Aspire

Quality Report

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This report describes our judgement of the quality of care at this location. It is based on a combination of what we found when we inspected and a review of all information available to CQC including information given to us from patients, the public and other organisations

Ratings

Overall rating for this location	Good
Are services safe?	Good
Are services effective?	Good
Are services caring?	Good
Are services responsive?	Good
Are services well-led?	Good

Mental Health Act responsibilities and Mental Capacity Act and Deprivation of Liberty Safeguards

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

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

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

Summary of findings

Overall summary

We rated Aspire as **good** because :

- Following our inspection in May 2016 we rated the services as good for effective, caring and responsive. Since that inspection we have received no information that would cause us to re-inspect these key questions or change the ratings.
- During this most recent inspection, we found that the services had addressed the issues that had caused us to rate safe and well led as requires improvement following the May 2016 inspection.
- The service had modified the patient environment to ensure the safety of staff and patients. They did this by implementing hand washing facilities in the clinic room and window restrictors across the floor the service occupied. Staff had improved the quality of their risk assessments, we found risk assessments to be comprehensive and detailed. Medication storage was appropriate and well maintained. Staff were checking temperatures on a daily basis and this was audited by management. Mandatory training had high levels of completion and now included duty of candour and basic life support. Staff welcomed the addition of basic life support training and felt it was necessary to their role.
- The service had updated some of their policies including their safeguarding policy and whistleblowing policy in line with concerns identified in our last inspection. The service had implemented a duty of candour policy which was not present during our last inspection in May 2016. The risk register was regularly updated and identified all the current risks within the service .There were clear communication methods between the service and the board. The service was able to demonstrate they had robust governance arrangements in place which provided higher level oversight.
- Aspire were now meeting Regulations 12 and 17 of the Health and Social Care Act (Regulated Activities) Regulations 2014. They were also meeting Regulation 18 Health and Social Care Act (Registration) Regulations 2014.

However,

- The service could not calibrate any of their clinic equipment.
- Management did not regularly review the usage of the lone working “alert a buddy” system to see if staff were using it. This meant the service managers could not always ensure staff were using it on a regular basis

Summary of findings

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Summary of this inspection

Background to Aspire

Aspire is an independent community mental health service based in Leeds, West Yorkshire. Its provider Community Links Ltd. Community Links Ltd delivers care services for both mental health and adult social care.

Aspire works with young people and adults from 14 to 65 years old who have experienced their first episode of psychosis. This early intervention service works intensively with its patients for up to three years before they are discharged back into primary or other secondary care services. Staff at Aspire deliver care within the community, at patient's homes, the Aspire base and local community provisions.

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

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

- Treatment of disorder, disease or injury.

The CQC last inspected Aspire in May 2016 and rated the service overall requires improvement. With Safe as requires improvement, Effective as good, Caring as good, Responsive as good and Well led as requires improvement. We issued Aspire with three requirement notices which related to the following regulations under the Health and Social Care Act (Regulated Activities) Regulations 2014:

- Regulation 12 HSCA (Regulated Activities) Regulations 2014 Safe care and Treatment
- Regulation 17 HSCA (Regulated Activities) Regulations 2014 Good governance
- Regulation 18 HSCA (Registration) Regulations 2014 Notification of other incident

Our inspection team

The inspection team was comprised two Care Quality Commission inspectors; the team leader was Hamza Aslam.

Why we carried out this inspection

We undertook this inspection to find out whether Aspire had made improvements to their service since our last comprehensive inspection of the provider on 16 May 2016.

When we last inspected the location in May 2016, we rated Aspire as Requires Improvement overall. We rated the service requires improvement for Safe, good for Effective, good for Caring, good for Responsive and requires improvement for Well-led.

Following this inspection we told the provider that it must take the following actions to improve :

- The provider must ensure medication management is in line with its policy.
- The provider must ensure staff keep patient risk assessments up to date and in line with contemporaneous notes, complete risk assessments accurately and in a timely way.
- The provider must ensure staff adhere to infection prevention principles and good hygiene to ensure they or patients are not put at risk of harm.
- Staff must undertake comprehensive risk assessments on the environment and its impact on patients. This to identify and mitigate risks in relation to the building environment.
- The provider must inform the Care Quality Commission of any safeguarding referrals, or concerns. The duty to inform the CQC must be reflected in the safeguarding policy for such events.

Summary of this inspection

- The provider must have a duty of candour policy, and enable its staff to understand its principles and function.
- The provider must ensure staff have basic life support training available all staff, more significantly staff who are facilitating depot clinics
- Staff must update its local risk register when a risk has been identified that meets the criteria.

We issued the provider with three requirement notices. These related to:

- Regulation 12 HSCA 2008 (Regulated Activities) Safe Care and Treatment
- Regulation 17 HSCA 2008 (Regulated Activities) Good Governance
- Regulation 18 HSCA 2009 (Registration Regulations) Notification of other incidents

We also told the provider that it should take the following actions to improve:

• The provider should find alternative rooms and provisions in the instance there is no availability at the head office.

• The provider should provide leaflets in languages that reflect the local community.

• The provider must include the contact details for the Care Quality Commission within their whistleblowing policy.

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?

On this inspection, we assessed whether the service had made improvements to the specific concerns we identified during our last inspection. We returned to inspect Aspire within six months of publication of our last report which mean we were able to re-rate the service.

This inspection was announced 48 hours prior to the inspection, this was due to the core service being a community mental health team, and to ensure staff would be available to help us complete the inspection.

Before the inspection visit, we reviewed information that we held about the location, asked a range of other organisations for information, (and sought feedback from patients and carers in focus groups).

During the inspection visit, the inspection team:

- toured the premises and looked at the quality and safety of the environment
- spoke to four patients who were using the service
- spoke to two carers
- reviewed medication management, including storage and documentation
- observed a 'red board' meeting
- interviewed the registered manager and operational manager
- interviewed four staff including a team leader, nurse , social worker and support worker
- reviewed 14 risk assessments and risk management plans
- reviewed policies, procedures and other documents relating to the running of the service.

What people who use the service say

We spoke with four patients and two carers. All four patients told us they had received a lot of help and support from Aspire and that they would recommend the service to other people experiencing similar mental health issues. Both carers we spoke with also said they would recommend the service and that they had received help for themselves, not just for the person they were supporting.

Summary of this inspection

One patient told us that before becoming involved with Aspire, they were too afraid to go out on their own. However, they were now are able to go out alone, shopping and paying bills. As a result, the patient told us they were “more confident” and “more independent.” Another patient told us when they saw the doctor at the service, they felt “listened to” and “supported”.

Three service users told us staff had helped them with practical matters such as benefits and housing. One carer told us the care coordinator supported them in accessing services within the local community. All patients confirmed that where they had a need to see the on-site doctor, they were able to access an appointment in a timely manner and receive appropriate help. None of the patients and carers we spoke with could identify any improvements they would have wished to see regarding their care. Two patients told us the service they received had totally transformed their lives for the better.

Summary of this inspection

The five questions we ask about services and what we found

We always ask the following five questions of services.

Are services safe?

Good

We rated safe as **good** because :

- The service had addressed the issues that had caused us to rate safe as requires improvement following the May 2016 inspection.
- In the May 2016 inspection we found risk assessments were not always up to date, detailed or accurately reflect the patients risk. In January 2017 we found most risk assessments were comprehensive and staff updated risk assessments to reflect the patients current risk profile. Staff were reviewing patient risk on a daily basis during a morning meeting and updating care records accordingly.
- In the May 2016 inspection we found the environmental risk assessment stated all windows above ground floor should have window restrictors, however the floor Aspire occupied did not have window restrictors. In January 2017 the service had implemented window restrictors across the floor of the building it occupied to ensure the safety of the people using the service.
- In the May 2016 inspection we found the service did not have adequate hand washing facilities in the clinic room. In January 2017 we found the service had implemented hand washing facilities in the clinic room which meant staff were adhering to infection prevention principles.
- In the May 2016 inspection we found the service were not always monitoring temperatures of medication they stored on site. In January 2017 we found medication was stored safely with temperatures monitored on a daily basis and audited by management.
- In the May 2016 inspection, staff who were administering depot injections were not all trained in basic life support. In January 2017 we found all staff received basic life support training as part of their mandatory training.

However,

- The service could not calibrate the clinic equipment.

Although there were suitable disposal arrangements for clinical waste, these were located away from the clinic room.

Summary of this inspection

- Management did not regularly review the use of the 'lone buddy alert' system in line with their policy. This meant the service managers could not always ensure staff were using it on a regular basis.

Are services effective?

Good

- At the last inspection we rated effective as **good**. Since that inspection we received no information that would cause us to re-inspect a core service or change this rating

Are services caring?

Good

- At the last inspection we rated caring as **good.** Since that inspection we received no information that would cause us to re-inspect a core service or change this rating.

Are services responsive?

Good

- At the last inspection we rated responsive as **good.** Since that inspection we received no information that would cause us to re-inspect a core service or change this rating.

Are services well-led?

Good

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

- The service had addressed the issues that had caused us to rate well-led as requires improvement following the March 2016 inspection.
- In the May 2016 inspection the service the safeguarding policy did not provide all the required information which outlined responsibilities of staff. In January 2017 the service had developed their safeguarding policy to inform the responsible person of their duties to inform the Care Quality Commission of any safeguarding concerns and serious incidents. The service were able to evidence statutory notifications sent to the Care Quality Commission over the last 12 months to evidence the change in policy.
- In the May 2016 inspection the service did not have a Duty of Candour policy in place. In January 2017 we found the service had implemented the Duty of Candour policy. Over 86% of staff had been trained and during interviews staff were clear about their roles and responsibilities under this regulation.
- There was an improved risk register which all staff could submit to. The risk register was updated regularly and had identified current risks within the service.

Summary of this inspection

- We saw improved governance and communication structures between Aspire and the senior management within Community Links Ltd. The service evidenced different governance meetings which demonstrated a clear line of communication improving the running of the service.

Detailed findings from this inspection

Mental Health Act responsibilities

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

Mental Capacity Act and Deprivation of Liberty Safeguards

We did not review the service's adherence to Mental Capacity Act and Deprivation of Liberty Safeguards during this inspection.

Good

Community-based mental health services for adults of working age

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

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

Good

Safe and clean environment

Aspire was located on the second floor of the Community Links building in Leeds.

The building had a locked entrance and visitors had to ring to the appropriate floor to which the relevant service would grant access. On the floor Aspire occupied, there was a separate suite for patients and staff. The patients' suite included therapy rooms, a kitchen, and a clinic. The staff suite contained access to patient care records, medication storage and offices. We saw all patient areas were clean and well maintained. Both suites required key pad entry, this meant patients could not enter without a member of staff present. There was disabled access for people with mobility issues by way of a lift.

At our last inspection in May 2016, we found the floor Aspire occupied did not have any window restrictors. This was contrary to the building risk assessment which stated that all windows above the ground floor had window restrictors. Some of the windows in the patient areas posed a risk as they were large, had low ledges and opened out fully. Patients who access this service can become acutely unwell and can suffer from delusional or suicidal thoughts as part of their symptoms, therefore, the windows without restrictors posed a potential risk. At this inspection, the service had re-assessed their environment and implemented window restrictors across the second floor. The service took further precautions to reduce risk by putting bars across the large window in the clinic room. The meant the service had assured themselves of potential risks that could occur if the restrictor in the clinic room failed.

At our last inspection in May 2016, we found the provider was not following safe infection control procedures. There were no handwashing facilities in the clinic room where staff were administering injections to patients. However, since our last inspection the provider had installed a sink in the clinic room. Next to the sink there was a handwashing poster which showed staff how to wash their hands effectively after a clinical intervention. We also observed that part of the floor near the examination couch had been covered with a washable floor covering. This meant that if there was a blood spill, for example, the floor could be cleaned effectively. The service had appropriate disposable arrangements for clinical waste. Staff brought sharps bins into the clinic rooms to dispose of needles for each patient. However, the service did not have a portable waste bins for other clinical waste such as cotton wool. This meant staff had to carry potential infectious material into a different room where the appropriate clinical waste bin was located.

We discussed the potential risks in relation to this with the provider, they said they would ask their waste management company for some portable clinical waste containers so potentially hazardous waste could be safely contained at the point it was generated. This would then minimise the risk to staff and patients from potentially infectious waste being transported around the building in unsuitable containers.

The clinic room had height, weight and blood pressure monitoring equipment. We found staff were not yet able to calibrate the equipment. This had already been identified on the risk register and the service were in discussion with a contractor to carry out the work.

Safe staffing

Aspire did not use a recognised tool to estimate the number of qualified nurses they needed, however, they felt the overall staffing levels were sufficient. We found no evidence of negative impact on patient care due to staffing. Staff numbers had increased since our last inspection because Aspire were now commissioned to deliver care to young people and adults between 14-65 years of age. At our last inspection they only delivered care to young people and adults between 14-35 years old.

There were a total of 37 staff working at Aspire, which included 6.7 whole time equivalent registered mental health nurses, six 'Band 6' care co-ordinators, five 'Band 5' care co-ordinators, four 'Band 4' care co-ordinators and one 'Band 3' Support, Time and Recovery worker.The care co-ordinators include mental health nurses and a social worker. There are two Team Leaders; one is a registered mental health nurse and one is an occupational therapist. The service manager is a registered mental health nurse. The service had two doctors which totalled 1.1 whole time equivalent and a clinical psychologist at 0.8 whole time equivalent.

A care coordinator is a member of staff assigned to a patient, to plan, assess and deliver their care. Each care coordinator had a case load of between 13 – 17 patients depending on their responsibilities and complexity of patients. For example, 'band six' care coordinators averaged 13 to 15 patients on their caseload, however, in addition they supervised less experienced staff as part of their responsibilities. Best practise and guidance from National Institute for Health and Care Excellence indicate the case load per care coordinator at Aspire was good practice. Having 12-15 patients per case load enables staff to work intensively with patients for a prolonged period of time. At the time of the inspection, there were no patients waiting to be allocated to a care coordinator. We found although the service was now targeting a larger service user group they had increased their staffing to maintain best practice with regard to managing caseloads.

Aspire had two psychiatrists who were employed by the local trust, however, were contracted to work at Aspire. Staff and patients felt emergency appointments could be easily accessed if needed. Patients could be seen within a day. In addition, the psychiatrists had held urgent slots in their schedules for patients who felt they needed to see a doctor urgently. When we spoke with patients using the service, they confirmed they had been able to access an urgent appointment with a clinician when they needed to.

Aspire had one long term agency worker within the team, and the manager felt there was enough administrative support available. Vacancy levels were at 10% (3 staff), however, management were in the process of employing new staff with two people to start in February and March 2017. Staff sickness was 3.6% for 2016.

The service had a completion rate of 86% for their mandatory training. This included safeguarding children and safeguarding adults training. It is important for staff within community teams to have safeguarding training as they work closely with families and children. During our last inspection, we identified staff were not trained in basic life support, including staff who administered depot injections to patients. A depot injection is a slow release medication usually given into muscle tissue. The service had now implemented basic life support training as part of their mandatory training for all staff and the completion rate was over 80%. Staff told us they felt more confident after having the training and thought it was beneficial to their role.

Assessing and managing risk to patients and staff

We reviewed 14 patient care records and focused on the risk assessments and risk management plans. During our last inspection, we found staff didn't always update risk assessments to reflect the patients risk accurately. All 14 records contained risk assessments carried out by staff using an evidence-based tool called a 'Functional Analysis of Care Environments' risk assessment. We found staff were reviewing risk assessments regularly, either as required in line with service policy, or more often in line with changes to a patient's risk profile. We were able to identify when a patients risk profile changed for the worse and for the better. This meant that other staff who might be involved with the patient knew what the current risks were and what the plan was to address them. All the risk assessments were detailed and comprehensive. Ten out of 14 risk management plans were detailed and aligned to the risk

assessments, we found three that were not as detailed and one record was missing risk management plan. However, we found overall the staff had improved their approach to capturing and managing risk.

The service had implemented a new quality assurance tool where managers reviewed and audited risk assessments and risk management plans during supervision. This meant that staff had the opportunity to improve risk management plans by learning from feedback. We reviewed three supervision files where this quality audit had taken place and team leaders had identified learning for staff and actions in order for them to improve their risk assessments.

Staff were regularly reviewing high risk patients in a morning 'red board' meeting. This system highlighted concerns with patients who were deemed as high risk. We observed a 'red board' meeting and found it to be comprehensive, staff used this opportunity to discuss concerns in a team environment. The multi-disciplinary approach demonstrated that staff took a shared responsibility in managing risk within the service. As well as the patient being on the red board, staff also updated their care records so that anyone accessing it could see there were increased concerns around risk.

Staff confirmed that patients had access to an on-site clinician in urgent situations where their mental health had deteriorated. There was a crisis service available out of hours between 6pm till 9am for seven days a week. The crisis service was provided by the local trust. All patients were provided with crisis numbers as part of their care planning.

We reviewed the on-site arrangements for the storage and management of medicines. At our last inspection, we found that staff could not be sure that medication was stored below 25 degrees Celsius in line with the manufacturer's recommendations. However, at this inspection, the service had arrangements in place which ensured temperatures were monitored to ensure that medicines were stored at the recommended temperatures. Actions was taken if the temperature exceeded the recommended guidance. This meant medicines were being stored safely.

Staff who administered depot injections told us they did not have up-to-date anaphylaxis training. This meant they might not be able to recognise the signs of anaphylactic shock in a patient. However, staff had received basic life support training which meant they would know what to do if a patient stopped breathing as a result of anaphylactic shock. The service manager confirmed that they were already aware of this and were in discussion with the local trust about ensuring anaphylaxis training was made available to the staff who required it. The registered manager was in the process of arranging the training.

The service had a lone working policy in place which provided staff with details on how to practice safely when visiting patients within the community. Staff told us that two staff were required to provide the initial assessment for patients. The staff also had access to a system called 'alert a buddy' to maintain their own safety when visiting patients at home or in the community. All the staff we spoke to said they used this system, which involved them having to send a text message prior to and after a home visit. If the staff member failed to send a text at the end of the visit, a manager would automatically be alerted to try to contact the staff member concerned. If no contact could be made, the manager would inform the police as to their last known whereabouts. None of the staff we spoke to had ever experienced an emergency situation during a home visit but two members of staff said they had sometimes forgotten to send a text message at the end of a visit. In this scenario, they found it reassuring that they received a call from a manager asking if they were alright and in need of any assistance. There were signs at the exit and entrance of the floor to remind staff to text an alert.

The service policy required managers to complete routine reports to audit how frequently staff were using the 'alert a buddy' system. Managers confirmed they did not routinely run reports to see whether staff were using the system, instead, they ran reports on an ad hock basis. The registered manager recognised the importance of doing the reports more routinely and assured us they would make this a regular audit.

Duty of Candour

The duty of candour is a requirement in the Health and Social Care Act 2014 for health services which was introduced in 2015. Providers of healthcare services must be open and honest with service users and other 'relevant persons' (people acting lawfully on behalf of service users) when things go wrong with care and treatment, giving them reasonable support, truthful information and a written apology.

Good

Community-based mental health services for adults of working age

During our last inspection the service did not have a duty of candour policy in place. However, since our last inspection the policy had been implemented and staff had completed the relevant training. All the staff we spoke to understood the principles about the Duty of Candour and felt that their organisation reflected the spirit of its purpose.

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

(for example, treatment is effective)

Good

At the last inspection in May 2016 we rated effective as good. Since that inspection we have received no information that would cause us to re-inspect this key question or change the rating.

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

Good

At the last inspection in May 2016 we rated caring as good. Since that inspection we have received no information that would cause us to re-inspect this key question or change the rating.

Are community-based mental health services for adults of working age responsive to people's needs?

(for example, to feedback?)

Good

At the last inspection in May 2016 we rated responsive as good. Since that inspection we have received no information that would cause us to re-inspect this key question or change the rating.

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

Good

Vision and values

The service principles and values as they described in three words were 'engagement', 'hope' and 'recovery'. Within these, Aspire had statements which they describe as their vision, Aspire endeavoured to deliver as part of their service ;

- Respects and acknowledges young people's needs within developmental approach.
- Supports young people to find their own level of recovery by integrating their experience.
- Recognises the role of family and friends in young person's recovery and their support needs.
- Encourages sense of belonging and having valued roles in community and society.

Staff at Aspire were aligned to their vision and values. They demonstrated a proactive approach to working with their patients. Staff were clear in what they had to achieve and were able to show us it in practice. Staff had a sound understanding of the organisational structure on a local level within Aspire and at a provider level, Community Links.

Good governance

At our last inspection, we found the service did not have robust governance structures in place. At this inspection, we found the service had improved their governance and implemented mechanisms to improve oversight, manage risk and improve quality.

At the time of last inspection, the service had had an acting manager in post. This person was then appointed Registered Manager substantively to the post on 2 May 2016 following successful application for the role.

At this inspection, the service had made appropriate amendments to their whistleblowing policy and safeguarding policy. The safeguarding policy now included the duty of the responsible person to inform the Care Quality Commission of any safeguarding incidents or

serious incidents. The registered manager notified the Care Quality Commission of 13 safeguarding incidents and three serious incidents in the last 12 months. There was no duty of candour policy in place at our last inspection, the service had implemented this and provided training to staff. The staff we spoke to were aware of their duties and responsibilities under the Duty of Candour.

The team leaders and registered manager had a dashboard which identified the key performance indicators for the service. It used a traffic light system and a percentage to identify how well the service was performing and it flagged any areas of concern. The dashboard showed the service overall was meeting its targets: appraisals 100% (target 100%), customer satisfaction 100% (target 85%), risk assessments 98% (target 95%) and referral to treatment within two weeks 53% (target 50%).

There were improved governance structures up to board level. We saw different examples of governance meetings which ensured information was being communicated from an operational level up to the board. The 'subcommittee meetings' reviewed the key performance indicators and ensured actions were in place to improve areas of concern.

The 'CQC Compliance meetings' were reviewing regulatory action across all services delivered by the provider, identifying themes and trends and implementing change. An example of this was the change in the safeguarding and whistleblowing policy. The senior management teams had 'clinical governance' meetings where serious incidents across the provider were reviewed and learning was disseminated to staff through team meetings and emails. The minutes showed that management from all levels were represented in these meetings.

The service had implemented a local risk register which staff could add to. This risk register fed into the provider risk register. The risk register was updated regularly and staff had already updated the register for issues found during the inspection, for example, the service not being able to calibrate equipment. The risk register used a matrix to identify the level of risk which prompted the urgency of any actions required. Aligned to the risk assessment was a detailed action plan which outlined what tasks were being undertaken to mitigate risks and what the plan was until the risk was either eliminated or safely managed.

Outstanding practice and areas for improvement

Areas for improvement

Action the provider SHOULD take to improve

- The service should ensure there is a system in place to calibrate the clinic equipment.
- The service should ensure management are regularly reviewing the usage of the “alert a buddy” lone working system in line with their policy.
- The service should ensure there are appropriate clinical waste products available at the service to prevent staff taking items into other areas of the building for safe disposal.