

# Aspire







## Quality Report

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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		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 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 it as good because:

- The service provided safe care. Clinical premises where patients were seen were safe and clean. Staff assessed and managed risk well and followed good practice with respect to safeguarding.
- Staff developed holistic, recovery-oriented care plans informed by a comprehensive assessment. They provided a range of treatments suitable to the needs of the patients and staff engaged in clinical audit to evaluate the quality of care they provided.
- The teams included or had access to the full range of specialists required to meet the needs of the patients. Managers ensured that these staff received training, supervision and appraisal. Staff worked well together as a multi-disciplinary team and with relevant services outside the organisation.
- Staff understood and discharged their roles and responsibilities under the Mental Health Act 1983 and the Mental Capacity Act 2005.
- Staff treated patients with compassion and kindness and understood the individual needs of patients. They actively involved patients and families and carers in care decisions.
- The service was easy to access. Staff assessed and treated people who required urgent care promptly and those who did not require urgent care did not wait too long to start treatment. The service did not exclude people who would have benefitted from care.
- The service was well led and the governance processes ensured that procedures relating to the work of the service ran smoothly.

# Summary of findings

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Good 

# 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 is Community Links Ltd. Community Links Ltd delivers both mental health and adult social care services.

Aspire works with young people and adults from 14 to 65 years old who have experienced their first episode of psychosis. This Early Intervention in Psychosis 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 deliver care within the community and in patients' homes, as well their office base. The service provides medical and psychosocial interventions.

The service has been commissioned to deliver early intervention services as an independent provider and covers the whole of the Leeds region. Aspire works closely with the local trust and stakeholders.

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

- Treatment of disorder, disease or injury.

In May 2016, we rated the service as 'requires improvement' overall. We issued Aspire with three requirement notices which related to regulation 12 and 17 under the Health and Social Care Act (Regulated Activities) Regulations 2014, and regulation 18 of the Health and Social Care Act (Registration) Regulation 2009.

However, the Care Quality Commission returned to Aspire in January 2017 for a focused inspection looking at the 'safe' and 'well led' domains to see if they had addressed the breaches in regulation from the previous inspection in May 2016. We found the service had addressed the issues we found and we re-rated Aspire as 'good' across all five domains and 'good' overall.

## Our inspection team

The team that inspected the service comprised two CQC inspectors, an assistant inspector and a two specialists advisors including a registered mental health nurse and clinical psychologist.

## Why we carried out this inspection

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

## How we carried out this inspection

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

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

Before the inspection visit, we reviewed the information that we held about the location and asked a range of other organisations for information.

During the inspection visit, the inspection team:

- looked at the quality of the environment and observed how staff were caring for patients
- spoke with five patients and three carers who were using the service

# Summary of this inspection

- spoke with the registered manager and operational director
- spoke with two team managers
- spoke with 12 other staff members; including doctors, nurses, support workers, a psychologist and social workers
- attended and observed one morning 'red board' hand-over meeting
- attended and observed one community visit and one patient review
- looked at six patients' care and treatment records
- carried out a specific check of the medication management and the clinic within the service
- looked at a range of policies, procedures and other documents relating to the running of the service.

## What people who use the service say

Patients and carers provided positive feedback about the service and the staff who delivered it. Patients told us staff were caring, kind, responsive and compassionate. They also told us staff were there in their time of need.

The last annual survey in 2017/18 found patients were overall very satisfied with the service. In addition, the service received a combined total of 93% of patients being 'likely' or 'extremely likely' to recommend this service in the friends and family test.

Patients were an integral part of the service delivery and were involved in all aspects from recruitment to developing the vision and values.

# 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?

**Our rating of safe stayed the same. We rated it as good because:**

- All clinical premises where patients received care were safe, clean, well equipped, well furnished, well maintained and fit for purpose.
- The service had enough staff, who knew the patients and received basic training to keep people safe from avoidable harm. They developed crisis plans when this was necessary, responded promptly to sudden deterioration in a patient's health and monitored patients on waiting lists to detect and respond to increases in level of risk. Staff followed good personal safety protocols.
- Staff understood how to protect patients from abuse and the service worked well with other agencies to do so. Staff had training on how to recognise and report abuse and they knew how to apply it.
- Staff kept detailed records of patients' care and treatment. Records were clear, up-to-date and easily available to all staff providing care.

Good



### Are services effective?

**Our rating of effective stayed the same. We rated it as good because:**

- Staff assessed the mental health needs of all patients. They developed individual care plans and updated them when needed. Care plans reflected the assessed needs, were personalised, holistic and recovery-oriented and staff updated them when appropriate.
- Staff provided a range of care and treatment interventions suitable for the patient group. They ensured that patients had good access to physical healthcare and supported patients to live healthier lives.
- Staff used recognised rating scales to assess and record severity and outcomes. They also participated in clinical audit, benchmarking and quality improvement initiatives.
- The teams included or had access to the full range of specialists required to meet the needs of patients under their care.

Good



# Summary of this inspection

Managers made sure they had staff with a range of skills need to provide high quality care. They supported staff with appraisals, supervision, opportunities to update and further develop their skill. Managers provided an induction programme for new staff.

- Staff had good working knowledge and appropriate application of the Mental Capacity Act and Mental Health Act.

## Are services caring?

**Our rating of Caring stayed the same. We rated it as good because:**

- Staff treated patients with compassion and kindness. They understood the individual needs of patients and supported patients to understand and manage their care, treatment or condition.
- Staff involved patients in care planning and risk assessment and actively sought their feedback on the quality of care provided. They ensured that patients had easy access to advocates when needed.
- Staff informed and involved families and carers appropriately.

Good



## Are services responsive?

**Our rating of Responsive stayed the same. We rated it as good because:**

- The service had a clear referral criteria and care pathway into the service as well as a discharge process.
- The teams met the needs of all people who use the service – including those with a protected characteristic. Staff helped patients with communication, advocacy and cultural support.
- The service treated concerns and complaints seriously, investigated them and learned lessons from the results, and shared these with all staff.
- In the last 12 months 71 % of patients who left the service were discharged back into primary care.

Good



## Are services well-led?

**Our rating of Well led stayed the same. We rated it as good because:**

- Leaders had the skills, knowledge and experience to perform their roles, had a good understanding of the services they managed and were visible in the service and approachable for patients and staff.
- Staff knew and understood the provider's vision and values and how they were applied in the work of their team.

Good





# Summary of this inspection

- Staff felt respected, supported and valued. They reported that the provider promoted equality and diversity in its day to day work and in providing opportunities for career progression. They felt able to raise concerns without fear of retribution.
- Our findings from the other key questions demonstrated that governance processes operated effectively at team level and that performance and risk were managed well.
- Teams had access to the information they needed to provide safe and effective care and used that information to good effect.
- Staff engaged actively in local and national quality improvement activities.

# 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.

Staff had good working knowledge of the Mental Health Act and the code of practice. They were clear on what different sections meant and how it impacted on the patients. Compliance with Mental Health Act training was 100%.

We reviewed a sample of patient care records including those on community treatment orders. A community treatment order is where a patient has been discharged from hospital but has conditions attached to their discharge to ensure compliance with medication and support. If a patient does not comply with their order,

they could be recalled back to hospital. The patient care plans outlined the conditions of the community treatment order to ensure patients and their families were clear on the expectations. Staff were regularly informing patients of their rights and documenting if they felt the patient had understood them or not. Patients had access to a local independent mental health advocacy service.

Staff at Aspire used the local trusts Mental Health Act office for support and advice. Staff and management told us they had a good rapport with the service and felt they could contact them at any time. Mental Health Act audits on detention documentation was carried out by the local trust.

## Mental Capacity Act and Deprivation of Liberty Safeguards

Staff had a good working knowledge of the Mental Capacity Act. They were able to tell us about least restrictive practices and how they adopted the principles throughout their everyday practice. Compliance with Mental Capacity Act Training was 100%.

The service had appropriate support mechanisms in place for staff to develop their understanding around the legislation, including an up to date policy, training and through discussion forums. Staff could also speak to the clinicians and could freely access the Act.

We found examples of consent being sought from patients to share their information. For example, if a member of staff wanted to share information about the care and treatment with family members the care records were clear if the patient had given consent. Where staff had concerns about capacity we saw it was discussed in a multi-disciplinary setting and in one case a two-stage mental capacity assessment was conducted. The concerns were decision specific and concluded the patient did have capacity to make decisions around that particular area.

## Overview of ratings

Our ratings for this location are:

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

# Community-based mental health services for adults of working age

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

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

Good 

### Safe and clean environment

The building in which the service was delivered was safe and fit for purpose. It had a locked entrance; visitors had to ring to the appropriate floor to which the relevant service would grant access. On the floor Aspire occupied, there was a separate suites for patients and staff. The patients' suite included a range of therapy rooms, a kitchen, and a clinic. The staff suite contained offices and medication storage. All patient areas were clean and well maintained. Both suites required key pad entry, this meant patients could not enter without a member of staff present. There was disabled access for people with mobility issues by way of a lift. The service had an environmental risk assessment which had been reviewed within the last 12 months. The clinic room was safe and fit for purpose, it had height, weight and blood pressure monitoring equipment, which was calibrated appropriately.

The environment was clean and well maintained. The service had a daily cleaning rota which ensured the upkeep of the environment. There were adequate hand washing facilities available for staff to ensure they complied with infection prevention standards.

The service was scheduled to move to a new location and improved premises in early 2019 as a result of expansion.

There were safety mechanisms in place to protect staff when patients visited the service. The patient therapy rooms did not have alarms, however, the service used an

electronic mobile system. Staff had to enter their appointments on their mobile device and sign out when their appointment finished. If staff did not sign out at the finished time an automatic alert was sent to administration staff and managers. Staff could sound an alert during the appointment should they require immediate support. Follow up procedures were initiated to ensure the member of staff was safe.

### Safe staffing

There were sufficient staffing levels to meet the needs of the service. The service used the workforce indicators for early intervention services determined by NHS England to establish the number of staff it needed. Aspire had a total of 48 substantive staff, ranging [CB1]from band three to band eight. They included, psychologists, nurses and support workers.

In addition, the service had a number of staff scheduled to start in the coming months but were undergoing their pre-employment checks.

In addition, the service had 1.6 whole time equivalent consultant psychiatrists and 1.0 whole time equivalent speciality trainee doctor. The medical staff were employed by the local trust. There were a low number of vacancies. Vacant positions included one care coordinator and three support workers. Staff sickness levels for the last 12 months was 4.5%. There was no use of agency or bank staff.

Staff had caseloads between 13 and 20 patients. National Institute of Health and Care Excellence guidance outlines care coordinators within early intervention services should have up to 15 patients on their caseloads. Although some staff had higher numbers of patients on their caseload, they were co-worked with colleagues or they were patients with a lower risk profile. The service did not use a weighting tool

# Community-based mental health services for adults of working age

to determine caseload size, however, staff could discuss their caseloads in the daily morning meetings where changes could be made if patient acuity increased. All new staff had a protected caseload to ensure they were familiar with operating procedures before managing a full caseload.

Patients had timely access to psychiatric support. All the doctors held daily emergency slots so that staff could schedule unexpected appointments. Staff told us patients could be seen by a doctor within 24 hours and in most cases on the same day.

Compliance with mandatory training was good. The service target was 75%. All the modules had a compliance rate of above 75 %; compliance with training in clinical risk was 81%, conflict management was 87%, and ligature training was 88%.

## Assessing and managing risk to patients and staff

### Assessment of patient risk

Aspire used a recognised risk assessment tool to assess and manage patient risk, the Functional Analysis of Care Environment (FACE) risk assessment. The risk assessments were comprehensive, individual and up to date. Staff were regularly reviewing and updating the risk assessments. Where there was specific concern around areas of risk, this was flagged up on the front page.

There was good oversight on risk, and a multidisciplinary approach to supporting staff in mitigating risk. The care coordinators and team leaders held a morning meeting every day to discuss their caseload, review any risks and decide on appropriate action. In addition, they had a 'red board' meeting twice a week, to review the most at-risk patients as a multi-disciplinary team. We observed one 'red board' meeting and found it to be detailed, well attended and effective.

All the records we reviewed had a crisis plan which was also provided to patients, and their carers where consent had been provided by the patient. The crisis plans were individual to the patient, identifying their personal symptoms, triggers and coping mechanisms for their mental health issues. In addition, the plans provided all the relevant numbers families and carers could contact in the event of a crisis, including, out of hours crisis teams, support lines and other emergency numbers.

### Management of Risk

The service had appropriate mechanisms in place to mitigate risk for both its patients and staff. There was a lone working policy in place which provided staff with details on how to practice safely when visiting patients within the community. Staff utilised the electronic patient records to share safety information for all staff accessing that record. For example, we saw one record where the alert made clear all visits should be made in twos.

In addition, the service used a mobile safety application 'alert a buddy' which staff used when visiting patients. The team leaders ensured staff were using the safety application by conducting regular weekly audits comparing the usage of the application to how many visits staff had scheduled. Any concerns were addressed with individual staff through supervision. As well as this, there were posters around the office to remind staff to use the application during patient visits.

### Safeguarding

Staff had good working knowledge around safeguarding including how to identify abuse and what procedures to take. Compliance with mandatory training in safeguarding adults was 83% and safeguarding children was 85%.

The service were making regular safeguarding alerts to the local authority and working closely with stakeholders to ensure they complied with their statutory duties. Senior management within the organisation had oversight of themes and trends and were able to address them in a timely manner. The service produced quarterly safeguarding reports for trend analysis to establish any patterns.

### Staff access to essential information

Staff had appropriate access to the information systems within Aspire. Patient records were stored electronically which meant all staff could access them in a timely manner. The service shared the same electronic patient record system as the local trust, which meant information sharing was made easier and was secure.

Some staff had access to the patients GP records which was stored on a different electronic system. This access was restricted to only those who required it, such as the psychiatrists.

### Medicines management

# Community-based mental health services for adults of working age

There was safe handling, dispensing and administering of medication. The service had an up to date medication policy which outlined the standards in which staff had to operate. The compliance with mandatory training around medication management was good, it included, anaphylaxis training 79%, medication management 84% and basic life support 85%.

The service did not have any controlled drugs, nor did it store stock medicine. All medication was ordered at the end of the week for patients which required a depot injection for the following week. There was little medication held onsite as most of the patients attended the clinic facilitated by the local trust. Where patients had their medication administered at home, there was safe procedures for staff to transport, administer and dispose of medicine and equipment. All staff administering medication carried an epinephrine injection, which would be used in the event of an allergic reaction.

The service received support from the local trust pharmacy where required.

Staff outlined on patient care records if patients had any allergies or side effects to anti-psychotic medication and what support was in place to manage it.

There was a locked cabinet where all medication was stored, temperatures were logged daily. The managers conducted regular medication audits to drive up improvement. We found where managers had identified gaps in practice they put processes in place to mitigate any risks. For example, managers had identified gaps in the recording of temperatures, as a result they assigned specific staff to take responsibility for this.

## Track record on safety

A total of 14 serious incidents were reported in the last 12 months. Themes included attempted suicide, violence and fire related incidents. The service conducted a comprehensive investigation for each serious incident where learning and best practice could be identified. For example, the service had identified an increase of fire related incidents, although not related, they called the local fire service to provide training to staff.

## Reporting incidents and learning from when things go wrong

There were robust systems in place to ensure the reporting and monitoring of incidents. The staff used an electronic

system to submit incident reports which were reviewed regularly by management through the governance systems. Themes and trend analysis were conducted to understand how future incidents could be prevented.

Due to a recent increase in violent incidents, the service was in the process of setting up resilience training led by the psychology staff. This was to ensure staff are able to maintain their wellbeing during difficult times.

Staff were debriefed and got feedback after incidents via various platforms. This included through supervision, team meetings, group supervision facilitated by the clinical psychologist, and electronically.

Staff understood what the duty of candour was and were clear on their responsibilities of being open honest and transparent when things go wrong. The service had a duty of candour policy in place to ensure staff had a clear operating procedure to follow.

## 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 used the nationally recognised assessment tool 'Comprehensive Assessment of the At-risk Mental State' to ensure the patients were appropriate for the service.

We reviewed a sample of six care records and found all the care plans to be very individual to the patient. The service used a recovery care plan which had sub-sections relating to different areas of a patient's life. All the care plans identified personal strengths, triggers and coping mechanisms on how the patient could manage their mental health. As well as this, the care plans looked at the patients' individual goals around medication, employment and education. All the care plans were recovery orientated, and we found good examples of the patient progression, for example patients' becoming medication free and being in full time education.

# Community-based mental health services for adults of working age

Staff were regularly reviewing patient care plans and updating them when things changed. This included changes in a patient's risk profile or significant developments within a patient's life. For example, when a patient had become unwell and their risk increased, this had been appropriately reflected within the care plans.

## Best practice in treatment and care

Staff at the service were delivering care and treatment in line with best practice and national guidance. There was good access to psychological intervention, and alternative therapies as well as support around physical health, education and employment.

The service could offer patients a range of psychological interventions approved by National Institute for Health and Care Excellence, including Cognitive Behavioural Therapy in Psychosis. A qualified family therapist in the team also offered family interventions. NHS England outline family therapy as good practice in supporting patients and their families alongside their cognitive behavioural therapy. Patients could access short term psychological intervention with no wait times, as well as more long term intervention. As well as this the service offered alternative therapies recognised by best practice, including 'drama therapy' which supported patients communicating their story through alternative means. Staff were also trained to delivered low level interventions around anger management, resilience and coping mechanisms.

There was a strong focus on psychosocial intervention and this was reflected within staff interviews and care planning. The service had staff specialised in employment, education and housing. This holistic approach to providing care and treatment meant patients were able to address other factors which had a significant impact on their mental health.

The service offered an 'At Risk Mental Health State' (ARMS) intervention for patients who did not meet the criteria for experiencing their first episode of psychosis but were experiencing some mental health issues including anxiety, paranoia and depression. This intervention, recognised by National Institute for Health and Care Excellence, was a newly developed care pathway, which offered six months of intervention including 24 sessions of Cognitive Behavioural Therapy. Patients accessing this service had to be help

seeking and after six months they were either discharged, signposted or offered the full three-year service. At the time of the inspection there were 14 patients receiving this service.

All patients were offered a physical health screening upon entering the service then a yearly check-up thereafter. Of the six care records we reviewed, four patients agreed to having a physical health check done which looked at their body mass index, cholesterol, glucose, smoking and nutrition. We saw examples of staff offering additional support for patients who wanted it, for example, smoking cessation. Where a patient declined a physical health screening staff had documented it on the records.

The service had robust systems to monitor patients on anti-psychotic medication. If patients were in their first year of having anti-psychotic medication, then secondary care services held responsibility to monitor this. The GP took responsibility for monitoring patients on anti-psychotic medication after the first year. All other physical health related issues were reviewed by the patient's GP. The service had a qualified nurse who was the physical health lead, as well as a number of staff who had specialist training like phlebotomy. The physical health lead introduced a variety of initiatives including nutritional packs for patients and a range of physical health activities as part of the interventions.

The service utilised the local trust's clinics as well as its own in supporting patients who were taking anti-psychotic medication which required regular monitoring, such as clozapine and lithium treatments. This meant patients had better accessibility and were more likely to attend the clinics.

Staff used outcome measures recognised by the Royal College of Psychiatry including the 'Health of the Nation Outcome Scale', 'Process of Recovery Questionnaire' and 'Dialogue'.

Staff undertook clinical audits to drive improvement within the service. This included medication audits and patient record audits. The team leaders were responsible for conducting the audits and the registered manager reviewed them and supported staff to address gaps.

## Skilled staff to deliver care

Aspire had a large multidisciplinary team including staff with a range specialist training and qualifications. They had



# Community-based mental health services for adults of working age

nurses, psychologists, psychiatrists, staff qualified in social work, occupational therapy, family therapy and cognitive behavioural therapy. The service received pharmacy support from the local trust. Staff were very experienced and well skilled for their roles. The range of skills and qualifications meant the service was able to meet the needs of the patients.

All staff received a formal induction where they were able to familiarise themselves with the service and its operating procedures. In addition to this, care coordinators were given a protected caseload for a period of time so they could feel comfortable in the role before moving to a full caseload.

There were a number of platforms through which staff could access supervision, this meant staff had good support mechanisms in place to help them in their role. As well as individual management and clinical supervision, staff also had peer supervision and group supervision facilitated by the clinical psychologist. Compliance with supervision was over 90% and annual appraisals was 100%. The service had an effective way to ensure all staff had their annual appraisal, all staff had an appraisal window in which they had to complete it, which meant all staff had to have it around the same period.

We found evidence of managers dealing with staff performance effectively. Where there were concerns with a staff member's performance, a personal development plan was in place to support the them.

## Multi-disciplinary and inter-agency team work

There was effective multidisciplinary working within the service. Staff who were care coordinators had daily morning meetings to review caseloads, absences and to share key information. In addition to this, the service held two 'red board' meetings a week which included all multi-disciplinary staff. The 'red board' meeting was in place so staff could review the most at-risk patients and develop a multi-disciplinary plan around them. Business meeting were held every six weeks and provided a platform for management to discuss the service as a whole, including incidents, lessons learnt, and things that may impact the service as whole.

We found good examples of the service working with the crisis team and sharing information with them early about potential clients who were becoming unwell.

Aspire was a service embedded within the Leeds community. They had good links with other services within the local area including substance misuse services, other mental health services, the local trust, and recreational facilities, including gyms, swimming pools and cafes.

## Adherence to the MHA and the MHA Code of Practice

Staff had good working knowledge of the Mental Health Act and the code of practice. They were clear on what different sections meant and how it impacted on the patients. Compliance with Mental Health Act training was 100%.

We reviewed a sample six of patient care records including those on community treatment orders. A community treatment order is where a patient has been discharged from hospital but has conditions attached to their discharge to ensure compliance with their medication and support. If a patient does not comply with their order, they could be recalled back to hospital. The patient care plans outlined the conditions of the community treatment order to ensure patients and their families were clear on the expectations. Staff were regularly informing patients of their rights and documenting if they felt the patient had understood them or not. Patients had access to a local independent mental health advocacy service.

Staff at Aspire used the local trusts Mental Health Act office for support and advice. Staff and management told us they had a good rapport with this office and felt they could contact them at any time. Mental Health Act audits on Mental Health Act documentation was carried out by the local trust.

## Good practice in applying the MCA

Staff had a good working knowledge of the Mental Capacity Act. They were able to tell us about least restrictive practises and how they adopted the principles throughout their everyday practice. Compliance with Mental Capacity Act Training was 100%.

The service had appropriate support mechanisms in place for staff to develop their understanding around the legislation, including an up to date policy, training and through discussion forums. Staff could also speak to the clinicians and could freely access the Act.

We found examples of consent being sought from patients to share their information. For example, if a member of staff wanted to share information about the care and treatment with family members the care records were clear if the

# Community-based mental health services for adults of working age

patient had given consent. Where staff had concerns about capacity we saw it was discussed in a multi-disciplinary setting and in one case a two-stage mental capacity assessment was conducted. The concerns were decision specific and concluded the patient did have capacity to make decisions around that particular area.

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

Good 

### Kindness, privacy, dignity, respect, compassion and support

Staff were kind compassionate and caring. During appointments, we observed staff treating and interacting with patients with dignity and respect. There was a positive rapport between patients and staff, which was evident through the interaction how well staff knew the patients and the time they had taken to understand their patients.

The patients told us staff were always there for them and they could be relied upon. One patient told us they “could not speak any more highly” about the care and treatment they received. Another patient thought the service was ‘excellent’ and told us if they needed to make a complaint they would but felt they would never have to. Patients felt as though there was a range of support offered to them which wasn’t restricted to just mental health.

Staff were clear about the diverse demographic of people in which the service was being delivered. They were clear on the different cultures, religions and languages within the area and how these factors may impact on the patients and their perception of mental health.

Patients’ confidential information was kept secure. Records demonstrated staff asked for consent from patients to share any information. During the inspection patients were asked if inspectors could shadow the visit. Where patients declined their wishes were respected.

### Involvement in care

### Involvement of Patients

The patient care records had a section where staff could document the views of the patients. All the records we reviewed had the views of the patient. Some records were more detailed than others, however, all clearly reflected the view of the patient.

The service conducted an annual patient survey, the results for 2017/18 were as follows:

- 83 % of patients felt as if their story had been shared and they did not have to repeat themselves
- 97% of patients felt they were treated as a human being with dignity and respect
- 87.5% of patients felt that staff went the extra mile
- 94% of patients felt they could make their own choices and staff supported them through it
- 100% of patients valued their relationship with their worker and felt listened to

In the friends and family test conducted alongside this survey, 62% said they were ‘extremely likely’ to recommend this service and 30% said they were ‘likely’ to recommend it.

Patients were involved with the delivery of the service including the recruitment of staff. There was a patient representative on interview panels to support the recruitment process. As well as this, patients had a two weekly ‘feedback forum’ where they met together in the local community to discuss the service, types of activities they would like to do, and things the service could do differently.

The service had mandatory training around ‘service user involvement’, staff had a compliance rate of 97%.

Advocacy services were available for patients to access.

### Involvement of families and carers

Staff involved carers and families within the delivery of care and treatment for the patients, where this was agreed by patients. This was evidenced within the care records and the carers we spoke with. The care records had a section where staff could document the views of the carer and we saw shared goals between them and the patient. Care plans incorporated specific family members as protective factors within the treatment for patients. This demonstrated how well staff knew the families and how they could play a key role in the patient’s recovery journey.



# Community-based mental health services for adults of working age

The service held monthly carer groups where families of patients could meet their peers and have discussions about the service, receive peer support and address any issues. In addition, Aspire used this platform to deliver training sessions to families and carers which could support them in caring for patients.

As well as supporting carers and families internally, the service would refer carers to a voluntary organisation for a carers assessment and additional support.

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

Good 

## Access and discharge

The service had a clear referral criteria for patients to access this service. Staff undertook a nationally recognised assessment framework to ensure patients met the criteria for the service. If patients did not meet the criteria the service signposted appropriately, or offered a six month 'At Risk Mental State' (ARMS) intervention. The service had an open referral system which meant patients could be referred from a range of services, this increased accessibility for patients to receive the appropriate care.

Access to treatment time standards require early intervention services to have a two week referral to treatment target. The service was meeting this target and there were no patients waiting to be allocated to a care coordinator at the time of inspection.

There was a total of 405 patients on the caseload for Aspire at the time of inspection. In the last 12 months the service had 182 new patients enter the service and 139 discharged from the service. The service discharged 71% of the patients in the last year back into primary care. This meant that the three-year intervention was successful and patients no longer required further statutory mental health services. The remaining 29% of patients were referred onto community mental health services with the local trust for longer term treatment.

Patients were not left waiting once they had been approved to receive support from the early intervention services. Staff held daily morning meetings to assign newly referred patients to a care coordinator.

The service used the local trust's crisis service. Patients could access crisis support out of hours and on weekends should they require it. All the patient care records had a crisis plan where patients were provided with the appropriate details. Staff said they had a good relationship with the crisis team and engaged with them early if they felt the patient was becoming unwell. This meant the crisis team were prepared if the patient required out of hours support.

The team were flexible when working with patients, aiming to engage them as best they could. They accommodated last minute cancellations and re-scheduled appointments. Staff were responsive if a patient required an earlier appointment and had enough autonomy to ensure they were able to meet the needs of the patient. Where a patient disengaged and there were identified risks, staff presented them at the 'red board' meeting to discuss as a wider team how they could re-engage the patient or their family.

The service used mobile phones as a way of communicating with patients including texting reminders for appointments, as well as sending appointment letters. Staff spoke with patients about their preference.

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

The service had a range of therapy rooms which could facilitate group work or one to one sessions. The rooms were adequately equipped and were comfortable. As well as this the service had its own kitchen for patients to access hot drinks and snacks and a clinic room. Majority of the appointments were facilitated within the community.

The service was in the process of moving to new premises in January 2019, with improved facilities and more space. This was primarily due to the increase in work force and expansion of the service.

## Patients' engagement with the wider community

The service ensured they provided patients with a holistic approach towards recovery. Staff responsible for

# Community-based mental health services for adults of working age

education, employment and housing were embedded in the team. This meant they were able to support patients who required support on wider social issues which impacted on their mental health.

We saw staff were working closely with the patients' families and carers. This was reflected within the care plans and risk assessments. In two records we found the family were a protective factor for the patient and key to their recovery journey. In addition, the service had platforms to support carers and families to ensure they were in touch with the service.

The service had good links with the wider community including voluntary sector and private organisations. A well-known coffee outlet supported the service to facilitate group sessions. In addition staff supported patients access local provisions such as gyms, museums and other leisure facilities.

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

There was appropriate access for people with mobility issues or a disability. The service had a lift access.

The service ensured it was able to support the communication needs of the patients it served. Due to the diverse demographic of the Leeds region the service produced information leaflets in a range of languages. They had recently undertaken an audit to establish the top four languages spoken in the area and created crisis cards in those languages.

The service paid for staff to use a language app, so they could communicate with patients where there were language barriers. In addition, staff could request language interpreters and British Sign Language interpreters. Information could also be provided in an easy read format for patients with learning disabilities.

Patients who were on community treatment orders had information leaflets outlining their rights. Staff also verbally informed them of their rights on a regular basis.

## Listening to and learning from concerns and complaints

In the last 12 months the service received three complaints of which one was upheld and one partially upheld. None of the complaints were taken to the ombudsman. There were no trends with the complaints and the service aimed to resolve the issues raised by the patients where possible.

For example, a patient made a complaint about their medication; their regime was reviewed by the doctor and changed. In contrast the service received 24 compliments in the last 12 months.

There was a robust complaints procedure in place with appropriate oversight from senior management. The service provided information to patients on how to complain. Staff told us they would support patients in making complaints if they required it. The registered manager told us they would try to resolve issues informally, which in most cases was sufficient. The patients we spoke to told us they would be happy to make a complaint and felt confident to do so.

Feedback and learning from complaints was communicated to staff through the business meetings, or other electronic communication, such as newsletters.

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

Good 

## Leadership

The service had strong leadership. Management were knowledgeable, experienced and knew the service well. The registered manager held the position for over three years, and was well established within the team. Managers within the organisation understood the organisational vision and strategy.

Leaders were visible. The regional director attended the service on a regular basis and the registered manager situated herself amongst staff so she was easily accessible. The service allowed newly employed staff to meet the regional director and / or chief executive for a personal meeting. This was to break down barriers and to ensure new staff felt comfortable and confident with the organisation.

The service offered development opportunities for aspiring leaders within the organisation. Staff could undergo management training if it was appropriate for their role. In addition, they offered team leaders a shadowing opportunity to work closely with regional directors to help them understand the role and the skills needed.

# Community-based mental health services for adults of working age

## Vision and strategy

Aspire launched its new strategic plan for the organisation in April 2018 after consultation with stakeholders including employees, service users, trustees, volunteers, commissioners and partners. The vision was “world of wellbeing” and its values included:

- Behaving with integrity – we are trust worthy open and honest
- Embracing individuality – we accept people as their authentic selves, respecting diversity and acknowledging disadvantage
- Valuing people – with service users at the heart of everything we do we support our employees, volunteers and trustees to be the best they can
- Taking pride in what we do – we are committed to do things better and give it everything we’ve got
- Achieving excellence – we embrace new thinking to deliver quality, safe, effective and responsive services.

Staff adopted the spirit of Aspire’s vision and values through their work, which they demonstrated through the interaction with patients we observed, their passion and knowledge. In addition, the service used a values-based interview methodology and the values were embedded within the annual appraisal process.

The senior management were well versed with the organisations strategy and the direction in which Aspire was going.

## Culture

There was a positive culture and strong team ethic within the organisation. Staff felt well supported and valued. Staff were proud to work for the organisation and felt a strong sense of work satisfaction. The overall moral within the teams was very positive.

Staff told us they were comfortable in raising any concerns to management and felt concerns were taken seriously. Staff were aware of the whistleblowing process and there was a policy in place to support them.

The service was addressing poor performance through supporting staff in supervision and creating a personal development plan. The service took a proactive approach to this, aiming to get the best out of their workforce. Staff

were supported in other ways including a staff wellbeing service which offered additional benefits to their employment. This included financial, physical and occupational health associated benefits.

## Governance

The service had several different regular staff meetings which regularly reviewed quality and performance. Incidents were reviewed in a number of separate meetings. The service produced a quarterly incident trend analysis report which reviewed the themes and trends of incidents and where possible planned actions to reduce incidents. The service monitored key performance indicators in a number of specialist reports and in a specific monthly key performance indicators report.

Mandatory training compliance was high with all of modules at or above the service’s minimum compliance target of 75%. Supervision was monitored and showed good compliance. All staff received an annual appraisal in quarter one of 2018/19. Staff files showed that the service met Regulation 19 requirements for fit and proper persons employed (staff).

The service had a risk register. There was evidence that the risk register had been reviewed recently and risk controls had been updated. Environmental risks including risk from ligature and fire were assessed. The service had an annual audit which ensured that checks to maintain health and safety were completed. Significant concerns were escalated to the regional director where it was reviewed and appropriately actioned.

## Management of risk, issues and performance

The service had an up to date risk register which was reviewed regularly. All associated risks had actions and responsibilities linked to them. The registered manager and regional director had oversight on these risks. Staff at all levels felt they were able to escalate concerns to management for it to be reviewed and put on the risk register.

We saw evidence of business continuity plans. In the event of an emergency the service had measures in place to ensure the safe running of the business.

# Community-based mental health services for adults of working age

The service was expanding and had been commissioned to do this. As a result, the team had significantly increased in the last 12 months with a range of staff at all levels. To factor in the growth of the service, the service was scheduled to move to bigger premises in January 2019.

## Information management

Staff had a sound understanding of information governance. Their compliance rates with mandatory training in Information Governance was 76% and General Data Protection Regulation was 100%.

Staff had appropriate access to the information systems they needed. The systems were secure and could only be accessed by authorised staff. All patient records were electronic which meant there was one central system staff could use. Staff had personal laptops with password access.

Team leaders could support management effectively in the running of the service; they had access to important data including key performance indicators, staff and patient information. There were no concerns raised by staff in relation to the information systems within the organisation.

The service made appropriate notifications to the relative bodies as part of their regulatory obligations including the local authority and the Care Quality Commission.

## Engagement

Staff received electronic newsletters to update them about any changes or developments within the service. In addition, staff were communicated with via email and through team meetings.

Patients undertook annual surveys to provide feedback on the service. Aspire utilised a mobile application to help patients complete the surveys. Since moving to the application, the service noticed an increased response rate. In addition to this the service facilitated group sessions twice a month to discuss the running of the service, the types of activities patients would like to take, and to gather

feedback. Patients were also involved in the recruitment process, sitting on the interview panel for all applicants. There were patient representatives within different levels of the organisation ensuring their views and opinions were embedded within decision making.

When the service revised its vision in 2018, a range of stake holders including staff and patients were catalysts in decision making.

The service was well established within the local community working closely with key stake holders including commissioners, local authorities and the local trust.

## Learning, continuous improvement and innovation

Aspire were involved in continuous development to improve their service through undertaking national audits and participating in research.

The service was in its first year of the 'National Clinical Audit of Psychosis' (NCAP) which is a three-year quality improvement programme looking at how services can improve care being delivered to people with psychosis. In addition to this the service was also taking part in the Royal College of Psychiatrists 'College Centre for Quality Improvement (CCQI)' which reviews services against established guidelines and standards with the aim of supporting services to improve the quality of care they offer.

The service offered a range of psychosocial interventions, and also offered alternative therapies such as 'drama therapy'. This therapy looks at supporting patients who struggle to communicate verbally and works to established other avenues of them delivering their story.

Staff in the service were working with a researcher to look at the impact of using virtual reality as a form of therapy. Although still in its early stages, the service was keen on ensuring they were part of any developments or pilots for this form of therapy.

# Outstanding practice and areas for improvement

## Outstanding practice

Staff at the service were offering alternative therapies, such as drama therapy. This therapy is recognised by the National Institute for Health and Care Excellence as

second or third line of intervention due to the resource needed. However, Aspire were offering these as part of their standard interventions to patients where this was appropriate.