Regulation 17 HSCA (RA) Regulations 2014 Good governance<br>Systems or processes were not established and operating effectively to: |

This section is primarily information for the provider

# Enforcement actions

| Regulated activity | Regulation |
| --- | --- |
| | - assess, monitor and improve the quality and safety of the services provided in the carrying on of the regulated activity (including the quality of the experience of service users in receiving those services)<br><br>- assess, monitor and mitigate the risks relating to the health, safety and welfare of service users and others who may be at risk which arise from the carrying on of the regulated activity<br><br>**This is a breach of Regulation 17 (1)(2)(a)(b), of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, which states: Good governance** |
| Assessment or medical treatment for persons detained under the Mental Health Act 1983<br><br>Treatment of disease, disorder or injury | Regulation 18 HSCA (RA) Regulations 2014 Staffing<br>Sufficient numbers of suitably qualified, competent, skilled and experienced persons were not deployed.<br><br>Persons employed by the service providerdid not receive such appropriate support, training, professional development, supervision and appraisal as is necessary to enable them to carry out the duties they are employed to perform<br><br>**This is a breach of Regulation 18 (1)(2)(a), of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, Staffing** |