Good

South Staffordshire and Shropshire Healthcare NHS Foundation Trust

Community-based mental health services for adults of working age

Quality Report

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Locations inspected

Location ID	Name of CQC registered location	Name of service (e.g. ward/ unit/team)	Postcode of service (ward/ unit/ team)
RRE11	St George's Hospital	71 Salop Road, Oswestry, Shropshire - CFNCT North Shropshire	SY11 2NQ
RRE11	St George's Hospital	Severn Fields Health Village, Sundorne Road, Shrewsbury - CFNCT EIT Shropshire, Telford and Wrekin	SY1 4RQ
RRE11	St George's Hospital	Severn Fields Health Village, Sundorne Road, Shrewsbury - CMHT Central Shropshire	SY1 4RQ

Summary of findings

RRE11	St George's Hospital	Castle Lodge, Attwod Terrace, Dawley, Telford - CFNCT Wrekin	TF4 2HQ
RRE11	St George's Hospital	Northgate Health Centre, Bridgenorth, - CMHT North Shropshire	WV16 4EN
RRE11	St George's Hospital	Codsall Area Social Services Office, Histon Hills, Wolverhampton - CMHT Seisdon	WV8 1AA
RRE11	St George's Hospital	Plantation Lane, Mile Oak, Tamworth, Staffordshire - CMHT Tamworth	B78 3NG

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

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

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

Summary of findings

Ratings

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

Overall rating for the service	Good
Are services safe?	Good
Are services effective?	Good
Are services caring?	Good
Are services responsive?	Good
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

W**e rated South Staffordshire and Shropshire Healthcare NHS Foundation Trust as good because**:'

- Patients had access to a wide range of professions who offered modern and holistic treatments. This included psychologist, psychiatrists, nurses, occupational therapists and social workers who were trained to deliver dialectical behavioural therapy, cognitive behavioural therapy and eye movement desensitisation and reprocessing therapy.
- Feedback from patients and carers was very positive about staff and the service overall.
- Referral to treatment times were good and there was a tiered approach which ensured that patients with an urgent requirement for treatment were assessed quickly.
- Teams had developed systems of working to ensure that information was shared throughout the team. Leadership was good across all of the services we inspected. Managers were well respected and could demonstrate good knowledge of their team.

However:-

- The quality of care planning and risk assessments was variable. In some cases these documents were filled out well and contained lots of patient centred information; we did find some however that were out of date or did not contain enough information.
- There was an issue in some teams linked to social work input. Social work services were externally sourced in some services and this had meant that the social workers changed regularly and did not have the same access to training and development as trust employed social workers.

Summary of findings

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

Are services safe?

Good

- All environments within the community-based mental health services for adults of working age were clean and fit for purpose. They were welcoming for patients with lots of information posted on noticeboards. There was enough staff to ensure that the service operated consistently.
- Caseload numbers were manageable and allowed staff the opportunity to spend time on direct care.
- There was rapid access to psychiatrists in all areas we inspected.
- Staff training and supervision percentages were all above trust key performance indicators.
- There were effective measures in place to ensure that information from incidents and investigations was cascaded to all staff.

However:-

- The quality of risk assessments and documentation in general was variable. Some notes and risk assessments we checked were patient centred and contained a good deal of information; in other cases, information was sparse and did not contain detail.
- We observed, at North Shropshire base, that once patients had gained access to the building they were able to access the main team area via an automatic switch. This could have allowed patients access to team offices and could have posed a risk to the security of information and to staff safety.

Are services effective?

Good

- The community-based mental health services for adults of working age offered modern therapies in line with guidance issued by the national institute for health and care excellence.
- The teams consisted of a range of disciplines such as medical staff, nurses, support workers, psychologists and occupational therapists.
- Staff received regular supervision and appraisal.
- Training levels were high across all services we inspected. Staff received training in the Mental Health Act (MCA) and Mental Capacity Act (MCA).

However:-

Summary of findings

- We found in some cases that information was either missing or out of date in patient care plans. Though some care plans were of a very high standard, this was variable.

Are services caring?

Good

- All interaction we observed between patients and staff were supportive and caring. Staff treated patients and carers with dignity and respect and involved them in the development and delivery of care.
- Staff had a good knowledge of individual patient needs.
- We saw three examples of staff reacting quickly to deterioration in either the physical or mental health of the patients they were visiting.
- All services used the Meridian feedback questionnaire to gain feedback on the services they provided. Information from the questionnaire was used to ensure that staff improved the services they provide to patients.

Are services responsive to people's needs?

Good

- Teams were exceeding trust targets for referral to assessment and assessment to treatment.The teams also employed systems to ensure that patients in crisis were seen urgently
- The teams take a proactive approach to re-engaging patients that did not attend their appointments.
- The community-based mental health services for adults of working age in South Staffordshire and Shropshire had developed medication clinics that could undertake testing relating to antipsychotic medication on site. This reduced waiting times for patients who required testing.

Are services well-led?

Good

- All staff we interviewed were aware of the trusts values and visions. The trust had integrated these into the appraisal process and had provided staff with literature.
- Staff also stated that senior managers were a visible presence within the trust. They stated that they would feel happy to approach them and confident that they could raise concerns if required.
- Staff appraisal and supervision levels were high within the community-based mental health services for adults of working age. Staff morale was high and people we interviewed stated that there was good job satisfaction.

Summary of findings

- Staff stated that they felt that their managers listened to them and that they could effect change within the service.

Summary of findings

Information about the service

We visited six community mental health teams and one early intervention team.

CFNCT North Shropshire was based in Oswestry and covered this area; this was the team's base and the area where they saw patients. This team were known as the North Shropshire community mental health team (CMHT).

CHFNCT EIP Shropshire, Telford and Wrekin were the early intervention team based in Severn Field Health Village in Shropshire.

CMHT Central Shropshire worked alongside the early intervention team at Severn Fields Health Village.

CFNCT Wrekin was based in Telford and covered the Telford and Wrekin area. The team base was at Castle Lodge. The staff team had moved into Castle Lodge the week before our inspection. Patients were seen at Leonard Street (both were in Telford about 10 mins apart).

CMHT Seisdon was based in the local social services offices in Histon Hills, Wolverhampton, at the time of our inspection. They were in the process of moving to the local council offices. This report includes details of a visit to the new location. Patients were also seen at a local GP surgery as a satellite location.

Tamworth CMH team was based on an acute hospital site and covered the Tamworth area. They were based on an area that was previously a ward. This was the staff base and the area where patients were seen. The team had re-located to this base 18 months ago.

CMHT South Shropshire was based in Bridgenorth.

Our inspection team

The inspection was led by:

Lead Inspector: James Mullins, Head of inspections, Care Quality Commission

Chair: Vanessa Ford, Director of standards and governance, West London Mental health NHS Trust

The team was comprised of: Two CQC inspectors, one CQC inspection manager, one expert by experience, two social workers, and one registered mental health nurse.

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 a number of focus groups.

During the period of our inspection we:-

Summary of findings

- visited 6 locations and 8 teams
- spoke with 17 patients
- spoke with five managers and four clinical leads
- spoke with 53 staff members including doctors, nurses, occupational therapists, social workers, support workers, psychologists, team secretaries, apprentice administration workers and assistant practitioners.
- spoke with five area managers with responsibility for these services
- accompanied staff on nine patient home visits
- observed staff in ten patient consultations
- spoke to 14 carers of patients who used the service
- attended and observed a formulation meeting for a patient conducted via skype, a senior staff meeting, a daily 'huddle', two multi-disciplinary team meetings and a morning meeting.

We also:-

- looked at 61 treatment records of patients.
- reviewed the four clinic rooms.
- Reviewed eight clozaril monitoring sheets and 27 medication charts
- looked at a range of policies, procedures and other documents relating to the running of the service

What people who use the provider's services say

All comments cards we received were positive.

The patients we spoke to were all complimentary of the staff that worked with them; the service and the trust in general. We received two comments from staff that they felt that reception staff were unwelcoming. These were the only two negative comments we received during the period of our inspection.

All carers were complimentary of staff, the service and the wider trust.

Good practice

During the period of our inspection, we witnessed three instances where staff responded extremely quickly and effectively to deterioration in either the physical or mental health of the patients they were visiting. In all three cases, the staff used their knowledge of the patient to establish deterioration. This knowledge was supported by information contained within the patients' notes. They acted quickly to establish the most effective course of action to take. All three patients were managed quickly by the team and, in each case, by the time we left the location the patients circumstances had been improved.

We noted that to ensure effective communication balanced against best use of resources that the Wrekin and North Shropshire teams used 'Skype'. This was to conduct patient planning and discharge meetings with the in-patient service. The in-patient service was based in Shrewsbury approximately a 45-minute drive away.

The Tamworth team attended a weekly meeting – Tamworth vulnerable partnership, attended by representatives from housing, police, fire services, alcohol services, veteran's link and children's services. The purpose of the meeting was to discuss the care of people who may be vulnerable or required safeguarding in the local area and to establish how best to support them.

The trust IT system had the ability to translate information leaflets into languages other than English. We were impressed that trust information was available to patients who used the service regardless of their ethnic background.

Summary of findings

Areas for improvement

Action the provider SHOULD take to improve

Action the provider SHOULD take to improve

- The provider should ensure that there are quality assurance processes in place in order to provide a consistent approach to care planning.
- The provider should ensure that there is a formal process in place for the review of care plans by the multidisciplinary teams.
- The provider should ensure that areas where confidential information is stored are secured.
- The provider should continue to monitor and embed learning from unexpected deaths in the community.

South Staffordshire and Shropshire Healthcare NHS Foundation Trust

Community-based mental health services for adults of working age

Detailed findings

Locations inspected

Name of service (e.g. ward/unit/team)	Name of CQC registered location
CFNCT North Shropshire	71 Salop Road, Oswestry, Shropshire,
CFNCT EIT Shropshire, Telford and Wrekin	Severn Fields Health Village, Sundorne Road, Shrewsbury
CMHT Central Shropshire	Severn Fields Health Village, Sundorne Road, Shrewsbury
CFNCT Wrekin	Castle Lodge, Attwod Terrace, Dawley, Telford
CMHT South Shropshire	Northgate Health Centre, Bridgenorth
CMHT Seisdon	Codsall Area Social Services Office, Histon Hills, Wolverhampton
CMHT Tamworth	Plantation Lane, Mile Oak, Tamworth, Staffordshire

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.

The trust delivers training in the Mental Health Act (MHA) as part of its mandatory training curriculum. The community-based mental health services for adults of working age teams were all above trust KPIs in this area with an overall KPI of 87%. Staff we spoke with all had a good knowledge of the Mental Health Act.

Detailed findings

We found no errors in recording. The paperwork was complete and stored securely. All recording was electronic. All information was stored in the correct sections of the electronic recording system.

Mental Capacity Act and Deprivation of Liberty Safeguards

Mental Capacity Act training was included in the mandatory training calendar. It was included as part of the Mental Health Act training. Community-based mental health services for adults of working age were at 87% compliance with this KPI.

The staff that we interviewed showed good knowledge of the Mental Capacity Act 2005 and were aware of its five guiding principles in most cases. We found no errors in recording during our review of patient notes.

There is a policy on the MCA and staff had access to this electronically.

Capacity had been assessed in all cases. This had been undertaken during referral meetings and admission to the service. These had all been reviewed regularly.

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

- We found that not all interviews rooms within the team bases had an alarm system. Staff took different measures to mitigate the risk. North Shropshire and Telford and Wrekin team had limited rooms with alarms. They would ensure that new patients were seen in a room that had an alarm. Tamworth CMHT did not have any rooms fitted with alarms but practiced safe working. Staff would sit closest to the room exit, see patients in pairs if they were unknown or risk existed and ask other staff members to be around the area. The Tamworth team had ordered alarms and they were due to be fitted in May 2016. Both the CMHT and the early intervention team (EIP) at Severn Health village carried personal alarms when interviewing patients. Both Seisdon CMHT and CMHT North Shropshire employed safe systems of working.
- All clinic rooms we checked during our inspection were well equipped. All equipment was in date. Where medication was stored, it was stored securely and all fridge temperatures were within limits and checked regularly.
- All areas were clean and well maintained. We saw cleaning records for all areas we checked and they were complete and in date.
- Staff adhered to infection control principles in all areas we inspected. We were encouraged by staff to use hand sanitiser upon entering the buildings. We also observed the safe disposal of sharps during clinic appointments and home visits.
- All equipment we saw was in date with any required checks. PAT testing stickers were in place on all electrical items.
- We were concerned at North Shropshire base that once patients had gained access to the building they were able to access the main team area via an automatic switch. This could have allowed patients access to team offices and could have posed a risk to the security of information. At Tamworth CMH, we saw that staff members escorted all patients entering the unit to appointments.

Safe staffing

- Staffing establishment levels in all areas had been set by the trust. This was done by undertaking a national benchmarking exercise.
- Staffing establishment levels across the trust were difficult to establish as some staff members work across two teams. The trust has a nurse vacancy rate of 0.1% across the trust. This shortfall was being covered by agency staff or overtime. There had been 94 staff leavers in the twelve months prior to our inspection.
- Staff sickness rates were 5.16% across all community mental health for adults teams which is slightly higher than the trust average of 4.77%.
- The Central Shropshire CMHT operated a weekend shift. Four staff were available from nine to five on Saturday and Sunday. For all other services; the teams worked nine to five Monday to Friday. This was staffed on a rota basis by regular staff. A qualified member of the team would always work the Friday prior to the weekend and the Monday after to ensure that a complete handover occurred.
- The largest care co-ordinator caseload we found was 49. This was an unusual case caused by the need to cover a member of staff on long term sick leave at Seisdon CMHT. On average caseloads were between 15 and 35 with the average caseload being 25. Medical staff and medication management caseloads were higher with the largest being 152 for medication management. These were appropriate, as there were no care co-ordinator duties attached to these numbers. The medication management caseloads mostly included patients that were stable and independent. The primary function of this part of each team was to administer and monitor medication.
- There were measures in place in all teams to manage sickness, leave and vacant posts. Bank or agency staff

Good

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were only used rarely to cover long term sickness. This was done on a temporary contract basis so that the same member of bank or agency was used to ensure continuity.

- All teams had urgent access to a psychiatrist when needed for existing patients. Psychiatrists were based within the teams; patients could be seen that day if needed. Psychiatrists were willing to accompany staff on home visits if patients were reluctant to attend the staff bases.
- Staff in all teams received annual mandatory training. All teams were above 85% compliance with mandatory training target.
- Patients were assigned a care co-ordinatior upon admission to the service. This meant that there were no patients waiting to be assigned a care co-ordinator.

Assessing and managing risk to patients and staff

- We looked at 61 care records across the seven teams and found variations in the quality of information contained within the records we checked. Risk assessments were reviewed or updated at a minimum of every six months or sooner if changes occurred. The teams used recognised risk assessment tools. The Sainsbury risk assessment and FACE assessment; both nationally recognised risk tools, were used alongside the trust risk assessment. All records checked contained a risk assessment. Of 18 records checked at North Shropshire; we found that only 10 risk assessments were current and up to date. All other records we checked had patient risk assessments present and up to date.
- Crisis plans were included in patient care plans. We saw that at Tamworth CMHT, Seisdon CMHT, Central Shropshire CMHT and CMHT North Shropshire; care plans contained early indicators of patients becoming unwell as well as advice on coping mechanisms for patients and carers. The plans were detailed and identified what would happen if the patient experienced a crisis. We also saw steps taken at EIP Shropshire, Telford and Wrekin CMHT to begin developing these personalised documents from first point of contact.
- We saw three examples during our inspection of staff responding quickly and appropriately to deterioration in patients' mental health. In one of these examples, it was established early in the day that a patients' health had deteriorated. By the time the inspection team left site at the end of the day; all assessments had been undertaken and the patient had been admitted to inpatient services.
- The teams received training in safeguarding. The trust had its own safeguarding team; staff knew how to contact them. Staff we spoke with had a good understanding of safeguarding and their responsibilities. Each team liaised with a different local authority for safeguarding and the processes for doing this were different. Tamworth CMHT attended a weekly meeting; Tamworth vulnerable partnership. Representatives attended this meeting from housing, police, fire services, alcohol services, veteran's link and children's services. The purpose of the meeting was to collectively look at people who may be vulnerable in the local area and to establish how best to support them. Additionally, the local authority safeguarding lead attended the team meeting on a three monthly basis. Similarly, Seisdon CMHT had a member of staff that sat on a safeguarding "hub" with local authorities and the police.
- Lone working protocols were in place. All staff completing community visits had access to mobile phones. The protocols varied across the teams but we were satisfied that the teams had processes in place to protect their staff. We saw local lone working protocols for all of the areas we inspected. These were appropriate and had been written to reflect the working patterns of each team.
- Medications were safely stored within the staff bases. We saw that fridge temperatures were checked on a daily basis. Staff who transported medication from their bases had access to lockable containers and transported medications in the boot of their cars as directed by policy.
- We saw three examples of staff reacting quickly to deterioration in either the physical or mental health of the patients they were visiting. They acted appropriately to address these issues quickly and effectively.

Track record on safety

- In the period October 2014 to September 2015, the services reported 38 serious incidents; 32 of which related to the unexpected death of a community patient. Due to the apparent high numbers of deaths,

Good

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we reviewed all serious incidents across all CMHTs for the period 2012-2015. We found that there were no trends in reporting which would suggest that any of the teams had consistently elevated levels of serious incidents. There are 16 CMHTs across the trust. Where serious incidents were higher, the reporting team serviced a more populated area than other CMHTs. We compared the figures to national data and saw that the trust is not an outlier in this area.

- As a result of serious incidents reporting and review procedures, the services had introduced working processes to try to reduce future serious incidents. For example, one of the services we inspected had made its systems for following up on DNA patients more robust. If a patient did not attend their appointment staff would attempt to make contact with them the same day. If this was not possible staff would attempt to visit the individual in person.We also saw that improvements were made in response to incidents from across the service and that learning had been identified following a suicide. When staff were on leave or off sick; patients were now provided with a named contact. The teams had adopted this practice.
- All teams had regular staff meetings in order to give all staff information about improvements to safety and findings from investigations

Reporting incidents and learning from when things go wrong

- Staff were able to describe incidents that should be reported. Reporting was via an electronic system which all staff members could access. We reviewed reported incidents across all CMHTs for the past three years, all incidents that should be are reported.
- Staff followed the trust policy regarding duty of candour and explained when things go wrong to patients
- The teams received feedback from both local incidents and trust wide incidents. There was a process in place for all incidents to be shared with team leaders via service managers. Team leaders then shared the outcomes and learning either via team or multi-disciplinary meetings. Where learning was involved, the team leaders also sent e-mails to staff members.
- Staff received de-brief following serious incidents. Immediate de-brief was offered to staff following the incident and a formal de-brief with senior managers took place with the individuals involved once any investigations were completed.

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

- Triage occurred in a timely manner. There was a graded approach whereby emergency referrals would be seen as quickly as possible within twenty four hours. Referrals considered to be urgent would be seen within four days. Standard referrals would be seen within 15 days. The teams used a clustering tool when assessing to ensure that they were comprehensive
- We reviewed 61 care records and found that there were variations in the quality of care plans. An assessment of patient need was present in all records.
- Quality of care planning was inconsistent across the teams. Out of the 61 records that we reviewed; only one did not have a care plan. Most care plans were up to date and had been reviewed by the MDT; however, although some were very detailed and person centred; others were generic and non-specific to individuals. We did find however that all care plans had a recovery focus.
- All records were kept on an electronic system. This meant that staff could access patient information when needed. We were informed that occasionally in Shropshire North there were issues with the electronic system; at the time of the inspection it was not possible to access information.

Best practice in treatment and care

- South Shropshire CMHT, North Shropshire CMHT and Wrekin CMHT patients were prescribed medication via their GPs following a consultation with the medical team. Therefore, there were no medicine cards for us to review. We reviewed medicine cards at all other locations that we inspected and found that prescriptions were in line with nationally agreed prescribing limits and guidance from the national institute for health and care excellence (NICE).
- The services offered therapies indicated in NICE guidelines - Psychosis and schizophrenia in adults: prevention and management 2014. This included behavioural family therapy, psychosocial interventions, EMDR, cognitive behavioural therapies and solution focussed therapy. D was available to patients with a personality disorder; as recommended in NICE guidelines; Borderline personality disorder: recognition and management 2009.Staff offered both individual and group based interventions for patients.
- Services had support, time, and recovery workers (STRs) within their teams who offered patients initial support with housing, benefits, and employment. If patients required support with more complex issues, the STR workers supported patients to access local services such as citizen advice bureau or local authority.
- Staff were familiar with the NICE guidelines; Psychosis and schizophrenia in adults: prevention and management 2014. Staff were aware that patients receiving anti-psychotic medication required regular physical health checks. The teams at North Shropshire CMHT, South Shropshire CMHT and Wrekin CMHT facilitated this by requesting that the GP completed the check. Staff had identified that there were no effective processes in place for staff to check on the outcome of the GP checks or the outcomes of tests. As a result, Tamworth CMHT had recently trained some of its own staff to complete physical health checks when needed. At Seisdon CMHT; there was evidence of good working links with GPs. Staff from the CMHT and practice nurses from the GP surgery ran joint clinics. The CMHT Central Shropshire team; based at Seven Fields Health Village; developed a clozaril monitoring clinic which will go live in April 2016 and are currently developing services to undertake physical health checks for patients receiving anti-psychotic medication.
- Staff used outcomes measures such as health of the nation outcome scales (HONOS) to review the progress of patients. Clinical outcome scales were used; the physical health questionnaire (PHQ), Becks depression scale, Liverpool University neuroleptic side-effect rating scale (LUNSERS) and generalised anxiety disorder (GAD) scale were used to monitor patient progress.
- At Seisdon CMHT, the manager had developed a range of audits to be undertaken by staff. This had been developed to improve staff knowledge and increase quality of care delivery within the service.

Skilled staff to deliver care

- The teams consisted of a range of disciplines including medical staff, nurses, support workers, psychologists and occupational therapists. Adult Social work

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arrangements to support community mental health services are different across the three local authority areas. In South Staffordshire, there is a Section 75 agreement for Mental Health Adult Social Care (Adults of working age only) between SSSFT and Staffordshire County Council, this means that Social Workers are directly employed by SSSFT and fully integrated within all CMHT's and Functional Teams such as CRHT and EI. In Shropshire County, Social Workers are employed by Shropshire Council and work alongside CMHT's guided by a non-Section 75 partnership arrangement. In Telford and Wrekin, Social Workers are employed by the council as generic workers and referral protocols are in place to support individuals social care needs. The teams were also supported by administration and domestic staff.

- The teams comprised of staff with varying levels of skills and experience.
- Staff received both a trust and local induction to the services. We spoke to a member of staff who had recently joined a team; she reported feeling supported by the team. Initially, she had not carried a caseload and spent time shadowing other workers and her caseload was being gradually increased.
- We checked appraisal records at all of the locations that we inspected and found they were current and complete. We found that the new appraisal process was centred on the visions and values of the trust and followed a process that was modelled on the literature that had been issued across the trust to promote improvement.
- Staff across the teams had received specialist training in cognitive behavioural therapy; dialectic behavioural therapy; solution focussed therapy; behavioural family therapy and eye movement desensitisation reprocessing (EMDR) therapy.
- None of the teams had any formal performance management issues at the time of our inspection; managers were able to describe issues that they had previously addressed.

Multi-disciplinary and inter-agency team work

- All teams we inspected; with the exception of Wrekin CMHT held weekly multidisciplinary team (MDT) meetings. When we questioned this with the manager of Wrekin CMHT, we were told that individual care co-ordinators could arrange their own reviews with members of the team who they felt were necessary to attend; these were referred to as MDT worker meetings.
- Regular handovers were carried out within the community teams. Wrekin CMHT and Seisdon CMHT both had a daily 'huddle'; this was where staff met for approximately five minutes to discuss any urgent team issues. E-mails were used for the sharing of clinical information across teams. Tamworth CMHT and North Shropshire CMHT had a duty worker folder that was used for the handover of information between professionals. North Shropshire, Telford and Wrekin CMHT had staff cover for weekends; this was rostered to ensure that staff that who had worked on Friday would be part of the weekend team. Similarly one of the weekend team would work Monday to ensure that information was handed over as and when required.
- Good working links existed with other teams within the service. Telford and Wrekin had good links with the crisis, home treatment team as they were based within the same building. Tamworth CMH had well established links with the crisis and home treatment team and the child and adolescent teams. They also met each week with their in-patient team to maintain good working relationships. All community mental health teams held monthly face-to-face meetings with the in-patient teams in order to enhance communication. Shropshire North team had less contact with the crisis home treatment team for their area as they were based approximately 40 minutes' drive away. However, the team said that if they did refer to crisis home treatment they got a good response. Approved mental health professionals were based within the Shropshire north, Tamworth, South Shropshire and Central Shropshire CMHTs; staff valued having their expertise within the teams.
- All of the teams reported positive working relationships with GPs and voluntary sector organisations within their respective areas. The teams discussed the relationships that had been developed with trident housing, MIND, charity based counselling services and enable; a project that provided support with employment, voluntary work & peer support.
- Team meetings took place at all but two of the services we inspected. Wrekin CMHT and Seisdon CMHT did not hold team meetings, instead they held a daily 'huddle'

Are services effective?

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and had a monthly business meeting. We saw minutes within the services that confirmed the meetings took place. We observed a "huddle" meeting at Seisdon CMHT.

- Peer recovery workers were employed in the Tamworth CMHT. Peer recovery workers were people who had previously used services as patients. The manager said they were particularly proud of this initiative as peer recovery workers had gone on to gain paid full-time employment.

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

- The trust provided mandatory training in the Mental Health Act (MHA); We reviewed training Data and found that on the 1st of March 2016 801 of their 933 staff had received training and were up to date. This represents 85% of staff. Staff we spoke with had a working knowledge of the MHA, guiding principles and community treatment orders (CTOs). Teams had access to the code of practice within their buildings.
- We reviewed 27 medication charts across five of the sites we inspected. We found that the necessary consent to treatment forms (T2) attached to the medicine cards as required at all sites except Tamworth CMHT. We pointed this out to the team at Tamworth and before we left and the issue was immediately rectified.
- All teams were aware that the trust had a central team for the administration of the MHA. Staff could name the person responsible. Staff also confirmed they received e-mails from the central office when any updates or changes were due to patient's detentions. The central MHA team completed audits of MHA paperwork. Staff confirmed that they received feedback if improvements were needed.
- We checked four CTO records on the electronic system. Relevant CTO paperwork had been scanned into the system. Two patient care plans contained information about the CTO and a further two did not.
- Provision of independent mental health advocacy (IMHA) services differed across the teams; however, staff were able to describe how to access the IMHA and engage support for patients

Good practice in applying the Mental Capacity Act

- All staff received mandatory training in the Mental Capacity Act (MCA) and Deprivation of Liberty Safeguards (DoLS). We reviewed training Data and found that on the 1st of March 2016 801 of their 933 staff had received training and were up to date. This represents 85% of staffStaff understanding of the MCA was variable. Most staff we spoke with could not effectively describe the five statutory principles. Staff were aware that capacity assessments were decision specific and that an individuals' capacity could fluctuate depending on their mental health. Staff told us that if they were unsure they would seek advice from other professionals within the team.
- The trust had a policy on MCA that all staff could access. The electronic records system had a specific tool to assess capacity if staff had reason to question a patients' mental capacity. We found that, in cases where a patient had impaired capacity, capacity to consent was assessed using a recognised tool and was recorded appropriately
- Wrekin CMHT proactively used assessments of capacity if it was felt that patients had capacity but were making unwise choices. The team used capacity assessments to support their clinical decision-making.
- People were supported to make decisions where appropriate. Where decisions were made for the patient this was done in their best interest.

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 ten patient consultations; staff were friendly, polite and professional. On home visits, staff checked with patients where they preferred them to sit; demonstrating respect for their homes. Staff addressed issues alongside patients' mental health such as family issues, finances and employment or vocational activities. We saw that staff actively assisted one patient to access their GP and agreed to accompany them to ensure that they were supported.
- All patients we interviewed reported that staff were respectful, kind and caring towards them and that staff listened. Patients told us they felt safe and secure with staff. One patient told us at Wrekin CMHT that the reception staff were not welcoming.
- Consultations were not rushed and although staff were focussed; the interactions followed a natural flow of conversation. Patients appeared relaxed with staff. Staff had a good knowledge of individual patient needs.
- All carers we spoke with reported staff were kind, compassionate and caring.

The involvement of people in the care they receive

- Patients felt involved in their care and advised that their views were taken into account.We found that both patient and carer access to care plans was variable with around half of those spoken to reporting that they had not had a copy of their care plan.We observed evidence in the care records that patients and carers had been involved in the formulation of care plans.
- The majority of carers felt that they were involved in the care of patients.Carers felt that staff would listen to their concerns. Carers were aware of support available to them and confirmed that staff had given them information about local support groups and activities. The teams' carried out carers' assessments and routinely checked on their welfare.We observed the care given to a carer during a skype formulation meeting.
- Advocacy services were available across the services.
- Service users, carers and peer support recovery workers had been involved in the recruitment of staff; this included interviewing a head of service and a consultant psychiatrist.
- All services used the Meridian feedback questionnaire to gain feedback on the services they provided. The North Shropshire team had recently introduced a counter system for patients who attended their base. The patient had a choice of red (poor), amber (all right), or green (good) counters which they placed in a box to rate their experience following appointments. One patient told us this was a good idea as they could not always put into words how they felt. Tamworth CMHT displayed patient feedback about the service on their noticeboard in the waiting area. Wrekin CMHT staff attended a monthly patient and carer event - Chorus held at the in-patient site; this was for the sharing of information.

Are services responsive to people's needs?

Good

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

Our findings

Access and discharge

- Referrals came mainly from two sources. The majority of referrals for the community mental health teams for adults are received from G.P.s. referrals are also received from inpatient services. Criteria for admission to the service is that the patient requires support but at a level that that does not require inpatient care.
- The trust target for referral to assessment for routine referrals was 28 days; all of the teams were meeting this target. Each of the teams also had effective processes in place to ensure that people who did not attend assessments were contacted and assessed as quickly as possible.
- The trust target for assessment to treatment was 18 weeks. There were waits within all services from the point of assessment to treatment for medical outpatients and psychology appointments. Psychology appointment waits were up to five months; outpatient appointment waits were up to five weeks.
- The teams had allocated staff within their services to respond to patients or carers who rang them. Patients and carers told us they were confident if they rang services they would get a response. Patients told us that their care co-ordinators always responded to them if they were not available at the time they rang.
- The teams took active steps to engage with patients who found it difficult or were reluctant to engage with mental health services. The way that this was managed varied across the teams. Shropshire North had dedicated staff with experience of working with this patient group; Wrekin CMHT used their complex care team with a whole team approach when they felt patients were at risk of disengaging with services; Tamworth CMHT used an assertive treatment model within their team for this client group.
- The trust had a process for patients who did not attend (DNA) for appointments. A DNA policy was in place. Staff could describe actions they would take depending on identified risks. This could include writing a letter; telephone contact; calling at patient property (both planned and unplanned) and liaison with GPs.
- Due to sickness, routine appointments were occasionally cancelled. Urgent appointments were not cancelled; the teams altered their planned workloads to accommodate these. One of the patients we spoke with had experienced a delayed medical appointment; the team had offered support during this time.
- Generally, appointments ran on time. One carer told us if the care co-ordinator was running late they always phoned and made them aware of this. Occasionally medical appointments over ran. No one who we spoke to complained about this.

The facilities promote recovery, comfort, dignity and confidentiality

- The teams at CMHT Tamworth, CMHT Central Shropshire, Early Intervention Team, Wrekin CMHT and Seisdon CMHT have clinic rooms available at their bases. These had equipment to support the delivery of care. Where required there were checks in place to ensure that this equipment was functioning properly. All of these checks had been documented and were in date. All teams had sufficient suitable rooms to complete individual and group based activities.
- During our inspection, we did not identify any issues with sound travelling between the rooms. Therefore, we were satisfied that all premises had adequate soundproofing.
- We saw that information leaflets were available in all waiting areas. We saw information on how to complain; advocacy services; self-help groups; help-line numbers and crisis support.

Meeting the needs of all people who use the service

- All services were accessible to people with disabilities, including wheelchair users. Toilet facilities were available and accessible for wheelchair users.
- Information leaflets were mainly available in English. We saw one leaflet in Welsh at North Shropshire; this service bordered Wales. Staff were able to get leaflets translated by the trust into languages other than English if needed. The trust computer system had the ability to translate information leaflets into other languages. Staff knew how to book interpreters if needed. We saw one leaflet displayed on sensory impairment.

Are services responsive to people's needs?

Good

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

- Wrekin CMHT had a patient with impaired sight; they had translated printed handouts into audiotapes, ensuring the patient received the information needed. Tamworth CMHT had arranged an interpreter from a specialist service in Birmingham for a deaf patient. Seisdon CMHT regularly used a British Sign Language interpreter when they had an appointment with one of their patients.

Listening to and learning from concerns and complaints

- The service received 51 complaints between September 2014 – October 2015 of these 24 were partially upheld and two were upheld. Three complaints had been referred to the ombudsman. At the time of our inspection these were ongoing meaning that none of the complaints had been upheld by the ombudsmen.
- All services provided information on how to complain as part of assessment pack they gave to patients. We were shown this during our visit. Patients who we spoke with were not always clear on how to complain. Patients said if they had concerns, they would be confident to contact either their care co-ordinator or the service base. No patients we spoke with had complained.
- Staff were aware of the complaints process. Patient advice and liaison (PALS) services dealt with formal complaints. Staff, if possible, tried to resolve complaints informally.
- There were processes in place for staff to learn from complaints and to identify any common themes. Feedback from complaints was received from senior managers and then cascaded to operational leads. Any learning was shared with team members via either team meetings or e-mails.

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

- Staff we met with were familiar with the trusts vision and values. The trust had provided information in the form of posters, information leaflets and lanyards to all staff to promote its visions and values. Information was visible in all staff areas around the service.
- The teams' objectives were reflective of the trusts values and objectives. The newly introduced appraisal process incorporated the trusts core values as part of the appraisal process; these values were re-enforced throughout appraisal documentation.
- Staff were familiar with the direct line managers for each of the services and said they were a regular presence in the service. All staff who we spoke with could name the chief executive and confirmed that he visited the service. Staff told us the chief executive was approachable and willing to listen to staffs opinions and ideas.

Good governance

- All services had administration staff; this allowed staff to spend more time on direct patient care activities.
- Staff knew what constituted an incident and reported it. We saw that learning from incidents was prevalent and shared among the teams with changes to practice visible.Processes for learning from complaints and service user feedback were also evident.Staff demonstrated duty of candour and apologised to patients when things went wrong.
- The services had key performance indicators that were used to gauge the performance of the teams. Senior staff received feedback on team performance in relation to these and developed action plans to address any shortfalls.
- All services we inspected were above trust KPI levels with mandatory training, supervision and appraisal levels.
- Team managers felt that had sufficient authority and support to complete their roles.
- Staff were able to submit items to the trust risk register; this was done via the staff electronic system.
- Staff did not participate in clinical audit. At the time of our audits were undertaken by staff from the trust that were external to the community teams.

Leadership, morale and staff engagement

- There were no current formal bullying or harassment cases within the teams.
- Staff we asked knew about the whistleblowing policy and the described the process to use this. The majority of staff members told us they would feel confident to raise concerns within their teams; although two staff told us that they were afraid of reprisals if they raised concerns about the trust plans.
- Staff confirmed they were offered opportunities for development by the Trust. Managers had completed management courses. We met one staff member who the trust had supported from being a porter, to a support worker and was now a registered nurse.
- The service was affiliated to Keele University for the training of medical students, social workers, occupational therapists and nursing. Students were allocated to services for placements and feedback received from students regarding their experience of the trust was positive.
- Relationships between team members were strong; all staff members that we with spoke with felt they worked in supportive teams.
- Staff members felt they did a worthwhile job and told us they felt proud of the work they completed.
- Listening into action (LIA) was implemented throughout the trust in order to ensure that the views of staff members were taken into account with regards to how the services operated. The community teams were subject to re-modelling. LIA was being used with the teams to look at how assessments could be completed and how patients would access the service. The trust was gathering the community teams views on the services provided. Eight staff members told us they were anxious about proposed changes; two staff did not feel that their contribution at LIA events would be listened to by the trust.

Are services well-led?

Good

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

Commitment to quality improvement and innovation

- To ensure effective communication balanced against best use of resources; the Wrekin and North Shropshire teams used 'Skype'. This was to conduct patient planning and discharge meetings with the in-patient services which were based in Shrewsbury approximately a 45-minute drive away.
- The trust computer system had the ability to translate information leaflets into other languages. We were impressed that trust information was available to patients who used the service regardless of their ethnic background.
- A member of staff in the Seisdon CMHT was involved in a national research project. This project is monitoring the use and effectiveness of EMDR in inpatient and community mental health settings.