Good

Birmingham and Solihull Mental Health NHS Trust

Community-based crisis services

Quality Report

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Locations inspected

Name of CQC registered location	Location ID	Name of service (e.g. ward/ unit/team)	Postcode of service (ward/ unit/ team)
Trust Headquarters	RXTC1	Central Home Treatment Team Sparbrook Home Treatment Team	B114HL
Trust Headquarters	RXTC1	Handsworth Home Treatment Team Ladywood Home Treatment Team	B19 1AG
Trust Headquarters	RXTC1	Central Assertive Outreach Team	B7 4JN
Trust Headquarters	RXTC1	Bed Management Team	
Trust Headquarters	RXTC1	Single Point of Access Team	B23 6OJ
Trust Headquarters	RXTC1	Rapid Assessment, Interface and Discharge	B75 7RR

Summary of findings

This report describes our judgement of the quality of care provided within this core service by Birmingham and Solihull Mental Health NHS 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 Birmingham and Solihull Mental Health NHS Trust and these are brought together to inform our overall judgement of Birmingham and Solihull Mental Health NHS 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 Community-Based Crisis Services	Good
Are Community-Based Crisis Services safe?	Good
Are Community-Based Crisis Services effective?	Good
Are Community-Based Crisis Services caring?	Good
Are Community-Based Crisis Services responsive?	Good
Are Community-Based Crisis 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

This service was safe. We saw that safeguarding and incident reporting mechanisms were well established within the teams. Staff told us that specific feedback regarding incidents reported was variable following changes regarding the input from social services. Lessons learnt from incidents relating to the service and in the wider trust were included in the agenda for monthly team meetings. We saw that risk assessments and care plans were updated and reviewed.

The service was effective. We saw that professionals worked together to ensure that all the needs of people who used services were met. The service provided a range of evidence based psychological therapies. Audits were undertaken by managers and provided to the governance team. Caseloads and capacity were monitored by the team manager through regular team meetings and monthly supervision. The provision of supervision, preceptorship and induction for staff was established.

We found the services provided by the trust had caring and compassionate staff that worked across the service.

We saw that staff worked positively with people and supported them well. Staff were skilled and knowledgeable so that they could respond to people's individual needs and preferences.

The service was responsive. We saw that people accessed the services by home visits or in some cases by attending the team base according to individual need and assessed risk. Services had been developed in consultation with local people. People who used services were given information about how to access help out of hours.

We saw evidence of trust-wide learning from complaints and incidents. We observed many examples of positive working relationships.

The service was well-led. Staff were dedicated and felt well supported by management. Some staff groups told us that they had attended the 'listening into action forum'. We saw a supportive culture within teams. Examples of the various team and management meetings and events demonstrated that staff were consulted about the trust's future plans. Staff had a broad understanding of the current and future need of the organisation. A trust-wide risk register was in place to identify risks to the trust, staff and people using services.

Summary of findings

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

Are services safe?

Good

We saw that safeguarding and incident reporting mechanisms were well established within the teams. Staff told us that specific feedback about incidents was variable within the teams since social care staff had been withdrawn from the City of Birmingham teams.

Lessons learnt from incidents relating to the teams, and in the wider trust, were included in the agenda for monthly team meetings. We saw that risk assessments and care plans were updated and reviewed.

Are services effective?

Good

We saw that professionals worked together to ensure that all the needs of people who used services were met. The service provided a range of evidence-based psychological therapies. Managers carried out audits and provided them to the governance team. Caseloads and capacity were monitored by the team manager through regular team meetings and monthly supervision. Provision of supervision, preceptorship and induction for staff was established.

Are services caring?

Good

People using services told us they were treated with dignity and respect. Clinicians were skilled and knowledgeable. Staff used language that was compassionate, clear and simple. Appropriate literature and information was freely available for people using services. Staff provided support for social and domestic issues for gaps in availability of community resources.

Are services responsive to people's needs?

Good

People accessed the services by home visits or, in some cases, by attending the team base according to individual need and assessed risk. Services had been developed in consultation with local people. People using services were given information about how to access help out of hours. We saw evidence of trust-wide learning from complaints and incidents. People in need of urgent assessment out of hours were directed to use the bed management team who acted as a triage and access to crisis services. We observed teams working in collaboration and saw many examples of positive working relationships.

Are services well-led?

Good

Staff were dedicated and felt well supported by management. Some staff groups told us that they had attended the 'listening into action forum'. We saw a supportive culture within teams. Examples of the various team and management meetings and events demonstrated

Summary of findings

that staff were consulted about the trust's future plans. Staff had a broad understanding of the current and future needs of the organisation. People using the service were regularly asked for their comments and opinions about the service. A trust-wide risk register was in place to oversee and identify risks to the trust, staff and people using services. Staff could use a variety of supervision support on a regular basis.

Summary of findings

Background to the service

Central Assertive Outreach Team (AOT)

This service provided mental health services within people's homes. The office was situated at Hobart Croft, Nechells in a refurbished church. Other services were also located in this building. The AOT team was recovery oriented and offered tailored packages of care and a variety of care pathways for people experiencing serious and/or enduring mental health problems. Services were offered to people aged 18-64.

Home Treatment Teams

This service supported people who have a severe mental illness, such as schizophrenia, manic depressive disorders, or severe depressive disorder. Some patients may also have substance misuse and alcohol problems (which are called a dual diagnosis). Patients treated by this service were having an acute psychiatric crisis of such severity that, without the involvement of the service, hospitalisation would be necessary.

Rapid Assessment, Interface and Discharge (RAID)

RAID was a specialist multi-disciplinary mental health service, working within all acute hospitals in Birmingham, for people aged over 16.

Bed Management Team

The bed management team manages a 24-hour service and place people in services and manage trust bed capacity. It aims to ensure and promote safe and clinically appropriate placement of people within the Trust. This includes everyone aged 18 and over, who are deemed to be in need of inpatient care by the relevant home treatment team or assertive outreach team (following recorded liaison with home treatment) or early intervention service and RAID.

Single Point of Access Team

The team triaged all referrals from GPs primarily to adult, older adult, youth services and addiction services. They also processed referrals from RAID and Birmingham healthy minds onwards into secondary care services. The team screened records and then triaged referrals to the appropriate team using similar criteria for similar services for example adult community mental health teams.

Our inspection team

Our inspection team was led by:

Chair: Dr Peter Jarrett

Team Leader: Julie Meikle, Care Quality Commission

The team included CQC inspectors and a variety of specialists.

The team that inspected these services consisted of a CQC inspector, Mental Health Act Commissioners, Nurses, Social workers and an Expert by Experience who was a person who had previously used mental health services.

Why we carried out this inspection

We inspected this core service as part of our comprehensive Wave 2 pilot mental health inspection programme.

Summary of findings

How we carried out this inspection

To get to the heart of people who use services' experience of care, we always ask the following five questions of every service and provider:

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

Before visiting, we reviewed a range of information we hold about the core service and asked other organisations to share what they knew. We carried out visits between 13 and 15 May 2014.

We undertook site visits to the teams' bases. During the visit we held focus groups with a range of staff who worked within the service, such as nurses, doctors and therapists. We observed how people were being cared for and reviewed care or treatment records of people who use services. We met and spoke with people who use services who shared their views and experiences of the core service.

This assisted the Care Quality Commission to obtain a view of the experiences of people who used this service.

What people who use the provider's services say

People said that they received compassionate and professional care from staff. They told us they were involved in the planning and treatment of their care and they could consent to their care and treatment as well as discussing and agreeing treatment options with staff.

People were very positive about the services they received and described staff as 'professional', 'caring', 'compassionate' and 'friendly'. We saw examples of how people were consulted about their care and treatment. The trust carried out surveys about the services provided and these showed us that there was a general satisfaction with these.

Good practice

- Staff received ongoing training in psychological therapy.
- Non-medical prescribing leads were in place for prompt assessment and treatment.
- Safeguarding practices were safe and staff were knowledgeable regarding making appropriate referrals.

Areas for improvement

Action the provider MUST or SHOULD take to improve

- The trust should ensure that improvements are made to demonstrate that the teams and the pharmacy audited the stocks of medications for administration to people, so that medicines are stored safely at all times and appropriate stocks of medicines stored on site.

Birmingham and Solihull Mental Health NHS Trust

Community-based crisis services

Detailed findings

Locations inspected

Name of service (e.g. ward/unit/team)	Name of CQC registered location
Central Home Treatment Team Sparbrook Home Treatment Team	Trust Headquarters
Handsworth Home Treatment Team Ladywood Home Treatment Team	Trust Headquarters
Central Assertive Outreach Team	Trust Headquarters
Bed Management Team	Trust Headquarters
Single Point of Access Team	Trust Headquarters
Rapid Assessment, Interface and Discharge	Trust Headquarters

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.

We saw information about the Mental Health Act was available in areas that people accessed. We saw this was made available in different languages and an interpreter service was available to people.

Records we looked at for people under a Community Treatment Order (CTO) were comprehensive with evidence of people's involvement and multi-disciplinary review. Records seen demonstrated that staff had received training on this Act.

Detailed findings

Mental Capacity Act and Deprivation of Liberty Safeguards

Staff were aware of their responsibilities under the Mental Capacity Act and were able to demonstrate, through some of the treatment records seen, how they recognised, responded and raised issues about mental capacity. Records seen demonstrated that staff had received training on this Act.

Good

Are services safe?

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

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

Summary of findings

We saw that safeguarding and incident reporting mechanisms were well established within the teams. Staff told us that specific feedback about incidents was variable within the teams since social care staff had been withdrawn from the City of Birmingham teams.

Lessons learnt from incidents relating to the teams, and in the wider trust, were included in the agenda for monthly team meetings. We saw that risk assessments and care plans were updated and reviewed.

Our findings

Track record on safety

Staff were trained in safeguarding vulnerable adults and children and were knowledgeable about their responsibilities regarding the safeguarding process. They described the process for referring any identified potential or actual concerns to the relevant department. The trust policies and procedures were accessible on the trust's own intranet site. They told us concerns were discussed with line managers. Safeguarding referrals were made to Birmingham City Council. We noted that in the City of Birmingham teams the local authority had removed the social care staff they employed from the home treatment teams There were concerns over the delays in receiving a response from the City Council about safeguarding referrals being acknowledged and resources allocated. We were not told about any individual risks to patients as a result.

Staff confirmed that the trust had an online reporting system to report and record incidents and near misses. We saw that staff had access to this system via 'password' protected computers. The trust wide evidence provided showed us that the trust was reporting concerns through the National Reporting and Learning System (NRLS). The levels of reporting were within expectations for a trust of this size.

Learning from incidents and improving safety standards

The trust's serious incident data showed us that trust wide learning from serious incidents had been reviewed by the Governance Intelligence Team and disseminated throughout the trust. Staff confirmed this and reported that the lessons learnt from these incidents had been discussed within their specific team and disseminated through the trust. We saw copies of the trusts online safety bulletins that provided information and guidance for staff to follow. Most members of staff were aware of the safety bulletins and we were told they were discussed at larger team meetings. Further trust wide learning was evidenced through the trust's online newsletter. This included updates and 'key messages' for staff. The evidence seen showed us that the trust had embedded learning from incidents within the organisation.

Staff confirmed that they had received risk assessment training and told us that they felt well supported by their line manager following any safety incidents.

Staff told us they used the trust's electronic incident reporting system, Eclipse for reporting any incidents, concerns or near misses. Feedback regarding incidents reports they had made was variable across and within the teams. However, we saw that feedback from serious untoward incidents was fed back to the individuals involved and wider trust incidents distributed by email globally. Lessons learnt from incidents relating to the team, and the wider trust, were included in the agenda for monthly team meetings. Managers told us action plans were developed from investigations and lessons learnt circulated throughout the trust with feedback given to specific teams. Staff told us they were supported and debriefed by their manager following any incidents that occurred when they felt unsafe. Managers were described as supportive.

Reliable systems, processes and practices to keep people safe and safeguarded from abuse

We saw there was information displayed in the team and patient's facilities on each site about the trust's

Good

Are services safe?

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safeguarding adult's policy. This was also available via the trust's intranet system so staff had been given the required guidance in order to support them to raise concerns when these were identified.

Staff were aware of the trust's safeguarding and other polices. They told us that they knew how to raise any safeguarding concerns. This was demonstrated by some of those individual treatment records seen. These showed us that risk assessments had been completed and identified if people were at risk of exploitation or were vulnerable due to their mental health needs. Staff were also aware of their responsibilities under the Mental Capacity Act and were able to demonstrate through some of the treatment records seen, how they recognised, responded and raised issues about mental capacity.

Staff were aware of the trust's whistleblowing policy and confirmed that they felt able to raise concerns with their direct line manager. Staff were included in the focus groups about the service improvement plan and there was a regular update on developments on the Trust's intranet.

We saw that medication was appropriately administered, securely stored and the keys were stored safely. Medicines management was seen to be effective with yearly audits undertaken by pharmacy. We found that there were suitable medicine management systems in place for the receipt, storage, administration and recording of information in most of the services visited

The monitoring systems in place should be improved in some services. Examples were seen of medication for intramuscular injection being ordered to be kept on site for use by community staff on site or in people's homes. This included medicines prescribed and supplied by the trust as part of people's treatment. In some teams medicines removed from safe storage to be administered to people were signed out and back in by community staff to ensure medications were handled appropriately. These arrangements were not consistent across the teams. The evidence seen showed us that improvements should be made by the trust to demonstrate that medications were signed in and out by staff in all services.

Records management was electronic and used the RIO system. Staff said they had good access to patient information and could record a detailed picture and background of individual risks to staff. We saw that care plans and risk assessments were generally completed within 48 hours of referral to the teams.

Assessing and monitoring safety and risk

We observed handovers and sat in on two multi-disciplinary meetings during our visit to the teams. These appeared well planned and organised. Each person currently receiving care was discussed especially those who were known to be of a higher risk, including any new referrals for follow up. Appropriate sharing of information to ensure continuity and safety of care was observed. On receipt of a referral people were seen within 24 to 72 hours of referral for assessment. Referrals were accepted by the recently formed single point of access team. Examples were seen of referrals from the bed management team, community mental health teams, inpatient services, accident and emergency and GP.

We reviewed six electronic records. Safeguarding and abuse issues were considered within the assessment document. We saw that staff worked jointly with other agencies and across services to promote safety. Caseloads and capacity were monitored by the team manager through daily and weekly meetings as well as monthly supervision. These supervisions included discussion around referrals, discharges and levels of risk which established capacity for new referrals. Levels of caseloads had agreed limits in the yet to be introduced service improvement plan. We saw case loads of up to 30 people in home treatment teams and 10 in assertive outreach.

In the single point of access service every person was contacted by staff prior to a triage decision being made about which service they were referred to. There were clear pathways in place for staff to refer people to other services within the trust. In the early stages of this service other senior managers had told us the service was assessing people within the timescales set and some referrals to the respective teams were not always appropriate but this was seen as at 'teething problem'. Managers told us there was weekly monitoring of the service and a review of performance after six months.

Concerns about patients walking out of the A&E department without being seen had been addressed by the

Good

Are services safe?

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

RAID team. A system had been put in place that informed the GP by fax of people's presenting at A&E. If required the police were informed about individual concerns and carried out a welfare check on the individual.

Understanding and management of foreseeable risks

Electronic records seen showed us that people who had recently been assessed by the single point of access team or bed management team had an initial risk assessment completed over the telephone to determine which service they would be directed to and the level of risk determined how quickly they could access services. We saw that referrals were seen within 24 to 72 hours.

Risk assessments were seen in those other records reviewed and these included assessments of the person's physical health and their risks to self or others where appropriate. Evidence was seen of the active involvement of the person in assessing risks for themselves. For example, linked to their discussions with their community mental health nurse, care coordinator or consultant psychiatrist. These assessed identified risks had a clear and relevant care plan in place that showed the involvement of the person themselves.

We saw good examples of risk assessments and subsequent care plans linked to those Community Treatment Orders (CTO) reviewed during our inspection.

Staff told us that they had received induction and training to prepare them for their role and were supported by their line manager. Each member of staff spoken with told us that they received supervisions and annual appraisals from their line manager as required.

Staff confirmed that systems were in place to monitor staff sickness and that they had access to occupational health support. Most staff told us that they felt well supported by their line manager.

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.

Summary of findings

We saw that professionals worked together to ensure that all the needs of people who used services were met. The service provided a range of evidence-based psychological therapies. Managers carried out audits and provided them to the governance team. Caseloads and capacity were monitored by the team manager through regular team meetings and monthly supervision. Provision of supervision, preceptorship and induction for staff was established.

Our findings

Assessment and delivery of care and treatment

We looked at records and saw that care plans were outcome based and reflected progress in achieving aims. Progress notes linked to the care plan in place. Records we were shown were person centred and demonstrated people's involvement. People told us they were aware of their care plans and they had been involved in their reviews.

We saw good evidence of comprehensive assessment by medical and nursing staff on initial contact and they had covered all aspects of care as part of a holistic assessment. However we saw in home treatment teams that the risk assessment of people on the safety boards used could have been improved.

Teams offered a good range of evidence based psychological therapies. People told us that they had benefitted from psychological therapies and understood the treatment contract about engaging in psychological therapy.

Staff were able to discuss issues around consent and capacity and how to undertake or organise an assessment for people as necessary. Mental Capacity Act and Deprivation of Liberty Safeguards are part of mandatory training programme.

Bed management took referrals from the person who has assessed the patient. This was often taken from the doctor and nurse involved or advanced mental health practitioner (AMHP) if this was a Mental Health Act Assessment. Staff told us that they referred people mainly to the assertive outreach and home treatment teams for crisis intervention and as an alternative to hospital admission.

The winter pressure initiative had enabled the RAID team to appoint an approved mental health practitioner (AHMP) to the service. This has meant the waiting time for Mental Health Act assessments had improved Senior staff highlighted that a new protocol was recently introduced allows staff to support people who presented at A&E with a minimal overdose and are not under the influence of alcohol. Mental health staff can engage with people with this presentation and start to plan their care rather than the previous working arrangement of having to wait for them to be assessed as medically fit by a doctor.

Outcomes for people using services

We saw a monthly audit tool completed by managers covering areas such as health and safety and records. Feedback about performance was shared with managers for action.

Staff, equipment and facilities

Staff told us they were supported to undertake training outside of mandatory training. We saw a robust supervision process in place. Staff received management supervision monthly. Performance issues and caseload capacity were imbedded in this process. This included specialist supervision, for Approved Mental Health Professionals (AMHP) and non-medical prescribers. Senior medical staff told us they had regular organised peer group supervision.

Teams we visited had daily or twice daily handover meetings, weekly clinical meeting for case discussion and also a monthly team meeting for more team related issues, which included information sharing.

Community staff had alcohol gel available to them as part of the infection control policy when visiting people in the community.

We saw the clinical areas were well equipped and included equipment for monitoring people's weight, blood pressure and heart. Clinics contained safe storage for medicines stored on site; we saw that the clinics had suitable supplies of personal protective equipment, syringes, needles and sharps boxes. We saw that equipment was checked for safety and safe working.

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.

In the single point of access team we were told initially there was no cover for sickness, leave or training. Staff said this was now being reviewed in light of the volumes of referrals the team was receiving. We saw evidence that staff had received three weeks induction training and live referrals on the electronic records system.

The RAID team manager told us they had supervision with their line manager every six weeks and for team members with the team manager every eight weeks as a maximum. Staff told us the manager was available for consultation and supervision.

Multi-disciplinary working

Requests for social worker input for patients in the Birmingham teams has to be made via the local authority as social work staff were no longer integrated into home treatment teams. The central assertive outreach team had social workers based in it.

Information on patients subject to the Care Programme Approach was shared on the electronic system which both health and social work staff could access. Documents were scanned into the social services database to share information about risk management and care plans.

Staff told us in all the teams we visited that capacity to meet demand was challenging but there was good team support from more senior nurses and manager. Staff were aware of the service improvement plan and the updates on the trust's intranet about the development and implementation of this. Staff could not say how this would impact upon them but did not raise any concerns about the plan.

In all the teams we visited staff described positive relationships with other services. This meant that a multi-disciplinary approach to care and treatment was optimal.

Multi-disciplinary team were made up of, or had input from, occupational therapists, nurses, social workers and medical staff. A good relationship was reported between the crisis teams and other mental health services.

The bed management team said they worked with the home treatment team consultant psychiatrists who were the gatekeepers to inpatients beds. There were only three routes in to the bed management process. Home treatment teams, assertive outreach and rapid assessment intervention and diversion team based within accident and emergencies. This meant that in patients beds were allocated dependent upon need and the crisis services could support people as an alternative to hospitalisation if appropriate.

In the single point of access team we saw that people could not access the site and there was no walk in service. This service only opened three weeks ago. The staff we spoke with were very positive about the service and initial period of operation. The current referral rate to the team was approximately 80 to 09 faxes a day. Five triage nurses deal with the referral process and make contact with the people referred. The manager said the main concern about multi-disciplinary working was that community mental health teams were disregarding the recommended one to seven days' timescale for seeing a person for assessment and were moving people into outpatient's appointments of up to four weeks.

Mental Health Act (MHA)

We saw information about the MHA was available in areas that people accessed. We saw this was made available in different languages and an interpreter service was available to people.

Records we looked at for people under a Community Treatment Order (CTO) were comprehensive with evidence of people's involvement and multi-disciplinary review.

Good

Are services caring?

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

Summary of findings

People using services told us they were treated with dignity and respect. Clinicians were skilled and knowledgeable. Staff used language that was compassionate, clear and simple. Appropriate literature and information was freely available for people using services. Staff provided support for social and domestic issues for gaps in availability of community resources.

Our findings

Kindness, dignity and respect

We spoke with ten people who used services and one carer. People were very complimentary about the care and treatment they received. One person told us, "They are always there at the end of the phone. If times get tough they never let me down".

We saw staff were compassionate, warm, friendly, positive and engaging with people. People did not visit the office base and were seen at home. We managed to speak with two people who were attending the out patent clinic on one site. These two people were also supported by the home treatment service.

In the assessment we saw and the records reviewed, we found that people's cultural needs and personal preferences were included as part of the assessment. There was a good mix of staff from different cultural backgrounds which reflected the ethnicity of the local communities.

Staff in the RAID team seemed passionate about their role. One senior nurse said they thought the service was 'inconsistent' We were not given any specific example of how the service was inconsistent. However, they went onto say that the team had, "Really great experienced staff, but I would not want to be without them".

People using services involvement

People we spoke with understood their medication, its use and described side effects demonstrating clear education provided around this. Outpatient clinics also contained patient information leaflets about the range of medications used.

People demonstrated they had a clear understanding about their mental illness and were able to discuss how medication impacted upon them. For example one person told us their consultant psychiatrist advised that the antipsychotic medication should be changed as they were not benefitting from the one prescribed.

Staff were clear about how to secure advocacy services for people but said there were long waiting lists for advocacy services. People told us the social care staff working within teams had supported them to access services and advocated when necessary.

Appropriate literature and information was seen that people were routinely provided with throughout their treatment. These were available as necessary in a variety of accessible formats. People told us that written information was available about other services. The carer of one person we spoke with said there was information available about other charitable and voluntary service to support people with mental health needs. As a result their family member attended a day centre and accessed social support and activities.

Emotional support for care and treatment

We met and spoke with two people and a carer who used the home treatment team. Staff we met with from assertive outreach and home treatment told us that people's carers were involved in their assessment and care planning. In all the care plans we sampled there was evidence that carers were involved where possible.

The carer of a person using the home treatment team told us that they were satisfied with the service provided.

Are services responsive to people's needs?

Good

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

Summary of findings

People accessed the services by home visits or, in some cases, by attending the team base according to individual need and assessed risk. Services had been developed in consultation with local people. People using services were given information about how to access help out of hours. We saw evidence of trust-wide learning from complaints and incidents. People in need of urgent assessment out of hours were directed to use the bed management team who acted as a triage and access to crisis services. We observed teams working in collaboration and saw many examples of positive working relationships.

Our findings

Planning and delivering services

The home treatment team was accessed by referral from General Practitioners via the community mental health team (CMHT) duty system during normal working hours. Otherwise it was through out of hours services, other primary care health professionals, secondary care inpatient, police stations and A&E departments. People that use services and their carers who were in the care of the service had direct access to the relevant team via locally agreed arrangements.

People and their carers, who were being cared for by the assertive outreach team, and who were in crisis outside of established working office hours, were given direct access as support. This was a potential fall back to presenting at local accident and emergency services.

The home treatment teams were able to provide telephone support and in a crisis assess people if the bed management team arranged this. Community mental health teams could alert the home treatment and bed management teams of any pending crisis. This meant that appropriate systems to share information with other services were established.

Staff informed us that people needing an inpatient bed had to access this through the bed management team. The bed management team operated twenty four hours a day, seven days a week, and accessed inpatient beds in and outside of the trust.

Right care at the right time

We saw that following referral people were seen by the home treatment or assertive outreach services within 24 to 72 hours. Assertive outreach teams work from 08:00 to 19:00 and home treatment teams offered a twenty four hour service.

The single point of access team was based at Northcroft Hospital and offered a telephone referral service for the whole trust and GPs. This is an eighteen plus ageless service led by nurses. There are no medical staff in the team. A triage service is offered at three levels. Level 1 a response within 2 hours, level 2 a response within 24 hours and level 3 within 7 days. Different colour codes are used for each response level for referrals. The team operated Monday to Friday 08:00 to 19:00.

Development of a non-medical prescriber assessment role was developed as part of the service. Crisis teams had non-medical prescriber nurses based in them. We spoke with two of the non-medical prescribing staff. We saw one treatment plan for a person people being supported by one of these staff. Staff told us this role was functioning well. The clinical team manager for the assertive outreach team demonstrated how they were prescribing anti-psychotic medication for one person. They showed us the process and the guidelines that they worked within. The staff told us they had been supported to complete the required additional training and had been supervised through their personal development.

Care Pathway

Staff told us that all members of the team were valued and respected regardless of discipline or level of seniority. We saw how team members worked collaboratively and worked well together. Transfer of care between teams and people living out of the area was said to be slow for some people due to the capacity of the teams where people were being transferred. Staff gave us several examples of how they kept these people on their caseload until the transfer had been completed so people still received the support to continue with their care pathway.

Staff were clear about the lines of accountability and who to escalate any concerns. Staff were able to describe the other services involved in people's care pathways and how the home treatment and assertive outreach teams fitted into it.

Are services responsive to people's needs?

Good

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

The teams were involved with people prior to their discharge from inpatient wards and requiring assertive outreach or home treatment follow up. Staff from the respective teams linked into inpatient and other teams multi-disciplinary and discharge planning meetings. This meant people's transition back into the community was not unnecessarily delayed.

Within teams initial triage was undertaken with people being referred either by phone or face to face to agree upon the immediate plan of care and level of contact. This had a degree of flexibility and was subject to change in consultation with people. This meant teams we visited operated with a degree of flexibility to meet patient needs.

We spoke with RAID staff and their view was that they worked well to ensure the patients care pathway to other services was smooth. We were told that access to older people's mental health community and mental health services was 24 hour seven days a week. However staff reported that older people's community mental health services closed at 4.30pm. Access to inpatient beds could take up to 15 hours, which caused concerns when the four hour target was not met and was seen as an acute trust issue.

Learning from concerns and complaints

Staff were aware of the trust's complaints policy. Complaints were received directly and passed to the team manager or from the Patient Advocacy Liaison service (PALS). We saw a number of posters in reception areas used by people regarding how to make a complaint. Information leaflets about each service included this information also. In waiting areas we saw information available and forms to complete alongside a post box to place completed forms in. People we spoke to had not needed to make a complaint but felt sure of how to take forward any issues they had. Investigations of complaints were undertaken by the service manager where appropriate.

Evidence of trust wide learning from complaints and incidents was demonstrated through the team manager sharing with staff and globally through updates via the trust email system. This information was included and discussed monthly team meetings.

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.

Summary of findings

Staff were dedicated and felt well supported by management. Some staff groups told us that they had attended the 'listening into action forum'. We saw a supportive culture within teams. Examples of the various team and management meetings and events demonstrated that staff were consulted about the trust's future plans. Staff had a broad understanding of the current and future needs of the organisation. People using the service were regularly asked for their comments and opinions about the service. A trust-wide risk register was in place to oversee and identify risks to the trust, staff and people using services. Staff could use a variety of supervision support on a regular basis.

Our findings

Vision and strategy

Most of the staff told us they felt well supported by their managers. They all spoke positively about their role and demonstrated their dedication to providing quality patient care. They told us that senior managers and the board engaged them, provided information and consulted with them in a variety of formats. Key messages about the trust were communicated to all managers at monthly senior management meetings and shared with the team. We ran a number of focus groups as part of the inspection and spoke to a wide number of staff groups. It was noted that psychiatrists had significant input into key organisational planning meetings. We spoke with a psychiatrist who was based in the home treatment teams. They told us that consultants had a 'strong voice' within the trust and had been involved in service developments.

They said the trust had been a pioneer in the development of community mental health services for a number of years and were not involved in the reconfiguration of services. This meant a number of consultant psychiatrist posts would be lost as a result but this would not impact upon services.

We saw the Service Integration Programme (SIP) Consultation Key Themes report summary. The consultation took place from October to November 2013 for a period of six weeks. Staff and the report confirmed that teams had, or were offered the opportunity, to have an initial briefing from the executive team members to all senior leads and managers within the trust to enable them to give briefings within their areas of service. Local briefings were then given by associate directors. Briefings or updates were provided at all key internal and external meetings taking place within the consultation period as appropriate. We saw that service development managers were still involved in team meetings and visited the services regularly.

Responsible governance

Staff told us that they felt well supported by their line manager. Staff told us that they received clinical, managerial and group supervisions as required. Staff attended monthly team meetings. The trust vision was cascaded through 'Connect' and the chief executive's weekly brief emails and shared in team meetings. Staff told us monthly business meetings were good for feedback in regard to audits undertaken.

We sat in on a quality audit feedback meeting in the assertive outreach team as well as seeing the audit process of care plans. The audit meeting took place every four weeks and monitored team and individual progress on good practice standards. For example how to involve people in their care pathway and care planning and around the recording of recording information about people on community treatment orders. A good practice discussion took place at the beginning of the meeting and advice shared on how to write more person centred plans. We saw good examples of advanced directives and mental capacity assessments being shared. The trust quality audit framework covered training, audit of the Care Programme Approach and drug information relating to adverse drug interactions. Feedback was provided on trust wide audits.

We saw evidence of how the trust monitored serious untoward incident within specific services. For example we saw a report on figures for the last six months on serious untoward incidents and deaths. There was some evidence that the trust was using the incidents as a learning experience. For example when they had not been given sufficient evidence about people risks or criminal or forensic histories. Some staff were unaware of the trust wide system for monitoring sudden and unexpected patient deaths within the community.

A trust wide risk register was in place and managers told us this was an effective tool for capturing ongoing concerns.

Are services well-led?

Good

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Staff told us that they were aware of the trust's whistleblowing policy and that they felt able to report incidents and raise concerns and that they would be listened to.

Monthly monitoring of records were submitted to the governance team by managers. They receive bi- monthly reports to monitor their performance. Audits of records we saw were in-depth in regard to outcomes for people contained in care plans and progress notes. Staff attendance on training was monitored by manager and we saw evidence of high attendance rates for staff attending training. A training grid was seen and this was updated and shared with staff. Staff reported that sickness and absence was monitored and we saw information from the trust that long term sickness absence is much lower than other trust service areas. Staff attendance on training was monitored by managers. A training grid was seen and this was updated and put up for staff to see. Mandatory training for the team was 93% and on an upward trend and above the trust average.

Leadership and culture

We saw a supportive culture within teams. Staff had a broad understanding of the current and future need of the organisation and a good understanding of the service improvement plan. We saw that staff were passionate about their work and showed a genuine compassion for people.

Staff told us that the chief executive had visited their teams and engaged with staff at all levels.

Staff also said the executive team visited teams and sat in on staff and multi-disciplinary and team meetings and asked for their views on the trust's plans. People we spoke with said they were aware of who the CEO was and they were asked for feedback about the services they received involved in.

Engagement

People were asked about their views of the service, for example in the assertive outreach team via satisfaction surveys which related specifically to the team that cared for them. These asked them to rate the quality of the staff that supported them. These were provided to people via 'real time' surveys on the intranet available in the sites teams were based in. Teams also provided people with surveys about the service they received and we saw evidence of the results of surveys in outpatients waiting areas and reception areas. There was a high satisfaction rate from people using the service. This meant the trust actively sought people's opinion and participation in improving service delivery.

Performance improvement

Staff we met with understood their aims and objectives in regard to performance and learning. Staff told us they valued the supervision they received and that it was "supportive". We saw that service developments were being monitored for risks, efficacy and with consideration of local needs. We saw that monthly team meeting focussed on team objectives and direction particularly through the implementation of new ways of working as part of the quality audit feedback.

Team performance was monitored through key performance indicators and we saw that overall, these services had been meeting the national targets where applicable.

The variations highlighted in the reports have been discussed at the IQC with actions noted to include the range of community engagement work being undertaken across the diverse communities. This meant the trust was trying to reduce the stigma and identify the performance of services and teams to address barriers and improve the take up of services where appropriate. One such service was the Assertive Outreach Team (AOT). The report we saw from November 2013 looked at key performance indicators (KPI's) for 2013-2014. The trust wide AOT had exceeded Monitor national standards for all applicable KPIs so far this financial year. For Care Programme Approach (CPA) 12 month reviews were at 93.05% but had improved significantly in recent months and had been greater than 97% in August and September 2014.