Aspire

Quality Report

Suite 5, Bank House Road, Leeds, LS8 5LJ
Tel: 0113 200 9170
Website: www.commlinks.co.uk

Date of inspection visit: 16 May 2016
Date of publication: 09/08/2016

This report describes our judgement of the quality of care at this location. It is based on a combination of what we found when we inspected and a review of all information available to CQC including information given to us from patients, the public and other organisations

Ratings

Overall rating for this location	Requires improvement
Are services safe?	Requires improvement
Are services effective?	Good
Are services caring?	Good
Are services responsive?	Good
Are services well-led?	Requires improvement

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

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

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

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

Summary of findings

Overall summary

We rated Aspire as **requires improvement** because :

We found the provider did not always have adequate provisions in place to ensure safe care and treatment of patients at their base. Facilities in the therapy rooms were not appropriate to use as depot clinics. They compromised hygiene and increased the risk of infection because adequate washing facilities were not easily accessible.

Risk assessments had not been completed to identify whether suitable alterations to the buildings needed to be made. For example, towards the window restrictors. This meant the provider had unknown risks which they could not mitigate. We found patient risk assessments did not always reflect patients current risk profile. Staff identified risk within case notes, however, did not always update them on the risk assessment templates.

The provider was not compliant with its medication management policy. The service had no way of ensuring medication was being kept below 25 degrees Celsius as recommended by their policy. Medications that do not need refrigeration should be kept below 25 degrees as it protects the medication from deteriorating. There was no thermometer to monitor temperatures.

The providers' governance structures did not always recognise its responsibilities it had to undertake towards the regulator. The safeguarding policy did not indicate staff at Aspire had to inform the Care Quality Commission of any safeguarding concerns or alerts they made. The service did not have a duty of candour policy in place even though they operated in a transparent, honest and open way.

We observed many good practises during our inspection. We had overwhelmingly positive feedback from patients, families and carers about the provider. We were told how responsive, caring, and supportive staff at Aspire were. Patients detailed how the provider had supported them in all aspects of their lives as well as with their mental health. We observed compassionate care; staff were dynamic, had developed positive rapport with patients and listened to them. Carers fed back on how well they were supported and how responsive the provider was to their needs. They felt comfortable in knowing what to do in a mental health crisis as the service had prepared them effectively.

The provider was meeting national targets in assessing a patient within two weeks of referral. There was evidence to show patients had developed their cognitive abilities over the three years, tests averaging 40% in the first year to 70% in the final year. Aspire were discharging over 70% of their patients back to the community and into primary care after three years. They were offering services which were in line with the National Institute of Health and Care Excellence.

Staff had good morale and everyone was complimentary about the team ethic. Staff felt supported amongst their peers and of management. Staff had regular supervision and all had been appraised within the last year.

We observed multi-faceted activity sessions. They not only supported patients with their mental health, but provided life skills, confidence, chances to network and improved physical

Summary of findings

Contents

Requires improvement

Aspire

Services we looked at :

Community-based mental health services for adults of working age

Summary of this inspection

Background to Aspire

Aspire is an independent community mental health service based in Leeds, West Yorkshire. Its provider Community Links Ltd, delivers care services for both mental health and adult social care.

Aspire works with adults and young people aged between 14 to 35 who have experienced their first episode of psychosis. This service works intensively with its patients for up to three years before they are discharged back into primary or other secondary care services. Staff at Aspire endeavour to deliver care within the community and at patient's homes. However, Aspire also have provisions to provide care at their base if required.

Aspire covers the whole of the Leeds region and are commissioned to provide care for 320 patients. At the time of inspection Aspire were supporting 330 patients.

This service is currently registered to carry out the following regulated activity :

- Treatment of disorder, disease or injury.

Aspire currently do not have a registered manager; however, there is an interim service manager in place. This manager is currently undergoing the process for registration with the Care Quality Commission to be the new registered manager for Aspire.

The CQC last inspected Aspire in December 2013 under the old standards. Aspire were found to be meeting all the standards in their last inspection. They included :

- Respecting and involving people who use services
- Care and welfare for people who use services.
- Safety and suitability of premises.
- Supporting Workers
- Assessing and monitoring the quality of service provision.

Our inspection team

Team leader: Hamza Aslam

The inspection team was comprised of six CQC inspectors, including a nurse specialist advisor and an expert by experience (someone who has developed expertise in relation to services by using them or through contact with those using them).

Why we carried out this inspection

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

How we carried out this inspection

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

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

Before the inspection visit, we reviewed information that we held about the location, asked a range of other organisations for information, and sought feedback from patients and carers in focus groups.

Summary of this inspection

During the inspection visit, the inspection team:

- looked at the quality of the therapy rooms and how staff were caring for patients
- spoke to 13 patients who were using the service
- spoke to six carers
- observed two community visits
- observed one medical review
- reviewed medication management, storage and documentation
- observed a referral team meeting
- spoke to the interim service manager and a team leader
- reviewed all eight community treatment order Mental Health Act documentation
- reviewed 22 care records, including, care plans, crisis plans and risk assessments
- observed 2 community group activities, 'action afternoon' "work star - employment session"
- reviewed policies, procedures and other documents relating to the running of the service
- spoke to 15 staff members including doctor, drama therapist, nurse and psychologist

toured the premises, visited the therapy rooms and observed how staff were caring for patients.

What people who use the service say

Patients were very positive about their experiences at Aspire. They told us about how staff were kind, caring and easy to get on with. Patients appreciated the levels of support staff had put in place. They praised the provider on supporting them with all aspects of their lives as well as their mental health.

Carers spoke highly of the provider. They told us about how responsive the service was during crisis, how well staff got on with the patients and the types of activities provided. Carers and families said their care was tailored to the needs of the patients, family members and carers.

Aspire supported families where they could; this meant the service was meaningful and effective. This was evident in the patient and carer feedback.

Summary of this inspection

The five questions we ask about services and what we found

We always ask the following five questions of services.

Are services safe?

Requires improvement

We rated safe as **requires improvement** because :

- Risk assessments were not always updated accurately to reflect the patients current risk profile.
- Staff had not correctly assessed the risk to patients or staff in relation to the use of window restrictors within the building.
- Staff could not ensure medication was being stored below 25 degrees Celsius, as there were no recording instruments.
- Staff facilitated depot clinics and were not trained in basic life support.

However :

- All patients had individualised crisis plans that were holistic and contained relevant information.
- Staff captured information and documented it in the contemporaneous notes. They were detailed and comprehensive.
- Staff knew when to make safeguarding alerts.
- A lone working system was in place to protect staff working in the community.
- We saw examples of how the service changed its practice as a result of serious incidents.

Are services effective?

Good

We rated effective as **good** because :

- Care plans were patient centred and holistic. They included important information about physical health issues and the conditions to their community treatment order.
- The team took a multi-disciplinary approach in assessing patients' needs.
- Aspire was achieving the quality standards for early intervention services set out by the National Institute of Health and Care Excellence.
- Staff at Aspire were measuring key performance indicators to improve practice and took part in national audits.
- Aspire had a range of skilled staff with different professional qualifications, such as qualified nurses, social work and occupational therapy.
- We observed effective multi-disciplinary working during meetings.

Summary of this inspection

Are services caring?

Good

We rated caring as **good** because :

- We observed kind, compassionate and genuine care between staff and patients.
- Staff were motivated in their roles, and passionate about supporting patients at Aspire.
- We spoke with 13 patients who were happy with the service they were receiving. They felt supported and cared for by staff.
- Aspire worked closely with carers and families. They supported carers and families in ways which suited their needs.
- Patients had access to a local advocacy group.
- Aspire held weekly patient meetings which focused on service user involvement and how the service could be improved.

Are services responsive?

Good

We rated responsive as **good** because :

- Aspire were achieving better than the national target to assess 50% of patients within two weeks from referral.
- There was no waiting times between assessment and treatment, patients were allocated a worker if they met the criteria for Aspire.
- Over 70% of patients were discharged back into primary care within the community after three years' of being supported by the service.
- Complaints and concerns were well investigated. Comprehensive feedback was given to complainants with the outcome and apologies were provided.

However :

- Therapy rooms were not always available for staff when they needed it.
- Leaflets in different languages were not available for patients and carers whose first language was not English.

Are services well-led?

Requires improvement

We rated well-led as **Requires Improvement** because :

- The safeguarding policy did not provide requirements for staff to inform the Care Quality Commission of any safeguarding issues or concerns. We found four examples of safeguarding concerns being made to the local authority, but the Care Quality Commission were not informed.
- There was no duty of candour policy in place.
- The local risk register was not updated with known risks.

However :

Summary of this inspection

- Staff were motivated in their roles, there was a strong team ethic and everyone was supportive of each other.
- Staff were happy with management systems in place and felt they were able to address issues with management without fear of victimisation.
- We saw innovative group work facilitated by Aspire, this included a 'drama therapy group'.

Detailed findings from this inspection

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.

Aspire were not the detaining authority. This meant staff employed by the local trust facilitated community treatment order recalls, and any Mental Health Act detentions. They also managed and audited any paper work. Aspire kept copies of all Mental Health Act paper work.

Aspire had seven patients that were on community treatment orders at the time of the inspection. These low numbers demonstrated the service endeavoured to use the least restrictive approach to treatment and practice.

We saw all community treatment order paper work had identified if patients had capacity to consent. Clinicians had assessed patients' capacity and documented it accordingly.

All the legal paper work had been completed in line with guidance. We saw the patients care plans had their community treatment order conditions embedded into them. The local trust monitored all Mental Health Act documentation. Documentation was stored safely on site, however, the local trust were sent a copy to be put onto the online system.

Mental Health Act training was not mandatory for this service. We found staff had a good knowledge around the Act and its guiding principles. The Mental Health Act policy was in line with the 2015 Mental Health Act code of practice.

Advocacy services were available for the patients. 'Advonet' are independent mental health advocates who provide a service for patients who found it difficult to articulate their views and opinions. For example, an advocate may support a patient in a review meeting with their psychiatrist.

Mental Capacity Act and Deprivation of Liberty Safeguards

Mental Capacity Act training was not mandatory for this service; however, over half the staff had undertaken Mental Capacity Act training in the last year. Staff had a reasonable working knowledge of the codes of practice. They were most familiar with acknowledging the presumption of capacity and supporting patients to make decisions in their best interests.

It was evident through reviewing care records staff were assessing patients' capacity if there was a reason to do so. Staff held best interests meetings for patients who were assessed to lack capacity around issues such as safeguarding and managing finances. We saw this was done collaboratively in a team approach.

We did not see any form of monitoring or ways the service could improve their application of the Mental Capacity Act. As this is a community team staff did not carry out any forms of physical restraint or physical de-escalation techniques on patients.

Overview of ratings

Our ratings for this location are:

Detailed findings from this inspection

	Safe	Effective	Caring	Responsive	Well-led	Overall
Community-based mental health services for adults of working age	Requires improvement	Good	Good	Good	Requires improvement	Requires improvement
Overall	Requires improvement	Good	Good	Good	Requires improvement	Requires improvement

Requires improvement

Community-based mental health services for adults of working age

Safe	Requires improvement
Effective	Good
Caring	Good
Responsive	Good
Well-led	Requires improvement

Are community-based mental health services for adults of working age safe?

Requires improvement

Safe and clean environment

Aspire is a community mental health team that supports patients within the community. Patients have access to therapy rooms at Aspires base. The therapy rooms are used for clinic appointments and group work activities.

We reviewed the therapy rooms and found staff facilitated depot clinics from one of them. These were for patients who were considered as high risk towards staff, or for those who could not have their medication administered within the community. A depot is a slow release special preparation of medication administered by injection. The numbers of patients requiring depot injections on site varied, at the time of the inspection there were two patient scheduled for the week. We found the room not to be suitable to facilitate depot clinics. The room provided basic provisions, such as a fold away clinic bed, weight and height instruments. However, infection control was not being effectively managed in relation to cleanliness and hygiene. The room had no facilities for staff to wash their hands apart from with alcohol gel. The nearest washing facilities meant staff had to navigate through two doors into the kitchen, or three doors into the bathroom. Some of the doors had a key pad entry system. This meant if someone acquired a sharps injury, they would have to go through more than one door to wash and clean their injury, exposing the risk of infection.

In addition to the lack of appropriate hand washing facilities, the clinic was not appropriate due to its physical environment and central location within the building. It had the potential to compromise patient dignity. The room did however have blinds in all window areas.

Nursing staff had identified the appropriateness of the clinic environments during team meetings. Management also acknowledged the feedback and said that they would try and run the depot clinic in appropriate clinic environments, for example the local GP. The local trust facilitated Clozapine clinics at the Becklin Centre.

The therapy rooms, large group rooms, and a kitchen available on site were comfortable, clean and well maintained. We felt they were appropriate for group activities and therapy sessions. The rooms provided a calming atmosphere conducive to therapeutic work.

Patients and staff both utilised the kitchen to store food, make snacks and hot drinks. There were no sharp utensils kept in the kitchen.

Safe staffing

Aspire did not use a recognised tool to estimate the number of qualified nurses they needed, however, they felt the overall staffing levels were sufficient. We found no evidence of negative impact on patient care due to staffing.

Aspire had six qualified nurses, only three were employed in registered mental health nurse posts. However all qualified nurses with confirmation of their registration could undertake roles typically associated with nursing, for example administering medication.

A care coordinator is a member of staff assigned to a patient, to plan, assess and deliver their care. Each care coordinator had a case load of 15. Band six care

coordinators had 12 patients on their caseload as they managed patients with a higher risk profile. Best practise and guidance from National Institute of Care and Excellence, and community care indicate the case load per care coordinator at Aspire was good practice. Having 12-15 patients per case load enables staff to work intensively with patients for a prolonged period of time. At the time of the inspection there were no patients waiting to be allocated to a care coordinator.

Aspire had one long term agency worker within the team, they employed their last agency worker as a full time member of staff. There were two vacancies at the time of the inspection, one for a band five care coordinator and one for a team leader. Staff sickness was low averaging below three percent in the last quarter.

There were two psychiatrists employed by the local trust who worked at Aspire. One covered 2.5 days a week and the other covered 3 days a week. This meant patients had regular access to a psychiatric support. As well as holding clinics the psychiatrists carried out home visits and were available for emergency call outs.

Completion of mandatory training for staff was over 75%. This included safeguarding children and safeguarding adults training. It is important for staff within community teams to have safeguarding training as they work closely with families and children. Mental Health Act and Mental Capacity Act training was not part of the mandatory training.

Assessing and managing risk to patients and staff

We reviewed 30 patient care records and looked at their risk assessments, care plans, crisis plans and contemporaneous notes.

Staff at Aspire used the functional analysis of care environments risk assessment tool. Eighteen out of 30 risk assessments were inadequate. The primary concern was risk assessments were not being updated in line with the live contemporaneous records. Staff were capturing risk accurately and in detail, however, they were not transferred to the appropriate record. This meant if a new member staff reviewed a patient's risk assessment, they may not find all the relevant information. We found a risk assessment that had not been updated in 18 months. Policy stated that risk assessments should be updated when a patients risk profile changed or every 12 months. In addition, we found an example of a patient's risk not being calculated accurately. For example a patient should receive a score of one if they had previous risk around suicide or self-harm. We found a patient who had that risk, but scored zero.

We reviewed the medication management on site and found it was adequate overall. However, there was no thermometer in the medication cabinet. Staff could not be sure medication was stored below 25 degrees Celsius as stated in the Aspire medication policy. Aspire did not keep any medications that needed refrigeration. They kept a low storage of medication, and did not have any controlled drugs or keep medication in stock, only what was prescribed to patients.

The Aspire office was located on the second floor of the building. Staff had carried out an environmental risk assessment. It stated that 'restricted openings' were in place on windows more than two meters above ground level. We found this to be inaccurate as Aspire occupied the second floor, which was above two meters. We found none of the rooms had window restrictors with the exception of one which had a restrictor which did not meet Health and Safety Executive guidance.

Window restrictors ensure the safety of patients by not opening out fully. Aspire works with patients whose psychotic symptoms could lead them to be, anxious, volatile, and unpredictable. Risks assessments to mitigate any potential risks had not been considered, and therefore was an unmanaged risk. We discussed this with the manager who advised they would lock all the windows until they were able to have the work to make the windows safe completed.

Staff were not trained in basic life support. Basic life support is important for the preservation of life in the event of an emergency. If applied it could have a significant impact on reducing harm to patients and prolonging life. Staff that facilitated depot clinics had no way of ensuring they could offer basic life support in the event of a patient having an allergic reaction to medication. This could be in the form of an anaphylactic shock.

The service manager showed us documentation to suggest basic life support training was in the process of being arranged for all staff.

We saw some good practice in record keeping in the form of crisis plans. This plan is given to patients, carers and families in the event of a mental health crisis. It provides

important information such as signs of relapse and emergency contact numbers if a patient's mental health was to deteriorate. All the crisis plan we reviewed were person centred and individual to the patient. The plans were detailed and comprehensive. In addition to crisis plans, we saw the contemporaneous notes were detailed and well written. These notes often documented the day to day contact with patients and were mostly up to date.

Staff had weekly referral meetings which gave them the opportunity to discuss patients in a multi-disciplinary setting. These meetings included consultants, care co-ordinators and input from other professionals. We observed one meeting and saw staff discussing risk in a comprehensive manner. There was a system in place that identified patients who were at highest the risk; they were flagged as red on the notice board. This meant patients at the highest risk were always being discussed by the team, and the team were aware of those individuals.

Staff were trained in adult and child safeguarding as part of the service's mandatory training. We saw four examples of safeguarding referrals appropriately made to both the adult and child safeguarding teams.

Aspire had a lone working policy in place that protected staff during community visits. The system was called "text you home". Each member of staff had a profile on an online database. They activated it during home visits. Staff entered the details of the patients address, how long they would be and if there were any risks. If staff did not log out after the visit, an automatic notification would be sent to the manager and a duty person. The system also had a panic alarm button which staff members' could activate during a visit.

Staff at Aspire were able to respond to patients in crisis or if their mental health was deteriorating. Staff had smaller caseloads that enabled them to do this. Patients were introduced to more than one member of staff which enabled continuity in care if the primary staff member could not attend. In the event of a crisis out of hours, the local crisis team would intervene. Patients were provided with their number on the crisis plans. During the focus group all the patients knew who the crisis team were and when they would contact them.

Track record on safety

Aspire had three serious incidents in the last 12 months. These were around violent or aggressive behaviour towards members of the public or staff. Aspire had taken steps to improve their safety as a result of serious incidents. Aspire introduced a clinic specifically for patients who did not engage or had low level contact. These 'none urgent but essential' clinics were designed so that patients who have low level contact were still being discussed within the multidisciplinary team. This meant all patients were considered and discussed whether they engaged or not.

Reporting incidents and learning from when things go wrong

Staff reported incidents on Aspires own reporting system, staff used paper records. Incidents were reported on a regular basis. We reviewed four investigations, all of which were captured in detail. We saw letters sent to patients explaining clearly the outcome of the incidents and sincere apologies provided where appropriate. We saw examples of how the organisation identified systems within itself that needed improvement. For example, improving communication methods and managers to have better oversight of activities.

An action plan was formulated and the outcomes were achievable. We saw minutes of the meeting where staff involved were debriefed.

Although patients received apologies, this was not done as part of the services responsibilities under the duty of candour. Staff were not aware of what the duty of candour was and there was no policy in place to support it.

Are community-based mental health services for adults of working age effective?

(for example, treatment is effective)

Good

Assessment of needs and planning of care

Staff carried out two waves of assessments. The first assessment formulated the patient's diagnosis to see if the service could meet their needs. Once accepted, staff, along with the patient looked at how the service would support them towards their recovery. Staff reflected this in patient care plans, risk assessments and crisis plans. There was support from the psychologist with the initial formulation

for diagnosis; this was an example of collaborative working in assessing patients. This meant there was more consistency in assessments, and more experienced staff supported staff with less experience.

We reviewed 30 care plans. The staff documented care plans on "Care Programme Approach Wellbeing Plans & Recovery Plan" templates. The care plans were only updated after care programme approach meetings. This meant staff could not always ensure care plans accurately reflected the patients' current presentation or situation. The care plans overall contained the relevant information. They were person centred and recovery focused. Staff reflected patients' physical wellbeing within the plans which meant staff could care for the patient safely. For example, if a patient had a condition such as diabetes, staff were aware on the patient medication and planned their care around those issues.

Patients that were on community treatment orders had their conditions embedded into their care plans. This was good practice as it set the parameters of the order, making it easier for staff to work more effectively. It also reminded patients who had copies of their care plans of what their conditions were.

Best practice in treatment and care

We saw good examples of best practice in treatment. Staff at Aspire worked within the guidelines of the National Institute of Health and Care Excellence . They were able to identify National Institute of Health and Care Excellence guidelines as their primary model of working and understood its relevance.

The National Institute of Health and Care Excellence outlines eight quality standards for early intervention services such as Aspire should aim to meet. We found Aspire were achieving seven of those quality standards. These standards included:

- treatment within two weeks of referral
- family intervention
- prescribing of clozapine
- employment programmes
- physical health assessments
- cognitive behavioural therapy
- smoking cessations
- carers support.

Aspire met all the above outcomes, however, they were unable to carry out all the standards themselves. For example, the local G.P. had to undertake the full physical health checks for the patients. Staff at Aspire could only carry out basic checks such as height and weight measurements. Staff encouraged and supported patients to have physical health checks once their referral to Aspire was accepted.

Aspire had a psychologist who supported staff to work with patients using different psychological frame works, such as solution focused therapy. This method of working aimed to help patients understand their experiences and ways they could cope. Aspire had one member of staff who was currently undertaking training in cognitive behavioural therapy in psychosis. In addition family intervention services were available to patients and their families. This looked to support the family unit in coping with issues that arise from having a family member suffering psychosis.

We saw innovative practises that provided alternative support mechanisms for patients and carers. For example Aspire facilitated weekly drama therapy groups. This enabled patients to 'have a voice without a voice'. The use of acting and performing to reflect feelings and emotion. Many of the patients we spoke with felt this form of therapy helped them to express themselves. Aspire had been facilitating drama therapy for over three years.

In addition to drama therapy, Aspire hosted a weekly 'women's group'. This was designed to address issues that female patients may experience and addressing them in a group setting. When speaking to patients it was evident that this group gave them a sense of empowerment.

Aspire had a dedicated employment worker who supported patients in accessing employment and further education. Statistics indicated that 42% of patients currently at Aspire were in some form of education or employment.

Clozapine was prescribed for some patients. The local trust managed and facilitated the Clozapine clinics. Clozapine medication requires regular blood monitoring due to its side effects.

Aspire took part in local and national outcome measures. The local ones provide a snap shot of how the service was performing per quarter.

Requires improvement

Community-based mental health services for adults of working age

- 16% of Aspire patients in the last quarter had required intervention from the crisis team. The national target is 20%. This meant Aspire 4% less patients than the national average for patients needing crisis intervention.
- Patients in their first year scored on average 42% on the social occupational and functional test. By year three the average score was above 75%. By their third year at Aspire, patients were better equipped to deal with day to day problems with living.

In addition, Aspire were a part of the commissioning for quality and innovation national outcome measures. Physical health monitoring under this outcome measure looked at understanding the cardio metabolic rates for patients suffering psychosis. The commissioning for quality and innovation national outcome reviewed factors that may impact on patients physical wellbeing, this included, substance misuse, body mass index, alcohol and smoking. The initial findings suggested alcohol and smoking were the two highest scoring factors that could impact patient health. These results could frame future work and areas in which services could focus to better support patients' physical health.

Skilled staff to deliver care

Aspire had skilled staff from different professional backgrounds. This ranged from social workers, occupational therapists, and teachers. These staff, however, were employed as care coordinators not as their professional backgrounds. This did not take away the skills, experience and levels of expertise they had to bring to the team. Staff were involved in the care they delivered and brought their wide range of skills together to enhance the service.

Staff received a comprehensive four week induction programme. The induction programme was designed to give staff time to understand their role, network and familiarise themselves with the company policies.

Staff received monthly supervision. This included clinical and management supervision. We reviewed the meeting records and saw staff were able to bring their own agendas. Staff were encouraged and supported to identify their own needs that they would like to address during supervision. Aspire had monthly peer supervision for staff, this enabled staff to support each other in small groups. Peer supervision often had psychology input to make it more structured and meaningful. All staff had received their appraisals over the last year.

Multi-disciplinary and inter-agency team work

We saw good examples of collaborative working with other organisations. Aspire were utilising resources from within the local community to support their patients achieve their recovery plans. For example, a member of staff from an external organisation came to talk to the patients about activity groups they facilitated to promote physical wellbeing. During the action afternoon session we saw patients were interested in what had been offered and signed up to it. Not only was this promoting patient autonomy, it increased their confidence, abilities to network and was supporting their physical health.

Aspire held regular multidisciplinary meetings. An example of this was the care programme approach meeting; it had the compliment of different professionals which included patients and carers. We saw a structured approach to the meeting. This took into consideration what the patient wanted, and the views of family and carers. The patient's, carers, care coordinator and a consultant were always included in these meetings where possible. Professionals from other agencies such as local authority safeguarding, probation and housing where invited if their services were involved in the patients care.

We observed a referral meeting, staff had these on a weekly basis. This gave opportunity for the team to discuss new referrals, risks and patients who are relapsing. We found staff discussed patients in detail and formulated management plans to see how they would reduce risk.

Adherence to the MHA and the MHA Code of Practice

Aspire were not the detaining authority. This meant staff employed by the local trust facilitated Community Treatment Order recalls, and any Mental Health Act detentions. They also managed and audited any paper work. Aspire kept copies of all Mental Health Act paper work.

Mental Health Act training was not mandatory within this organisation. We found most staff had received in-house training. This was not formal training, but a support session around the Mental Health Act facilitated by the manager.

Requires improvement

Community-based mental health services for adults of working age

Staff had good awareness of the Act. They were able to provide examples of mental health sections being used appropriately and were able to identify good practice in relation to the guiding principles.

We reviewed all seven community treatment orders for patients under the care of Aspire. Staff had completed the documentation correctly; they had recorded consent for treatment and capacity where appropriate. Staff informed patients of their rights regularly and this was documented on the PARIS record keeping system. The local trust audited the Mental Health Act documentation.

We found Aspire had a low number of patients on a community treatment order. Of 330 patients only seven had conditions placed upon them. This was indicative of the team's ethos in their promotion of patient autonomy and supporting patients in the least restrictive way.

The local trust provided Aspire with legal and administrative support. Staff told us they would contact the mental health office if they had any queries. The Mental Health Act policy was in line with the 2015 Mental Health Act code of practice.

Advocacy services were in place to support patients who found it difficult to represent their views. These independent mental health act advocates can attend appointments and meetings with the patient and help them communicate their views and wishes.

The psychiatrists at Aspire undertook Mental Health Act assessments on their own patients if required. This meant they had a better understanding of the patients they were assessing. In addition patients were less likely to be distressed as they were familiar with the doctor.

Good practice in applying the MCA

We saw over half of the operational staff, 15, had completed Mental Capacity Act training in the last year. This training was not mandatory. Aspire had a Mental Capacity Act policy which staff were aware of. The team's knowledge on the Mental Capacity Act was adequate. They were able to identify some of the statutory principles such as the presumption of capacity and the ability to supports patients to make decisions in their best interests.

We saw examples of capacity to consent and treatment based discussions about patients' capacity around specific issues such as safeguarding and finances. Staff documented this on the patients' contemporaneous notes.

We saw a team approach when a patient's capacity was in question. This approach helped ensure decisions were being made in the best interests of the patient. The example we saw was in relation to child safeguarding. The meeting had a compliment of multi-disciplinary team and members of the patient's family.

Staff did not practice restraint techniques. This was due to the nature of the community team and level of risk the patients posed. We were not aware of any incidents whereby a staff member needed to restrain a patient.

Are community-based mental health services for adults of working age caring?

Good

Kindness, dignity, respect and support

We saw staff were motivated and passionate about their roles at Aspire. We observed kind, compassionate and meaningful care throughout the inspection. We saw staff adapted to patients' needs, were flexible and interacted in a genuine way.

We spoke to 13 patients' all of which were very positive about their experiences at Aspire. They spoke about how staff supported them in all aspects of their lives as well as their mental health. Patients gave us examples of how they were cared for during difficult times, for example homelessness. It was evident that staff at Aspire took a holistic approach in caring for patient's needs.

Staff were clear about the notion of confidentiality. The team demonstrated this this by not wearing their I.D. badges during community visits so that patients could not be identified with the service. Staff however, had their identification badges available if required.

The involvement of people in the care they receive

Patients were involved in their care, it was evident in the care plans, care programme approach records and contemporaneous notes. We saw little evidence of patients having a copy of their care plans, however, during the focus group some said they were offered it and they had declined.

Aspire held weekly "action afternoon" meetings which enabled patients to plan and achieve their own activities. It

Requires improvement

Community-based mental health services for adults of working age

also enabled patients to give feedback about the services they received and ways in which they could improve. Patients' artwork could be seen in the therapy rooms as decorative pieces.

The local trust carried out surveys and patient feedback on a local level. This enabled services to see how Aspire fitted in with the wider community of mental health services in Leeds. We did not see any results from the trust.

We spoke to six carers and family members all of whom were positive about their experiences overall. They felt adequately supported. We were told Aspire allocated workers to work with carers, or for those who needed extra support. Two carers felt communication could have been better. We were given examples of not having telephone calls returned and not always receiving information.

The carers felt that they were given good support around crisis planning. They felt confident in being able to respond to a crisis should one occur. Carers complimented the service around meeting their needs. Care programme approach meetings and reviews were arranged so that carers and families could make the appointments, for example at the end of a day after carers come back from work, or on a day that suited them. .

Aspire facilitated monthly 'friends and family' meetings, which was an opportunity for carers and families to meet and offer each other for support. Carers that we spoke with felt this meeting was helpful. It gave them an opportunity to meet people in the same place as they were and look at alternative coping strategies.

Aspire appointed an independent advocacy service for its patients; the service was called 'Advonet'.

Are community-based mental health services for adults of working age responsive to people's needs?
(for example, to feedback?)

Good

Access and discharge

Aspire made provisions for patient referrals to come from any source. This meant patients could be referred to the service by anyone, for example their G.P, family, friends, or themselves. This system enabled more people to access the service. All referrals were triaged through the 'single point of access', where a duty worker undertook an initial screening. If a referral was not appropriate for Aspire, the duty person signposted to other services within the locality which could support their needs.

Aspires target for patients to be assessed within two weeks from referral was 50%. This was in line with the national target documented in the report 'Guidance to support the introduction of access and waiting time standards for mental health services in 2015/16' by NHS England. Aspire achieved 70% in assessing patients within two weeks of referral.

The service appointed a care coordinator once the patient's referral onto the service was accepted. This meant there was no waiting time between assessment and treatment.

Discharge figures for 2015/16 show,

- Over 70% of patients were discharged back into primary care after three years.
- 10% of patients remained with the service as it was assessed to be beneficial for their recovery. The journal of 'Advances in psychiatric treatment' states early intervention services that are able to facilitate extensions to their service were beneficial to the patient is considered good practice.
- 20% of patients were transferred onto further secondary services such as the Community Mental Health Team or Assertive Outreach Team.

Patients and carers told us how staff at Aspire responded in a timely manner during a crisis. They felt confident with the service and its ability to respond in the time of need. Families' and carers told us, staff were flexible in their approach and maintained regular contact with patients. Staff told us if patients were difficult to engage then they would liaise closely with family, carers or other support groups that the patient had. All the patient records we observed had comprehensive crisis plans which were holistic and unique to the patient. Crisis plans were given to the families and carers we spoke with. They were clear on what they would do during a crisis.

Aspire did not discharge patients who failed to engage. Staff understood the importance of recovery within the first three years of experiencing psychosis and the impact that

could have for the patients' future. This meant patients would remain in services and would be able to access support should their mental health deteriorate or they chose to.

Appointments were not cancelled. Aspire promoted flexible working by enabling patients to work with other members of staff within the team. This meant during sickness and absence patients continued to work with familiar staff. This model of working was effective as many of the symptoms of psychosis include paranoia and anxiety. Patients being familiar with staff reduced their levels of stress.

The facilities promote recovery, comfort, dignity and confidentiality

Patient contact was primarily in the community; however, Aspire had facilities which enabled patients to come to their headquarters. The therapy rooms available were comfortable, and appropriately furnished. We saw the therapy rooms were sound proof. This meant confidentiality was maintained during appointments. Patients had access to a kitchen where they could make hot drinks and snacks. All the therapy rooms had blinds that could be closed to promote privacy.

The use of the clinic in the therapy room was not appropriate and not fit for purpose. It compromised patient recovery and safety. Staff told us they found it difficult at times to have sessions at the Aspire office as the rooms were regularly booked.

Meeting the needs of all people who use the service

Aspire endeavoured to meet the needs of the patients using the service. It had provisions to aid patients and carers requiring disabled access. The service had a lift facility which supported patients and carers to the second floor. We spoke to one patient who was cared for and had their needs met by staff during a period of homelessness. This support was important as part of his recovery as his homelessness impacted directly on to his mental health. Another patient spoke to us about how Aspire supported her through pregnancy.

Aspire provided easy read leaflets for patients who had visual impairments and learning disabilities. We saw Aspire was able to meet the needs of people who had language difficulties or English was not their first language. Interpreting services provided by the local authority were readily available. However, they did not have leaflets produced in different languages that were indicative of the diverse communities in Leeds. They acknowledged that having leaflets in different languages pertinent to the local communities would be a useful resource. In the event of an emergency Aspire could utilise interpreting services from other Community Links provisions. This demonstrated the good relationship they had with other organisations.

Listening to and learning from concerns and complaints

In the year 2015/16 Aspire had four complaints about the service. All of the complaints shared similar themes. Patients did not feel supported within aspects of their care. We saw all the complaints were 'partially upheld'. This was indicative of how Aspire approached complaints and concerns. We found that in each complaint Aspire took responsibility where they felt they could have done something differently, which may have had an impact. This demonstrated a service which was transparent and open to criticism and change.

We reviewed four letters sent to patients and carers to discuss the outcome of the complaint. They were all very comprehensive, sincere and full apologies provided where appropriate. Aspire implemented changes in response to the complaints, for example changing a patient's care coordinator.

We saw leaflets readily available for patients, carers and families which provided clear routes to which they could make a complaint. The carers we spoke with said they would feel comfortable raising issues with the management at Aspire. This was because of their open culture.

Are community-based mental health services for adults of working age well-led?

Requires improvement

Vision and values

The service principles and values as they described in three words were 'engagement', 'hope' and 'recovery'. Within these, Aspire had statements which they describe as their vision, Aspire endeavoured to deliver as part of their service ;

- Respects and acknowledges young people's needs within developmental approach.
- Supports young people to find their own level of recovery by integrating their experience.
- Recognises the role of family and friends in young person's recovery and their support needs.
- Encourages sense of belonging and having valued roles in community and society.

Staff at Aspire were aligned to their vision and values. They demonstrated a proactive approach to working with their patients. Staff were clear in what they had to achieve and were able to show us it in practice. Staff had a sound understanding of the organisational structure on a local level within Aspire and at a provider level, Community Links.

Good governance

Governance structures were poor which reduced the functionality and performance of the organisation. The issues we found did not interfere with the organisations overall objectives. However, they failed to identify key requirements in which an organisation such as Aspire had to adhere to.

The whistleblowing policy did not provide contact details for the Care Quality Commission. Instead, whistleblowers were advised to speak to an external charity which could signpost them to the regulators. We found this was not adequate as staff should be clear on the role of the Care Quality Commission and how to contact us should they wish to whistleblow. A whistleblower is when a member of staff, passes on information of concerning about the organisation.

Aspire did not have a duty of candour policy in place. The duty of candour sets out the responsibilities for organisations to be transparent, open and honest. It sets requirements for organisations to acknowledge wrongdoing and provide sincere apologies when things have gone wrong. Although the organisation did not have the policy in place, they were able to demonstrate a transparent culture. We saw examples of sincere apologies with full explanations after a complaint or serious incident.

The safeguarding policy did not provide correct information in relation to Aspires duty to inform the Care Quality Commission of any safeguarding issues or alerts. The policy only outlined the responsibilities of care homes to notify the Care Quality Commission of safeguarding. The service manager was unaware of the duty to inform the regulator of such incidents, as the policy did not stipulate it. It is important the Care Quality Commission are informed of safeguarding concerns as it provides us with a better oversight on how the organisation is responding and acting upon protecting vulnerable people. We found four safeguarding alerts had been made to the local authority, the Care Quality Commission were not informed of these alerts.

Staff were not always able to maximise their shift-time on direct care due to issues around the online electronic patient records. They regularly had issues with connectivity and the speed at which the system operated. To mitigate this, staff documented their work on Microsoft Word and stored it safely until they could transfer work onto the system. This was identified as an organisational issue; however, it was not documented on the local risk register.

Management used quarterly key performance indicators to measure how the organisation was performing. Staff took part in audits, for example, medication management, commissioning for quality and innovation and audits on care records. These were used to identify gaps in practice and to improve performance and quality.

Administration support was available for the team, however, we could not quantify whether there were any issues with effectiveness of administration support. There were no issues raised at the time of inspection.

Leadership, morale and staff engagement

At the time of the inspection Aspire did not have a registered manager, however, had someone acting in this post. They were in the process of becoming the registered manager.

Aspire had low sickness levels of 2.4%. Staff were motivated in their roles and happy with the team structures. They were supportive of each other and felt confident within the service manager.

We saw staff were encouraged to progress within the organisation and supported to develop themselves. For example one member of staff was doing training in cognitive behavioural therapy in psychosis.

There were opportunities for staff to address issues with regular supervision. We reviewed the supervision notes and saw how management were trying to support staff. Staff did not raise any issues around bullying. They felt as

though they could address issues with management and would be listened to. However, we spoke with one member of staff who was not happy about the support they had received. Managers were in the process of rectifying this situation.

Commitment to quality improvement and innovation

Aspire were committed to improve the quality of the service they deliver. This was reciprocated by the positive relationship they had with the local commissioners. We saw they were measuring quarterly key performance indicators across the service. Managers told us they were always

looking to improve the service.

Aspire were involved in national audits and quality improvement, for example, the 'Health Education England audit of skills in Early Intervention'. This underpinned services meeting performance standards such as referral to assessment in two weeks. It did this by reviewing the skilled workforce within early intervention services.

We saw good examples of innovation during the inspection. Aspire ran activity sessions which were multi-faceted. These psycho-social sessions provided patients with life skills, confidence, and addressed their mental health simultaneously.

'Drama therapy' enabled patients to express themselves. It supported them to express their emotions with the use of drama. Aspire piloted drama therapy, they found this successful and bid for funding to continue it. Patients we spoke to said they enjoyed it and told us how it helped them express themselves. One patient said she lacked the confidence to speak her thoughts, another told us she couldn't express how she felt in words. Drama therapy they felt was an ideal tool to support them with their mental health, confidence and personal achievements.

Aspire facilitated weekly, "womens groups". This provided female patients a safe space to be able to talk about issues that impacted on their lives. Patients gave each other peer support, and they were able to discuss important topics around their physical health, mental health, lifestyles that were pertinent to them. The carers we spoke to felt this group was empowering to the patients and it was a positive way to address health issues.

Outstanding practice and areas for improvement

Outstanding practice

The area of outstanding practice was 'drama therapy' sessions. It was initially piloted for three years and the results exceeded what the service expectations. Aspire bid for funding to continue this form of therapy. Drama therapy enabled patients to express themselves without using their voice. Providing this alternative method of communication and expression has been powerful for patients and carers a like. Many of the patients struggled to articulate themselves due to their mental health, confidence, and other issues. This alternative therapy gave the patients a voice and provided a platform on which they could be heard. The carers we spoke to praised the effectiveness and innovation behind this form of therapy.

Areas for improvement

Action the provider MUST take to improve

- The provider must ensure medication management is in line with its policy.
- The provider must ensure staff keep patient risk assessments up to date and in line with contemporaneous notes, complete risk assessments accurately and in a timely way.
- The provider must ensure staff adhere to infection prevention principles and good hygiene to ensure they or patients are not put at risk of harm.
- Staff must undertake comprehensive risk assessments on the environment and its impact on patients. This to identify and mitigate risks in relation to the building environment.
- The provider must inform the Care Quality Commission of any safe guarding referrals, or concerns. The duty to inform the CQC must be reflected in the safeguarding policy for such events.
- The provider must have a Duty of Candour Policy, and enable its staff to understand its principles and function.
- The provider must ensure staff have basic life support training available all staff, more significantly staff who are facilitating depot clinics
- Staff must update its local risk register when a risk has been identified that meets the criteria.

Action the provider SHOULD take to improve

- The provider should find alternative rooms and provisions in the instance there is no availability at the head office.
- The provider should provide leaflets in languages that reflect the local community.
- The provider must include the contact details for the Care Quality Commission within their whistleblowing policy

This section is primarily information for the provider

Requirement notices

Action we have told the provider to take

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

Regulated activity	Regulation
Treatment of disease, disorder or injury	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment Risk assessments were not always updated to reflect patients current risk profile. We found risk assessments which were not reviewed in a timely manner and risks were not always calculated accurately in line with the guidance. Risk assessments had not been accurately completed to address the environmental risks posed to patients. Staff were not able mitigate any environmental risks as they had not been accurately assessed. This is a breach of **regulation 12 (2) (a)** Medication temperature was not being monitored, therefore staff could not ensure the temperature was being kept below 25 degrees Celsius as per policy. This is a breach of **regulation 12 (2) (h)** Staff did not have washing facilities easily accessible to them during depot clinics. They had to go through more than one door to either the kitchen or the bathroom. Staff could not ensure they were able to maintain levels of hygiene thus putting themselves and patients at risk of infection. This is a breach of **regulation 12 (2) (g)**

Regulated activity	Regulation
Treatment of disease, disorder or injury	Regulation 17 HSCA (RA) Regulations 2014 Good governance

This section is primarily information for the provider

Requirement notices

Staff did not update the local risk register even though they had identified a risk that would warrant such thresholds. This was in relation to the online patient electronic system not working effectively.

There was no duty of candour policy in place.

This is a breach of **regulation 17 (2) (a)**

Regulated activity	Regulation
Treatment of disease, disorder or injury	Regulation 18 CQC (Registration) Regulations 2009 Notification of other incidents The safeguarding policy did not inform staff of the duty to notify the Care Quality Commission of any safeguarding alerts or concerns. We found four examples of safeguarding concerns that had been made of which the Care Quality Commission were not notified. This was a breach of **regulation 18 (2) (e)**

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.