

**Good**

# 5 Boroughs Partnership NHS Foundation Trust

# Community-based mental health services for older people

## Quality Report

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## Locations inspected

Location ID	Name of CQC registered location	Name of service (e.g. ward/unit/team)	Postcode of service (ward/unit/team)
RTV02	St Helens Hope & Recovery Centre	Community-based mental health services for older people	WA9 3DE
RTV03	Brooker Centre	Community-based mental health services for older people	WA7 2DA

This report describes our judgement of the quality of care provided within this core service by 5 Boroughs Partnership NHS Foundation Trust. Where relevant we provide detail of each location or area of service visited.

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

Where applicable, we have reported on each core service provided by 5 Boroughs Partnership NHS Foundation Trust and these are brought together to inform our overall judgement of 5 Boroughs Partnership NHS Foundation Trust.

# Summary of findings

## Ratings

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

### Overall rating for the service

Good 

Are services safe?

Good 

Are services effective?

Good 

Are services caring?

Good 

Are services responsive?

Good 

Are services well-led?

Good 

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

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

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

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

# Summary of findings

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# Summary of findings

## Overall summary

We rated community-based mental health services for older people as good because:

Both the community mental health services (CMHS) we visited had safe, clean facilities that were suitable for delivering care to older people. There were robust systems to ensure security and safety for patients and staff.

Managers planned and reviewed staffing to ensure patients received safe care and treatment. They ensured caseloads were manageable and staff received support to deal with complex issues.

Staff understood their responsibilities regarding safeguarding patients from abuse and the process for reporting safeguarding concerns.

Staff knew what constituted an incident and how to report it. They told us they felt supported and would take responsibility for incidents of harm or risk of harm. After high-level incidents, the trust sent out safety alerts to ensure that staff were aware of incidents and risks and learning was shared.

The care records we saw were of good quality. They included the patient's views, covered the full range of the person's needs and were recovery based. Physical health care was well planned and documented.

Although the teams had access to a range of disciplines to support patients, there was no input from clinical psychologists as recommended by the National Institute for Clinical and Health Excellence (NICE).

We found examples of practice designed to improve services; for example, the memory service was accredited by the Royal College of Psychiatrists and there were good examples of work being carried out to meet patients' diverse needs.

The staff were clear about their responsibilities in undertaking assessments of patients' mental capacity to

make decisions about their treatment. They understood how to ensure that patients were able to understand and agree to decisions or that decisions made by others were in the best interests of the patients.

Staff demonstrated good knowledge and understanding of patients. We observed staff treating patients with respect, kindness and dignity, and it was clear they had a good understanding of their needs. We saw people were comfortable both in the services we visited and when staff visited them at home. Patients we observed taking part in activities appeared relaxed.

The patient, carers and family members we spoke with all told us they felt involved in planning care. They told us staff listened to their views and included them in the care plan. The care records we saw showed that patients and their carers were involved in making decisions about care. Carers said they were offered support when they needed it.

People were supported to maintain their independence as far as possible; for example, by attending neighbourhood groups.

The teams focused on helping people to remain in the community and avoid being admitted to hospital where possible. They made efforts to meet people's individual needs, including their cultural, language and physical needs. We saw staff engage with patients with kindness and respect. They made plans for people's continuing support from the start of their treatment.

Patients and their carers and families were involved in planning care and treatment and in making decisions. They told us staff listened to them and supported them. Issues people raised were shared with the teams so they could learn from people's experiences.

We saw clear examples of strong local leadership. Staff told us they felt respected, valued and supported. They were clear about the vision and direction of the service and about how their work linked into the trust's vision and values.

# Summary of findings

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

### 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**

We rated the community-based mental health services for older people as good because:

- there were safe, clean facilities that were suitable for delivering care to older people
- the staffing skill mix ensured patients received safe care and treatment
- there were robust, effective systems to ensure risks were reviewed regularly
- staff had a good understanding of safeguarding patients from abuse and they knew how to escalate concerns
- staff understood their responsibilities in reporting incidents of harm or risk of harm.

Good



### Are services effective?

**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.**

We rated the community-based mental health services for older people as good because:

- care records were good quality. Physical health care was well planned and documented
- staff used standardised assessment tools
- the teams had access to colleagues from a range of disciplines to support patients
- staff were supported to deliver effective care by means of supervision, appraisal processes and team meetings
- there were good links with organisations external to the trust
- staff understood how people were assessed, cared for and treated in line with the Mental Health Act 1983 and the associated Code of Practice

Good



# Summary of findings

- staff understood their responsibilities under the Mental Capacity Act 2005 (MCA).

However:

- patients did not have access to and input from clinical psychologists.

## Are services caring?

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

We rated the community-based mental health services for older people as good because:

- staff demonstrated good knowledge and understanding of patients
- staff engaged with patients with kindness and respect
- patients and their carers and families received clear information about their care
- carers said staff listened to their views
- patients and their carers and families were involved in planning care and treatment and in making decisions
- patients were supported to maintain their independence
- family members were able to attend review meetings and were encouraged to be involved.

Good



## Are services responsive to people's needs?

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

We rated the community-based mental health services for older people as good because:

- the CMHS focused on assisting people to remain in the community and avoid admission to hospital where possible
- staff evaluated people's needs and the care and treatment options available to them. They made plans for people's continuing support from the start of their treatment
- staff supported people to attend community groups and activities
- the staff respected people's diversity and human rights. They showed us good examples of work they had carried out to meet people's diverse needs

Good



# Summary of findings

- learning from issues people raised was shared with teams at the monthly business meetings and in supervision.

## Are services well-led?

**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.**

We rated the community-based mental health services for older people as good because:

- staff were clear about how their work linked into the trust's vision and values
- there were local systems to ensure staff were well supported
- we saw clear examples of strong local leadership from the service managers
- staff were encouraged to be open and honest when things went wrong
- the CMHS used clinical tools to audit the effectiveness of interventions
- there were good examples of practice designed to improve services
- the CMHS were involved in a national study evaluating the effectiveness of memory assessment services.

Good



# Summary of findings

## Information about the service

The 5 Boroughs Partnership NHS Foundation Trust provided a range of community based mental health services. During our inspection we visited two of the five community mental health services (CMHS) for older people. These services have not been inspected by the Care Quality Commission before.

The CMHS teams were made up of staff from multiple healthcare disciplines who provided mental health assessments, treatment, rehabilitation and support for people primarily aged 65 and over who had functional or organic disorders. The teams undertook initial assessments to understand how they could meet people's needs and provided on-going support to patients and their carers or family members. Potential support included further appointments with a psychiatrist, community mental health nurses, speech and language teams and occupational therapists, plus arrangements for aftercare where it was required.

Ninety five per cent of referrals came from GPs but the teams accepted referrals from wards and liaison psychiatry as well. A single point of access operated and there was a duty system for urgent referrals.

The CMHS included a memory service that assessed and diagnosed the nature of people's memory difficulties and advised on further intervention. This service was accredited by the Royal College of Psychiatrists.

The teams also operated a range of clinics and groups and all the patients were seen in their own homes or other outpatient settings. Post-diagnostic support was available for people with dementia and their carers.

The CMHS also linked with other trust services, such as psychiatric liaison, and the acute hospital trust, to provide a comprehensive service for people. However, patients did not have access to and input from clinical psychologists as recommended by the national institute for clinical and health excellence (NICE).

The CMHS monitored people's mental health and planned interventions to prevent relapse. Staff promoted independence and rehabilitation of social skills by supporting and encouraging patients to access and be involved with local services. They ran groups such as a reading group and a post-diagnosis support group.

The teams worked in line with the principles of the recovery model, demonstrated by their focus on supporting patients to remain in the community.

## Our inspection team

Our inspection team was led by:

**Chair:** Kevin Cleary, medical director and director for quality and performance, East London NHS Foundation Trust

**Head of Inspection:** Nicholas Smith, Care Quality Commission

**Team leaders:** Sarah Dunnett, inspection manager, Care Quality Commission

Patti Boden, inspection manager, Care Quality Commission

The team that inspected community based mental health services for older people included two CQC inspectors, two qualified nurses, an occupational therapist and a person who has experience of caring for someone who has used services.

## Why we carried out this inspection

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



# Summary of findings

## How we carried out this inspection

Before the inspection visit, we reviewed a range of information we hold about the trust and asked other organisations to share what they knew. We carried out announced visits to the service on 23 July 2015.

During this inspection we:

- visited two community teams and looked at the quality of the office environment
- spoke with one patient and 13 carers and family members
- spoke with the managers of each community team

- spoke with 13 other members of staff including nurses, occupational therapists, pharmacists and support workers
- accompanied staff on three visits to patients at home and observed how they cared for them
- attended and observed two activity groups, one memory clinic and one multi-disciplinary team meeting.

We also:

- looked at care and treatment records of 17 patients
- looked at a range of policies, procedures and other documents relating to the running of the service.

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

During the inspection, we spoke with 13 people who were carers or family members and one patient. People described the services as 'supportive' and 'caring'. They told us staff were friendly and treated them with kindness and respect. They felt involved in making decisions about

their relative's care and treatment. They said they felt staff listened to their views and that the service was flexible. They said access to the CMHS was good and that they were offered support when they needed it.

## Good practice

The CMHS showed us good examples of work designed to meet people's diverse needs, such as a spirituality conference and work with gender diversity, homeless people and the traveller community.

## Areas for improvement

### Action the provider **SHOULD** take to improve

The trust **should** ensure that patients have access to psychological input in line with national guidance.

# 5 Boroughs Partnership NHS Foundation Trust

## Community-based mental health services for older people

### Detailed findings

#### Locations inspected

Name of service (e.g. ward/unit/team)	Name of CQC registered location
Community-based mental health services for older people	St Helens Hope & Recovery Centre
Community-based mental health services for older people	Brooker Centre

#### 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.

At the time we inspected this service, there were no patients who were subject to the Mental Health Act (MHA)

1983 but staff we spoke with understood their responsibilities in relation to the MHA and the Code of Practice. At Halton, 81.2% of the staff had completed MHA training and 75% at St Helens.

#### Mental Capacity Act and Deprivation of Liberty Safeguards

Staff we spoke with understood that capacity fluctuated and that people may have capacity to consent to some things but not others; for example, to be able to pay for shopping but not for more complex banking matters. They were clear about their responsibilities in undertaking

assessments of the mental capacity of patients to make decisions about their treatment. They understood the need for continuous monitoring to ensure that patients were able to understand and agree to decisions being made or that decisions made by others were in the best interests of

# Detailed findings

the patients. They understood the circumstances when an independent mental capacity advocate (IMCA) would be accessed. The 17 care records we looked at showed that staff carried out mental capacity assessments only when they were needed. We saw that assessments were carried out at times when the patient performed best to give them

a better chance of demonstrating their capacity. This meant that people received appropriate support to help them make specific decisions. At Halton, 93.7% of staff had received training on the Mental Capacity Act 2005 and 95% at St Helens.

# Are services safe?

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

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

## Our findings

### Safe and clean environment

Both teams had facilities for people to attend clinics and groups. The environments were clean, safe and suitable for delivering care to older people. All fixtures, fittings and equipment were clean and in a good state of repair. There was space with comfortable seating for interviewing and meeting individual patients and carers. There were no alarms in the rooms but there was a personal alarm system for staff to use to maintain their personal safety. Doors were fitted with anti-barricade locks.

There were effective systems to ensure security and safety. On the days we inspected we were asked to show identification and to sign into and out of the building.

All medical equipment was available and checked routinely.

Staff adhered to infection control principles including handwashing. The weekly cleaning records were up to date. The matron carried out monthly audits of cleanliness standards and the CMHS were compliant with the audits.

### Safe staffing

Managers planned and reviewed the staffing skill mix to ensure patients received safe care and treatment. The staff were all trained in the skills needed for assessment, memory and community mental health. This meant staff could provide safe cover across all areas the team worked in. The managers had assessed the minimum staffing levels at which each service could operate safely. There were no current vacancies or sickness affecting staffing levels. Sickness levels were 2.7% at the O'Hanlon Centre and 3.7% at the Brooker Centre; this was in comparison with the national NHS average of 4.7%. Managers had planned for forthcoming absences and cover was arranged. None of the patients' carers and family members we spoke with reported that they had experienced any cancelled groups or appointments.

We saw from records we looked at that staff had caseloads of approximately 22 cases per full time equivalent. Caseloads were monitored during supervision at least every two months to ensure they were manageable and staff received support to deal with complex issues.

Managers monitored compliance with mandatory training through supervision and an electronic database. Training records we looked at showed that staff compliance ranged from 89% - 100%.

There was a lone worker policy in place and the CMHS had developed local protocols to ensure staff were safe. Staff explained what they would do if they were concerned about their safety while on a visit or if someone did not return when they were expected to.

### Assessing and managing risk to patients and staff

Systems to ensure risks were reviewed regularly were robust and effective.

Staff carried out risk assessments either before or at the start of people's involvement with the CMHS as part of a comprehensive assessment. Risk assessments had been carried out in all of the 17 case records we reviewed and consolidated into detailed risk management plans where needed. Individual risk assessments were updated whenever a risk issue changed or at least every six months. All the risk assessments and management plans were complete and up to date.

Managers carried out an audit of case records every two months that included ensuring risk assessments were up to date.

Every 12 months, a comprehensive quality audit was carried out to ensure that risk was monitored and reviewed. A manager from a different service carried out the audit, to ensure objectivity and independence. The audit included points that needed action and timescales for completion. We saw that these were up to date and actions had been completed within the timescales.

The multi-disciplinary team at both locations met every week to discuss the team's caseload. This meant that they monitored patients so that changes in level of risk could be detected early.

Clinical staff all had a clear understanding of their responsibilities regarding safeguarding and the process for reporting safeguarding concerns. All had completed safeguarding adults training. At Halton, 86.7% of staff had completed safeguarding children training at level two and 89.5% at St Helens.

# Are services safe?

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

There were clear policies and procedures covering all aspects of medicines management. There were appropriate systems for the storage and administration of medicines. Following a medication error whereby a patient received the wrong medication, a system had been developed to avoid future errors. This was discussed with the Medicines Management Group. As a second safety check, nursing homes were being asked to fax the current prescription chart to confirm what medicines the patient was receiving. Training in medicines management was low at 35% for Halton and 66% for St Helens.

## Track record on safety

No serious incidents had been recorded or reported in the last 12 months.

## Reporting incidents and learning from when things go wrong

Staff knew what constituted an incident or a near miss and how to report it. They told us they felt supported within the team and would take responsibility for incidents.

There was a process for de-briefing and investigating incidents should they occur.

Managers attended a monthly quality and risk meeting. Issues and information from this meeting were discussed with staff at the monthly business meeting. We saw notes of these meetings confirming this.

Following high-level incidents, the trust sent out safety alerts to ensure that staff were aware of incidents and risks. These were also discussed at monthly business meetings and signed off to confirm that they had been discussed. This meant that staff were aware of risks and took action to mitigate them. We saw minutes of a meeting which included discussion of a safety alert that related to ligature risks identified in accessible toilets.

# Are services effective?

Good 

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

## Our findings

### Assessment of needs and planning of care

Staff saw patients within 10 working days of referral. Patients referred urgently were seen within 24 hours. A target had been set of 12 weeks from referral to diagnosis. Both teams had exceeded this and were reaching diagnosis within seven to 10 weeks.

The community mental health services (CMHS) completed comprehensive assessments of patients' needs using standardised assessment tools. Assessments included patients' social, occupational, cultural, physical and psychological needs and preferences.

Staff talked about their work in terms of the recovery model. Their focus on supporting people to remain in the community was clear. The 17 care records we saw were of good quality, although one was not complete as the care plan was missing. They included the patient's views, covered the full range of the person's needs and were recovery based. Recovery based means care being focused on helping patients to be in control of their lives and build their resilience so that they can stay in the community and avoid admission to hospital wherever possible. All the records contained a physical health assessment and a risk assessment. Where needed, this was consolidated into a risk management plan. This meant staff had a clear and accurate understanding of the patient's needs so they could provide appropriate care.

Information needed to deliver care was stored on the trust's electronic database system. However, social work staff used a different system. They had access to the trust database but they did not record on it. The systems were password protected so that they were secure. There was also a paper system in which all clinical staff made records. Despite this, staff reported no problems coordinating between the systems. Paper records were stored securely in a locked office.

### Best practice in treatment and care

The teams had access to a range of disciplines to support patients. However, patients did not have access to or input from clinical psychologists as part of their assessment, treatment and recovery as recommended by the National Institute for Clinical and Health Excellence (NICE). Some CMHS staff were trained in cognitive behaviour therapy and this was provided as part of post-diagnostic support.

Staff considered physical health needs routinely as part of the assessment process. Physical health care was well planned and documented. We found some good examples of how teams ensured patients' physical health care needs were met. The CMHS included assistant practitioners and support time recovery staff who provided support around physical health care. Two health care support staff were trained in electrocardiogram testing (ECG). As they could carry out ECG tests within the CMHS, this meant patients did not have to wait for appointments and avoided delays in diagnosis.

We found examples of practice designed to improve services. The memory service was accredited by the Royal College of Psychiatrists. There were clinics to meet people's needs, such as a post diagnostic support clinic for people with dementia that looked at practical help and benefits available. There were good examples of work being carried out to meet patients' diverse needs. The team at the Brooker Centre had been nominated for the trust's 'Creating positive cultures' award.

There were good examples of initiatives to help meet the needs of patients who used the CMHS; for example, a spirituality conference to raise awareness of dementia in different faith denominations in the community.

The CMHS provided people with written information about dementia and dementia services. This is in line with NICE guidelines.

Staff were able to explain how they incorporated best practice guidance into their practice; for example, they spoke knowledgeably about medicines used for dementia.

Outcomes were being measured. Staff were completing Health of the Nation Outcome Scales (HoNOS). HoNOS measure the health and social functioning of people with severe mental illness. They are designed to be used by clinicians before and after interventions, so that changes attributable to the interventions (outcomes) can be measured.

### Skilled staff to deliver care

The teams included and had access to a range of disciplines to support patients. This included managers, nursing staff, pharmacists, psychiatrists, social workers, support workers and allied health professionals such as assistant practitioners and occupational therapists. They

# Are services effective?

Good 

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

provided a range of therapeutic interventions to support people's recovery in line with best practice guidance. Staff we spoke with recognised the benefit of close working with allied professionals.

As well as mandatory training, both teams had identified further training relevant to their work and managers encouraged them to develop skills in specialist areas. We saw discussion about additional training noted in supervision records. For example, some staff were trained in cognitive stimulation therapy and some in ECG.

Staff were supported to deliver effective care by means of supervision and appraisal of their work performance, to identify additional training requirements and manage performance. Staff were also expected to demonstrate how they incorporated the trust's values into their practice. All staff supervision was up to date. All the staff had had an appraisal in the last 12 months.

We looked at minutes of team meetings that took place every month. Discussion included such issues as team performance, training, safeguarding, trust safety alerts and communications, outcomes measurement and the duty of candour.

Staff and managers discussed individual performance in supervision. We saw evidence of this in the records we looked at. Managers told us that they felt well supported in dealing with poor performance.

## Multi-disciplinary and inter-agency team work

Both teams held a weekly multi-disciplinary team (MDT) meeting to review and discuss current cases.

The CMHS comprised smaller teams working with client groups with different needs; for example, for assessment, memory and community mental health. They referred internally and worked together according to need. This meant patients received treatment from the team most appropriate to meet their needs.

Both teams made links with organisations external to the trust. We saw a range of information on display about how to access neighbourhood groups. The post-diagnostic support group invited local speakers to talk about relevant issues, such as solicitors to talk about advance statements and directives.

The CMHS had developed a care home liaison service. This was well accepted and provided an opportunity to develop good external working links.

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

At the time we inspected, no patients were subject to the Mental Health Act (MHA) 1983 but we were assured by talking with staff that they understood how people were assessed, cared for and treated in line with the Act and the MHA Code of Practice. At Halton, 81.2% of staff had received training on the MHA and 75% at St Helens.

## Good practice in applying the Mental Capacity Act

Staff we spoke with understood that capacity fluctuated and that people may have capacity to consent to some things but not others; for example, to be able to pay for shopping but not for more complex banking matters. They were clear about their responsibilities in undertaking assessments of the mental capacity of patients to make decisions about their treatment. They understood the need for continuous monitoring to ensure that patients were able to understand and agree to decisions being made or that decisions made by others were in the best interests of the patients. The 17 care records we looked at showed that staff carried out mental capacity assessments only when they were needed. We saw that assessments were carried out at times when the patient performed best to give them a better chance of demonstrating their capacity. This meant that people received appropriate support to help them make specific decisions. At Halton, 93.7% of staff had received training on the Mental Capacity Act 2005 and 95% at St Helens.

We were told that the trust had carried out a case note audit to check information about advance statements. We were not able to look at this but the trust confirmed that it had carried out an audit of care plans, crisis plans and contingency plans to assess compliance with NICE quality standard 14, which includes crisis planning. A crisis plan should contain details of advance statements and decisions. The analysis and report of this audit's findings was not complete at the time of our inspection.



# Are services caring?

Good 

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

## Our findings

### Kindness, dignity, respect and support

Staff demonstrated a good knowledge and understanding of patients. When we accompanied staff visiting patients, it was clear that they had a good understanding of their needs. We observed staff treating patients with respect, kindness and dignity. They were caring, compassionate and supportive. All the staff we observed demonstrated this. The patient we spoke with was positive about the support they had been receiving and the kind and caring attitudes of the staff. We saw people were comfortable both in the services we visited and when staff visited them at home. Patients we observed taking part in activities appeared relaxed.

Staff gave patients and their carers and families clear information about their care and the support they could offer. The patient and carers we spoke with all said staff were helpful and they could ask about anything. Carers told us staff kept them informed and they felt involved in making decisions about their relative's care and treatment. They said staff listened to their views and included them in the care plan. They said access to the CMHS was good, the service was flexible and that they received support when they needed it.

All the staff teams maintained patients' confidentiality at all times. When we accompanied staff on home visits the staff members asked if the patient was happy for a Care Quality Commission team member to be present prior to the visit. All staff we spoke with were aware of the need to ensure confidential information was kept securely. Access to electronic case notes was protected by passwords.

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

The patient, carers and family members we spoke with all told us they felt involved in planning care. Their feedback

was positive, particularly about the way staff treated them. They told us staff listened to them and supported them during their care and treatment. We saw information about advocacy services displayed in waiting areas.

People were supported to attend community groups and activities; for example, neighbourhood groups, learning or volunteer opportunities, and there was a post-diagnostic service for people with dementia that explained the practical help and benefits available to them and their carers. This enabled patients to maintain their independence as far as possible.

The care records we saw showed that patients and their carers were involved in making decisions about care. All but one of the records we looked at contained personalised, holistic care plans. Patients' family, friends and advocates were involved in their care if the patient wished.

Staff provided copies and recorded this. However, four carers said they did not have a copy of the care plan.

Family members were able to attend review meetings and were encouraged to be involved.

We observed clinical appointments during which patients were involved in their care and supported emotionally. Staff were sensitive and respectful of patients' wishes and were committed to providing personalised care based upon their needs. Carers and family members we spoke with told us they had the opportunity to provide feedback about the services and to monitor their stress levels. The teams asked people to complete the 'friends and family' test. Feedback was discussed at the monthly business meetings but it was not specific to the services we inspected.

Patients and their families and carers were given information about complaints, advocacy information, support groups and self-help groups and literature to promote independence and learning.



# Are services responsive to people's needs?

Good 

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

## Our findings

### Access and discharge

The community mental health services (CMHS) focused on assisting people to remain in the community and avoid admission to hospital where possible.

The teams operated a single point of access. The assessment team saw patients within 10 working days of referral, or within 24 hours if they were acutely unwell or at risk. There was a duty system so that staff triaged referrals as they came in.

Staff carried out an initial assessment that incorporated a life history, mental and physical health assessments and further health investigations where necessary. Following assessment, they evaluated people's needs and the care and treatment options available to them. There were clear care pathways and structure for care. Care records we looked at showed that staff assessed people when they were referred to the CMHS and then referred them on to the appropriate team; for example, the memory clinic. Staff made plans for patients' continuing support from the start of their treatment.

People were supported to attend community groups and activities; for example, neighbourhood groups, learning or volunteer opportunities. The teams had initiated a post-diagnostic service for people with dementia that explained the practical help and benefits available to them and their carers. This enabled patients to participate in the activities of the local community so that they could exercise their right to be a citizen as independently as they were able to.

Staff attempted to engage people who missed appointments, mainly by phone calls and letters and discharged them if they no longer accessed the service.

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

The premises were clean, welcoming and comfortable. There were facilities for various activities; for example, a reading group and depot clinics.

There was information displayed for patients, their families and carers; for example, information about social support, advocacy services, carers groups, diagnoses and treatments. Leaflets were available in various languages upon request.

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

The staff respected people's diversity and human rights. They made efforts to meet individual needs including cultural, language and physical needs. Interpreters were available to staff if required. There were leaflets produced in several languages. The two premises we visited were accessible to people who had physical disabilities.

The CMHS showed us good examples of work they had carried out to meet people's diverse needs, such as a spirituality conference to raise awareness of dementia in different faith denominations in the community and work with gender diversity, homeless people and the traveller community. An initiative called 'Tackle your memory' visited local rugby clubs and had a stand on match days to help raise awareness and engage the community in education about memory problems.

### Listening to and learning from concerns and complaints

The CMHS had received one complaint in the last six months; this had been partly upheld. The complaint concerned a medication error and the team had implemented new systems to ensure this did not happen again. However, not all staff had undergone medicines management training.

All the carers and family members we spoke with said they had received information about the service. Most said they knew how to complain if they wanted to but three told us they were not sure. We saw posters in the reception areas telling people how to complain or offer suggestions or compliments. Staff explained how they dealt with issues when they were raised directly with them.

Learning from issues people raised was shared with the teams at the monthly business meetings and in supervision.

# Are services well-led?

Good 

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

## Our findings

### Vision and values

The trust had adopted a set of principles called the '6 Cs' as its values. The '6Cs' were developed in 2012 by the NHS Commissioning Board against a backdrop of concerns about standards of nursing care in England. They are care, compassion, competence, communication, courage and commitment. The trust made staff aware of its vision and values through emails and newsletters. The trust also made use of social media to disseminate information. We saw posters of the trust's vision and values displayed in the offices and used as screen savers on computers. One manager was a care-maker with NHS England. Care-makers act as ambassadors for the 6Cs and help staff understand how to implement them.

Staff understood the vision and direction of the service they worked in at local level and about how their work linked into the trust's vision and values. At each supervision session, managers expected staff to demonstrate how they incorporated them into their practice.

### Good governance

There were local systems to ensure staff were well supported and received suitable training to enable them to do their jobs.

Supervision was structured. Sessions covered performance, development and staff issues and addressed matters outstanding from the previous meeting. Staff were expected to demonstrate how they incorporated the '6Cs' into their practice. All staff received appropriate clinical supervision. All supervision was up to date. Staff told us they found the supervision they received helpful and supportive.

All staff had had an appraisal of their work performance.

Staffing levels and skill mix were sufficient to ensure safe, good quality care and treatment.

There was a meeting structure to escalate and cascade information through all levels of staff. The meetings were well-organised and covered appropriate governance issues relevant to the service and learning from incidents and complaints.

Staff had a good understanding of safeguarding, the Mental Health Act 1983 and the Mental Capacity Act 2005.

Staff were completing Health of the Nation Outcome Scales (HoNOS). HoNOS measure the health and social functioning of people with severe mental illness. They are designed to be used by clinicians before and after interventions, so that changes attributable to the interventions (outcomes) can be measured.

Key performance indicators set by commissioning bodies were being met.

We also saw evidence of robust local audits being carried out that could be used to ensure that systems were working and drive improvement. A manager from a different service carried out a quality audit every year. This was being used to measure how well processes were being implemented and where the services could improve. The completed audit included points for action and timescales for completion. We saw that these were up to date and actions had been completed within the timescales.

Managers carried out a case note audit every two months to ensure records were complete and up to date. They discussed findings in supervision and at team meetings.

CMHS managers met as a peer group to discuss and share practice and protocols. They had sufficient autonomy to authorise initiatives for improving service delivery and encouraged staff to develop ideas. We saw notes of discussions in supervision and team meetings.

### Leadership, morale and staff engagement

Staff told us they felt well supported by their local managers and peers. We saw clear examples of strong local leadership from the service managers, such as implementing initiatives to meet the diverse needs of patients and ensuring the trust's vision and values were embedded into individual practice and service delivery.

Sickness and absence rates were low in the teams we visited, at less than 4%.

Staff understood the whistleblowing process and said they would use it to escalate concerns.

Staff we spoke with felt respected, valued and supported. They had opportunities for career progression. They told us they enjoyed their work and were proud of the culture of care within their team.

Managers encouraged staff to be open and honest when things went wrong. The duty of candour was discussed at monthly business meetings so that staff had a good

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understanding of the duty. Staff we spoke with understood what a notifiable safety incident was and explained what they were expected to do. They were clear that they would explain and apologise to patients and their families in any event.

## **Commitment to quality improvement and innovation**

The CMHS used clinical tools to audit the effectiveness of interventions, such as HoNOS.

We found examples of practice designed to improve services, such as the memory service and a post-diagnostic support clinic for people with dementia that looked at practical help and benefits available. There were good examples of meeting patients' diverse needs, such as a spirituality conference to raise awareness of dementia in

different faith denominations, work with gender diversity, homeless people and the traveller community and an initiative to help raise awareness and engage the community in education about memory problems.

The team at the Brooker Centre had been nominated for the trust's 'Creating positive cultures' award.

The teams asked people to complete the 'friends and family' test. Feedback was discussed at the monthly business meetings but it was not specific to the services we inspected.

The CMHS at the Brooker Centre was involved in a national study evaluating the effectiveness of memory assessment services. This was commissioned by the Department of Health and carried out by the London School of Hygiene and Tropical Medicine.