Outstanding ☆

North Staffordshire Combined Healthcare NHS Trust

Community-based mental health services for older people

Quality Report

Harplands Hospital
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Locations inspected

Location ID	Name of CQC registered location	Name of service (e.g. ward/ unit/team)	Postcode of service (ward/ unit/team)
RLY00	Trust HQ	Memory Clinic - City Team	Marrow House Forrister Street Meir Hay Stoke On Trent ST3 1SQ
RLY00	Trust HQ	Older Age Community Mental Health Team (City)	Marrow House Forrister Street Meir Hay Stoke On Trent ST3 1SQ

Summary of findings

RLY00	Trust HQ	Memory Clinic - County Team Older Age Community Mental Health Team (County)	Maple House Bradwell Hospital Talke Road Bradwell ST5 7NJ
RLY00	Trust HQ	Vascular Well-being	Harplands Hospital Hilton Road Stoke - On - Trent Staffordshire ST4 6TH
RLY00	Trust HQ	Older Age Outreach Team	Harplands Hospital Hilton Road Stoke - On - Trent Staffordshire ST4 6TH

This report describes our judgement of the quality of care provided within this core service by North Staffordshire Combined Healthcare NHS Trust. Where relevant we provide detail of each location or area of service visited.

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

Where applicable, we have reported on each core service provided by North Staffordshire Combined Healthcare NHS Trust > and these are brought together to inform our overall judgement of North Staffordshire Combined Healthcare NHS Trust.

Summary of findings

Ratings

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

Overall rating for the service	Outstanding ☆
Are services safe?	Good ●
Are services effective?	Good ●
Are services caring?	Outstanding ☆
Are services responsive?	Outstanding ☆
Are services well-led?	Good ●

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

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

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

Summary of findings

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Summary of findings

Overall summary

We have changed the rating for community mental health services for older people with mental health problems from good to outstanding and effective from requires improvement to good because:

- During our inspection in September 2015, we asked the trust to ensure that patients have crisis and contingency plans that reflected patients individual circumstances and that these were easily accessible to staff. At this inspection we found that skilled staff worked within a multidisciplinary approach to ensure they were responsive to urgent referrals or patient crises.
- The teams had developed excellent external links to GPs, care homes, social services and other local agencies, to ensure that patient's holistic needs were thoroughly care planned.
- During our September 2015 inspection, we asked the trust to ensure that accurate and up to date risk assessments were completed for patients. At our inspection in September 2016 we found that staff had the information they needed to consistently assess and review risks to patients.
- The service used audit and outcome measures to great effect in order to improve patient care whilst evaluating the effectiveness of the service.
- In our inspection in September 2015, we asked the trust to ensure that care plans reflected patient views and were person centred. At this inspection patients received individualised treatment and their care plans were personalised and holistic.
- Innovative ways to improve patients' health and wellbeing were used that were based on evidence from research and from working with a local university and clinical commissioning group.
- In September 2015, we asked the trust to ensure that staff had the skills and knowledge to routinely undertake and record mental capacity assessments in accordance with the Mental Capacity Act 2005. At this inspection we found that staff had a good working knowledge of the Mental Capacity Act and recorded this fully in patients' care records.
- Patients told us staff were caring, compassionate and responsive to their needs, providing emotional and practical support. Staff involved patients and their carers in their care and looked after their best interests. Staff showed excellent levels of care for both patients and carers. Carers told us that staff "went the extra mile".
- There were adequate numbers of staff available to provide information to patients, carers and referrers ensuring they knew what to do if the patient's condition deteriorated.
- The service used opportunities to learn from incidents, complaints and audits which resulted in improvements being made.
- Staff received regular supervision and support from their team managers, and attended to their training needs. Staff told us morale was good and they worked well as a team.

However:

- Clinical supervision was not offered to all staff and formal supervision was not recorded in all teams.
- Appropriate signage was not provided to help patients find their way around the memory service at maple house.
- Patients had access to psychological therapies but not always to psychologist.

Summary of findings

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

Are services safe?

Good

We rated safe as good because:

- Staff consistently assessed and reviewed risks to patients.
- Staff were able to respond in a timely manner to patients who had experienced a sudden deterioration in their health.
- Staffing levels across the teams were sufficient to ensure that care was delivered in a timely and safe manner.
- There were safe lone working practices in place which all staff followed.
- Compliance with mandatory training was above the trust target.
- All premises were clean and well maintained and staff followed infection control principles.
- Staff reported incidents and there were good examples of lessons learnt from incidents.

However:

- Medication could not be stored at maple house as the room was too hot and above normal limits.

Are services effective?

Good

We rated effective as good because:

- The service had developed good external links with GPs and primary care services and with other teams within the trust. This had strengthened their working relationships and meant all services could act quickly and efficiently to the needs of their patients.
- Staff were skilled and used a range of nationally recognised assessment and diagnostic tools to effectively treat and support their patients.
- Patients received individualised treatment and their care plans were personalised and holistic. Consideration and discussion of patients' physical health needs occurred when deciding on diagnosis and treatment.
- There were examples of innovative practice such as the vascular wellbeing team and the use of FLO (text messaging service to remind people with short term memory problems) and Autographer camera and the mild cognitive impairment practitioner. These helped to delay the onset of dementia and improved patients' health and wellbeing.

Summary of findings

- Staff utilised and worked closely with external agencies such as Approach (voluntary agency that worked with people living with dementia).
- Capacity assessments were well recorded and were time and decision specific.
- Management supervision and appraisal rates were 100%.

However:

- Clinical supervision was not available for all staff.
- There was limited access to a psychologist.

Are services caring?

Outstanding 

We rated caring as outstanding because:

- Patients and relatives told us that all staff went the extra mile when caring for them.
- All patients were appreciative of care and felt treated like a person.
- All staff were observed to be caring, respectful and showed empathy.
- All relatives felt cared for too and told us this was invaluable.
- All patients were involved in care planning and deciding on what, when and how they received care and treatment.
- Staff advocated on behalf of patients.
- We observed that staff offered emotional and practical support to patients and their relatives.

Are services responsive to people's needs?

Outstanding 

We rated responsive as outstanding because:

- All teams responded quickly to referrals and there were no waiting lists.
- The number of did not attend (DNA) had reduced by finding out the causes for this and responding accordingly.
- Patients and their relatives were given accessible information about the service and the treatment offered.
- The vascular wellbeing team used technology to empower patients to manage their own health and lifestyle.
- Teams worked together to enable appropriate responses to patients' needs.
- Staff used signers and interpreters where needed.
- Memory clinics were held in care homes to reduce the number of patients who missed appointments because care home staff could not escort them.

Summary of findings

- There had been no complaints. Staff responded to patients concerns and made changes where possible to resolve these.

However:

- The signage provided at the memory clinic at maple house was limited and we saw patients were not sure where to go for their appointment.

Are services well-led?

Good

We rated well led as good because:

- Staff were engaged in trust wide projects and said that changes were made as a result of their ideas being listened to.
- Individual teams were cohesive and worked well with external teams and professionals.
- Sickness rates were low.
- Staff morale was high and said it was a good trust to work for.
- The trust was supportive of staff training and development.
- The local managers were accessible and led well.
- The board and senior managers were visible and visited the teams.
- Staff could submit items to the trust risk register and did so appropriately.
- Staff demonstrated how they had learnt lessons from incidents and managers had provided an excellent debrief to staff following a serious incident.

Summary of findings

Information about the service

North Staffordshire Combined Healthcare NHS Trust provides community mental health services for older people in the city of Stoke on Trent and across North Staffordshire. It provides services from three locations, which we visited during the inspection.

We visited the memory services at marrow house and at maple house and spoke with the manager of the vascular wellbeing service and the manager of the mild cognitive pathway pilot. We also visited the outreach service at Harplands Hospital and the CMHTs at marrow house and maple house.

Our inspection team

Our inspection team was led by:

Chair: Beatrice Fraenkel, Chair of Mersey Care NHS Foundation Trust

Head of inspection: James Mullins, Head of Hospital Inspections, Care Quality Commission.

Team Leader: Kathryn Mason, Inspection Manager, Care Quality Commission.

The team was comprised of:

One CQC inspector, one psychiatrist specialist advisor, one mental health nurse specialist advisor and one social work specialist advisor.

Why we carried out this inspection

We undertook this inspection to find out whether North Staffordshire Combined Healthcare Trust had made improvements to its community mental health services for older people with mental health problems since our last comprehensive inspection of the trust on 7 – 11 September 2015.

When we last inspected, we rated community mental health services for older people with mental health problems as good overall. We rated the core service as good for Safe, requires improvement for Effective, good for Caring, good for Responsive and good for Well-led.

Following this inspection we told the trust that it must take the following actions:

- The trust must ensure that patients have crisis and contingency plans that reflect patients individual circumstances and that these must be easily accessible to staff.
- The trust must ensure that accurate and up to date risk assessments are completed for patients.
- The trust must ensure that care plans reflect patient views and are person centred.
- The trust must ensure that staff have the skills and knowledge to routinely undertake and record mental capacity assessments in accordance with the Mental Capacity Act 2005.

We also told the trust that it should take the following actions to improve:

- The trust should consider if they are applying a blanket ban by not supporting older people within the Care Programme Approach system.

We issued the trust with three requirement notices that affected community mental health services for older people with mental health problems. These related to:

- Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment
- Regulation 17 HSCA (RA) Regulations 2014 Good governance
- Regulation 9 of the Health and Social Care Act 2008 (RA) Regulations 2014 Person centred care

Summary of findings

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 focus groups.

During the inspection visit, the inspection team:

- visited the facilities where staff see patients for three of the teams, looked at the quality of the environments and checked all clinic rooms.
- spoke with the manager of the vascular wellbeing team.
- spoke with 24 patients who were using the service and nine of their relatives/carers when visiting or on the telephone.
- accompanied nine members of staff on home visits where we observed their interactions with patients.
- spoke with the managers for each of the teams.
- spoke with 33 other staff members; including doctors, nurses and social workers.
- interviewed the divisional director and medical director with responsibility for these services.
- attended and observed one hand-over meeting and one best interests meeting.
- looked at 31 care records of patients.
- looked at a range of policies, procedures and other documents relating to the running of the service.
- observed cognitive stimulation therapy (CST) group.
- spoke with a GP, practice nurse, care home manager and extra care housing manager.

What people who use the provider's services say

One patient told us that the community team had saved their life. Another patient said that they could not have managed without the support of the outreach team.

A relative told us that the outreach team had gone beyond the call of duty and done everything they could to keep my relative out of hospital. They said, "I don't know what I would have done without them".

Another relative said that they had nothing but praise for the outreach team as they had not only looked after their relative (the patient), but all of the family too and kept them all involved.

A relative of a patient said that staff at marrow house CMHT were always patient, respectful and willing to help. They said the patient attended groups run by the team. They had previously tried many services and groups but these were the only ones they had continued to attend.

A patient told us that their Community Psychiatric Nurse (CPN) had really helped them to improve and they did not know what they would have done without them.

Another patient told us that their assessment was a lot more pleasant than expected and a really positive experience.

One patient told us that the staff that visited them were a credit to the NHS.

Good practice

The vascular wellbeing team manager published a paper that was presented at a Health conference in Nottingham in 2014 on the use of Autographer camera for people with short term memory problems. They have since worked with the lead from a local Clinical Commissioning Group (CCG) to incorporate the use of FLO (text messaging service) with the Autographer camera. This has enabled patients to retain responsibility for their own health and

Summary of findings

wellbeing, despite their short term memory problems. They are now working on an 'app' for patients with early onset dementia and mild cognitive impairment. Bids are being submitted for this and they are working with a local technology company. An exhibition of this project was held at a local arts centre in July this year.

The care home liaison team held multi – disciplinary patients meetings at five care homes that included GPs and families where appropriate. GPs and families have reported that this worked well. The input of physiotherapy into care homes with patients at risks of falls had reduced hospital admissions.

The mild cognitive impairment (MCI) Practitioner pilot had delayed the onset of dementia in patients with MCI, giving them an improved lifestyle and wellbeing.

The dementia primary care liaison team had improved relationships between GPs and the teams and enabled better support for patients following diagnosis.

Areas for improvement

Action the provider SHOULD take to improve
Action the provider SHOULD take to improve

- Formal supervision should be recorded.
- Arrangements should be made for all staff to have access to clinical supervision.
- Appropriate signage should be provided at the memory clinics to enable all patients to access.

North Staffordshire Combined Healthcare NHS Trust

Community-based mental health services for older people

Detailed findings

Locations inspected

Name of service (e.g. ward/unit/team)	Name of CQC registered location
Memory Clinic - City Team and Older Age Community Mental Health Team (City)	Trust HQ
Memory Clinic - County Team	Trust HQ
Vascular Well-being	Trust HQ
Older Age Outreach Team	Trust HQ

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 received training in the Mental Health Act 1983 and demonstrated an awareness of its principles.

There were no patients on a Community Treatment Order (CTO) at the time of this inspection.

Staff had access to a central team for enquiries and advice relating to this legislation.

Detailed findings

Mental Capacity Act and Deprivation of Liberty Safeguards

- Staff had received training in the Mental Capacity Act (MCA). Staff we spoke with were knowledgeable and understood the principles of MCA and Deprivation of Liberty Safeguards (DoLS).
- The use of the MCA was documented fully within the care records and reasons for decisions made were fully explained.
- We saw evidence of consent to treatment and capacity requirements recorded within care records.
- We observed that where patients did not have the capacity to consent to decisions about their care and treatment, these decisions were made in their best interests and documented in their records.

Good

Are services safe?

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

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

Our findings

Safe and clean environment

- Patients were not seen on the premises of the outreach team; therefore, we did not inspect their interview rooms. Interview rooms at the memory clinics at marrow house and maple house were not fitted with alarms, however, staff always were provided with personal alarms when using the rooms.
- At marrow house and maple house, the clinic rooms were well equipped with the necessary equipment to carry out physical examinations such as electrocardiogram (ECG), blood pressure monitoring and blood tests. The temperature of the clinic room at maple house was too warm and above normal limits to safely store medicines. This issue had been added to the trust risk register and as a precaution their medicines were stored within premises used by the outreach team. An air conditioning system had been costed but not installed at the time of our inspection as the hospital where maple house was located was under review for potentially closing down.
- All areas were observed to be clean and well maintained.
- We observed that staff adhered to infection control principles including handwashing and all were up to date with infection control training.
- All equipment was checked by staff and serviced by an engineer when required. Equipment was clean and stickers to show this were visible.
- At our last inspection in September 2015, we saw that ligature risk assessments for community teams were not available. During this inspection, we saw that in areas used by patients ligature risk assessments were up to date and ligature cutters were available.

Safe staffing

- Overall, the teams had sufficient staffing to respond appropriately to their patients' needs.

Staffing establishments for each team as of 30 April 2016 were as follows:

Maple House CMHT 5.2 whole time equivalent (WTE) qualified nurses and 4.7 health

care assistants with 0.2 vacancies for qualified nurses and 0.4 for health care assistants.

Maple House Memory Service 7.4 WTE qualified nurses and 0 health

care assistants with 0 vacancies.

Marrow House CMHT 6 WTE qualified nurses and 6 health

care assistants with 0 vacancies for qualified nurses and 1 for health care assistants

Marrow House Memory Service 5.3 WTE qualified nurses and 0 health

care assistants with - 0.5 vacancies for qualified nurses and 0 for health care assistants

Vascular Wellbeing Team 2 WTE qualified nurses and 0 health

care assistants with 0 vacancies for qualified nurses and 0 for health care assistants.

- At the time of inspection the **Outreach team manager told us that there was 1 WTE qualified nurse vacancy due to staff secondment and 1 health care assistant vacancy.**

Maple House CMHT manager said that there were 7 WTE qualified nurses, 5 health care assistants and 1 qualified band 5 vacancy. This was previously a health care assistant post which they hope to transfer to a band 5 post.

- Caseloads were managed and reassessed regularly. At the outreach team, the average caseload per care co-ordinator was 19. However, these could change from day to day as they were reviewed at each daily handover depending on the referrals received. All staff we spoke with said that their caseloads were manageable.
- There were no patients awaiting allocation of a care co-ordinator from within the teams. The role of the care co-ordinator was taken on by team members where patients were waiting for this to be allocated by social services.
- Trust data from May 2015 to April 2016 showed that sickness rates for this core service were 2.9%, compared

to the trust average of 7.6% for this period. During the inspection, the managers at marrow house told us that the staff sickness rate for the CMHT and memory was at 0.6% for the last 12 months.

- Data provided by the trust in April 2016 showed that community older people services had zero shifts that were filled by either bank or agency staff and zero shifts were filled by agency staff. Staff in all teams worked extra as bank to cover so that unfamiliar staff did not cover vacant shifts. Annual leave was planned to reduce the need for cover by agency and bank staff.
- In all teams, there was rapid access to a psychiatrist when required.The trust target for mandatory training was 90%. The trust data showed that at 30 April 2016, Older People Community services had achieved a rate of 91.1% of staff completing mandatory training. All five teams in this core service achieved a higher compliance rate than the trust average of 87.2%. At the time of inspection, the outreach team had 93% of staff who had completed mandatory training.

Assessing and managing risk to patients and staff

- We looked at 31 sets of care records across all teams. Staff assessed each patient's risks during initial assessment. All records, apart from two at maple house memory service, had an up to date risk assessment and risk management plan and had been updated when patient needs changed or during a planned review. One of these records showed that the patient's risk assessment had not been reviewed during an appointment and in the other a risk assessment was not available. Both these patients were seen by doctors at the service. We observed that robust assessments of risk were completed during all visits and patients were offered a copy of their risk assessment. Patients were encouraged to identify their own risks, goals, problems and protective factors.
- Risk markers could be added to a patient's record on the combined healthcare information patient system (CHIPS). These were immediately flagged up when staff typed in a patient's name. For example, if a patient with memory problems needed appointments and letters to be sent to their relative, or two staff needed to go to visit a patient where a risk to staff was identified, this would automatically come up on the system after typing in the patient's name. Each patient's risks had also been identified on an 'at a glance' board in the outreach team office.
- In the outreach team, we saw in one patient's records that the visits from the team had increased as their mental health had deteriorated. The outreach team also had a flow chart for staff to follow if they had no response from a patient when they visited. We were given an example of a visit to a patient who had not responded when staff rang their door bell. Staff found that the patient had fallen and was trapped behind their door so they called an ambulance and the patient was taken to hospital. Staff had access to the local health I - portal system (electronic records) so that they could check if a patient had been admitted to hospital.
- None of the teams had a waiting list.
- Data from the trust showed that staff had completed training in safeguarding adults up to level two and safeguarding children up to level 3. Staff demonstrated a good understanding of how to recognise and report safeguarding concerns. Safeguarding alerts were made electronically and followed up by a telephone call to ensure that they were received.
- All teams had effective protocols on personal safety and they followed the lone working policy. All staff had trust mobile phones. Systems ensured that all staff were accounted for at the end of each working day. In areas where staff felt uncomfortable or for an initial assessment where the patient was not known to the service, staff visited in pairs. All staff had received updated conflict resolution training.
- At the outreach team we saw that medicines were stored safely in a cupboard in the staff kitchen area as air conditioning was available there. Medicine records showed that medication was signed for when taken out and a balance of the stock was kept. This was correct at the time of inspection. Medicines were transported safely by the CPN. All teams checked room temperatures consistently and kept them within normal ranges. This ensured the effectiveness of the medicine was not impaired. When a patient was discharged, the pharmacist was contacted and came to dispose of the medication. We observed that one patient at maple house memory service was prescribed anti-depressant medication. However, staff only discussed the possible side effects with them and not how long they would need to take medication before it became effective. This could result in the patient not taking the medication, which could increase the risks to their safety and welfare.

Good

Are services safe?

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

Track record on safety

- Two serious incidents had occurred at marrow house CMHT in the 12 months prior to the inspection. A root cause analysis investigation of the incident was carried out and subsequent learning shared with staff for one incident. The other incident had occurred less than two weeks before the inspection and this had been assigned to the investigating officer.

Reporting incidents and learning from when things go wrong

- All staff spoken with knew what and how to report incidents on their electronic reporting system.
- All managers told us they promoted an open and transparent culture and explained to patients if and when something went wrong. Patient records looked at did not show examples of this.
- Staff told us that learning lessons from incidents was a standing item on monthly team meeting agendas. Each month, learning lessons were updated to the trust intranet and this information was cascaded to all staff across the community teams. Staff told us of an example where a staff member had a needle stick injury in the community. They followed incident reporting procedures by completing an incident form. As a result, more robust sharp boxes were provided.
- Staff at marrow house CMHT told us how well they had been supported by the manager and whole team following the serious incident ten days before the inspection. Staff involved had also been referred to the trust staff counselling team. The team manager had also booked to complete debrief training to ensure that they had the knowledge and skills to debrief staff.
- Staff in all teams told us they received a debrief after incidents and the culture within the teams was to learn from incidents rather than put blame on staff.

Are services effective?

Good

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

Our findings

Assessment of needs and planning of care

- We looked at the care records of 31 patients. All contained a comprehensive assessment of patients' needs. The assessments were holistic and considered the needs of carers. During visits to patients we observed that staff completed assessments in a professional and sensitive manner, which enabled the assessment to be thorough.
- All care records looked at contained up to date, personalised, holistic and recovery-oriented care plans. The patients' needs were identified and goals and outcomes stated. Records included a crisis plan as to how the patient would need to be supported and what support they would require.
- Information about patients was stored on the electronic records system called CHIPS (combined healthcare information patient system). Records had been transferred to this system since our last inspection in September 2015. Staff told us that this had made patient records available to staff when they needed it. Staff could follow the patient journey when they moved between teams which made it easier to know the patients' needs and how to support them. Staff also had access to the 'I portal' system so they could see when patients had been seen by their GP or were admitted to hospital within another trust.

Best practice in treatment and care

- We looked at the care records of 31 patients. There was evidence that staff followed national institute for health and care excellence (**NICE**) guidance when prescribing medication for dementia, depression and anti-psychotic medication. NICE guidance was also considered when making treatment decisions. These included specific dementia examinations such as the addenbrookes cognitive examination (ACE) revised tool. Teams used the LUNSERS (liverpool university neuroleptic side effect rating scale) tool to measure the side effects of patients who took anti-psychotic medication. If medication was prescribed to patients diagnosed with dementia, a follow up appointment was arranged to assess the effects of medication and ensure that dosages were monitored in line with NICE guidance.
- Memory service staff told us there was no funded psychology for patients with dementia but they could access this and had links with the neuro psychology team. In all teams, there were staff trained in counselling and cognitive behavioural therapy (CBT) and this was offered to patients where appropriate. Staff also facilitated anxiety management groups and for patients with dementia, cognitive stimulation therapy (CST) groups were offered by staff that had been trained in this. Psychological therapies were offered to patients who had a diagnosed memory difficulty and if the patient consented, a family session was also offered.
- At the memory clinics, a voluntary organisation (Approach) held drop in sessions. They provided advice to patients on benefits and support in the community from social services.
- All records we looked at showed that staff had considered physical healthcare needs. Health care assistants as well as nurses were trained to take bloods and do electrocardiograms (ECG). All patients attending the memory clinics had blood tests and an ECG before their appointment to assist with diagnosis and prescribing of medication where this was appropriate. Records showed that patients prescribed lithium or antipsychotic medication had regular blood tests to monitor the use of these medications.
- The physical health needs of patients were considered. One patient told us that the staff looked at all of their needs, not just mental health. They said they had some walking problems and the staff had arranged for aids and adaptations to be provided in their home which had improved their mental wellbeing. The teams also carried out blood tests, monitoring of blood pressure, weight and electrocardiograms. These were recorded on the patients' records and could be viewed by all staff.
- People received text messages through FLO to remind them about their vascular risks, for example, stopping smoking, and drinking alcohol. An evaluation of the project showed that these risks were reduced. The Warwick-Edinburgh Mental Well-Being Scale (WEMWBS) scores were taken at the beginning and end of the project and showed improvement in patient scores.
- The vascular wellbeing team (VWT) ran the 'Take Heart' programme. The service was unique to the area as Public Health England had identified that at one GP surgery, rates of vascular disease were very high. The programme ran for eight weeks and was for patients who did not have mental health needs but memory problems. Each patient had a vascular management

Are services effective?

Good

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

plan which identified their existing vascular risk factors and goals they would like to work on. They referred people to lifestyle programmes offered by primary care services for 12 weeks. Since the project started in 2009, only two patients had been admitted to inpatient beds. One patient, who was regularly attending the diabetes clinic and the pain clinic, was now discharged from both and was using the gym three times a week. The VWT are now intervening very early on when vascular risks are identified so that the onset of dementia can be delayed. At the memory clinics, we saw that the addenbrookes cognitive examination (ACE) tool was used and this was compared with the patient's results from their appointment with the GP who referred them. The Outreach team were trialling the use of health of the nation outcome scores (HONOS) 65+ as an outcome measure. CST groups used the 6-item cognitive impairment test (6CIT used by GPs as an outcome measure) at the beginning of the group and after 12 weeks to test the outcome for each patient following attendance at the group. They also used a satisfaction questionnaire and had received very positive feedback from these. Staff at the memory clinic and CMHT at maple house told us that they were devising their own outcome measures that were tailored to patients needs as they had found that the STAR assessment for older adults and HONOS65+ had not given them much information about the outcomes experienced by patients. The trust research and development team were involved in this. The manager at marrow house memory clinic was researching (as part of the Masters course they were doing) an outcome measure that would suit the needs of patients and service better. The vascular wellbeing team (VWT) was commissioned initially in 2009 and run in GP surgeries following a successful pilot. It aims to delay the onset of dementia in people who have vascular risks. The age range was initially for 50 years plus but research and evidence showed that early onset dementia could be missed, so the service is was broadened for people who are 40 years old and above. They used a specific assessment that was devised in collaboration with doctor at the memory clinic. They completed the addenbrookes cognitive examination (ACE) assessment on an IPad and found this reduced human error, making the assessment more reliable, accurate and efficient. Staff said this assessment gave a good indication of where the patient was at and if a referral was needed to the memory clinic. They also used Warwick-Edinburgh mental well-being Scale (WEMWBS) at the beginning and end of treatment to see what had improved and what else the patient needed. The information from this was inputted onto CHIPS for each patient.

- Staff at maple House CMHT had restarted their 'journal club' to enable them to identify research that would help to develop their practice. At the last meeting they looked at reflective practice and have identified that at their next meeting they would focus on outcome measures.Nursing staff did not participate in clinical audits. However, care plan and risk assessments audits were completed fortnightly by the team leader and registered nurses. There was evidence that improvements had been made as a result of these. For example, in the outreach team, staff had struggled with ensuring that the patient's voice was recorded in care plans and risk assessments. Through the audits, compliance with this had risen to 100%. All records we looked at showed the patient's voice was recorded.

Skilled staff to deliver care

- All the teams that we visited included nurses, health care assistants and doctors. The CMHTs had practitioners, some of whom were qualified occupational therapists. Each team had access to psychologists whom they could refer patients to. None of the teams had social workers within the teams but liaised with social services when needed. Staff spoken with did not think that this model impacted on the care provided to patients.
- All staff were able to undertake further training to equip them in their role. Some staff were training to become nurse prescribers and leadership and career development opportunities were available to staff. Some staff had completed training in caring for patients diagnosed with a personality disorder while others had completed training in cognitive stimulation therapy (CST) and anxiety management so that they could facilitate groups for patients.
- All staff had received an appropriate induction.
- All staff received management and caseload supervision at least monthly. However, formal supervision was not recorded at the outreach team so it was not possible to assess the effectiveness of this. All staff had access to monthly team meetings and the minutes of these were kept electronically so staff not able to attend could read

Are services effective?

Good

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

these. Weekly band 7 meetings were held in the directorate and staff spoken with found these useful. In all teams, except for the vascular wellbeing team (VWT), staff did not have separate clinical supervision. Staff in the VWT had access to external counsellors for clinical supervision. Qualified occupational therapists within the teams had bi-monthly peer supervision.

- Information provided by the trust showed as at 30 April 2016 this core service had an appraisal rate of 97.6% for non – medical staff. At the time of the inspection, 100% of the staff within the outreach team and maple house CMHT had received an appraisal. Staff spoken with gave examples of how goals set in their appraisal were being achieved through opportunities given by their manager to develop their skills and knowledge.
- Staff received the necessary specialist training for their role.
- Information provided by the trust showed as at 30 April 2016 100% of the doctors in this core service had revalidated.
- We did not see any evidence that poor staff performance had been addressed. However, we did not see any examples of poor staff performance.

Multi-disciplinary and inter-agency team work

- All teams we visited included nurses, health care assistants and doctors. The care home liaison team also had a physiotherapist and a physiotherapy technician. Social workers were based in local authority teams and staff reported good working relationships with the local authority teams.
- There were effective handovers within teams. We observed the handover in the outreach team in which all staff were involved and showed concern for individual patients and risks were identified and discussed. Handovers were recorded electronically so that all staff could access these.
- There were effective handovers between teams within the organisation. The outreach team had a link worker to each of the older adult's wards at Harplands Hospital. A band 6 nurse or team leader attended the ward rounds of patients allocated to the outreach team. We saw that all teams liaised with each other as needed and this included the care home liaison team, dementia primary care nurses, the stay at home team and the neuropsychiatry team. Memory services also worked with the voluntary service Approach who held drop-ins at the memory clinics. A monthly memory clinic practitioners meeting was held where doctors also attended and good practice was shared.
- There was a mild cognitive impairment practitioner working with the teams. They were running a pilot in the county working with younger people to identify what could be done to stop the cognitive impairment progressing.
- There were good working links, including effective handovers with primary care, social services and other teams external to the organisation. Staff at the outreach team gave us an example of how they had visited a patient with staff from the fire service in order to advise on fire safety in the home.
- The outreach team were the emergency support contact for care homes after 5pm and at weekends. All staff were able to access the system at the acute hospital so they could get blood test results through quickly.
- Staff referred patients to the Healthy Minds counselling service where needed. One patient was concerned about travel so staff ensured they had access to the telephone counselling service.
- The practice nurse and care home manager spoken with described the benefits of the primary care dementia liaison service in terms of early intervention and avoidance of referral to secondary care. The GP described a report of the outcome of the liaison service after one year which was presented to the Clinical Commissioning Group (CCG) board and showed evidence of reduced hospital admissions.

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

- Staff received training in the Mental Health Act and demonstrated an awareness of the code of practice and guiding principles. Data provided by the trust at 30 April 2016 showed that 91.4% of staff in this core service had received training in the MHA.
- There were no patients on a community treatment order (CTO) at the time of the inspection.
- Administrative support and legal advice on implementation of the MHA and its code of Practice was available from a central team and staff knew how to access this.

Good practice in applying the Mental Capacity Act

Are services effective?

Good

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

- There was a trust policy available on Mental Capacity Act which staff were aware of and could refer to.
- Staff had received training in the Mental Capacity Act and demonstrated that they understood its five statutory principles. The outreach team provided training to staff in care homes and advised them when to make a Deprivation of Liberty Safeguard (DoLS) application where applicable. We observed a best interests meeting in which staff from marrow house CMHT had good knowledge and understanding of capacity and DoLS issues.
- For people who might have impaired capacity, capacity to consent was assessed and recorded appropriately. This was done on a decision-specific basis with regards to significant decisions and people were given every possible assistance to make a specific decision for themselves before they were assumed to lack the mental capacity to make it. Records included capacity assessments which were documented at the initial referral assessment. They included the need for advocacy involvement and information sharing.
- Patients were supported to make decisions where appropriate and when they lacked capacity, decisions were made in their best interests. Two of the staff at marrow house CMHT were best interest assessors. Staff at the outreach team gave an example of how they had assessed the capacity of a patient to agree to being admitted to hospital. The patient lacked the capacity to consent to this at that time so the decision to admit them was made in their best interests.
- Where patients had a Lasting Power of Attorney (LPA) this was recorded in their notes.
- Staff knew where to get advice regarding Mental Capacity Act within the Trust.
- There were arrangements in place to monitor adherence to the Mental Capacity Act within the trust.

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Outstanding ☆

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

- During visits with staff from the teams, we observed all staff to be respectful, kind, warm and caring. Staff gave patients time to respond during assessments and put the patient at ease. Staff actively listened to the patient's account of how they were feeling that day.
- All patients that we visited with staff had been asked for their consent to us visiting before the visit and this was repeated at the time of the visit.
- During an appointment at a memory clinic we observed the nurse showed empathy. They clearly described the process to the patient and their carer and explained what would happen at this appointment and for future tests.
- Patients told us that they are a person to the nurse who cares about them and their recovery. They said that all staff in the team had treated them with patience and compassion, were always respectful and polite and interested in their wellbeing.
- Staff were knowledgeable of patient needs and showed empathy to the patient and their carers.
- One patient told us that they knew that what they said was kept in confidence and staff understood them like a 'professional friend'. They said that staff visited them for a specific reason but had time for them and looked at the whole of them, not just their mental health needs.
- 32 comment cards were completed about the CMHT, memory clinic and stay at home teams at marrow house. Ninety seven per cent of the responses were positive. Patients and their carers said the service was excellent and staff were caring and compassionate.

The involvement of people in the care they receive

- We observed staff involving patients in their care plans and all records looked at included the patients' thoughts and wishes. All patients spoken with told us that they were involved in their care plan and had been offered a copy. We observed that staff went through the goals with a patient, which were small and achievable and the patient agreed with them. At another visit, we observed that the patient was encouraged to identify their progress with the goals set in their care plan. This helped them to be involved and see for themselves their progress.
- One patient told us that their medication was changed at their request. They said they had a copy of their care plan, were given choices of the treatment they received and their relative was involved at their request. Their relative told us they felt very involved and was pleased with the service received.
- We saw a nurse giving a patient a depot injection that was given in their preferred site. They also discussed with the patient the use of oral medications or injections and the benefits and risks of each. Staff said "it is about what is best for the patient".
- One patient told us that their relative was involved in their care plan which had helped them to achieve their goals. During a visit to a patient with staff from marrow house CMHT, we observed that the staff member offered emotional support to the carer.
- Where patients agreed to their relatives being involved in their care, they were referred to the North Staffs carers association. Carer's checklists were used as part of the patient's assessment. The outreach team planned to run a carers group from October 2016 onwards.
- All teams told us they could refer patients to advocacy where needed and we saw that there were links on the patient record system for this.
- We observed that patients had a choice of which staff visited them often so they were comfortable with the staff supporting them.
- Staff told us that they asked for feedback from patients and carers in surveys and made improvements as a result of this.
- One student nurse surveyed 20 patients who attended the memory clinic at maple house in August 2016, 12 responded. One hundred per cent said that they would recommend the service to family and friends and that overall it was a good experience. 100% felt that information given prior to the appointment was adequate and they felt welcome on arrival.
- At each memory clinic, we saw that a range of leaflets were available about memory problems, dementia, voluntary organisations and emergency contact numbers.
- The vascular wellbeing team offered a support group at a local church hall for patients who had used the service. This was run by patients and a volunteer as a continuation of the service they had received to enable them to continue to support each other and take responsibility for their own wellbeing.

Outstanding ☆

Are services caring?

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

- We observed a cognitive stimulation therapy (CST) group. The group was structured and the atmosphere was relaxed and engaging. All patients said they enjoyed the group and looked forward to going each week.

Are services responsive to people's needs?

Outstanding ☆

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

Our findings

Access and discharge

- Referrals were made from GP's, social workers, relatives and carers, self (the patient), other health professionals, police, community workers and housing officers. All teams had a 'duty professional' available as well as a support from a healthcare assistant. They triaged calls and referrals and contacted patients and their carers to follow up. We observed that staff responded promptly and professionally to all referrals received.Data provided from the trust in April 2016 showed that the trust's national target of '126 days from initial assessment to onset of treatment' was met by all teams in this core service. For the teams we visited the average number of days from initial assessment to onset of treatment were:

  Vascular Wellbeing Team – 18 days

  Marrow House CMHT – 9 days

  Maple House CMHT – 4 days

- The memory services were the top performing service in the West Midlands for diagnostic rates for dementia and the 8th overall in England. The time from referral to appointment at the time of the inspection was four weeks at marrow house memory clinic. Staff recognised that this was longer than the targeted three weeks. This could then delay the diagnostic appointment being within eight weeks to meet the service specification of providing diagnosis 12 weeks from referral. There had been an increase in referrals so routine referrals were screened by the memory clinic practitioners to help reduce the time from referral to appointment. If a referral was urgent, the duty worker responded that day.

- The outreach team aimed to provide a 33 day service from referrals until the patient was discharged or referred to another team or service. Referrals were followed up straightaway by phone and if the person did not answer, a team member would visit them. The team worked from 8am to 8pm seven days a week. Outside of this time, an answerphone directed people to emergency services and organisations such as the Samaritans.

- At both marrow house and maple house CMHT, staff worked from 9am to 5pm Monday to Friday. Patients referred to marrow house would be seen within a week, or if urgent, within an hour. At maple house, the team would see routine referrals within two working weeks and if urgent on the day of referral. All staff said that they worked flexibly so if an urgent referral was received at 4.55pm the patient would be seen that day.

- A patient, their relative and their GP told us that they had received a rapid response from maple house CMHT the previous week in response to an escalation of the patient's behaviour which was challenging. This had prevented the patient being admitted to hospital under the Mental Health Act.

- A student nurse had surveyed 20 patients who attended the memory clinic at maple house in August 2016. Twelve patients had responded and 100% were satisfied with the waiting times for appointment.

- The care home liaison team had improved referrals for people from care homes by being clear about why referrals would not be accepted. Care homes now had triage forms that asked if the person had been seen by the GP or physical health screening had been done to rule out if physical health needs were causing the person to be unwell. They also asked for an up to date summary from the patients with their prescribed medication. They said this had reduced inappropriate referrals.

- The dementia primary care liaison and GP liaison teams and the physiotherapists going into care homes had helped to reduce hospital admissions. This showed more agile and innovative ways of working.

- The memory services criteria was based on need, not just age. The vascular wellbeing team visited memory clinics, set up sessions in sheltered housing complexes and had direct contact with GPs. They held clinics at a neighbourhood centre and a shared care centre on five mornings each week and at another primary care centre one day a week. This helped them to identify the patients who needed the service.

- The primary care liaison team was commissioned in 2015 and consisted of three band 6 nurses. Patients from the community teams were discharged to the team and were seen in GP surgeries and the prescribing was handed over to the GP. Staff told us that an average of 50 patients were transferred to the primary care liaison team every month from marrow house.

Are services responsive to people's needs?

Outstanding ☆

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

- The manager of the care home liaison and dementia primary care teams did some work through 'listening into action' as to why people did not attend appointments (DNA). They found there were a lot of people who lived in care homes who DNA. They identified this was because there were not enough staff to bring people to appointments, agency staff were sent who did not know the person and families were not informed of the appointments. In response to this, they set up memory clinics in care homes and invited families to attend where appropriate. Staff from the memory clinics visited patients who could not get to the clinic at home or arranged transport to support them to attend their appointment. Staff gave us an example of a patient with a history of disengaging with services and told us they had allocated a worker who the patient was willing to see.
- The outreach team gave us examples of three patients whose stay in hospital had been reduced because of input from the team. All three patients had on admission been assessed as needing nursing or residential care on discharge. However, all three patients with the support of the outreach team returned home with care packages and were doing well.

The facilities promote recovery, comfort, dignity and confidentiality

- Patients attended the memory clinics at maple and marrow house. At both clinics, there were a full range of rooms and equipment to support treatment and care.
- Marrow house memory clinic and CMHT had been on separate sites until March 2016. Staff said that the joining of the two services in one building had helped to provide a better service as the two teams worked together.
- The memory clinic at maple house had been recently refurbished. This had created a larger waiting area for patients and more comfortable surroundings.
- Accessible information on treatments, local services and patients' rights and how to complain were available at both memory clinics. There were several leaflets with information on how to support a person living with dementia which also signposted carers to support agencies.

Meeting the needs of all people who use the service

- The memory clinics were accessible to people who require assistance or have a physical disability.
- The toilets in the memory clinics had signs on the doors that were accessible to people living with dementia. However, at maple house, no other signage was provided and we saw people lost around the clinic.
- Leaflets were available in accessible formats and could be translated when needed to suit the needs of the local community.
- At marrow house memory clinic, we saw that letters following appointments were written in an accessible way to patients with no acronyms or medical language used.
- A relative told us that staff visited their home to take bloods from their relative so they did not have to go to the GP surgery as attending the GP surgery caused the patient to become distressed.
- There was limited public transport in some of the rural areas of the county.One patient said they would not be able to attend an anxiety management group as they had no access to transport. Staff put them in touch with the voluntary transport service, advised them of the cost and how the service worked.
- The occupational therapist at maple house CMHT showed us a leather lacing tool that they used which they said was excellent for people with literacy problems. This was called the allen cognitive level screen (ACLS). The ACLS is an assessment tool that helps to identify the cognitive levels of people with Alzheimer's disease, dementia, and other cognitive disabilities.
- All staff said that if needed, interpreters were booked online and this included sign languages. They said this was an easy process.
- Some staff had received training in British Sign Language (BSL) and used this where necessary to communicate with people. However, one patient who was Deaf completed a comment card and told us that the doctor did not understand them so their relative had to interpret for them. Staff at the outreach team told us they used flash cards where needed to help with communicating with patients who may not hear or understand what was asked of them.

Are services responsive to people's needs?

Outstanding ☆

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

Listening to and learning from concerns and complaints

- None of the complaints received by the trust between April 2015 and March 2016 related to older people's community services. There had been no complaints at the time of inspection.
- All patients spoken to knew how to complain if they needed to but had no complaints about the service.
- Staff at maple house memory service told us that before the waiting area was refurbished, they received concerns from patients about the waiting area. They had listened to these concerns and provided a waiting room that addressed these. Patients told us that they had no concerns since the new waiting room had been provided. One patient said they used to find the small space distressing when sat next to a person whose dementia was more advanced.
- All staff told us that they were proactive at dealing with concerns so they did not become complaints. At maple house CMHT, staff told us that if a patient or relative expressed dissatisfaction with the service, they would contact them to iron out the issues and learn from it.
- The trust told us that between April 2015 and March 2016, three compliments had been received related to older people's community services, two for the outreach Team and one for the care home liaison service. In all services we saw that cards from patients and relatives had been received complimenting the service and thanking staff.

Are services well-led?

Good

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

Our findings

Vision and values

- All staff were aware of and agreed with the vison and values of the trust.
- The objectives of each team reflected the trust's values and objectives.
- Staff knew the senior manages in the trust and said that they had visited the teams. Staff told us that the current Chief Executive and trust board were visible.

Good governance

- Records showed that statutory and mandatory training was completed, or staff were booked onto the training courses.
- Staff received an annual appraisal. All staff received regular (at least monthly) management and caseload supervision and attended monthly away days. However, clinical supervision was not available for all staff.
- Staff participated in audits of care plans, care records and risk assessments. There was evidence of an improvement in these as a result of the audits.
- Staff reported incidents and all staff were able to recall what they had learnt from incidents that had occurred.
- The teams provided patients with written information about how to complain. Staff told us of improvements that had been made through 'Listening into action'.
- Procedures relating to safeguarding were widely followed and staff knew how to raise an alert.
- Staff adhered to procedures relating to Mental Capacity Act and Mental Health Act and demonstrated their knowledge in applying this legislation in their day-to-day work with patients.
- Appropriate numbers of staff were available and staff told us that direct patient care was their priority.
- All teams monitored and adhered to their key performance indicators, such as staff training and waiting times.
- All team managers were able to feedback any concerns to their line managers and peers in monthly meetings and submitted items to the risk register as required.

Leadership, morale and staff engagement

- Sickness rates for this service for the 12 months at 30 April 2016 were 2.9%. The overall sickness rate of the trust in the same period was 7.6%.
- No teams had reported any bullying and harassment cases. All staff that we spoke with said they were aware of the whistleblowing policy and felt confident they could raise concerns without fear of victimisation. Staff were aware of the freedom to speak guardian, their role and how to contact them.
- Staff across all teams said that morale was good and that they enjoyed working within the teams and with their patients. They had developed good working relationships and said they worked well as a team. All staff were complimentary about their managers and considered them approachable and supportive. Team managers considered their line managers to be supportive and approachable.
- Staff were engaged in trust wide projects. They said that they had been listened to and as a result, updates had been made to the combined healthcare information patient system (CHIPS) and laptops were provided to community psychiatric nurses (CPNs).
- The trust encouraged staff to develop their leadership skills by promoting leadership and management training. Some staff told us they had attended and had gained new skills. The manager of the memory service at marrow house was being supported by the trust in doing a master's degree in advanced clinical practice.
- Each team member had a lead role within the team to ensure that the needs of patients were met. For example, there was a link nurse for hydration and nutrition to ensure that the team were assessing this for patients. There was also a lead for training to ensure that targets were met.
- The team managers told us they met monthly with other band 7 nurses where they reflected on their practice and discussed common themes.
- Staff across the service showed awareness of being transparent and open with patients and carers when things went wrong.
- The directorate manager told us that operational managers were now involved in the planning and development of services. They also said that the trust board were accessible and several board members had attended the last monthly staff away day. Staff told us that when they made suggestions to improve the service they were well received by managers and service changes were always discussed. Some staff had struggled with the changes to IT systems. However, they had been well supported through this and thought that the monthly away days had helped with this.

Are services well-led?

Good

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

Commitment to quality improvement and innovation

- Several teams and individual staff had recently received awards. For example, the outreach team had won the 'Rising Star team of the year' award and the manager had been highly commended for leading with compassion. Two band 6 nurses from the memory clinic at maple house had won 'leading with compassion' awards and the team was nominated for the trust award. The band 6 nurse who was the mild cognitive impairment practitioner won the 'reach award for excellence' for their work in this programme. The physiotherapist had won a 'Spotlight on Excellence' award.
- The memory service at maple house had applied to participate in Memory Services National Accreditation Programme (MSNAP). They had waited to do this until the clinic had been refurbished as they were aware that this had previously not met the standard required.
- The manager of the vascular wellbeing team had worked with the Clinical Commissioning Group (CCG) and Keele University on the Autographer and FLO (Florence Simple Telehealth text messaging system, or 'Flo' for short, was named after Florence Nightingale) project. FLO in this case helps people with short term memory problems to remember what to do during the day so enabling the person to have more control over their life. This was combined with the use of the Autographer camera. Text messages would remind the person to put the camera on. An evaluation report of the project showed how people's memory of events had improved. For example, one person had taken pictures on their Autographer of a visit to their son. They were able to play this back and remember the visit and the emotions associated with it. Another person had forgotten they had their car serviced so rebooked it with the garage. When they looked at the images from their Autographer they saw that it was already done and so cancelled the second service.