# CareQuality Commission

**Good** 🟢

## Solent NHS Trust

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

**Quality Report**

Solent NHS Trust
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## Locations inspected

| Location ID | Name of CQC registered location | Name of service (e.g. ward/unit/team) | Postcode of service (ward/unit/team) |
|---|---|---|---|
| R1C17 | St Mary's Hospital | Recovery Team North | PO3 6AD |
| R1C17 | St Mary's Hospital | Recovery Team South | PO3 6AD |
| R1C17 | St Mary's Hospital | A2i (Assessment to Intervention) | PO3 6AD |

This report describes our judgement of the quality of care provided within this core service by Solent 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.

# Summary of findings

Where applicable, we have reported on each core service provided by Solent NHS Trust and these are brought together to inform our overall judgement of Solent 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 the service | Good | 🟢 |
|---|---|---|
| Are services safe? | **Good** | 🟢 |
| Are services effective? | **Good** | 🟢 |
| Are services caring? | **Good** | 🟢 |
| Are services responsive? | **Good** | 🟢 |
| Are services well-led? | **Good** | 🟢 |

**Mental Health Act responsibilities and Mental Capacity Act / Deprivation of Liberty Safeguards**
We include our assessment of the provider's compliance with the Mental Health Act and Mental Capacity Act in our overall inspection of the core service.

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

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

# Summary of findings

## Contents

# Summary of findings

## Overall summary

We rated community-based mental health services for adults of working age as good because:

- Managers were aware of staff caseloads and adjustments were made to take account of the complexity of patients. Recovery teams were piloting a case load tool which looks at risks, care coordination and time spent on cases, assigning scores of one to five depending on seriousness of risk.

- Patients who required regular blood checks to ensure maintenance of therapeutic levels of medicines and to detect any signs of serious side-effects, attended clinics run by the "wellbeing" staff. The trust had introduced point of care haematology testing for clozapine.

- Care records we reviewed showed care plans were up to date, personalised, holistic, recovery orientated and included evidence of ongoing physical care, informed consent and appropriate consideration of mental capacity.

- Staff had a very good understanding of the needs of their individual patients. Staff were committed to

patient care and care was patient centred. Staff were responsive to patients' needs and able to demonstrate how they could draw on increased support from colleagues if required.

- There were clear care pathways dealing with access and discharge to the community teams.

- Staff were overwhelmingly positive about the culture of the teams which they described as mature, supportive and very open. They also felt supported by line managers and colleagues.

However,

- The Trust should within the main base of the community mental health teams risk assess the three interview rooms which are L shaped. This is because when staff were sat at the desk with patients, they could not be observed through the door.

- The Trust should consider providing prevention of violence and aggression or breakaway techniques training for staff.

# Summary of findings

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

### Are services safe?

**We rated safe as good because**:

- Managers were aware of staff caseloads and adjustments were made to take account of the complexity of patients. Recovery teams were piloting a case load tool which looks at risks, care coordination and time spent on cases, assigning scores of one to five depending on seriousness of risk.

- We observed good assessment and management of risk in all of the teams we visited. There was a robust risk management system in place based on a RAG rating (red, amber green) and teams held daily meetings where high risks were discussed and reviewed.

- Patients who required regular blood checks to ensure maintenance of therapeutic levels of medicines and to detect any signs of serious side-effects, attended clinics run by the "wellbeing" staff. The trust had introduced point of care haematology testing for clozapine.

However:

- In the team base there were three interview rooms that were L shaped. Therefore if staff were sitting at a desk with a patient they could not observed through the door.

**Good** ●

### Are services effective?

We rated effective as good because:

- Care records we reviewed showed care plans were up to date, personalised, holistic, recovery orientated and included evidence of ongoing physical care, informed consent and appropriate consideration of mental capacity.

- Staff in both A2i and the recovery teams offered a range of evidence based therapeutic interventions including cognitive behavioural therapy for psychosis, family interventions, family therapy and multi-family groups.

- The trust had established a recovery college scheme which was a partnership between the trust, a local college and Solent Mind. This enabled patients to access sessions and established programmes that covered a wide range of subjects including; understanding recovery, managing finance, skills for life, substance misuse and managing money.

**Good** ●

# Summary of findings

- The recovery teams worked closely with the crisis and home treatment teams to prevent patients being admitted to hospital. There were clear protocols in place and staff told us they felt these were working well.

**Are services caring?**                                                    Good ●

We rated caring as good because:

- Staff had a very good understanding of the needs of their individual patients. Staff were committed to patient care and care was patient centred. Staff were responsive to patients' needs and able to demonstrate how they could draw on increased support from colleagues if required.

- All staff understood the importance of including families in the care of patients with their consent. Staff routinely offered support to families and carers and we saw evidence of meetings taking place.

- Patients and carers were encouraged to give feedback about their care and treatment via the friends and family survey. The team managers showed us the monthly results which are collated and reported on centrally. These were overwhelmingly positive.

**Are services responsive to people's needs?**                             Good ●

We rated responsive as good because:

- There were clear care pathways dealing with access and discharge to the community teams. The crisis team operated a single point of access to community mental health services and triaged these first. All urgent referrals were dealt with by the crisis team. Routine referrals primarily came to the A2i team and averaged 120 per month. The patients referred were all usually assessed within two weeks.

- In the early intervention in psychosis pathway there was a requirement to assess and allocate 80% of new patients within two weeks. Teams were meeting this target and trying to further improve their accessibility. Patients were allocated for a face to face assessment within a day of receipt of the referral. Managers had good systems in place to track the progress of referrals.

- Waiting areas were welcoming, well furnished, and well-lit and equipped with a water dispenser so that people waiting could have a drink. People waiting had access to toilet facilities including specially adapted ones for less able patients.

# Summary of findings

**Are services well-led?**        **Good**   🟢

We rated well led as good because:

- Clear governance structures supported the delivery of safe and effective care and supported the flow of communication from the teams to senior management. The team managers participated in the local governance group which met on a monthly basis.

- Managers had access to information about the training and appraisal rates of staff in their teams, but commented there could be delays in getting accurate and timely data. They also received monthly reports of mandatory training, which highlighted when staff needed to renew or complete training. Supervision compliance was managed within the teams and we saw how managers kept records of the sessions.

- Staff were overwhelmingly positive about the culture of the teams which they described as mature, supportive and very open. They also felt supported by line managers and colleagues.

# Summary of findings

## Information about the service

There are three mental health community teams serving Portsmouth city. They are all integrated with Portsmouth city council.

The assessment to intervention (A2i) team carried out initial mental health assessments and subsequent treatment for patients not requiring care coordinators. Staff worked with patients for up to six months before either discharging or transferring patients, dependant on need.

The two recovery teams are separated into the north and south of the city but based in the same building. They can work with patients who have severe and enduring mental health problems for as long as required. There was an early intervention in psychosis function within the recovery teams, which is planned to become a separate team later this year. All teams have a core group of staff which includes: psychiatrists, registered nurses, psychologists, social workers, occupational therapists, and administrative staff. Support staff are employed by voluntary and charitable organisations and include: support time and recovery workers, peer workers, wellbeing workers. These staff are co-located in the same building as the NHS staff.

## Our inspection team

The inspection was led by Joyce Frederick, Head of hospital inspection.

The team that inspected this core service comprised: an inspection manager, two assistant inspectors and one specialist advisor.

## Why we carried out this inspection

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

## How we carried out this inspection

To 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?

During the inspection visit, the inspection team:

- visited the three community mental health teams and looked at the quality of the patient environment and observed how staff treated patients

- spoke with eight patients who were using the service
- spoke with the managers for each of the three teams
- spoke with all the professional disciplines involved in the delivery of care and treatment
- spoke with 24 staff members; including doctors, nurses and social workers
- attended and observed one care programme meeting and three multi-disciplinary meetings
- collected feedback from five patients using telephone interviews
- looked at 26 treatment records of patients
- looked at a range of policies, procedures and other documents relating to the running of the service

# Summary of findings

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

Overall, all the patients we spoke with were happy with the care and service provisions by the team. Once referrals were received by the team, they were quick to act and assessed patients with an efficient and timely manner. A clear pathway of referrals was followed – and patients were able to identify their goals and achievements with the support they had received. Patients found it especially helpful to have flexible times and locations for appointments and visits. Most had experienced the team offering appointments outside of normal routine times, and had the option of being seen in the comfort of their own home. Patients have found the team to be highly motivated and dedicated.

With regards to their involvement in the care, patients reported that they are consulted on care planning and felt well-supported by the team. Their comments are taken on board and included in the care plans. All patients we spoke with had been given a copy of their care plan, and had regular reviews. One patient mentioned that during their initial time with the team, they felt uncomfortable travelling to new locations (for example, the clinic). The team was understanding to his needs, and helped to build his confidence in new environments.

One patient mentioned that the only issue they have faced at the service is getting in direct contact with their nurse/CPN as and when required.

## Good practice

- Recovery teams were piloting a case load tool which looked at risks, care coordination and time spent on cases, assigning scores of one to five depending on seriousness. Staff completed forms of workload weighting every month ready for the meeting and then it was assessed together. The tool also allowed for the other duties of a staff member such as running nurse led clinics or running psychological therapy sessions. We saw how this was used in supervision with staff to maintain safe levels.

- A blood analyser machine was used in the clinic to enable a patient's blood to be tested on site and the result transmitted directly to the clozaril patient monitoring service.

- Psychologists and medical staff were involved in research in collaboration with other institutions. Staff had papers or posters published on such subjects as; looking at cost effectiveness of the team, what general practitioners want from community mental health teams.

## Areas for improvement

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

- The Trust should within the main base of the community mental health teams risk assess the three interview rooms which are L shaped. This is because when staff were sat at the desk with patients, they could not be observed through the door.

- The Trust should consider providing prevention of violence and aggression or breakaway techniques training for staff.

# Solent NHS Trust

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

**Detailed findings**

## Locations inspected

| Name of service (e.g. ward/unit/team) | Name of CQC registered location |
| --- | --- |
| Recovery Team North | St Mary's Hospital Portsmouth |
| Recovery Team South | St Mary's Hospital Portsmouth |
| A2i (Assessment to Intervention) | St Mary's Hospital Portsmouth |

## 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.

- Doctors had received training in the Mental Health Act and nurses received training during their preceptorship period. However, the Mental Health Act was not mandatory training for staff. Most nurses and social workers had detailed knowledge of the Act and all teams had a member of staff trained as a mental health act lead with a more detailed knowledge of the Act, which they shared with colleagues.

- Staff told us they felt confident in their understanding of their responsibilities under the Mental Health Act and knew where to obtain advice about the Mental Health Act. This was via the trust Mental Health Act administration office or from approved mental health professionals.

- Patients had access to independent mental health advocacy services when needed.

# Detailed findings

## Mental Capacity Act and Deprivation of Liberty Safeguards

- There was a policy on the Mental Capacity Act which included the deprivation of liberty safeguards. Staff we spoke with they had access to this through the trust's intranet.

- We observed staff discussing the assessment of a patient and they considered the potential for impaired capacity at a multi-disciplinary meeting. Staff covered mental capacity and consent to treatment in the initial assessment process. Staff documented consent to treatment in the care records that we viewed.

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**Good** 🟢

# Are services safe?

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

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

## Our findings

### Safe and clean environment

- Staff saw patients and carers in interview rooms on two floors, none of which were fitted with alarms. Staff had to use personal alarms to call for help if they needed it and these were available via the reception or team offices. All rooms had two doors and small observation holes. However, three interview rooms were L shaped, so if staff were sat at the desk they could not be observed through the door.

- The clinic room was well equipped with the equipment needed to carry out physical health examinations.

- Cleaning schedules and records were completed. Plastic bins used for the disposal of sharp objects including syringes and needles were labelled with the date of first use. Staff disposed of clinical waste safely and appropriately.

- Patient waiting areas were visibly clean and well-maintained, along with all corridors and rooms. Posters in the clinical areas reminded staff of the safest way to wash their hands and minimise the risk of cross infection. There was hand cleaning gel available in all reception areas.

- Equipment, such as weighing scales and blood pressure monitors, were either new or well-maintained and calibrated annually to ensure measures were accurate.

### Safe staffing

- The teams had 3.5 wte vacancies. These existed they were being actively recruited to. For example, the recovery teams had two vacancies for occupational therapists (OT) which had been advertised. However, staff told us they were concerned about the ability to retain OT staff as they would move on to seek promotion elsewhere, due to limited opportunities within the trust.

- Caseloads of care co-ordinators in recovery teams were between 25 – 30 patients, with an aim to be 28. In the A2i team this was an average of 28. Managers were aware of staff caseloads and adjustments were made to take account of the complexity of patients. Recovery teams were piloting a case load tool which looked at risks, care coordination and time spent on cases, assigning scores of one to five depending on seriousness. Staff completed forms of workload weighting every month ready for the meeting and then it is assessed together. The tool also allowed for the other duties of a staff member such as running nurse led clinics or running psychological therapy sessions. We saw how this was used in supervision with staff to maintain safe levels.

- Patients were allocated promptly to a care co-ordinator in the recovery teams following referral, which predominately came from the A2i team, although could come direct from a ward. The A2i team did not operate a care coordination role as they worked in partnership with other professionals such as the GP. They did not have any patients on their waiting lists for allocation beyond 10 working days.

- All staff and patients could access to a psychiatrist when they needed one, and they were embedded in each team.

- Staff had completed the trust mandatory training, which was mainly computer based learning. Eighty per cent of staff were compliant with mandatory training in the teams we visited. Where training was incomplete staff were booked onto training courses. We noted that prevention of violence and aggression or breakaway techniques did not form part of this training. We felt this was something the trust should address as staff were seeing unknown patients in the interview rooms.

- Staff sickness rates across the teams was 6.3% overall. Staff we spoke with told us that they felt the sickness rates had significantly decreased over the last two years, with the developing skills and maturity of the teams.

### Assessing and managing risk to patients and staff

- We observed good assessment and management of risk in all of the teams we visited. There was a robust risk management system in place based on a RAG rating (red, amber green) and teams held daily meetings

# Are services safe?

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

where high risks were discussed and reviewed. Staff reviewed lower risk patients at weekly meetings. There were clear plans in place to manage the risks identified and these were updated at each meeting.

- Patient records we reviewed contained crisis plans outlining what should happen and who to contact in an emergency. Crisis plans contained information on relapse indicators and early warning signs.

- In the recovery teams the staff used an intensive case management model to increase interventions and help patients whose mental health had deteriorated. This was provided by a daily duty rota which all staff participated in. This enabled staff to increase the frequency of patient visits up to twice a day, in response to any increasing risk or need. We also saw clear protocols for referring to the crisis teams if evening or weekend support was required.

- Staff were trained in safeguarding and knew how to make an alert. All staff had completed safeguarding adults and children training. The managers were the safeguarding leads in each team and provided advice to colleagues on safeguarding matters. All staff were expected to be able to raise safeguarding alerts in response to concerns. Several social work staff had been trained as safeguarding adult's managers and inquiry officers. Staff considered and made safeguarding referrals in multidisciplinary team discussions we attended.

- Patients who required regular blood checks to ensure maintenance of therapeutic levels of medicines and to detect any signs of serious side-effects, attended clinics run by the "wellbeing" staff. The trust had introduced point of care haematology testing for clozapine. Staff had undertaken additional training that allowed them to carry out blood testing on site. A blood analyser machine was used in the clinic to enable a patient's blood to be tested on site and the result transmitted directly to the clozaril patient monitoring service. This had significant benefits for patients as it provided a 'one-stop service' and reduced the number of times they needed to visit the service.

- Medicines were stored securely and managed safely. Medicines were transported in secure containers when staff needed to take them off the premises. Drug fridge temperatures were recorded consistently. We reviewed

eight medicine administration records in the teams we visited. All records were completed and signed appropriately. Pharmacists attended meetings with patients to discuss any concerns staff had about medicines.

- The trust had a lone working policy in place to support staff working alone in the community and ensure their safety. Staff used a whiteboard to indicate where they were and what time they were due back. All staff contact records were kept and easily accessible by managers if required. Staff we spoke with explained the precautions they took to ensure that home visits were safe; this included two members of staff going together to assess patients not known to the service.

### Track record on safety

- The trust reported that there had been three serious incidents involving patients since September 2015.

- If a serious incident occurred the trust now external investigators from outside the trust to complete investigations instead of team managers.

- Serious incident reports were presented and discussed at monthly Governance and Essential Standards Committee which included all team managers and matrons. They would bring back a report of the discussion and learning to team business meetings.

- An example of a change in practice following a previous serious incident was the production of a protocol for patients who missed their depot injection appointment. If this occurs, it will be flagged up on the records system and a process of active engagement by phoning and writing to them would commence. If no contact has been made within two weeks the case is passed to the intensive case management team for follow up.

### Reporting incidents and learning from when things go wrong

- Staff knew what type of incidents they should report and how to report them via the electronic reporting system. Managers described an open reporting culture amongst the team. Staff said they were encouraged to report incidents.

# Are services safe?

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

- The trust used a newsletter to share information about learning from incidents with staff in all services. However the team manager told us she rarely got any detailed information about trends or themes of incidents from the trust risk management team.

- Staff were given support and a de-brief session after incidents by the team managers. They could call on support from psychologists but this process was not formalised.

**Duty of Candour**

- Staff understood their responsibilities under the duty of candour. The duty of candour means that providers must operate with openness, transparency and candour. If a patient is harmed they are informed of the fact and offered an appropriate remedy. Staff described incidents where patients were informed when things went wrong, apologised to and offered the opportunity to make a complaint. The trust had provided an information leaflet for staff explaining the duty of candour.

## Are services effective?

**Good** ●

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

## Our findings

### Assessment of needs and planning of care

We reviewed 24 care records

- Patients were normally assessed by the A2i team staff prior to commencing treatment. The recovery team would also assess patients following triage by the crisis team or direct referral from an acute ward. The outcome of the initial assessment was discussed with the patient and a plan agreed. The outcome was minuted.

- Care records we reviewed showed care plans were up to date, personalised, holistic, recovery orientated and included evidence of ongoing physical care, informed consent and appropriate consideration of mental capacity. Patients under care programme approach (CPA) in recovery teams, were reviewed every three months by a consultant psychiatrist and had a CPA review every six months.

- Staff stored patient care records electronically in a new system the trust had purchased the previous year. The information was secure and only accessible via passwords to access the system.

### Best practice in treatment and care

- Staff used the national institute for health and care excellence (NICE) guidelines when making treatment decisions. Staff were able to access NICE prescribing guidelines on the trust website. Staff operating for the early intervention in psychosis function offered NICE compliant packages of care to patients within two weeks of their referral to the service. Staff in both A2i and the recovery teams offered a range of evidence based therapeutic interventions including cognitive behavioural therapy for psychosis, family interventions, family therapy and multi-family groups. New staff had been given copies of NICE guidelines such as guidelines for anxiety, depression and post-traumatic stress disorder.

- Patients in all teams had access to psychological therapies. This was provided by trained nursing staff and psychologists who were all integrated into the teams. Patients referred to a psychological therapy were generally seen within 20 weeks. However, the psychology service had undertaken research into how to

improve the situation and had received additional funding from NHS England to train two extra staff. The anticipated timeline to improve access was about 18 months.

- Staff offered support for patients' social needs such as housing, benefits and employment. For example, in the recovery teams staff arranged for advice and support on benefits via dedicated staff employed by the third sector. Staff worked in partnership with local voluntary sector organisations to provide social inclusion programmes which supported patients' recovery.

- The trust had established a recovery college scheme which was a partnership between the trust, a local college and Solent Mind. This enabled patients to access sessions and established programmes that covered a wide range of subjects including; understanding recovery, managing finance, skills for life, substance misuse and managing money. Patients we spoke with were very positive about the help and support they had accessed through the college. Peer workers are in place to support patients and these are employed via Solent Mind. They are based within the building and attend team meetings.

- Patient records showed staff monitored and considered patients' physical health needs. Staff in the recovery teams carried out regular physical health checks on patients. There was a commissioning for quality and innovation target that 90% of patients on CPA should have an annual health check, including checks on their blood sugar, body mass index, smoking and alcohol intake. Staff in the depot clinics checked and recorded the weight, blood pressure, pulse and body mass index of patients each time they attended the clinic. They also assessed the side effects of medicines experienced by patients at each visit. Staff were able to compare medication changes with any increase or decrease in side-effects.

- Staff used a range of tools to measure outcomes for patients using the services. These included positive and negative symptom scales, psychotic symptom rating scale.

- Psychologists and medical staff were involved in research in collaboration with other institutions. A

# 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.

number had papers or posters published on such subjects as; looking at cost effectiveness of the team and what GPs want from community mental health teams.

## Skilled staff to deliver care

- Teams were multidisciplinary and integrated with the local authority. They were made up of a range of disciplines including nurses, occupational therapists, doctors, social workers, psychologists and administrative staff. Support time and recovery workers were employed by third sector organisations but based within the same offices.

- Appraisals were set to be completed by the end of June 2016 along with objectives for the following year. Staff are booked in for these and the trust monitors the information centrally. This information was on training matrix but there were time lags between when appraisals were completed and when the system shows as completed. Staff in all teams had completed an annual appraisal in the last 12 months. Supervision was carried out monthly for staff, and staff would go through caseloads as well as checking staff welfare.

- Staff were able to undertake further training to develop their knowledge and skills thus enabling them to run either group or individual therapy sessions, such as dialectic behaviour therapy. Psychologists had completed or were completing training in advanced cognitive analytical therapy. The lead for the early intervention in psychosis function had responded to the introduction of new standards for early intervention teams in April 2016. The service had been proactive in sending staff to be trained in family interventions, to deliver the goal of providing a NICE compliant package of care to patients, within two weeks of assessment.

- All new staff including any locum staff received an induction to their area of work and responsibilities. Permanent staff received a three day corporate induction when they started.

## Multi-disciplinary and inter-agency team work

- Team members would meet several times a week either in clinical or business meetings. We saw how staff shared information and worked effectively on a daily basis. We attended a range of multidisciplinary team meetings and saw how well the different disciplines worked together. For example, in the recovery team staff from different disciplines worked very well together to devise treatment plans. Each team member contributed their professional knowledge and experience to the meeting. There appeared to be a blending of roles between disciplines, such as delivering psychological therapies. Staff told us they felt this was very positive.

- The recovery teams worked closely with the crisis and home treatment teams to prevent patients being admitted to hospital. There were clear protocols in place and staff told us they felt these were working well. Staff would also attend meetings with community child and adolescent mental health service (CAMHS) teams to identify young people about to transfer to adult teams. Again there clear protocols in place which staff said enabled them to provide appropriate support to the young person.

- The A2i staff worked closely with patients GPs to inform their progress, and offer suggested options when patients were discharged. The two recovery teams were aligned with GP practices across the city and had established links with groups of surgeries. Staff told us they felt relationships with primary care colleagues and the third sector organisations were effective and responsive.

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

- Doctors had received training in the Mental Health Act and nurses received training during their preceptorship period. However, the Mental Health Act was not mandatory training for staff. Most nurses and social workers had detailed knowledge of the Act and all teams had a member of staff trained as mental health act lead with a more detailed knowledge of the Act, which they shared with colleagues.

- Staff told us they felt confident in their understanding of their responsibilities under the Mental Health Act and knew where to obtain advice about the Mental Health Act. This was via the trust Mental Health Act administration office or from approved mental health professionals.

- Patients had access to independent mental health advocacy services when needed.

# 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.

- There was only one patient on a community treatment order (CTO). Staff told us the number of patients had reduced considerably over the last few years following a national audit on the effectiveness of CTOs. We reviewed the one community treatment order and found staff had completed it appropriately.

## Good practice in applying the Mental Capacity Act

- 75% of staff had received training in the Mental Capacity Act 2005 (MCA) but it was not mandatory. The trust had produced a short and clear summary of the MCA for staff and we saw the statutory principles displayed in staff offices. Some staff were very knowledgeable and spoke confidently about the legislation. However, this varied and not all staff we spoke with had a good understanding of the MCA and the implications for their practice.

- Mental capacity assessments were not carried out routinely as capacity was assumed. Where there was concern about a patient's capacity staff conducted assessments. These were clearly documented.

- Staff understood the importance of gaining the informed consent of patients. The trust policy for consent to examination or treatment gave detailed guidance to staff on when and how to seek and document consent.

# Are services caring?

**Good** 🟢

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

## Our findings

### Kindness, dignity, respect and support

- We observed staff speaking respectfully and showing kindness, compassion and concern for their patients during meetings and assessments. They actively listened to their opinions and wishes. Staff communicated clearly in assessments without using unnecessary jargon. They listened actively to patients, were non-judgemental and checked they understood the information given to them.

- During telephone assessments staff demonstrated caring and concern through their tone of voice.

- Most patients we spoke with or received feedback from were positive about the care and treatment they had received from the staff. Patients described community staff as friendly, kind, helpful, respectful and polite.

- Reports of patient feedback questionnaires in the first six months of 2016 showed that 85% of patients using the community mental health services, considered they were treated with dignity and respect by staff. 75% said their quality of life had improved as a result of the care and treatment they had received.

- Staff had a very good understanding of the needs of their individual patients. Staff were committed to patient care and care was patient centred. Staff were responsive to patients' needs and able to demonstrate how they could draw on increased support from colleagues if required.

- Staff we spoke with were clear about the boundaries of patient confidentiality and sharing information about

patients. Patient records indicated where patients had consented for staff to share information with family members and others. The trust provided guidance to staff on issues of patient confidentiality and respecting patients' privacy.

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

- Patients we spoke with told us they felt listened to and included in their care. They felt they were offered choices in relation to their care and treatment. We saw examples in care records which evidenced how patients contributed to care and treatment decisions. The care plans included the patient voice, were patient centred and holistic.

- All staff understood the importance of including families in the care of patients with their consent. Staff routinely offered support to families and carers and we saw evidence of meetings taking place.

- We observed in an assessment staff enabled the patient to make their own decisions about their care, and offered support and information about who to contact in the event of a crisis. Staff from different disciplines met with the patient and together they created an individual management plan.

- Patients and carers were encouraged to give feedback about their care and treatment via the friends and family survey. The team managers showed us the monthly results which are collated and reported on centrally. These were overwhelmingly positive. 91% of patients said they were extremely likely or likely to recommend the service to their friends or family.

# Are services responsive to people's needs?

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

## Our findings

### Access and discharge

- There were clear care pathways dealing with access and discharge to the community teams. The crisis team operated a single point of access to community mental health services and triaged these first. Routine referrals primarily came to the A2i team and averaged 120 per month. The patients referred were all usually assessed within two weeks. Patients were then directed to the appropriate care pathway for individual or group therapy. Some patients were referred to a brief interventions pathway if short term treatment was considered most appropriate. The teams had clear criteria describing the type of patients they would offer a service to.

- Referral to a care coordinator for the recovery teams had an average waiting time of 1.5 weeks.

- In the early intervention in psychosis pathway there was a requirement to assess and allocate 80% of new patients within two weeks. Teams were meeting this target and trying to further improve their accessibility. Patients were allocated for a face to face assessment within a day of receipt of the referral. Managers had good systems in place to track the progress of referrals.

- Upper age limits in the teams had recently been removed in response to national guidance. The service accepted patients of any age who were experiencing mental health problems.

- Patients did not wait for more than a few days while a care co-ordinator was allocated in the recovery teams.

- Staff told us of the efforts made to engage with patients who were reluctant to contact or use the teams. For example, they would visit a patient at home, leave phone or written messages and had an escalation protocol in place which was risk based.

- In the A2i team the aim was to support and treat patients for up to six months before discharging them back to their GP or transferring them onto the recovery service. Patients using the recovery teams had no length of treatment target but the emphasis was on recovery. As part of that process a nurse led clinic had been established to help patients progress back to the care of the GP.

- The A2I team had offered flexible appointments in the past for patients such as the evening or Saturdays. However this had proven unpopular with referred patients who preferred to be able to be seen either during the day or before their work started.

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

- Staff displayed information leaflets on a range of relevant topics for patients and carers in patient waiting areas. These supported people to make decisions about their care and treatment.

- The interview rooms were well furnished with low stimulus decoration. They were also sound proofed to maintain privacy.

- Waiting areas were welcoming, well furnished, and well-lit and equipped with a water dispenser so that people waiting could have a drink. People waiting had access to toilet facilities including specially adapted ones for less able patients.

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

- Patients with mobility concerns, including wheelchair users, could access all of the services via a lift and had level access to the building. Consultation rooms were located on the second and third floors and accessed via wide corridors.

- Information leaflets were available in different languages upon request. Staff told us they could ask for printed information in different languages for patients from their trust headquarters .

- Teams told us they tried to honour patient requests to work with staff of a particular gender, but the recovery team currently did not have a male nurse. The manager told us they were going to address this through the planned recruitment process.

### Listening to and learning from concerns and complaints

- Information about how to complain was clearly on display in patient waiting rooms. Patients we spoke with said they knew how to make a complaint.

- The community teams received 14 formal complaints over the last 12 months.

# Are services responsive to people's needs?

**Good** 🟢

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

- Managers confirmed they had not received any complaints this year. However they were clear about the process that they would follow which was in line with the trust complaints investigation policy. Complaints would be discussed in team meetings and in management governance meetings to make sure any learning was identified and acted upon.

# Are services well-led?

**Good** 🟢

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

## Our findings

### Vision and values

- Staff we spoke with knew and understood the values of the organisation.

- Staff knew who senior managers in the mental health services were and said they were visible. However not all staff were sure of the trust board members or whether they had visited the teams.

### Good governance

- Clear governance structures supported the delivery of safe and effective care and supported the flow of communication from the teams to senior management. The team managers participated in the local governance group which met on a monthly basis.

- Managers had access to information about the training and appraisal rates of staff in their teams, but commented there could be delays in getting accurate and timely data. They also received monthly reports of mandatory training, which highlighted when staff needed to renew or complete training. Supervision compliance was managed within the teams and we saw how managers kept records of the sessions.

- Managers and staff met monthly to discuss summaries of any learning from incidents or complaints related to the service. They reviewed monthly patient experience reports and considered team performance data such as referral times or assessment availability slots.

- Managers told us of their access to and use of the local mental health risk register. If they have any issues to add

they can put it on and then discuss with their divisional line manager. This in turn can be escalated to the divisional governance committee and if warranted to the trust risk register.

- Staff were trained in safeguarding adults and children, understood trust procedures and made appropriate safeguarding referrals.

### Leadership, morale and staff engagement

- There were no reported cases of bullying or harassment in the any of the teams we visited. Staff were aware of how to use the whistleblowing process. Staff were confident they could raise concerns and would be listened to by managers.

- Managers told us there were opportunities for leadership training and development in the trust. Several managers had completed, or were completing, leadership and management learning modules.

- Staff were overwhelmingly positive about the culture of the teams which they described as mature, supportive and very open. They also felt supported by line managers and colleagues.

- Sickness absence rates across the teams were 6.3 %.

### Commitment to quality improvement and innovation

- Staff we spoke with in all disciplines told us they were actively participating in quality improvement initiatives. These included such areas as: clinical audits looking at the quality of patient involvement, changing practice after analysing feedback from the friends and family survey, monthly reflective practice sessions and participating in research programmes.