Care Quality Commission

Manchester Mental Health and Social Care Trust

Community-based mental health services for older people

Quality Report

Chorlton House
70 Manchester Road
Chorlton-cum-Hardy
Manchester
M21 9UN
Tel: 0161 882 1000
Website: www.mhsc.nhs.uk

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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)
TAE03	Park House	Community mental health team for older people North West Community mental health team for older people North East	M9 8GQ
TAE02	Laureate House	Community mental health team for older people South Team North Community mental health team for older people South Team South	M20 2LR

Summary of findings

TAE01	Edale House	Mental health day service for older people	M14 5QN

This report describes our judgement of the quality of care provided within this core service by Manchester Mental Health and Social Care Trust. Where relevant we provide detail of each location or area of service visited.

Our judgement is based on a combination of what we found when we inspected, information from our 'Intelligent Monitoring' system, and information given to us from people who use services, the public and other organisations.

Where applicable, we have reported on each core service provided by Manchester Mental Health and Social Care Trust and these are brought together to inform our overall judgement of Manchester Mental Health and Social Care Trust.

Summary of findings

Ratings

We are introducing ratings as an important element of our new approach to inspection and regulation. Our ratings will always be based on a combination of what we find at inspection, what people tell us, our Intelligent Monitoring data and local information from the provider and other organisations. We will award them on a four-point scale: outstanding; good; requires improvement; or inadequate.

Overall rating for the service	Good	🟢
Are services safe?	**Requires improvement**	🟠
Are services effective?	**Good**	🟢
Are services caring?	**Good**	🟢
Are services responsive?	**Good**	🟢
Are services well-led?	**Good**	🟢

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

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

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

Summary of findings

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Summary of findings

Overall summary

There were effective systems, processes and practices in place to keep people safe and safeguard them from abuse. There was openness and transparency about safety. Staff understood their roles and responsibilities to raise concerns and report incidents and near misses. However, the community mental health teams did not have appropriate systems in place for the storage and recording of medicines. Systems to ensure risks were reviewed regularly were not robust or effective.

There was evidence of effective multi-disciplinary team working across all the teams. They also made links with organisations external to the trust. The day service team provided a range of activities and therapeutic interventions to support people's recovery in line with best practice guidance. However, the CMHTs did not have the facilities to provide similar services and focused mainly on visiting people who used services, usually at home.

Some of the community mental health team (CMHT) services had experienced significant pressures due to high absence levels. Despite this, waiting times, delays and cancellations were minimal. Access to care and treatment was timely and services were planned and delivered to take into consideration people's individual needs and circumstances. Reductions in staffing levels were offset in some teams by use of long term agency staff who were familiar with the team's work.

Current information was stored on the trust's electronic mental health recording system. Social work staff also had access to the system used by the local authority.

A lot of staff time was taken up travelling, especially as the teams did not have facilities to run clinics or groups for people who used services to attend. We were told about one nurse-led out-patient clinic that patients could attend.

Staff talked about their work in terms of the recovery model. Their focus on supporting people to remain in the community was clear. However, some care plans, while containing elements of a recovery based approach, tended to be mainly generic and whilst they were goal

focused, they were not always recovery based. Some staff said they did write full holistic care plans wherever possible but their time was pressured and they prioritised seeing the person above inputting data.

We found some good examples of how teams ensured the physical health care needs of people who used services were being met. The south team included an assistant practitioner who provided support around physical health care. There was a comprehensive tool in use for reviewing physical health needs. Physical health care was well care planned and documented.

Staff had the skills, knowledge and experience to deliver effective care and treatment. They were supported by means of supervision and appraisal processes, to identify additional training requirements and manage performance.

Overall, there was a holistic approach to assessing, planning and delivering care and treatment, using best practice guidance. However, some care plans and risk assessments were out of date although notes reflected more recent discussion and review. This meant people's care needs were not being reflected accurately and may not be being met.

We gathered information from a range of sources to gain feedback from people who used services and their carers. Their feedback was positive, particularly about the way staff treated them. People and their family members were treated with kindness and respect and they were involved in decisions about their care. They told us they felt they were listened to and supported during their care and treatment. Staff were sensitive and respectful of the wishes of people who used services and were committed to providing personalised care based upon their needs.

A single point of access, the Gateway service, had been introduced to manage and prioritise referrals into the service. We found that the Gateway was embedded, effective and responsive in prioritising the needs of people who used services.

Consent was recorded and reviewed to ensure people were involved in making decisions about their care. Consent to care and treatment was sought in line with

Summary of findings

the Mental Capacity Act 2005. People who were subject to the Mental Health Act (MHA) 1983 were assessed, cared for and treated in line with the Act and the MHA Code of Practice.

At a local level, we found staff were clear about the values and vision of the team they worked in. A divisional plan was in place and had recently been taken forward. Part of the plan was to ensure that with recent bed reductions, community developments would take place quickly. However, staff were less clear about the direction of the trust and there was concern about its future. Some staff thought the trust had been "branded" in a negative way and that this was historic rather than objective. They expressed concern about the nature of the relationship between the trust and commissioners of its services. They thought this may have meant the jobs of senior management were not secure, leading to decisions made not being as objective as they could have been.

The trust had put in place a range of initiatives to improve engagement with staff. These were welcomed but people thought there should be more; for example, of the Chief Executive's forums where staff could meet her.

The services managed complaints and concerns effectively. They listened to concerns and learning was disseminated to the teams so it could be used to improve the services.

Summary of findings

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

Are services safe?

We rated safe as requires improvement because:

- The CMHTs did not have appropriate systems in place for the storage and recording of medicines.
- Systems to ensure risks were reviewed regularly were not robust or effective.

However:

- Staff had a good understanding of safeguarding and how to escalate concerns.
- Staff understood their responsibilities in reporting incidents.

Requires improvement 🟠

Are services effective?

We rated effective as good because:

- Overall, staff assessed people's needs, drew up care plans and delivered care in line with best practice.
- Staff offered carers an assessment of their needs and advised them of their statutory right to a formal carers assessment provided by social care services
- Staff were supported by means of clinical and management supervision, appraisal, handovers and team meetings.
- Staff were encouraged and supported to develop their skills, knowledge and experience.
- Multi-disciplinary teams managed the referral process, assessments, ongoing treatment and care by discussing the best treatment and pathway options for each individual.

However:

- Care plans were not always up to date, person centred, holistic or recovery based.

Good 🟢

Are services caring?

We rated caring as good because:

- Staff engaged with people who used services with kindness and respect.
- People who used services and their families were involved in planning care and treatment.
- At the day service, there was a quarterly user group where people could be involved in developments and decisions.
- Care plans included evidence of carers' involvement.

Good 🟢

Summary of findings

Are services responsive to people's needs?

We rated responsive as good because:

- There were systems in place to triage referrals based on the individual needs of people who used the service.
- Services were planned and delivered to meet people's needs in a person centred way taking their cultural needs into account.
- People who used services had timely access to care and treatment.
- Staff at the day service made plans for people's continuing support from the start of their treatment.
- The teams had access to interpretation services
- People who used services knew how to make a complaint if necessary.

Good ●

Are services well-led?

We rated well-led as good because:

- A meeting structure was in place to escalate and cascade information through all levels of staff. This included governance, incidents and performance monitoring.
- Staff understood their roles and responsibilities, including accountability.
- Staff felt respected, valued and supported by their managers and their peers.
- Staff were encouraged to develop by management at local level.

However:

- Some staff were not clear about how their team's work linked into the trust's vision and values. They felt disconnected from the wider trust.

Good ●

Summary of findings

Background to the service

Manchester Mental Health and Social Care Trust provided a range of community based mental health services. During our inspection we visited a sample of the community mental health services for older people. These services have not been inspected by the Care Quality Commission before.

The community mental health teams (CMHTs) included the North East, North West, South Team South and South Team North (divided by the River Mersey). They were multi-disciplinary teams which provided mental health assessments, treatment, rehabilitation and support for people primarily aged 65 and over, who have functional or organic disorders. However, reaching 65 did not lead to automatic transition to older people's services if people's needs could be better met by adult services. The teams undertook initial assessments to understand how they could meet people's needs and provided on-going support to people who used services and their carers or family members. Support included further appointments with a psychiatrist, psychologist, community mental health nursing support and occupational therapy support, and arrangements for after care, where this was required.

Referrals were accepted from inpatient services or via the Gateway referral service. The gateway team was introduced as a single point of access and we found that it was embedded, effective and responsive in prioritising people's needs. A duty system also operated in the teams for urgent referrals. The North East and North West CMHTs included a memory service that assessed and diagnosed the nature of people's memory difficulties and advised on further intervention. This was accredited by the Royal College of Psychiatrists. The South teams accessed a separate memory clinic but due to the high rate of referrals to the clinic, the CMHT nurses also carried out memory assessments.

Due to the lack of suitable venues, the CMHTs did not currently operate any clinics or groups and all the people who used services were seen in their own homes, at the day service or other outpatient settings. Post-diagnostic support was offered to people with dementia and their carers; this was offered collaboratively with the Admiral nurses (specialist nurses who work with family carers and people with dementia in the community). The CMHTs also linked with the day service to provide a comprehensive service for people who needed different levels of care and treatment. All the CMHTs operated from Monday to Friday, 8.00 a.m. to 5.00 p.m. Crisis service were available outside those hours.

The day service was a nurse-led service providing assessment and treatment for people primarily aged 65 and over who had severe and enduring mental health needs. Referrals were taken either from the CMHTs or consultant psychiatrist. The service linked closely with the CMHTs and in-patient services to provide a comprehensive pathway. Following a six to eight week assessment period at the day service, people were prepared for discharge. The day service monitored mental health and interventions were planned to prevent relapse. They offered assessment of functional ability and the maintenance and restoration of daily living skills. They promoted independence and rehabilitation of social skills by supporting and encouraging patients to access and be involved with local services. Groups such as an anxiety management group and a depression group were run by the day service, as well as less formal groups for assessing social interaction. The groups were open to any person who used the CMHT services as well as those who used the day service. The day service also offered support for carers. The service was open from Monday to Friday, 8.00 a.m. to 4.30 p.m.

All the teams worked in line with the principles of the recovery model. This was evidenced by their focus on supporting people who used services to remain in the community.

Our inspection team

Our inspection team was led by:

Summary of findings

Chair: Steve Shrubb, Chief Executive Officer, West London Mental Health NHS Trust

Team Leader: Brian Burke, Care Quality Commission

Head of Inspection: Nicholas Smith, Care Quality Commission

The team that inspected this core service included two CQC inspectors, a consultant psychiatrist, a mental health nurse, a mental health social worker, an occupational therapist and one person who had experience of using mental health services.

Why we carried out this inspection

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

How we carried out this inspection

To get to the heart of 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?

We carried out announced visits to the service from 24 March to 26 March 2015. We carried out an unannounced visit to Laureate House on 9 April 2015 to return to Cavendish ward.

During the visit we met and interviewed 31 members of staff who worked within the service, including administrators, nurses, occupational therapists, psychiatrists, senior managers, social workers and support workers.

We met with seven people who were using the services who shared their views and experiences of the services we visited.

We accompanied staff during home visits with the consent of the person who used the service.

We observed how people who used services were being cared for, we talked with 11 carers and family members and we reviewed 19 care and treatment records. We looked at a range of records including clinical and management records. We attended one handover, one allocation meeting, two review meetings and one governance meeting.

We inspected five of the community-based mental health services for older people which included community mental health teams and day services.

What people who use the provider's services say

During the inspection, we spoke with seven people who used services and 11 carers.

People described the services as "brilliant" and "wonderful". They told us staff treated them with kindness and respect. They felt involved in the decisions being made about their care and treatment. They said they felt their views were listened to and the service was flexible. People told us their cultural needs had been taken into account.

They said access to the service was good and support was given when needed; for example, in a crisis situation or just when they wanted some advice.

Summary of findings

Areas for improvement

Action the provider MUST or SHOULD take to improve

- The trust must ensure that appropriate arrangements are in place for the storage and recording of medication.
- The trust should ensure there are clear processes in place to ensure that risk is monitored and reviewed regularly.
- The trust should ensure there are clear processes in place to ensure that care needs are monitored and reviewed regularly.

- The trust should work with its partner agencies to ensure information stored is not duplicated or at risk of being missed.
- The trust should take steps to address the amount of staff time lost due to computer systems and time spent travelling.

- The trust should ensure staff are consistent in using the system provided to maintain their personal safety.

CareQuality Commission

Manchester Mental Health and Social Care 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
Community mental health services for older people North West	Park House
Community mental health services for older people North East	Park House
Community mental health services for older people South Team North	Laureate House
Community mental health services for older people South Team South	Laureate House
Mental health day services for older people	Edale House

Mental Health Act responsibilities

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

Staff we spoke with understood their responsibilities in relation to the Mental Health Act. We saw care plans for people subject to community treatment orders (CTO) which provided appropriate details about the conditions relating to the CTO.

Detailed findings

Mental Capacity Act and Deprivation of Liberty Safeguards

Staff demonstrated understanding of the MCA. For example, they could explain how capacity would be established, how the best interests of people who used services would be assessed and the circumstances in which an IMCA would be accessed. The care records we inspected supported this.

Are services safe?

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

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

Summary of findings

We rated safe as requires improvement because:

- The CMHTs did not have appropriate systems in place for the storage and recording of medicines.

- Systems to ensure risks were reviewed regularly were not robust or effective.

However:

- Staff had a good understanding of safeguarding and how to escalate concerns.
- Staff understood their responsibilities in reporting incidents.

Our findings

Safe environment

- The day service was the only one of the community based services we visited which had facilities for people to attend. It had a clean, safe environment which was suitable for delivering care to older people. There were clear, simple signs at a visible height which included symbols as well as words. All fixtures, fittings and equipment were in a good state of repair. There was a room for interviewing and meeting individual patients and carers, which had comfortable seating.
- Some building works were planned to make the premises more appropriate for therapeutic activity. This would allow optimum use of the available space and rooms.

- At the day service, medical equipment was available and checked routinely.

- At the office base of the South Team North, there were no effective systems in place to ensure security and safety. The office was located on the first floor in a building which was also used by other teams. On the day of our inspection we were not asked to sign into the

building or show any form of identification. Staff told us that they did not sign in and out. Thus there was no log to ensure everyone's safe exit in the event of an emergency

- There was a lone worker policy in place and a system for staff to use to maintain their personal safety. Staff were aware of the system; however, they did not use it consistently.

Safe staffing

- Staff skill mix was planned and reviewed to ensure people who used services received safe care and treatment.
- Referrals were allocated to staff in allocation meetings, based on existing caseload and expertise of staff. There was no formal caseload management system in place; however, case load management was discussed with staff individually during management supervision to determine their case load. A case load weighting tool was being trialled within the adult CMHT.

- Staffing levels were reduced by high levels of sickness absence. Across the teams, sickness absence ranged from 5% to 9%. This was offset in some teams by use of long term agency staff who were familiar with the team's work. At the Stables, the manager also provided social work cover.

Assessing and managing risk to patients and staff

- Stocks of intramuscular depot injections were locked in a cupboard within a locked room. Injections were 'in date'. All the nurses had keys and three more keys were kept in the drawer of an administrator's desk. There was no record of who had keys or system for signing the keys in the office 'in and out'. Access to the team's offices and working area was restricted. However, for the north east and north west teams, the locked room was not fully supervised at all times. This was because it was located outside the restricted area. Stocks were ordered from Lloyds pharmacy by one of the nurses. Copies of orders were kept but there was no audit trail of stock received or of ampoules taken from the cupboard. This is a

Are services safe?

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

breach of regulation 13 of the Health and Social Care Act 2008 as the provider had not made appropriate arrangements for the storage and recording of medicines.

- Staff had drugs cases for transportation of medication and portable sharps bins for safety of used needles.

- Risk assessments were carried out either prior to or at the start of people's involvement with the community services as part of the comprehensive assessment. Where a risk had been identified, there was a plan in place to reduce or manage the risk to make sure people who used services were safe. These were generally holistic and comprehensive.

- For most people, risk was reviewed regularly. However, staff told us that frequency was at the discretion of the care coordinator and there was no clear process to ensure that risk was monitored and reviewed. Although daily care notes reflected recent discussion, three of the 19 risk assessments we looked at had not been updated and were not being monitored to ensure changes were identified and people's care needs reflected accurately. One risk assessment we saw had not been updated since 2012 although there was evidence on the file of a Care Programme Approach (CPA) review in December 2014. Not ensuring risk assessments were up to date meant staff did not have a true understanding of current risk.

- The electronic system incorporated pop up notes to alert staff to incidents such as safeguarding, allergies, whether the person was subject to a Community Treatment Order (CTO) under the Mental Health Act 1983.

- Clinical staff all had a clear understanding of their responsibilities regarding safeguarding and the process for reporting safeguarding concerns. However, safeguarding training was not mandatory for administrative staff although they were often the first point of contact for people who used services.

Are services effective?

Good ●

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

Summary of findings

We rated effective as good because:

- Overall, staff assessed people's needs, drew up care plans and delivered care in line with best practice.
- Staff offered carers an assessment of their needs and advised them of their statutory right to a formal carers assessment provided by social care services
- Staff were supported by means of clinical and management supervision, appraisal, handovers and team meetings.
- Staff were encouraged and supported to develop their skills, knowledge and experience.
- Multi-disciplinary teams managed the referral process, assessments, ongoing treatment and care by discussing the best treatment and pathway options for each individual.

However:

- Care plans were not always up to date, person centred, holistic or recovery based.

Our findings

Assessment of needs and planning of care

- People were seen within two to three weeks of referral.
- The teams completed comprehensive assessments of the needs of people who used services. These included their social, occupational, cultural, physical and psychological needs and preferences.
- Care plans were not always personalised or holistic. The quality varied across all teams. Some care plans were comprehensive and clear. Others lacked detail in relation to a holistic approach and were not always recovery based. Of the 19 care and treatment records we looked at, four contained information which were not up to date or complete. Some records did not record reviews of capacity and consent, although the daily notes indicated discussion had taken place. Another contained safeguarding information which was not up to date. One contained a risk summary which had not been reviewed by the due date. This meant staff did not have a clear and accurate understanding of the person's needs thus may not always be providing appropriate care.

- Current information was stored on the trust's electronic mental health recording system. Social work staff also had access to the system used by the local authority. They told us the two systems were not synchronised and their perception was that this led to duplication of work.

Best practice in treatment and care

- Staff considered physical health needs as part of the assessment process. They used the Rethink Physical Health Check. This is a comprehensive tool which enables a structured conversation with the person who uses services to identify unmet need and incorporates an action plan to address identified needs. It is designed to improve physical health outcomes for people affected by mental illness.

- A Clinical Audit Programme was in place. The South team manager described participating in a medicines management audit and the outcomes of the audit.

Skilled Staff to deliver care

- The teams were compliant in the trust's mandatory training. They also identified further training relevant to their work and they were encouraged to develop their skills in specialist areas. For example, some staff had recently undertaken training in cognitive stimulation therapy and anxiety management, and dementia awareness training had been developed.

- Staff told us they felt supported in their roles and that they received regular supervision. Supervision was structured and addressed matters outstanding from the previous meeting and covered performance, development and staff issues. All staff supervision was up to date.

Multi-disciplinary and inter-agency team work

- The teams included a range of disciplines to support people using the service. This included psychiatrists, managers, deputy managers, social workers, nursing staff, support workers, allied health professionals such as occupational therapists and speech and language teams (SALT) and administrators.

- The day service had information on display about how to access to neighbourhood groups and volunteering and educational opportunities.

Are services effective?

Good 🟢

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

- The CMHTs had facilitated training days with local GPs. This was an opportunity to develop good working links between the services. Further joint sessions were planned.

- However, the day service was not being used as effectively as it could be by other services. In particular, inpatient services were not referring early enough so that engagement could begin prior to discharge from the ward.

Adherence to the MHA and the MHA Code of Practice

We found evidence to demonstrate that the MHA was being complied with.

Staff we spoke with understood their responsibilities in relation to the Mental Health Act. We saw care plans for people subject to community treatment orders (CTO) which provided appropriate details about the conditions relating to the CTO.

People told us how they could access advocacy services if they wanted assistance.

There were effective systems in place to assess and monitor risks to individual people who were detained under the Mental Health Act.

Good practice in applying the MCA

We found that 42% of staff had received training on the Mental Capacity Act (MCA) and 39 % on the Deprivation of Liberty Safeguards (DoLS). This was part of the mandatory training provided by the trust. The trust's target for compliance was 90%.

The staff we spoke with understood that capacity fluctuated and that people may have capacity to consent to some things but not others. They were clear about their responsibilities in undertaking capacity assessments and continuous monitoring to ensure people were able to understand and agree to decisions being made or that they were made in the best interest of the person.

Are services caring?

Good ●

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

Summary of findings

We rated caring as good because:

- Staff engaged with people who used services with kindness and respect.
- People who used services and their families were involved in planning care and treatment.
- At the day service, there was a quarterly user group where people could be involved in developments and decisions.
- Care plans included evidence of carers' involvement.

Our findings

Kindness, dignity, respect and support

- Staff treated people who used the service with respect, kindness and dignity. We saw people were comfortable both in the services we visited and when staff visited them at home.

- Staff gave people who used services clear information about their care and what they could offer.
- People's confidentiality was maintained with confidential waste bins and locked files.
- People who used services said staff were helpful and they could ask about anything.

The involvement of people in the care they receive

- People who used services told us they felt involved in planning their care. All the records we looked at contained a care plan. Copies were sent to the person by administrative staff unless the person had said they did not want a copy and this was clearly recorded.
- Family members were able to attend review meetings and were encouraged to be involved.
- The day service held a quarterly forum for people who used services and their carers. This meeting provided an opportunity for them to be consulted about changes and to raise concerns.
- We observed clinical appointments where care and treatment options were clearly explained.

Are services responsive to people's needs?

Good ●

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

Summary of findings

We rated responsive as good because:

- There were systems in place to triage referrals based on the individual needs of people who used the service.
- Services were planned and delivered to meet people's needs in a person centred way taking their cultural needs into account.
- People who used services had timely access to care and treatment.
- Staff at the day service made plans for people's continuing support from the start of their treatment.
- The teams had access to interpretation services
- People who used services knew how to make a complaint if necessary.

Our findings

Access, discharge and transfer

- The teams focussed on assisting people to remain within the community and avoid admission to hospital where possible.
- The teams also facilitated the early discharge of some people from hospital by offering them intensive support during the move from hospital to the community.
- The Community Mental Health Teams (CMHTs) accepted referrals from in-patient wards, other trust services and via the Gateway system. People who used services were seen within two to three weeks from referral. GPs were able to refer their patients directly via the Gateway or the duty system.
- The initial assessment evaluated people's needs and the care and treatment options available to them.
- People attending the day service were accepted for a period of assessment and supported to attend, for example, neighbourhood groups, learning or volunteer opportunities.
- Staff attempted to engage people who missed appointments, mainly by phone calls and letters and discharged them if they no longer accessed the service.

- People who used services told us they had not experienced delays or any cancelled groups or appointments.
- Transport was available so that people could access the service.
- All the teams had developed links with the acute wards and bed managers to make sure that people who used services were admitted to and discharged from hospital when clinically appropriate. Aftercare support was agreed through the Care Programme Approach (CPA) process. The patients' CPA care co-ordinator remained consistent throughout admission and discharge from hospital. This meant that the process was 'seamless' and people who used services received continuity of care.
- The day service used a red (emergency), amber (urgent) and green (routine) (RAG) rating system to triage each referral made to the service. Ratings were made according to the needs of people who used the service and the rating was not changed until the needs were met. The system was used, for example, for monitoring side effects of medication or ensuring a review had taken place.
- Staff expressed concern about the relocation of the day service following a fire in December 2014. The service had become city-wide rather than the local service it had been previously.
- At the day service, activities were arranged for groups and individuals. These were designed to encourage independence from the service and access continuing support from the wider community and other services following assessment. However, the day service reported that the need for independence was not always accepted outside the service and it was sometimes difficult to discharge people to other services. The CMHTs also reported that it was not always possible to discharge people, for example, to their GP for depot injections.

Facilities promote recovery, dignity and confidentiality

- The day service location was clean, welcoming and comfortable.
- At the day service, there were facilities for various activities; for example, creative groups, discussion

Are services responsive to people's needs?

Good ●

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

groups, a reading group and a large sensory garden. There was a large, well equipped kitchen and we were told how this was to be used for therapeutic cooking activities once staff had received food hygiene training.

Meeting the needs of all people who use the service

- The staff respected people's diversity and human rights. Attempts were made to meet individual needs including cultural, language and physical needs. Interpreters were available to staff if required. The premises were

accessible to people who had physical disabilities. Reaching the age of 65 did not lead to automatic transfer to older people's services if their needs could be better met elsewhere in the trust.

Listening to and learning from concerns and complaints

- People who used services told us they knew how to complain if they wanted to. We saw posters in the reception area of the day service about how to offer suggestions or compliments. There was a suggestions box so people could raise matters anonymously if they wished.

Are services well-led?

Good ●

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

Summary of findings

We rated well-led as good because:

- A meeting structure was in place to escalate and cascade information through all levels of staff. This included governance, incidents and performance monitoring.

- Staff understood their roles and responsibilities, including accountability.

- Staff felt respected, valued and supported by their managers and their peers.

- Staff were encouraged to develop by management at local level.

However:

- Some staff were not clear about how their team's work linked into the trust's vision and values. They felt disconnected from the wider trust.

Our findings

Vision and values

- Staff were made aware of the trust's vision and values through emails and blogs from the chief executive. The trust also made use of social media to disseminate information. We also saw posters of the trust's vision and values and business plan displayed in the offices.

- Staff we spoke with were clear about the vision and direction of the service they worked in at local level. However, they were not always clear about how those linked into the trust's vision and values.

- Staff at some teams said they felt the board was not visible. However, others gave us examples of how the board, including the chief executive, had visited their team. Staff at one office told us how the chief executive had quickly resolved staffing issues which had been outstanding for some time. They told us they had felt listened to by the chief executive.

Good governance

- Local systems were in place which ensured staff were well supported and received adequate training to do their job. There was learning from incidents, complaints and service user feedback.

- We attended a team governance meeting. This was well organised and covered appropriate governance issues relevant to the service although most of the information disseminated was top down. The duty of candour and a 'Saying Sorry' document were discussed.

- We saw some evidence of local audits being carried out which could be used to ensure that systems were working and drive improvement.

- Performance was discussed at business meetings. All Health of the Nation Outcome Scales (HoNOS) had been completed within the last 12 months. Reviews had been carried out for all people on the Care Programme Approach (CPA). The teams were also using the NHS Safety Thermometer for mental health. This is an improvement tool for measuring, monitoring and analysing commonly occurring patient 'harms' and 'harm free' care. It enables teams to measure the proportion of people who use services who are free from self-harm, violence and aggression, omissions of medication and are psychologically safe. We saw that, generally, no incidents of harm had been reported.

- The teams held local risk registers and could put issues forward for the trust's risk register so matters were escalated to the board.

- Appraisal meetings had been carried out.

- Supervision was structured and addressed matters outstanding from the previous meeting and covered performance, development and staff issues. All staff supervision was up to date.

- Commissioning for Quality and Innovation (CQUIN) targets set by commissioners had been met.

Leadership, morale and staff engagement

- We saw that the CMHTs and the day service were well led. The managers were visible and accessible. Staff told us they were well supported by their local managers and peers and were encouraged to develop.

- Staff were aware of the whistleblowing process and said they would use it to escalate concerns.

- Some staff had been involved in reviews of services in other parts of the trust and felt supported as they worked alongside trust board members.

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.

- One manager told us that staff at all levels had the same access to messages from the board and chief executive and this manager encouraged the team to access those so they were up to date with trust business.
- The trust had put in place a range of initiatives to improve engagement with staff. These were welcomed but people thought there should be more; for example, of the Chief Executive's forums where staff could meet her.

Commitment to quality improvement and innovation

- The service used clinical tools which could be used to audit the effectiveness of an intervention such as Health of the Nation Outcome Scale (HoNOS) and the NHS Safety Thermometer for mental health. We found some evidence of local audits being carried out. There were pockets of practice designed to improve services. For example, the teams had facilitated training days with GPs which would help improve working relationships with primary care services. We attended a team governance meeting at which performance was discussed and we saw minutes of monthly quality and governance meetings which managers attended. However, we found little consistent evidence to show how the service used audits, performance indicators or quality outcome measures to improve service provision locally.
- Only at the day service did we find any evidence to show how patient's views and experiences were gathered so that they could be used to drive improvement or influence service development.

Compliance actions

Action we have told the provider to take

The table below shows the essential standards of quality and safety that were not being met. The provider must send CQC a report that says what action they are going to take to meet these essential standards.

Regulated activity	Regulation
Nursing care Treatment of disease, disorder or injury	Regulation 13 HSCA 2008 (Regulated Activities) Regulations 2010 Management of medicines We found that the registered person had not protected people against the risk of unsafe medication arrangements. This was in breach of regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) regulations 2010, which corresponds to regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. At the office base of the north east and north west community mental health teams, the arrangements for recording the stocks of medication and ensuring safe access to medication were not adequate.