Good

North Staffordshire Combined Healthcare NHS Trust

Community-based mental health services for older people

Quality Report

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Locations inspected

Location ID	Name of CQC registered location	Name of service (e.g. ward/ unit/team)	Postcode of service (ward/ unit/ team)
RLY88	Harplands Hospital	Care home liaison team	ST4 6TH
RLY88	Harplands Hospital	Outreach team	ST4 6TH
RLY88	Harplands Hospital	Memory Clinic Hazelhurst unit	ST4 6TH
RLY00	Trust Headquarters	Memory Clinic Maple house	ST5 7NJ
RLY00	Trust Headquarters	Community mental health team The Eaves, Abbots House	ST2 8DU

This report describes our judgement of the quality of care provided within this core service by <Enter provider name>. Where relevant we provide detail of each location or area of service visited.

Summary of findings

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 <Enter provider name> and these are brought together to inform our overall judgement of <Enter provider name>.

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?	Requires improvement
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 the community based mental health services for older people as **Good** because:

- Staff showed good knowledge of their patients.
- Staff had a good understanding of safeguarding adults and children policies and the procedures to keep people safe from abuse.
- Patients we spoke to were very positive about the service they received.
- Patients told us they could get appointments when they needed them and doctors were accessible to both staff and patients.
- Patients told us that they could easily contact their allocated worker when they needed to speak with them.
- Individual teams within the service had well-developed systems to gather patient and carer feedback.
- The service worked well with other teams and agencies to enable patients to move between services as their needs changed.
- The service was responsive to the needs of patients, carers and care homes.
- The service worked well together in order to prevent hospital admissions and support patients to be cared for in their own homes.
- Local leaders were visible and accessible to staff and demonstrated that they led their teams well

However

- Risk assessments were not routinely completed or updated.
- Patients did not have crisis plans so plans to mitigate risks to patients in a crisis were not in place.
- The trust failed to provide evidence that patient areas were free from ligature risks or that any risks were appropriately mitigated.
- Records of patient care and treatment were not always up to date.
- Records of patient care were not always easy for staff to use because files were stored in a number of locations.
- Mental capacity assessments were not routinely undertaken.
- The trust could not tell us how many patients were on staff caseloads.

Summary of findings

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

Are services safe?

Good

We rated safe as **Good** because:

- Staff had a good understanding of safeguarding adults and children policies and the procedures to keep people safe from abuse.
- Premises used by patients were visibly clean, comfortable and clutter free.
- Staff knew how to report incidents and most felt able to do so without fear of recrimination.
- Medication was stored safely and staff had a good understanding of infection control measures.
- Risks to patients were considered at daily meetings and patients requiring extra support were effectively identified.

However:

- Records of risk assessments were not routinely completed or updated to reflect changes.
- Patients were not provided with crisis plans and there was no evidence that plans were in place to mitigate against risk when a crisis occurred.
- Ligature risk assessments for the location of the community teams were not available during the inspection

Are services effective?

Requires improvement

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

- Staff did not demonstrate a good understanding of the Mental Capacity Act and did not routinely carry out mental capacity assessments.
- Records of patient care and treatment were not always accurate or up to date.
- Staff could not easily access patient notes to record information because files were stored in different locations.
- Across the services, care planning was variable in terms of quality. We also found that some service users had no care plans at all. We reviewed 69 patient records across the service.

However:

- Patients were assessed and had treatment and discharge plans in place.
- Staff supported patients to address their physical health care needs.
- Patient information was stored securely.

Summary of findings

- Training was available to enable staff to further develop their skills
- There was good multi-disciplinary working within the teams.
- Staff had a good understanding of the Mental Health Act.
- Patients were supported to develop their skills and move forward with their treatment.

Are services caring?

Good

We rated caring as **good** because:

- Patients and their carers or relatives told us that staff treated them with dignity, kindness and respect.
- During the inspection we saw and heard positive interactions between staff and patients.
- The service received a large number of positive comments from patients, carers and other professionals.
- We saw evidence that showed that patients and their families had been involved in developing care plans.
- Carers' needs were routinely considered. Staff appropriately referred them for carers' assessments when necessary.
- Patients' emotional needs were considered and staff supported them to attend therapy sessions that could help manage the emotional impact of their condition.
- When appropriate, patients were supported and encouraged to move forward with their treatment plans.
- There were independent advocacy services available to support patients and carers if they needed it. These were well advertised throughout the service.
- Patients were given explanations of their condition and their treatment plans. Questions or concerns were routinely addressed.

Are services responsive to people's needs?

Good

We rated responsive as **good** because:

- Patients were prioritised based upon their need and risk. Urgent referrals were seen within the target time.
- Patients were able to move through the service as their needs changed. Those seen in the memory clinic would be referred to the community mental health team or outreach team if they needed further support.
- Staff were flexible wherever possible and appointments could be made to suit the patient. Home visits were routinely carried out for patients who could not attend clinic appointments.
- Staff actively monitored and supported patients who did not attend for their appointments.

Summary of findings

However:

- There were long waiting times for patients to access psychology services in most teams.
- Most patients did not know how to make a complaint about the service.

Are services well-led?

Good

We rated well-led as **Good** because:

- There was little evidence that the trust had a thorough understanding of the workloads within the community teams for older people because they could not provide a central list of caseload numbers.
- No service-wide audits were undertaken to ascertain patient outcomes and the effectiveness of the service. It was not possible to determine if the trust was meeting key performance indicators for this service and stakeholders had also experienced difficulties obtaining key statistical information from the trust.
- The trust struggled to gather accurate and up to date information about the work within the teams, often failing to provide information for the inspection, even when requested.
- Assessing mental capacity in line with the principles of the Act was not embedded within the service.

However:

- Staff were aware of the trust's vision and values.
- Local leaders were visible and accessible to staff. Staff said their local leaders were supportive.
- Lessons learned from incidents were widely shared throughout the teams and the trust in meetings, events and newsletters.
- Patients were encouraged to provide feedback about the service via questionnaires.
- Staff were confident they could report concerns without the risk of recrimination.
- Morale was good within the teams, despite high caseloads and recent organisational change.

Summary of findings

Information about the service

North Staffordshire Combined Healthcare NHS trust provides a range of community-based mental health services for older people. The service includes: a vascular wellbeing team which supports patients with mild cognitive impairment; a care home liaison team which provides support and specialist advice to care homes who are managing the needs of people with complex mental health needs; memory clinics which provide assessment, diagnosis and treatment for patients with dementia; community mental health teams which provide ongoing support to patients who live in their own homes and have complex mental health needs; an outreach team which supports patients in crisis by providing an alternative to hospital admission or facilitating a timely discharge from hospital. The care home liaison team had recently been incorporated into two newly formed dementia care primary care liaison teams, which were based at Harplands hospital. We inspected only the function of the care home liaison team. The rapid assessment interface discharge team also supports the safe discharge of older people from the acute Royal Stoke University hospital between 7am and 11pm each day and this was inspected as a separate core service.

We inspected the following teams:

- the outreach team based at Harplands hospital
- the community mental health team at the Eaves, Abbots house
- the county memory clinic at Maple house
- the city memory clinic at Hazlehurst unit including the aspect of the service run from the Eaves, Abbots house
- the care home liaison team at Harplands hospital

Our inspection team

The comprehensive inspection was led by:

Chair: Paul Lelliot, Deputy Chief Inspector (Mental Health), Care Quality Commission.Head of Inspection: James Mullins, Care Quality Commission.Team Leader: Kenrick Jackson, Inspection manager, Care Quality Commission.

The team that inspected community-based mental health services for older people comprised of: two CQC inspectors, a Mental Health Act reviewer, a social worker, a nurse and a consultant psychiatrist.

Why we carried out this inspection

We carried out this inspection as part of our ongoing comprehensive mental health inspection programme.

How we carried out this inspection

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

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

Before the inspection visit, we reviewed information that we held about these services, asked a range of other organisations for information and sought feedback from people using the service.

During the inspection visit, the inspection team:

Summary of findings

- visited five of the community services for older people including: the outreach team, two memory services, the care home liaison team and a community mental health team
- spoke with 10 patients who were using the services, either face to face or by telephone
- spoke with eight carers or relatives of patients
- spoke with the managers or deputy managers of the teams;
- spoke with 31 other staff members including: health care support workers, doctors, consultant psychiatrists, nurses, psychologists, occupational therapists, physiotherapy technicians, administrative support staff and a volunteer
- spoke with seven managers of other services including care homes and older people's wards who worked alongside the service
- attended and observed 19 home visits and four patient meetings
- attended and observed a clinic, a multi-disciplinary team meeting and a handover meeting
- looked at 69 care and treatment records of patients
- looked at a range of policies, procedures and other documents relating to the running of the service.

What people who use the provider's services say

We spoke with patients and their relatives both in person and by telephone. Patients were very positive about the care and treatment that they received. They described community staff as friendly, kind, helpful, respectful and polite. Patients and carers felt listened to and included in their care. They felt they were offered choices in relation to their care and treatment. Some patients had copies of their care plans but others said they had not seen a care plan for a long time.

Patients liked the information leaflets staff gave them. Most patients said that, if they wanted them to be, their relatives were involved in their care. Carers said communication with the community team was very good and they always felt informed and were contacted when there were any concerns to share. Patients and carers said they were very happy with the support provided to them and staff were responsive to their needs.

The majority of patients that we spoke with were unaware of the complaints process. However, most patients and carers thought they would be able to find out how to complain if they needed to. They had not had any reason to complain but felt confident that they would be listened to and taken seriously if they did. Patients were routinely encouraged to complete feedback questionnaires about the service.

Good practice

- The memory clinic operated from the Eaves, Abbots House, had a volunteer whoserole was to make telephone calls to patients to remind them about their appointments. The volunteer also encouraged patients to attend their appointments if they were undecided about the benefits of attending and staff said this had reduced the number of patients who did not turn up for their appointments.
- The care home liaison team were developing a formal dementia training package which was specifically aimed at staff working in care homes. Feedback from care homes was very positive. The training had been devised in line with the Dementia Workforce Innovation Programme and the NHS Constitution Dementia Education and Learning Through Simulation programme.
- The care home liaison team employed a physiotherapist and a physiotherapy technician to support patients with complex physical and mental health needs. This meant that patients, who might otherwise be unable to access routine community physiotherapy services, could get treatment in an

environment that was familiar to them. However, the service was only commissioned by one local clinical commissioning group so was not available to all of the patients within the team.

Areas for improvement

Action the provider MUST take to improve

- The trust must ensure that patients have crisis and contingency plans that reflect patients individual circumstances and that these must be easily accessible to staff.
- The trust must ensure that accurate and up to date risk assessments are completed for patients.
- The trust must ensure that care plans reflect patient views and are person centred.
- The trust must ensure that staff have the skills and knowledge to routinely undertake and record mental capacity assessments in accordance with the Mental Capacity Act 2005.

Action the provider SHOULD take to improve

- The trust should consider if they are applying a blanket ban by not supporting older people within the Care Programme Approach system.

North Staffordshire Combined Healthcare NHS Trust

Community-based mental health services for older people

Detailed findings

Locations inspected

Name of service (e.g. ward/unit/team)	Name of CQC registered location
Care Home Liaison team	Harplands hospital
Hazlehurst unit Memory Clinic	Harplands hospital
Outreach team	Harplands hospital
Community mental health team, The Eaves, Abbots house	Trust headquarters
Maple house Memory Clinic	Trust headquarters

Mental Health Act responsibilities

We do not rate responsibilities under the Mental Health Act (MHA) 1983. We use our findings as a determiner in reaching an overall judgement about the Provider.

- All staff had undertaken training on the MHA as part of their mandatory training. Staff demonstrated a good understanding of the MHA in relation to their patients. Staff knew where to get further information and help if they needed it.
- Trust data showed that 19 referrals were made for patients at Harplands hospital who had needed an independent mental health advocate. However, the trust did not show which teams had made the referrals.

Detailed findings

Mental Capacity Act and Deprivation of Liberty Safeguards

- Staff had received training in the Mental Capacity Act but some staff could not remember the training. Most staff were not confident to carry out and record mental capacity assessments and told us they would refer the patient elsewhere if a mental capacity assessment was required. It was mainly doctors who carried out mental capacity assessments, when other professionals would have been expected to have a greater role. We looked for capacity assessments or evidence that patients' mental capacity had been considered in a sample of records across the service. We found that 75% of records in the care home liaison team and 50% in the outreach team contained no evidence of patients' mental capacity. Only 13% of records at the city community mental health team contained evidence of patients' mental capacity. Assessing mental capacity in line with the principles of the Act was not embedded within the service.

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

Our findings

Safe and clean environment

- Patient areas were visibly clean, well-ordered and clutter free.
- Infection control procedures were visible and there were hand washing opportunities at all sites.
- Clinic rooms contained equipment for patients to have physical examinations or depot medication if required. The clinic rooms contained audit checklist logs for cleaning, temperature (room and fridge where applicable), infection control and equipment maintenance. These were completed routinely and effectively. Records showed that any issues identified (such as fridge or room temperature) were identified by staff and managed effectively.
- We asked the trust to provide copies of ligature risk assessments for patient areas. However, they only provided one which was for the community mental health team and day hospital at Maple house, Bradwell hospital. This was dated December 2014 and had been reviewed in August 2015. The environmental ligature risk assessment stated that it mitigated against patients harming themselves with ligature points by supervision and individual patient risk assessments. As we did not inspect this site and the day hospital had ceased to function, we were not able to ascertain if patient areas within the whole service were ligature free and if risks were managed effectively.

Safe staffing

- The trust were not able to provide us with information about the caseloads of any teams within the service. We were told that managers in the community mental health teams and care home liaison team held cases. We asked the trust for details of managers' case numbers but they did not provide the information.
- Staff told us there were no agency or locum nurses working within the teams. There was one locum doctor and an agency administrative assistant. There were vacancies for staff within the service which were being actively addressed and there were no restrictions on new recruitment. Managers were positive about recent recruitment and redeployment of staff within the teams. They said the recruitment process had been positively progressed after staff had drawn attention to delays. Trust data showed that there were 7.5 vacancies across the service, 4.2 of which were nursing. There were no vacancies in the care home liaison team.
- Staff turnover rates were generally low. There was no staff turnover in the outreach team or the care home liaison team. Some staff had moved between teams for career development opportunities and their posts had been filled quickly. There had been an increase in turnover in March 2015 in the older people's psychology team (11.4 staff) but this data was not specific to teams within the service. The trust did not supply staff turnover rates for the memory service.
- Mandatory training included: safeguarding adults and children, Mental Health Act, fire safety, Mental Capacity Act, equality and diversity, clinical risk management, information governance, conflict resolution, prevent, health and safety, manual handling, and cardiopulmonary resuscitation. Records showed that mandatory training was routinely completed and staff were up to date. Staff and managers were sent email alerts advising them when specific training was due to expire. New staff had been recruited to the care home liaison team and were awaiting completion of their full induction and mandatory training. However, administrative staff who managed patient waiting areas were not provided with safeguarding children training.

Assessing and managing risk to patients and staff

- Assessment and management of risk took place in most of the teams we visited. Teams used a basic impact on safety assessment, which was a tick box risk measurement tool that allowed a small free-text space for observations and comments. However, The Outreach team supplemented this with daily handover meetings where they considered risk and escalated or de-escalated risk concerns. Patients were triaged and allocated based upon their risk and need in all teams. This meant that patients with the greatest need were seen more quickly. The memory service was a diagnostic and signposting service and did not carry out

risk assessments. We sampled patient records across the service and found that in the care home liaison team, 75% of records contained no risk assessment for patients who had been supported by the service from between 10 days and 1.5 years. In the outreach team, 83% of records contained a risk assessment and 50% were up to date. 69% of records in the city community mental health team at the Eaves contained a risk assessment, 56% of which were up to date.

- The service did not use crisis or contingency plans. This meant that there were no plans in place for when patients experienced a crisis.
- Regardless of individual complexity, no older people were cared for using the Care Programme Approach (CPA) in the 12 months leading up to the inspection. This meant that older people with complex mental health needs were not subject to the same provision as adults of working age.
- Staff were trained in safeguarding adults and children and they knew how to make an alert. Staff knew how to report concerns and knew where to get specialist advice if they needed it. Safeguarding contact details were easily available in the teams. Records showed that safeguarding concerns were regularly made and staff showed confidence in the processes and procedures. There were four recorded safeguarding referrals made by the outreach team and the community mental health teams. Staff told us that they had good relationships with local safeguarding teams.
- Patients who needed regular blood tests to safely monitor the effects of their medication were well supported. They had their blood checked regularly to ensure they maintained therapeutic levels of medication and to detect any signs of side-effects. Medicines were stored securely and managed safely. The Outreach team had identified risks to medication management for some patients living in their own homes. To manage this they had introduced digital medication safes. They loaned these to patients for the duration of their involvement. Staff told us that some patients and families were so pleased with the safes that they purchased their own when the team was no longer involved with them.
- There were systems in place to safely manage medication collection, storage and delivery. Staff understood their responsibilities and supported patients to manage their own medication when appropriate.
- We observed safe and effective management of a fire evacuation process at the Eaves, Abbots house.
- The trust had a lone working policy in place to support staff working alone in the community and to promote their safety. Staff were clear about the policy and followed it. Most teams used “safe words” to communicate that they were in danger when working alone.

Track record on safety

- The service recorded two serious incidents last 12 months which were shown for the “EMI CPN” teams. However, none of the teams in the service corresponded to this name and the trust were not able to provide data that showed exactly which of the teams these serious incidents had occurred in.

Reporting incidents and learning from when things go wrong

- Staff knew what type of incidents they should report and how to report them. They used an online incident reporting system which most staff were confident to use. Staff who were less confident knew how they could get support to report incidents. Incident reporting was a standing agenda item in team meetings. Managers attended weekly meetings to consider all incidents.
- We saw evidence that staff had learnt lessons from when things had gone wrong. Incidents were discussed in team meetings so the learning could be shared. This included learning from incidents that had occurred in other teams and services in the trust. Staff gave us examples of incidents that had occurred and the subsequent improvements that had been made as a result which included developing a “no response” flow chart to guide staff if they were unable to make contact with a patient. The flow chart highlighted the need to contact local acute hospitals and the police.
- Staff attended trust wide lessons learned events. The events considered incidents that had occurred both locally and nationally so there were good opportunities for staff to learn from what had gone wrong and what

Good

Are services safe?

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

measures had been implemented to prevent similar things happening again. However, doctors did not routinely attend these events so they were less aware of trust wide learning.

Are services effective?

Requires improvement

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

- Comprehensive assessment of patients' needs were carried out by staff in the community mental health teams. The assessments were holistic and considered the needs of carers.
- Patients within the service were not cared for using the Care Programme Approach (CPA). The trust operational policy on CPA (October 2012) stated that the CPA policy was applicable to older people and adults of working age. However, regardless of individual complexity, there were no older people subject to CPA in the 12 months leading up to the inspection. This meant that older people with complex mental health needs were not subject to the same provision as adults of working age.
- Assessments did not include information about advance decisions and patient views were not clearly set out.
- Where needs had been identified, there were usually care plans in place to address them. The memory service was a diagnostic and signposting service so did not develop care plans for patients. We reviewed 69 patient records across the service. The care home liaison team sample showed that 58% of care plans were not present in patient files. None recorded that a copy had been given to the patient and only 25% were personalised. Care plans comprised of a brief one page photocopied sheet which showed problem, goal and plan. The patient's name was handwritten onto the care plan. They were pre-populated with standardised information. In the Outreach team, 100% of patients had an up to date care plan and 75% were partially holistic in nature, which meant that they considered the wider needs patients. However, in the sample we inspected, no patients were recorded as having been given a copy of their care plan and 92% of care plans were not personalised. In the City community mental health team sample (the Eaves, Abbotts House) 83% of patients had a care plan. 67% were up to date but were not personalised and were partially holistic I nature. Only 17% of care plans were recorded that a copy was given to the patient.
- Patients' physical health needs were addressed and discussed in multi-disciplinary and handover meetings. The teams were able to carry out routine monitoring of physical healthcare needs. They carried out blood tests, monitoring of blood pressure, weight and electrocardiograms. However, there were no designated areas to record physical health checks or status so there was a risk that this information could be lost within the main body of recording. Depot injections were administered by staff in the community mental health teams (CMHTs) and the city CMHT were considering the benefit of operating a depot clinic as they had only recently taken over the administration of depot injections. Referrals to general practitioners and other specialisms were made when necessary.
- Information about patients was stored securely in patient files. Some information was stored on the electronic records system called CHIPS (corporate health information programme) and some information was stored in paper files. Paper files were stored in a number of locations. The location of the file depended upon which team had most involvement with the patient. The service used an electronic file tracking system called Genysis and staff used this to identify the location of patient files. However, we found that there could be more than one file for the patient and that these were located at different sites. Staff travelled to different locations to record in patient files. As files were located in several locations, some did not contain up to date information about the patient. Therefore, there was a risk that inappropriate care or advice could be provided because care records were not always accurate or complete.
- Staff told us that audits of case files took place so we asked to see details of these but we were only provided with an audit of "health records" which had taken place during 2014-15. The audit looked at "legibility, timeliness of entries and attributability" and covered learning disabilities, neuropsychiatry and old age psychiatry services. The trust did not provide details solely relating to the community-based mental health services for older people. A number of teams did not submit data for the audit or submitted data that was missing. Therefore, we are unable to ascertain if the audit was effective.

Best practice in treatment and care

- We saw evidence that staff considered national institute for health and care excellence (NICE) guidelines when making treatment decisions. These included specific

Are services effective?

Requires improvement

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.

dementia examinations such as the Addenbrookes Cognitive Examination – Revised tool. The care home liaison team followed NICE guidelines for cognitive enhancers (drugs or therapies that may enhance memory). Staff were able to access NICE prescribing guidelines. Doctors prescribed medicines in line with the guidelines. Most teams included nurse prescribers. Staff ensured that patients had regular physical health checks and monitoring. However, in 6/8 records sampled form the care home liaison team, there was no evidence that patients received regular monitoring of their physical health.

- Psychological therapies offered were in accordance with those recommended by NICE. The community mental health team (CMHT) at the Eaves, Abbots House, had a psychologist based within the multi-disciplinary team and there was no waiting list, so patients could access therapy quickly. The psychologist was able to offer advice to other disciplines within the team. Therapeutic groups were available to patients in the CMHTs and Memory Clinics. The groups included cognitive stimulation therapy, anxiety management and relaxation. Staff transported patients who would otherwise have been unable to attend the group sessions.

Skilled staff to deliver care

- New staff and students underwent an induction before they took up their full role responsibilities.
- Nursing and medical staff were able to undertake further training to equip them in their role. Some were studying to become nurse prescribers and there were leadership and career development opportunities for staff. Some nurses were trained as both mental health and general nurses which gave them a broad knowledge and skills base. Health care support workers were recruited from specialist older people's services as well as other disciplines so also brought a broad knowledge base to the teams. Staff training was considered in the supervision and appraisal process.
- Staff had received an annual appraisal within the last 12 months and most received regular individual supervision. The trust supervision policy identified that supervision should take place at a minimum of three monthly intervals and the teams met this, although a number of staff told us that supervision was often "put back" due to work pressures within the teams. The service had recently introduced a "supervision tracker" which detailed the frequency of supervision within teams. Trust data showed that 29% of staff in the outreach team had received supervision within the last three months. All staff in the community mental health teams had received supervision within the last three months. The trust did not supply data for staff in the memory service nor the care home liaison team but we saw during the inspection that staff in the care home liaison team had received supervision in line with trust policy.
- Student placements were offered within the service for occupational therapy and nursing students. We looked at student placement feedback forms and saw mostly very positive comments.

Multi-disciplinary and inter-agency team work

- The community teams mostly included nurses, health care support workers and doctors. The care home liaison team also had a physiotherapist and a physiotherapy technician. Social workers from the local authority had been co-located in the community mental health teams until a recent organisational change. The teams missed the joint working they had benefitted from when their teams had been co-located but felt that relationships with the local authorities were still good. However, most staff noted that there could be delays obtaining social care support for their patients and they often had to make follow up calls to pursue referrals they had made.
- Staff shared information and worked effectively. We attended a range of multi-disciplinary meetings and saw how well the different disciplines worked together. Staff showed each other mutual professional respect and working relationships were effective and positive.
- General practitioners (GPs) were routinely advised of the outcomes from patient assessments. Staff had access to local GP electronic databases which meant that if staff urgently needed to check prescription details or medical conditions of their patients on an evening or weekend, they could do this in an effective and timely way. Due to confidentiality restrictions, staff were required to justify any access they had to the GP system but felt that this was proportionate.

Are services effective?

Requires improvement

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.

- The Outreach team worked closely with hospital wards and community teams to facilitate smooth and timely hospital discharges and to prevent patients being admitted to hospital if they could be supported more intensively at home.
- One care home told us that seven out of their 20 residents were being supported by the care home liaison team. They were very positive about the way the team supported their care home and residents. The manager was certain that the support they received was responsible for reducing their patient admissions to hospital to just one in six years.

Adherence to the MHA and the MHA Code of Practice

- Staff received training in the Mental Health Act and demonstrated an awareness of the principles.
- Trust data showed that 19 referrals were made for patients at Harplands hospital who needed an independent mental health advocate. However, the trust did not show which teams had made the referrals.

Good practice in applying the MCA

- Staff had received training in the Mental Capacity Act (MCA) but most did not demonstrate confidence in carrying out mental capacity assessments. A number of staff told us that if a capacity assessment was required, they would refer the patient elsewhere. One doctor told us that they often carried out mental capacity assessments even though other staff had received training. In the records we inspected, we saw one MCA best interests assessment but there was no assessment of capacity. One health care support worker told us that assessments of capacity for patients to use pre-prepared medication boxes were not carried out; if a patient was reluctant to use the system, the worker would tell them that this was the pharmacy's preferred way of dispensing medication and the patient would usually be persuaded by this explanation. The staff member did not demonstrate any awareness that this covert action was not person centred and also did not fully involve the patient in the way their care was delivered.

Good

Are services caring?

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

Our findings

Kindness, dignity, respect and support

- Staff spoke respectfully about their patients and showed understanding and compassion during home visits and clinic appointments. Staff treated patients with skill, kindness and respect. They actively listened to their opinions, questions and wishes. Most staff used a person centred approach when communicating with their patients. Treatment options were discussed and staff encouraged patients to engage in assessments and appointments.
- Staff demonstrated skill in active listening, positive encouragement, validating patients'' feelings and sensitively but openly discussing risk.
- All the patients were positive about the care and treatment they had received from the community teams. Patients described staff as friendly, kind, helpful, respectful and polite.
- Some patients said they had been given information about the service but some said they had not. However, even though some patients said they had not been given information, we saw that they had it. Most patients said that their relatives were involved in their care if they wanted them to be. Carers said communication with the team was very good and they were really happy with the support provided to them.
- Staff were committed to providing good patient care. Staff showed a good understanding of the needs of individual patients.
- Both clinical & reception staff were responsive to patients' need. We observed kind interactions between them. Telephones were answered swiftly and effectively.

The involvement of people in the care they receive

- Patients and carers felt listened to and included in their care. They felt they were offered choices in relation to their care and treatment. Some patients had copies of their care plans but most did not. Patients were not routinely supported to make an advanced decision, which would have included their wishes should they become more unwell or need to be admitted to hospital.
- Patients and carers were not routinely involved in regular multi-disciplinary meetings.
- Carers' needs were considered and carers were referred elsewhere for assessment and individual support if they needed it.
- Patients had access to a variety of advocacy and support services which were well displayed in patient areas and in patient information packs.
- Patients were able to give prompt feedback about the service they had received via satisfaction surveys and questionnaires. Staff routinely encouraged patients to complete these and the trust had recently introduced a freepost service to better enable and encourage patients to return them.
- The trust was developing a Patient Council in order to involve patients in the development of services and had recently introduced a patient newsletter. Patients were not involved in the recruitment of staff for the service and were not involved in service development groups.

Are services responsive to people's needs?

Good

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

Our findings

Access and discharge

- The trust was not able to give clear target times from referral to assessment for all teams within the service. Trust data showed that local targets for referral to initial assessment times were 14 days for the county community mental health team (CMHT) and memory service which was being met. The city CMHT and memory service had a target of 28 days which was also being met. Initial assessment to treatment onset targets were 126 days which the county met in 42 days and the city teams in 53 days. Staff told us that target times differed depending upon which clinical commissioning group (CCG) was commissioning the service. The CCGs set a target time for the memory service at Maple house and Hazelhurst unit of eight weeks from assessment to diagnosis and a diagnosis rate of 67%. The Maple house memory service said they exceeded the diagnosis rate by achieving 71% but said they occasionally did not meet the assessment to diagnosis timeframe target. NHS England manages and administers the local area diagnostic rates. As of September this was 84.5 % for the Trust. The National target is 67%
- Hazelhurst unit told us that patients waited for three to five months from being referred by their GP to receiving a diagnosis and the CCG target time had recently changed from 18 to eight weeks. The care home liaison team had recently been incorporated into two newly formed dementia care primary care liaison teams, which were collocated at Harplands hospital. They had differing CCG targets to meet. As the dementia care primary liaison was a new team and was not part of this inspection, we did not look further at their performance. The care home liaison team had a small waiting list. The oldest referral waiting to be seen was almost four weeks but an appointment had been made. One referral had been waiting for two weeks for an appointment to be booked.
- The trust were unable to tell us how many referrals and discharges each team managed. However, the trust supplied data for the memory service which showed that average monthly referrals for the six months between March and August 2015, were 120 for the county service and 92 for the city service. Average monthly discharges for the same period were 21 from the county service and 25 from the city service. All patients were discharged back to their general practitioner. The county sent out an average of 467 review appointments each month and the city service sent out 304. An average of 86 patients did not attend their appointments each month at the county memory service and 38 at the city service.
- Home visits were sometimes completed by other teams within the service if this was of benefit to the patient or if one of the teams were unable to respond as quickly as they felt was necessary. Patients were seen in their own homes if they were unable to attend clinic appointments. Staff also drove patients to the clinics and therapy groups if they would otherwise have been unable to attend. The outreach team was available from 8am – 8pm daily to support and respond to patient need.
- All new referrals were triaged to determine who was at higher risk and should be seen quickly. Less urgent referrals were seen after urgent ones. The community mental health teams provided a duty service in order to triage referrals and support patients most in need. Doctors were available to provide consultation to staff when they needed it.
- The outreach team told us that the service had reduced the number of hospital admissions for patients by providing intensive support at home. However, no data was available to corroborate this. Memory clinic at the Eaves, Abbots house, had the support of a volunteer who worked for 3 hours twice a week. The role was embedded within the service and encouraged patients to attend their appointments by making telephone calls to remind them. The volunteer was proud of their ability to persuade some patients to attend when they had been unclear of the benefits. We were advised that the volunteer role had reduced the number of patients who had failed to turn up for appointments. However, there was no data evidence to support this.
- All community teams could arrange short notice urgent appointments for patients who confirmed that they were able to see staff when they most needed to.
- There was no waiting list for patients to be seen by a psychologist in the Eaves community mental health

Are services responsive to people's needs?

Good

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team. Patients were seen very quickly following referral. However, staff in other teams told us that patients had to wait around six months to be seen by a psychologist in other areas of the service.

The facilities promote recovery, comfort, dignity and confidentiality

- Community teams had access to rooms to see patients when they needed to. Rooms were private and appeared to be comfortable. However, some rooms that were used for group therapies at the Eaves also contained office space so they were not free from disruption. Despite the interruption, staff managed this well and therapy sessions did not appear to be negatively affected.
- The patient waiting area at Maple house memory clinic was in a corridor. Several patients told us they felt this arrangement was unsuitable. However, the Eaves and Hazelhurst memory clinics had small waiting areas for patients and carers. All patient areas had access to toilet facilities.
- Information about local support services and mental health conditions were on display in waiting areas. All sites displayed a wealth of local information for patients regarding advocacy services, social activities and support groups.

Meeting the needs of all people who use the service

- People with mobility issues and who used wheelchairs could access community team premises. Consultation rooms were provided on the ground floor.
- Information leaflets and leaflets about different mental health issues were available in a range of different languages. Staff used the trust intranet to locate and print out the version the patient required. Staff were able to obtain interpreters when they needed them to facilitate appointments with patients who did not speak English or were not confident using English.

Listening to and learning from concerns and complaints

- During the previous 12 months, the trust received two complaints relating to this core service; one in November 2014 which was partially upheld and one in July 2015 which was still under investigation. Managers knew how to investigate complaints but all staff told us that the level of complaints was very low and they dealt with anyone who wasn't entirely happy at the earliest opportunity, which prevented minor concerns escalating to complaints. Team managers told us how they responded positively to concerns and complaints, using the experience to make improvements in the services. The outreach team told us that patients told them it was difficult for them to get through to the team by telephone because they had to connect via the main hospital switchboard. So the team installed a direct line telephone number which meant that patients could contact them easily.
- Information on how to complain was displayed in waiting rooms where patients could see it. Staff were confident that they could support patients to make a complaint and knew that the Patient Advice and Liaison Service (PALS) would support patients. Details of PALS were displayed in patient areas. Patients told us that they were unaware of the complaints process and had not been specifically advised how to make a complaint. However, patients and carers told us that they would be able to find out how to make a complaint and they all felt confident that if they had cause to complain, they would be listened to and taken seriously by staff. The service received very low levels of complaints.
- When we visited the teams, we saw numerous compliment and thank you cards from patients and carers. However, the trust did not collate this information and were only able to tell us about three compliments to the service. All three compliments related to the memory service. The trust were unable to tell us about any of the compliments shown in patient feedback questionnaires or thank you cards that were displayed throughout the teams.

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 understood the vision and values of the trust and told us that they had been encouraged to learn them before the inspection.

Good governance

- Some staff knew who the senior managers were in the trust and some were aware that senior managers had visited their work places.
- Local leaders were visible and accessible to staff. The teams were well led by their local leaders. Staff felt supported by their team managers and respected them.
- Staff had been encouraged to learn about the Duty of Candour and knew the importance of informing patients and carers if errors had been made or when things had gone wrong. Managers provided examples of when this had happened.
- Regular team meetings were held and these were minuted and available for inspection. Issues were openly discussed and the whole team was involved in discussing operational issues, safeguarding, and learning from incidents and complaints.
- Managers had access to staff training and compliance information. The system flagged when mandatory training was due.
- Teams had recently developed self-assessments and peer reviews of their services. However, the trust did not supply any information regarding these. Service wide audits of performance and outcome monitoring did not take place. The trust was not able to provide data regarding referrals and discharges from teams, nor the number of cases allocated to staff within the teams. This meant that the service could not determine if it was achieving outcomes and providing a service that met its key performance indicators.

Leadership, morale and staff engagement

- Staff morale was good within the teams and staff were able to provide feedback about service development. The Listening into Action initiative was well publicised in the service and some staff spoke of it. Staff were encouraged to complete a daily stress thermometer. Some staff did not find this helpful but one team noted that completing it had enabled them to produce a satisfactory solution to a simple but time consuming problem with shredding their confidential waste. Previously they had had to carry the waste to another part of the site but the results of the safety thermometer enabled them to buy a shredding machine for their own office. The trust produced a staff newsletter called Junction which was visible in communal areas. The trust hosted staff recognition awards called REACH (Recognising Excellence and Achievement in Combined Healthcare) which were well publicised within teams and the local media. The outreach team had won a REACH award within the last year and the community mental health team at the Eaves was nominated by a patient's family and won a REACH award for "service user carer" category during the inspection.
- Local managers met weekly to consider staffing and service issues. The meeting also provided an opportunity for them to support each other. They reported that effective and supportive systems were in place to help them in their roles as managers, which included links with the human resources department and their own line manager. .
- Staff turnover was very low but recent closures of the Day Hospitals had meant that some staff had been redeployed within the service.
- Levels of staff sickness were generally low within the directorate but the trust did not show how this was distributed amongst the services we inspected. Between April 2014 and March 2015, directorate sickness levels peaked at around 5.3% and fell to around 2.9%.
- Staff were aware of how to raise concerns and said they could do this without fear of recrimination. Staff were aware of the "Dear Caroline" initiative that encouraged staff to raise concerns and communicate with the chief executive of the trust. An example was given regarding difficulties staff experienced trying to park at one of the sites they were needed to visit during the course of their work. The difficulty had been resolved by the chief executive listening to a staff suggestion and agreeing to rent additional nearby car parking space. Staff reported that this had sped up their work and reduced their stress. Staff felt confident of the whistleblowing

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procedures but some had had a poor experience of using it in the past so felt that experience may deter them from using it again. The whistleblowing policy had recently been renamed the "Raising Concerns" policy.

Commitment to quality improvement and innovation

- Staff were committed to acting on patient feedback and routinely encouraged patients to provide feedback on the service. However, the trust did not collate this feedback for the service as a whole and each team had devised their own system for obtaining, collating and acting on the information.
- The directorate was involved in numerous active research projects but unfortunately, trust data did not show which of these was specific to the service we inspected. However, the following dementia themed research projects were most likely open to patients of the service and the community mental health team at the Eaves told us that a research nurse regularly attended the team to discuss patient involvement and analyse records. The "Brains for Dementia" project was aimed at patients over the age of 65, who may wish to be involved in annual assessments or donate their brains for research. The "GERAS Addendum" study was investigating resource use and associated costs of Alzheimer's disease for patients and carers along with caregiver burden, over a sufficiently long period of time to capture changing levels of severity or changes in formal caregiving situations. The "AD Genetics" research aimed to build a better understanding of the causes of Alzheimer's disease and to detect susceptibility genes for patients with late onset of the condition. The "Effective Home Support Care" project was a national survey of current provision, investigating what types of support are available and from whom. "ATLAS" Very Late Onset Schizophrenia / Amisulpiride was a clinical trial supported by the Mental Health Research Network which was looking at side-effects, safety, effects of treatment on quality of life and the cost effectiveness of Amisulpiride.
- The service was not part of any accreditation scheme.

This section is primarily information for the provider

Requirement notices

Action we have told the provider to take

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

Regulated activity	Regulation
Treatment of disease, disorder or injury	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Care and treatment was not always provided in a safe way. · Patients did not have crisis and contingency plans. Plans to mitigate risks to patients in a crisis were not always in place or were not stored where they could be easily found in a crisis. · Risk assessments were not always present or updated. This was in breach of regulation 12 (1)(a)(b)(d)

Regulated activity	Regulation
Treatment of disease, disorder or injury	Regulation 17 HSCA 2008 (Regulated Activities) Regulations 2010 Respecting and involving people who use services Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. · Patient files were located in several offices and staff had to travel between offices to record their notes. This meant that there was a risk that accurate, contemporaneous records would not be maintained. This was in breach of regulation 17 (2) (c) (a, b)

This section is primarily information for the provider

Requirement notices

· The trust could not provide assurance that environmental ligature risk assessments were carried out for areas that were accessible to patients.

This was a breach of regulation 17 (1) (b)

Regulated activity	Regulation
Treatment of disease, disorder or injury	Regulation 9 HSCA 2008 (Regulated Activities) Regulations 2010 Care and welfare of people who use services Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

· Patients were not provided with care which was personalised specifically for them.

· Patients' capacity and ability to consent to be involved in the planning, management and review of their care and treatment was not routinely established.

This was a breach of regulation 9 (3) (b,c,d,e,f)