

Requires improvement



Manchester Mental Health and Social Care Trust

Community-based mental health services for adults of working age

Quality Report

Chorlton House
70 Manchester Road
Chorlton-cum-Hardy
Manchester
M21 9UN
Tel: 0161 882 1000
Website: www.mhsc.nhs.uk

Date of inspection visit: 23-27 March 2015
Date of publication: 05/10/2015

Locations inspected

Location ID	Name of CQC registered location	Name of service (e.g. ward/unit/team)	Postcode of service (ward/unit/team)
TAE02	Laureate House	South Mersey Community Mental Health Team and Assertive Outreach Team	M20 2LR
TAE02	Laureate House	North Mersey Community Mental Health Team	M20 4XP
TAE03	Park House	North West Community Mental Health Team and Assertive Outreach Team	M9 5XS
TAE03	Park House	North East Community Mental Health Team	M9 4DP

Summary of findings

TAE01

Edale House

Central West Community Mental
Health Team and
Assertive Outreach Team

M15 5DD

This report describes our judgement of the quality of care provided within this core service by Manchester Mental Health and Social Care Trust. Where relevant we provide detail of each location or area of service visited.

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

Where applicable, we have reported on each core service provided by Manchester Mental Health and Social Care Trust. and these are brought together to inform our overall judgement of Manchester Mental Health and Social Care Trust.

Summary of findings

Ratings

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

Overall rating for the service

Requires improvement



Are services safe?

Good



Are services effective?

Requires improvement



Are services caring?

Good



Are services responsive?

Requires improvement



Are services well-led?

Requires improvement



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

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

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

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

Summary of findings

Contents

Summary of this inspection

	Page
Overall summary	5
The five questions we ask about the service and what we found	6
Information about the service	9
Our inspection team	9
Why we carried out this inspection	9
How we carried out this inspection	9
What people who use the provider's services say	10
Areas for improvement	10

Detailed findings from this inspection

Locations inspected	11
Mental Health Act responsibilities	11
Mental Capacity Act and Deprivation of Liberty Safeguards	11
Findings by our five questions	13
Action we have told the provider to take	24

Summary of findings

Overall summary

We rated the service as requires improvement because;

- Care plans were primarily focused on maintaining levels of functioning and were not sufficiently recovery focused
- Care and treatment was not always delivered and reviewed in line with the care programme approach best practice guidance
- There was a lack of effective discharge planning which meant that it wasn't always clear what was required for a patient to move on. As a result the average length of stay for patients was higher than comparable services and outside of the trust's own timeframe. This meant that some patients within the CMHTs remained in the service for longer than they needed to and were not progressing in their recovery. Due to these factors access to CMHT services was impacted and the trust was significantly outside of its target for time between referral and assessment
- There were inconsistencies in the liaison between the community teams and the inpatient wards. Staff reported poor communication resulting in practice that presented risk to patients. This included examples of patients who had been discharged without the community team's knowledge or involvement
- There was no consistent use of caseload weighting tools in the allocation of caseloads and limited evidence that acuity and numbers within each area had been considered in service development
- There was limited evidence of coherent pathways developed in line with National Institute of Health and Care Excellence (NICE) guidance. A waiting list was in place for access to psychological services and specialist training in psychological therapies for staff was inconsistent across the service. This meant that different treatment options may be available for patients in different teams

- The trust's values and vision were not effectively embedded within the service. Senior management within the trust did not have a visible presence to the teams. Staff did not feel valued by senior management and as a result they were not engaged with trust initiatives and morale was low
- A previous review of community services had been implemented 18 months ago but there was no evidence that this had been evaluated. A new Standard Operating Procedure has been developed but it was unclear what level of involvement staff had in the process and how its effectiveness would be evaluated
- Compliance with mandatory training and appraisals was not in line with trust policy
- Learning from incidents was not embedded across the service
- There were no effective systems in place to monitor, improve and evaluate the quality of service provision across teams, including feedback from patients

However;

- Comprehensive risk assessments were in place and regularly reviewed
- Patients and their carers reported positive, respectful relationships with staff who treated them with dignity and compassion
- Patients' physical health needs were met
- There were good processes and support in place for identifying and reporting safeguarding concerns
- The service had embedded good practice in medicines management
- Compliance with the Mental Capacity Act and Mental Health Act was good overall

Summary of findings

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

Are services safe?

We have rated safe as Good because:

- Comprehensive risk assessments were in place and regularly reviewed
- There was a policy and supporting technology in place to protect lone workers
- Caseloads for staff were between 25 to 28 patients each which is below the Department of Health guidance
- There were good processes and support in place for identifying and reporting safeguarding concerns
- The service had embedded good practice in medicines management

However;

- There was inconsistency in the recording of information to support risk management. This meant that information was not always accessible in one location within the care record and important information could easily be missed
- There was no consistent use of caseload weighting tools in the allocation of caseloads. There was limited evidence that acuity and numbers within each area had been considered. This impacted on the equity of caseload distribution
- There was limited evidence of effective learning from adverse incidents and staff told us they did not receive feedback
- There were inconsistencies across teams regarding the completion of mandatory training. This had been captured on each teams risk register

Good



Are services effective?

We have rated effective as requires improvement because:

- There was not a strong recovery focus evident in the care records we reviewed
- The average length of stay for patients in each team was high in some cases, over 10 years. There was evidence of delayed discharge and patients being retained on the caseload of teams longer than was clinically required
- There was limited evidence of coherent and consistent care pathways developed in line with National Institute of Health and Care Excellence (NICE) Guidance. There was inequitable access to psychological therapies across the teams
- There was limited evidence of the effective use of outcome measures and performance data

Requires improvement



Summary of findings

- There were inconsistencies across teams regarding appraisals. This had been captured on each team's risk register
- Liaison with inpatient wards was inconsistent. We saw evidence of patients having been discharged without the involvement of community care coordinators
- The service carried out 95% of care programme approach (CPA) reviews within 12 months in line with the trust target however, there was evidence of poor attendance of medical staff at CPA reviews which was not consistent with CPA best practice guidance

However;

- There were good multi-disciplinary team and allocation meetings. These were comprehensive in nature and covered all key areas for each patient discussed
- Assessments were in place in each record we reviewed. The assessments were of a good standard and there was evidence of regular reviews
- There was evidence in care plans that physical health care was being monitored and that annual checks were occurring

Are services caring?

We have rated caring as good because:

- The feedback we received from patients was positive. Patients and carers all reported that they were happy with the service they received. Patients told us that staff treated them with compassion and in a respectful manner
- We observed staff interactions with patients. Staff took the time to listen to patients and to understand their needs. Engagement was a two way process and patients were given space and encouragement to express their opinions
- We found evidence of how staff had proactively involved patients and family members in all aspects of their care
- We saw evidence of carers' assessments and care plans that were in place. The majority of carers we spoke to said they felt supported by staff

Good



Are services responsive to people's needs?

We have rated responsive as requires improvement because:

- With the exception of South Mersey, Central West and the Central East CMHTs, each team had a waiting list in place and there was evidence of delayed discharge and transfer across the service

Requires improvement



Summary of findings

- The average time from referral to assessment was 64.7 days. This was against a trust target of 21 days
- The trust viewed assessment as the first stage of treatment. Therefore there were no figures available on the average length of time from assessment to treatment
- Buildings the teams worked from did not always promote recovery, dignity and confidentiality. Not all sites had facilities to meet patients on site. South Mersey CMHT was located outside of its geographic catchment area. North Mersey CMHT had a disability discrimination act (DDA) action plan in place that had not been completed

However;

- Teams had access to translation services and we witnessed these being used
- 96% of patient received follow up within 7 days of discharge from the inpatient service
- Staff were aware of the complaints policy and there was evidence that they were discussed within teams

Are services well-led?

We have rated well led as requires improvement because:

- The majority of staff we spoke to did not feel valued by the trust. Staff morale was low
- Staff told us that they did not know the senior management within the trust and that the board was not a visible presence
- Staff felt supported locally but not above the level of community service manager
- Staff were committed to delivering quality care but did not feel they were adequately resourced to do so
- There was limited involvement in service development and improvement initiatives
- There was a lack of evidence that previous service reviews and changes had been effectively evaluated
- Compliance with mandatory training and appraisals was inconsistent across the service

Requires improvement



Summary of findings

Information about the service

Manchester Mental Health and Social Care Trust provides six community based mental health teams across the Manchester catchment area at six registered locations.

The community mental health teams work with people with a wide range of mental health difficulties and help people to cope with periods of mental illness and severe distress. They offer support to those people with a GP who require short term interventions alongside those

requiring longer term care planning, supporting them to stay out of hospital where possible. The service is available to people aged 18 or over and operates Monday to Friday between 9am-5pm.

Four of the teams we visited had integrated assertive outreach teams. The assertive outreach teams are recovery oriented and offer intensive and longer term support tailored packages of care to people who have struggled to engage with services. The service is available to people aged 18 or over and operates from 8.00am-8.00pm seven days a week.

Our inspection team

Our inspection team was led by:

Chair: Steve Shrubbs, Chief Executive Officer, West London Mental Health NHS Trust

Team Leader: Brian Burke, Care Quality Commission

Head of Inspection: Nicholas Smith, Care Quality Commission

The team included a CQC inspector, a CQC inspection manager and a variety of specialists: a mental health nurse, a mental health social worker, a Mental Health Act reviewer and an expert by experience.

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 get to the heart of the experiences 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 visiting, we reviewed a range of information we hold about the trust and asked other organisations to share what they knew. We attended the trust's annual

members' meeting and invited patients and members of the public to meet with us. We also arranged a focus group prior to the inspection, facilitated by a voluntary organisation. We carried out announced visits to the service from 24 March to 26 March 2015.

During this inspection we;

- spoke with 17 people, six of whom we visited in their homes
- spoke with 67 members of staff from a range of disciplines and roles
- looked at 31 care records of which we case tracked two.
- spoke with five carers or relatives.

Summary of findings

- attended one handover, one depot clinic and two allocation meetings.
- held two focus groups with staff.

What people who use the provider's services say

Before and during this inspection, we held a series of focus groups and listening events to gain feedback from people who used services and carers about their experiences of using the services. We reviewed the results of our latest survey which looked at the experiences of people receiving community mental health services in 2014.

The feedback we received from patients was positive. Patients and carers all reported that they were happy with the service they received. Patients told us that staff treated them with compassion and in a respectful manner.

Areas for improvement

Action the provider **MUST** take to improve

The provider must ensure that there are effective recovery focussed care plans and discharge planning in place for each patient to make sure patients do not remain in services longer than is clinically appropriate.

The provider must ensure that care and treatment is delivered in line with CPA best practice guidance. This includes medical representation at patients' CPA reviews.

The provider must ensure that incidents are investigated in line with trust policy and there are robust systems in place to make sure learning or good practice is shared within and across the service.

The provider must ensure that all staff receive mandatory training and appraisals in line with trust policy.

The provider must ensure there are systems in place to effectively monitor, improve and evaluate the quality of service provision across the service.

The provider must ensure that patients are discharged from hospital in line with the CPA guidance and with their community care coordinator and consultant's knowledge and involvement.

Action the provider **SHOULD** take to improve

The provider should ensure that the recording of information to support risk management is consistently recorded in patients' care records.

The provider should ensure consistent use of caseload weighting tools in the allocation of caseloads. There was limited evidence that acuity and numbers within each area had been considered. This impacted on the equity of caseload distribution.

The provider should ensure that access to psychological therapies is equitable across all services.

Manchester Mental Health and Social Care 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
South Mersey Community Mental Health Team and Assertive Outreach Team	Manchester Mental Health and Social Care Trust
North Mersey Community Mental Health Team	Manchester Mental Health and Social Care Trust
North West Community Mental Health Team and Assertive Outreach Team	Manchester Mental Health and Social Care Trust
North East Community Mental Health Team	Manchester Mental Health and Social Care Trust
Central West Community Mental Health Team and Assertive Outreach Team	Manchester Mental Health and Social Care Trust
Recovery Connect South Team	Manchester Mental Health and Social Care Trust

Mental Health Act responsibilities

Staff understood their responsibilities with regards to the Mental Health Act (MHA). The teams we visited delivered care in line with the MHA and the MHA Code of Practice. Appropriate risk assessments and care plans were in place for patients subject to a Community Treatment Order (CTO). However we found that eligibility for section 117 was not always recorded.

Staff had access to training around the MHA however compliance with this was varied across the service. Staff had access to advice and support from a trust team regarding the application of the MHA.

Detailed findings

Mental Capacity Act and Deprivation of Liberty Safeguards

Staff were able to articulate the principles of the Mental Capacity Act (MCA). Care records we reviewed showed that capacity had been considered during the assessment process and recorded appropriately.

Staff had access to training around the MCA and Deprivation of Liberty Safeguards, however compliance with this was varied across the service. Staff had access to advice and support from a trust team regarding the application of the MCA.

Are services safe?

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

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

Summary of findings

Our findings

Safe and clean environment

The community mental health team (CMHT) locations we visited were clean and generally well maintained. There were staffed reception areas in each site which controlled access and egress into the building. All staff and visitors were required to sign in and out which provided a record of who was in the building in the event of an emergency.

All of the teams had alarms available for staff use with the exception of the North West CMHT. There was no explanation provided for this.

Some staff at Central West CMHT informed us they did not feel safe in the area. Staff referred to a recent incident where a staff member had been mugged outside of the building. It was unclear what measures had been put in place to address this risk.

We reviewed two clinic rooms. The clinic room in the North East CMHT was small but well maintained and secure. Lockable cupboards were available for the storage of medication with separate area for individual medications. There was a medications fridge and temperatures were monitored regularly.

The clinic room in the Central West team was not fit for purpose. There was an IT server located within the clinic room and several exposed wires. In addition all medications and equipment, including needles had to be transported from the first floor to the ground floor where the actual depot clinic was held. Staff told us that the trust was in the process of extending the lease on the ground floor room. This will enable dedicated use and allow for depot medication to be stored in the room at all times.

All of the teams had access to necessary personal protective equipment to reduce the risk of infection. Training records showed that 73% of staff within the teams had completed mandatory training in infection control and prevention.

Safe staffing

Caseloads for staff were between 25 to 28 patients each. This figure is below the Department of Health 'Policy Implementation Guide' for CMHTs (2002).

However there was no consistent use of caseload weighting, caseload management or validated tools in this allocation. Staff told us that allocation was based primarily on numbers rather than acuity. In North Mersey CMHT the manager had completed a caseload weighting tool every six months however there was no evidence to indicate how this was used to adjust staffing and staff caseloads.

Across the teams there was limited evidence that acuity and numbers within each area had been considered when allocating staff and caseloads. This meant that the variances in staffing levels did not match the variance in caseloads.

Overall the total caseload for each team varied from 243 in North Mersey CMHT through to 438 in the South Mersey CMHT. North Mersey CMHT had the lowest staffing numbers at just under 10 whole time equivalents (WTE). However the other CMHTs all had approximately the same establishment of between 12 – 14 WTE. This did not reflect the difference in caseload.

The majority of staff we spoke to expressed concern over the manageability of their caseloads and stated they worked additional hours despite caseloads being below the Department of Health guidance.

Each of the teams we visited had a risk register and the risk to quality and safety due to demand exceeding capacity was identified by each team with the exception of the Central West CMHT. The risk had been identified in April 2014 and last reviewed in March 2015. The risk was rated as 'major' scoring 14 out of 25.

There was one control measure in place which was to review excess demand at the weekly allocation meeting. We observed this happening during our inspection. There were two actions in place. The first was the routine evaluation of staff caseloads in supervision to facilitate discharges. Staff told us caseloads were discussed in their supervision. The second action was the application of the discharge framework. This had been implemented at North

Are services safe?

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

West CMHT and resulted in 50 patients being stepped down to a pilot health and social care clinic. However, there was a lack of evidence to show effective discharge planning across the other CMHT's.

Sickness levels for the South Mersey CMHT (8.3%) and North West CMHT (9%) were above the trust average of 6%. However sickness rates at North Mersey, North East and Central West CMHTs were below the trust average.

Staff vacancy rates varied across the teams. The North West team had the highest vacancy rate at 16% over the previous 12 months. The North East, North Mersey and South Mersey teams vacancy rates were between 6%-9%. The Central East and Central West teams had the lowest rates between 1%-2%.

Teams utilised locum, bank and agency staff to cover for sickness, leave and vacancies. Some agency staff had been in post for up to a year. Only one of the agency staff we spoke to stated they had not received a local induction. All agency staff had access to training. South Mersey CMHT had the highest use of bank and agency staff.

Staff reported mixed experiences when trying to secure rapid access to a psychiatrist. In teams where doctors were located within the teams such as North Mersey CMHT this was not an issue. However, in other teams where doctors were not integrated, access was more variable.

Compliance with mandatory training across the teams was variable. The North East CMHT was 63% compliant, Central West CMHT was 65% compliant, North Mersey CMHT was 68% compliant, North West CMHT was 72% compliant and the South Mersey CMHT was 80% compliant. Staff reported they could access mandatory training but struggled to find the capacity to attend due to workloads. Staff also cited logistical issues with training including slow IT access at South Mersey CMHT.

Assessing and managing risk to patients and staff

The teams used the Manchester Care Assessment Schedule as an initial assessment and risk assessment tool.

Overall we found that the risk assessments were comprehensive. They identified historical and current risk and had contingency plans in place. There was evidence of patient and carer involvement in this process. However there was some inconsistency in recording this information.

Risk information was not always captured on the assessment but was recorded in the main body of the case notes. This could cause delays for staff trying to access the information.

We reviewed training records for the teams in relation to clinical risk training. Across the service 86 out of 111 staff identified as requiring the training had completed it. This is 77% compliance.

We observed multi-disciplinary and allocation meetings where waiting lists were reviewed and prioritised. Prioritisation was based on changing circumstances and risk factors.

The service had protocols in place to protect lone workers. Lone worker risk assessments were in place and there were risk markers on electronic patient records. Staff visited in pairs where a risk had been identified. Staff also utilised the Argyll system for reporting their location and estimated time of return. In general staff said they felt safe working in the community.

Staff were knowledgeable about their responsibilities regarding safeguarding. Across the service there was a 70% compliance rate for safeguarding training. Safeguarding referral rates from teams varied but this was linked to the social demographics of the geographical areas each team covered.

Each team had an allocated safeguarding lead. However the leads that we spoke to stated they did not have protected time or a reduction in their caseload to help deliver this function. There was a trust safeguarding lead who provided support and guidance around safeguarding issues. There was a robust programme of audit which reviewed the quality and appropriateness of safeguarding referrals. Findings of these audits were fed back to teams. Staff reported they had an opportunity to discuss safeguarding during multi-disciplinary team meetings and during supervision.

We reviewed the trust prevention and management of violence and aggression (PMVA) training matrix. The service had a 54% compliance level with Conflict Resolution and Disengagement training. Therefore almost half of staff had not received the mandatory training to safely break away from a situation where there was a threat to their safety.

We observed good practice in medicines management. Medications were stored appropriately in locked cupboards

Are services safe?

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

and depot cards were well maintained. Appropriate bags were available for the transfer of medication in the community. We observed one depot clinic that was delivered at a local GP surgery. Practice in the clinic was safe but patient numbers meant there was limited time to spend with each patient.

Track record on safety

Since 2004 trusts have been encouraged to report all patient safety incidents to the National Reporting and Learning System (NRLS). Since 2010 it has been mandatory for trusts to report all death or severe harm incidents to the CQC via NRLS.

The most commonly reported incident type to NRLS was 'unexpected death of community patient in receipt of care'. The trust reported 25 such incidents during the period 1 January 2014 to 31 December 2014. As of 20 January 2015, 23 of these incidents remained overdue for closure.

Reporting incidents and learning from when things go wrong

The trust used an electronic incident reporting system called Datix. Staff within all teams had access to the system

and were able to explain the procedure for reporting incidents. Staff had reported 286 incidents during the calendar year 2014. The most commonly reported incident types were abuse (39), incidents related to the standard of care (38), medication incidents (33) and incidents of violence (23). This indicated that staff were aware of reporting procedures and were reporting incidents. However, the majority of staff we spoke to told us there was no or limited feedback from incidents they had submitted. Incidents were sometimes discussed in team meetings or supervision but there was no formal structure to this. The majority of staff could not provide examples of learning that had been shared across the service or from team to team.

There was no evidence of effective analysis of these incidents in order to facilitate and promote shared learning or good practice. This presents a risk that preventable incidents may be repeated. However, one team manager made reference to a learning event they had attended after a serious untoward incident (SUI) elsewhere within the trust.

Are services effective?

Requires improvement 

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

Summary of findings

Our findings

Assessment of needs and planning of care

We reviewed 31 care records across the service and case tracked two records.

Each patient had a Manchester Care Assessment Schedule assessment in place and where indicated this had triggered a full risk assessment. Assessments were generally of a good standard and were regularly reviewed.

Care plans were developed under the care programme approach (CPA) framework and there was evidence that patients and where appropriate carers and advocates were involved. The care plans were regularly reviewed however there was little evidence of a recovery focus or comprehensive discharge planning.

The service carried out 95% of CPA reviews within 12 months in line with the trust target. However, there was a lack of medical input into CPA reviews which often consisted of the care coordinator and patient only. This meant that reviews were taking place outside of the CPA framework best practice. Staff told us they sometimes 'piggy backed' onto the back of outpatient appointments in order to facilitate CPA reviews.

All information was stored on the trust's electronic reporting system. This was accessible to most staff. However staff in the South Mersey CMHT reported IT issues that meant logging onto the system could take anything up to three hours.

Best practice in treatment and care

There was some evidence of NICE guidance being followed in particular areas. Staff referred to the specialist affective disorder service and the allocation of practitioners to liaise with GPs around physical health care.

There was limited evidence of coherent and consistent care pathways developed in line with National Institute of Health and Care Excellence (NICE) Guidance. The service manager told us that clearer pathways based on NICE guidance were being introduced in a new statement of purpose. This was in draft form at the time of the inspection.

Shared care medication protocols were in place with GPs. Outpatient Clozapine titration was available through the home treatment team. Consultant psychiatrists from CMHTs retained responsibility for patients who were prescribed high doses of anti-psychotic medication rather than their care being transferred to the patient's GP.

There was evidence in care plans that physical health care was being monitored and that annual checks were occurring.

Health of the nation outcome scales were being undertaken but there was no evidence that the data from these was being used effectively. Staff we spoke to felt that care cluster information was not being used effectively and did not take into account the social profile of the patient group.

There was a robust audit programme around safeguarding and we spoke to a doctor who was involved in a NICE guidance audit around the management of treatment resistant depression. However in general staff we spoke to told us they were not involved in audit and were unaware of audit results being fed back.

Skilled staff to deliver care

Teams were multi-disciplinary in nature and staff had access to OT and psychology although there were waiting lists for both of these disciplines. Social workers were integrated into the teams and this worked effectively.

Teams had access to consultant psychiatrists but the speed and effectiveness of this was impacted by their location. There was also inconsistent consultant involvement in CPA review meetings.

The trust policy requires each staff member to have had a personal appraisal in the past 12 months. Compliance with this policy was varied across the teams. In North Mersey CMHT there was 0% compliance, in the North West CMHT was 41%, in the North East CMHT compliance was 55%, in the North West CMHT compliance was 59% whilst in South Mersey CMHT compliance was 92%.

Compliance with mandatory training and appraisal was identified on the risk registers of the teams.

Staff we spoke to confirmed that they received supervision. Frequency was variable but most staff had either a 1:1 or group supervision session approximately every four to six weeks.

Are services effective?

Requires improvement 

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

Access to additional specialist training for staff was mixed. We spoke to some staff who had received training in areas such as psycho- social interventions, cognitive behavioural therapy and family intervention training. However we also spoke to staff who had not been received any specialist training and did not believe that they would be given the opportunity too. There was no coherent strategy evident across teams which resulted in discrepancies in available treatment options for patients.

Multi-disciplinary and inter-agency team work

The teams operated within an MDT framework. However not every team housed the members of the MDT under the same roof. Staff told us this impacted upon the accessibility of staff and attendance at meetings. We saw evidence of poor medical attendance at CPA reviews which meant that these activities were being conducted outside of CPA best practice.

We observed MDT and allocation meetings in both CMHTs and assertive outreach teams. The meetings were well planned and structured. Each patient who had been referred or who was receiving care was discussed. These discussions were effective and comprehensive covering areas such as risk, changes in presentation and safeguarding concerns.

Staff reported a mixed experience in their liaison with inpatient wards. However the majority of staff reported difficulty in accessing inpatient beds and problems maintaining care coordination when patients were admitted. They stated that communication was poor, they were not always informed of admissions and they struggled to attend ward rounds either because they were unaware they were taking place or the time had been changed at short notice.

Several staff members had experienced patients being discharged from wards without their involvement or knowledge. Staff gave us examples of patients who had been discharged without a Community Treatment Orders (CTO) when they should have been on one and patients discharged on a CTO without the knowledge of their care coordinators or consultant psychiatrists.

Referral pathways were in place between different community services. However most of the staff we spoke to in the CMHTs had experienced difficulty accessing the crisis

and home based treatment teams within the trust. Staff in assertive outreach teams reported problems in accessing CMHT services for their patients due to capacity issues and the waiting lists in place.

Staff reported they had access to therapies through the psychology service. This access varied across teams and there was a waiting list in place. Intelligence monitoring data highlighted that out of 290 referrals for psychological therapy a total of 250 patients had waited more than 28 days from referral to first treatment. Staff told us some patients had waited up to 12 months.

Staff reported good links with local GPs, pharmacists and third sector organisations. However staff and patients expressed concern about changes that were being made to the provision of third sector support organisations they have previously linked in with and how this would impact upon patient recovery. Changes in the funding for these services meant they will be reduced in the future.

There was no evidence that the trust had considered the potential impact of these changes on their own service and patient community. There was no evidence of discussion or planning to prepare for these changes or the development of actions to minimise the associated risks.

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

Staff had access to training on the Mental Health Act. However compliance with this varied. Both the Central West and North East CMHTs had 50% of staff trained. North Mersey had 56%, South Mersey 68% and the North West CMHT 76%.

The teams provided care and treatment to patients in accordance with the Mental Health Act (MHA) and the MHA Code of Practice.

In the care records that we reviewed we found appropriate risk assessments and care plans in relation to patients subject to Community Treatment Order (CTOs). Paperwork was completed appropriately and care plans reflected relevant elements of the CTO. However eligibility for section 117 was not always recorded.

Staff had access to advice and support from a trust MHA team.

Are services effective?

Requires improvement 

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

Good practice in applying the Mental Capacity Act

Staff had access to training on the Mental Capacity Act (MCA). However compliance with this was varied. The North Mersey CMHT had 56% of staff trained, the North East CMHT had 64%, the South Mersey CMHT had 68% and the North West CMHT 86%.

Training in deprivation of liberty safeguards (DoLS) was equally varied. The North Mersey CMHT had 56% of staff trained, the North East CMHT had 71%, the South Mersey CMHT had 74%, the Central West CMHT had 75% and the North West CMHT had 90% of staff trained.

Staff were able to articulate the principles of the MCA. Staff were aware of where to go for support and advice about the MCA and DoLS within the trust.

In the care records we reviewed we found that capacity had been considered during the assessment process and recorded. Where they were in place capacity assessments had been completed appropriately.

We found examples of care plans that incorporated Advanced Statements where applicable. Staff had access to advice and support from a trust team regarding the application of the MCA.

Are services caring?

Good 

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

Summary of findings

Our findings

Kindness, dignity, respect and support

Patients told us they were happy and satisfied with the service they received. Staff treated them with respect and were responsive to their needs.

We observed staff engaging with patients in a respectful and dignified manner. Staff treated patients in a caring and compassionate way.

We observed meaningful two-way conversations between staff and patients during appointments and effective patient involvement in care decisions. Staff used their knowledge to explain issues such as the potential side effects of medication.

Staff were interested and engaged in providing good quality care to patients and showed empathy and

understanding in their therapeutic relationships. When staff spoke about patients, they discussed them in a respectful manner and showed a good understanding of their individual needs.

The involvement of people in the care that they receive

Patients and carers told us that they were involved in decisions about their care. The care records we reviewed demonstrated this.

Patients had been offered copies of their care plan and this was recorded in their care records.

There was strong involvement of families and carers where applicable. Carers we spoke to had received a carer's assessment and had an associated care plan in place. One carer told us how they had been supported in the role by staff and had been able to access carer breaks.

We spoke to one patient who had attended their appointment with their advocate. Access to advocacy was in place across the services.

Some of the teams we visited did use exit questionnaires and patient experience surveys. However, this was ad hoc and the data was not utilised in a meaningful manner.

Are services responsive to people's needs?

Requires improvement 

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

Summary of findings

Our findings

Access and discharge

The trust had a functioning single point of access for all external referrals which were managed by a central Gateway Team. The Gateway team did not manage internal referrals from within the trust. Internal referrals were sent directly to the CMHT to triage.

There was evidence of waiting lists and delayed discharge across the service. This created a block in the throughput of patients and meant it was harder for patients who required the service to access it.

Staff in assertive outreach teams informed us they often had difficulty in stepping patients down to CMHTs due to CMHT waiting lists. As a result patients were being kept in an inappropriate service longer than was required which can negatively impact their recovery.

The average time from referral to assessment was 64.7 days. This was against a trust target of 21 days. The trust considers assessment to be the first stage of treatment and there were no figures available to illustrate the average wait from referral to assessment. We spoke to one patient who had been waiting 3 months to be assessed by a CMHT. The patient had not been given any information about the service and received no contact from the team during this time to support or monitor mental health issues. During this time the patient remained under the care of his GP.

Crisis services were available within the trust but staff reported difficulty in accessing them.

96% of patient received follow up within 7 days of discharge from inpatient services.

Staff told us that it was difficult to discharge patients and proactively engage in recovery work with patients. Staff told us that one of the primary reasons for delayed discharge was concern over the reduction of community support services. This was reflected in the length of stay figures. Many patients had been in the service for several years and treatment and care was based upon maintaining their level of functioning and health rather than promoting recovery

and discharge. The mean length of stay on the case loads of the teams ranged from 1394 days in the North Mersey CMHT up to 1996 days in the Central West CMHT. This was higher than trust target figures for the service.

The trust had attempted to address this with a pilot scheme which has involved setting up a health and social care clinic at the Central West CMHT. The clinic provided support to patients well enough to be stepped down from CMHT services through a transitional period to ensure that physical and mental health needs were met. The clinic had been in place for three months and resulted in a reduction in the waiting list for admission to the Central West CMHT from 50 to 0. However, the scheme has not been rolled out across the service and as a result there were continuing issues with blockages in the other CMHT's systems.

There were assertive outreach teams in place in three of the CMHTs. These teams provide a service to people who find it difficult or who are reluctant to engage with mental health services. There are plans to merge the three AOTs into one city wide service.

There were issues with the depot clinics the service was running from the Central West CMHT. The clinics operated on a drop in basis without allocated appointments. This meant that patients could be waiting a long time for their injection. If they missed the clinic there were no further clinics for another week. It was unclear what contingency measures were in place for these patients.

The facilities promote recovery, comfort, dignity and confidentiality

The North Mersey CMHT building was not compliant with the disability discrimination act 2005 (DDA). An action plan had been developed however staff told us that no action had been taken. This meant that patients with mobility problems could not access the building if it was there preferred option. Staff told us they would visit these patients at their home but this does not promote choice.

Staff in the CMHTs and assertive outreach teams (AOT) told us they generally visited patients within their own homes although most of teams also had facilities to meet with patients on site if that was their preference. However, staff located at South Mersey and Central West CMHTs raised concerns over the suitability of their buildings. South Mersey CMHT did not have facilities to host appointments with patients. In addition the building was located outside of the geographic area the team serves. This added

Are services responsive to people's needs?

Requires improvement



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

additional travel time for staff and impacted upon their capacity. Staff told us the trust were aware of the problems and that the lease on the building expired in the next 12 months. The trust were looking for alternative premises within the team's catchment area.

In Central West CMHT staff raised concerns over the suitability of consultation rooms. Some of these rooms were on the ground floor away from the main team offices which were located on the first floor. The rooms were equipped with alarms but were isolated from the main team in the event of an emergency requiring a prompt response.

North Mersey CMHT had consultation rooms but the soundproofing of these was poor. Whilst present in one of the consulting rooms, an inspector could hear discussions in adjoining rooms.

Meeting the needs of all people who use the service

Some of the community locations were not accessible for patients with mobility needs due to the location and/or building design.

The teams had access to translators. We observed the use of face to face translation during a carer's visit with an individual whose first language was Urdu. Staff told us they could access leaflets in different formats and languages as required through the trusts corporate services.

Listening to and learning from concerns and complaints

The majority of patients we spoke with were aware of how to make a complaint and told us that they would feel confident in doing so. Overall staff we spoke with were able to explain the complaints procedure and the actions they would take in line with the trust policy. They told us that where possible they would try to resolve the complaint locally but that if this was not possible or appropriate they would escalate it to the team manager and trust complaints team.

Although it was not consistent across the service, the majority of staff told us that complaints were discussed at their team meetings so that they could share learning.

During 2014 the community services received 49 formal complaints of which three were referred onto the Ombudsman. North West and South Mersey CMHTs each reported 12 complaints during this timeframe, joint highest across the service.

Are services well-led?

Requires improvement 

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

Summary of findings

Our findings

Vision and values

In all of the teams that we visited staff told us that there were disconnected from trust leadership. Staff told us that the trust did not communicate effectively. However we did speak to one staff member who stated that he had attended a Listening in Action event.

Staff acknowledged that they received a daily e-mail known as the Midday Mail. Whilst some staff thought this was useful others felt it was a token exercise.

Staff were not able to discuss the organisation's vision or values and many said they were unaware of who the senior management within the trust was. Teams reported that they felt the board was not visible.

Good governance

The majority of staff we spoke to felt they were unable to maximise shift-time on direct care activities. There were concerns raised about caseload capacity and workload.

There were systems in place within the teams to monitor staff compliance with mandatory training and appraisals was inconsistent across the service. Compliance with supervision was good.

Incidents were reported however staff did not feel they received feedback on the outcomes or that there were effective systems in place to ensure learning from incidents was shared.

There were good systems in place around safeguarding. However the safeguarding leads in each team expressed difficulty in fulfilling their obligations due to time constraints in connection with high case loads.

There was adherence to the MHA and MCA. Procedures were followed appropriately.

Staff understood the complaints procedure and there was evidence that outcomes were discussed within teams.

Each team had a risk register and managers had the ability to submit items to the trust risk register.

Staff were aware of whistle blowing processes. Staff stated that they would raise concerns but they were not confident they would be acted on. Some of the staff we spoke to felt there was a blame culture within the trust.

Leadership, morale and staff engagement

Staff told us they felt supported within their own team and by their team managers. They felt services were managed well locally. However they did feel supported or valued by senior management within the trust.

Staff told us that morale was low. There was concern over the future and the direction of the trust. However staff told us they remained committed to providing the best care they could for the patients they cared for.

Most of the team managers we spoke to said they felt supported by the service manager but not by senior management above that post.

Staff told us that they felt that their teams were under-resourced but that the trust did not appreciate this. There were concerns that impending changes both internal and external to the trust would increase the pressure on teams

Management of the community services recognised the need for a revised and updated standard operating procedure which was currently in draft form. It was unclear what level of involvement staff had in developing this document. Two staff members stated they had attended a meeting about this and had expected there would be further meetings. However they stated a draft policy was then circulated for comments. They did not feel their concerns had been listened to.

The trust has a process in place to continue to develop the standard operating procedure with the involvement of staff. Further drafts will be discussed at team meetings and in the Operational Management team meeting. The Transformational Programme Board will be responsible for ratifying the document. The Operational Management Team will be responsible for the implementation and evaluation of the document.

One staff member we spoke to was due to leave the trust shortly. However they stated they had not yet been given an exit interview and weren't aware of staff who had.

Are services well-led?

Requires improvement 

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

Commitment to quality improvement and innovation

There was limited evidence of a consistent approach to improvement. One of the team managers we spoke to felt that there were a lot of 'flavour of the month' initiatives that were not then followed through.

There was little evidence to show how the service monitored and improved service provision by the use of audits, performance indicator or quality outcome measures.

There was no evidence to show how patients views and experiences were captured and used to drive improvement or influence service development.

A previous review of community services had been implemented 18 months ago and an evaluation of implementation received by the trust board.

This section is primarily information for the provider

Requirement notices

Action we have told the provider to take

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

Regulated activity

Treatment of disease, disorder or injury

Regulation

Regulation 9 HSCA (RA) Regulations 2014 Person-centred care

We found that the provider did not ensure that patients received person centred care. This is in breach of regulation 9(1) (b) of the Health and Social Care Act 2008 (Regulated Activities) regulations 2010, which corresponds to regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

How the regulation was not being met:

The provider did not ensure that each patient had an effective recovery focussed care plan and discharge plan in place to make sure they did not remain in services longer than was clinically appropriate.

The provider did not ensure that care and treatment was delivered and reviewed in line with CPA best practice guidance. This included medical representation at patients' CPA reviews and ensuring patients were discharged from hospital without their community care coordinator and consultant's knowledge and involvement.

Regulated activity

Treatment of disease, disorder or injury

Regulation

Regulation 10 HSCA 2008 (Regulated Activities)
Regulations 2010 Assessing and monitoring the quality of service provision

We found that the provider did not have systems or processes established and operating effectively to assess, monitor and improve the quality of service provided in the carrying on of the regulated activity (including the quality of the experience of service users involved in receiving those services). This is in breach of regulation 17 (2)(a) of the Health and Social

This section is primarily information for the provider

Requirement notices

Care Act 2008 (Regulated Activities) regulations 2010, which corresponds to regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

How the regulation was not being met:

The provider did not ensure that incidents were investigated in line with trust policy and there were robust systems in place to make sure learning or good practice was shared within and across the service.

The provider did not ensure that all staff received mandatory training and appraisals in line with trust policy.

The provider did not ensure there were systems in place to effectively monitor, improve and evaluate the quality of service provision across the service including feedback from patients.

This section is primarily information for the provider

Enforcement actions

Action we have told the provider to take

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