Good

Leeds and York Partnership NHS Foundation Trust

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

## 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) |
|---|---|---|---|
| RGD05 | St Mary's Hospital | Community Mental Health Team , West North West | LS9 7BE |
| RGD02 | Aire Court Community Unit | Community Mental Health Team, South South East | LS10 4BS |
| RGD01 | St Mary's House – North Wing | Community Mental Health Team, East North East | LS7 3LA |

This report describes our judgement of the quality of care provided within this core service by Leeds and York Partnership NHS Foundation Trust. Where relevant we provide detail of each location or area of service visited.

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

# Summary of findings

Where applicable, we have reported on each core service provided by Leeds and York Partnership NHS Foundation Trust and these are brought together to inform our overall judgement of Leeds and York Partnership NHS Foundation Trust.

# Summary of findings

## Ratings

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

| | |
|---|---|
| Overall rating for the service | Good |
| Are services safe? | Good |
| Are services effective? | Good |
| Are services caring? | Good |
| Are services responsive? | Good |
| Are services well-led? | Good |

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

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

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

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

# Summary of findings

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# Summary of findings

## Overall summary

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

- The community-based mental health services for working age adults were safe because teams had sufficient staff to protect patients from avoidable harm and abuse. Managers supported staff to be open and honest and carried out thorough investigations when something went wrong. Staff recognised and responded appropriately to identified risks to patient safety.
- The community based mental health services for working age adults were effective because patients received care and treatment that met their needs. Staff were appropriately skilled, experienced and supported by managers to develop their practice. Staff used best practice guidelines to deliver effective care and treatment. Staff had regard for the Mental Capacity Act and ensured they protected the rights of patients detained under the Mental Health Act. Staff worked with a range of other teams and services to co-ordinate patients' discharge and took patients' needs into account.
- The community based mental health services for working age adults were caring because patients and carers told us they felt supported by staff. Staff treated patients and carers with dignity and respect. Patients felt involved in their care and we saw staff supported patients with kindness and compassion during their interactions.
- The community based mental health services for working age adults were responsive because the service was reviewing the way it organised and delivered care. This was focused on making improvements to meet the needs of working age adults in the local population. The teams provided short term interventions as well as long term. This meant patients had better access to services and timely discharges. Patients had timely access to the service and the trust were meeting their targets to assess patients from referral.
- The community based mental health services for working age adults were well-led because staff were proud of the service they delivered to patients and their carers. The teams had a culture that focused on improvements to deliver high quality person-centred care. All teams were involved in individual projects and used a quality improvement methodology to share good practice across the localities.

However;

- The East,North East team could not always ensure their building was secure due to the length of time the electric door at the entrance remained open. There were concerns that staff had high caseloads and this had an impact on staff morale. The service had caseloads outside of recommended guidance from the Department of Health 2002. The lone working procedures could not always ensure staff safety during community visits which meant staff could be left vulnerable.
- Physical health monitoring and recording was inconsistent throughout the teams. Some teams were able to monitor bloods more effectively than others were.
- There were concerns that patients who were referred to the psychology service waited up to 20 weeks for psychological therapies. This meant that patients did not have timely access to specific treatments to meet their needs.
- Staff were not up to date with their mandatory training and teams had not reached the trust target of 90% in areas such as Mental Health Act and Mental Capacity Act training. Appraisal rates had not met the trust targets and supervision rates varied across the teams.

# Summary of findings

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

**Are services safe?**

Good

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

- Staff understood their responsibility to raise concerns and managers supported staff to report incidents appropriately. Managers investigated incidents and ensured lessons learned were communicated across the teams to support improvements.
- The service followed clear processes to safeguard patients from abuse. Staff understood their responsibilities under safeguarding. We saw staff acted promptly when there was a safeguarding concern and they made appropriate referrals to the local safeguarding authority.
- There was a sufficient number of staff to meet patient needs and keep people safe. Managers were actively recruiting to vacant posts and there were systems in place that ensured any staff shortages did not affect the safety of patient care.
- Staff assessed risks to patients and monitored and managed these on a regular basis.This meant that staff could respond quickly to any changes in risks.
- Managers and staff had identified and recorded local risks to safety and had plans in place to respond to those risks.

However;

- Staff had caseloads of 40 to 55, which was above the recommended Department of Health 2002 guidelines. However, managers had acknowledged this and were taking action to address this.
- The lone working procedures the teams adopted could not always ensure staff safety during the day.
- The East, North East team could not always ensure their building was secure due to the length of time the electric door at the entrance remained open.

**Are services effective?**

Good

We rated effective as good because:

- Staff completed comprehensive assessments of patients' needs, which included their physical and mental health, and social care needs. Care plans were individualised and focused on the patients' recovery.

# Summary of findings

- Staff planned and delivered patients' care in line with current evidence based standards, best practice, and legislation. Staff collected information about the outcomes of patients' care to monitor progress.
- Teams were multidisciplinary and a range of staff met regularly to review and plan patients' care and treatment.
- Staff understood the Mental Health Act and Mental Health Act Code of Practice and adherence to this was audited across all teams. The conditions associated with a Community Treatment Order were included in patients' care plans where appropriate.
- Clinical staff were involved in national and local audits and reviews of the services. Staff used this information to make improvements. For one team this included peer review and an accreditation of the service by the Royal College of Psychiatrists.
- Staff received meaningful appraisals and supervision, which supported them to deliver effective care and treatment. Staff were skilled and experienced, and where learning needs were identified, staff received relevant training to develop their professional skills.
- Staff worked in a collaborative way with a range of different teams and organisations such as GP's, police and social care agencies to assess, plan and deliver care to patients in a coordinated way.

However;

- Physical health monitoring and recording was inconsistent throughout the teams. Some teams were able to monitor bloods and electro-cardiograms more effectively than others were. Some teams had to rely on primary care services to deliver physical health monitoring.

**Are services caring?**

Good

We rated caring as good because :

- Patient feedback was very positive about relationships with staff and the way staff treated them. We observed that staff treated patients with kindness and compassion during all interactions. The feedback we received highlighted areas of good practice within the teams such as staff responsiveness, empathy, and understanding.

# Summary of findings

- When patients and their carers visited the South, South East community mental health locality, a volunteer who was familiar with the service greeted them. There were five volunteers who worked in the reception area to meet and greet visitors to the service.
- Staff involved and encouraged patients to be partners in decisions about their care plans. Staff ensured patients understood their care and treatment and provided easy read versions of care plans when required.

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

Good

We rated responsive as good because :

- Patients had timely access to the service which meant there were no long wait times.Teams were actively discharging patients who did not require the services any more. Staff used creative methods such as 'kit kat weeks' to facilitate discharge patients into primary care.
- We saw patients had detailed crisis plans, which enabled them to understand and respond safely when they were in a crisis. Teams had access to crisis services via the intensive care support team.
- The teams displayed a wide array of leaflets and posters, which included information about services such as housing and how to raise complaints. We saw posters for mental health support groups in different languages for British minority ethnic communities within the Leeds district.
- Staff within the service were responding to complaints and taking action where necessary. Patients received letters outlining their complaints, and any action plans as a result of the outcome. Management were proactive in making changes in practice for complaints that were upheld.

However,

- There were delays in patients' treatment for some psychological therapies and patients waited for up to 20 weeks to receive psychological therapy from a psychologist.

**Are services well-led?**

Good

We rated well-led as good because :

- Trust vision and values were embedded into the appraisals and staff understood how they contributed towards the trusts vision and values at a local level.

# Summary of findings

- There were good governance and performance management arrangements for the service to effectively report on and deliver good care and treatment to patients. There was a culture of collective responsibility, with each team responsible for specific projects to make improvements to the service.
- There was a strong focus on continuous learning and improvement in the service. Information from incidents, complaints, and clinical audit were shared with staff and used to drive improvements in the safe care of patients.
- Managers encouraged staff to take regular time out to review their performance and make improvements. We saw staff used “kit-kat weeks” to update their mandatory training and complete administrative tasks.
- Managers had the necessary experience and knowledge to provide leadership to the teams. Managers were visible and approachable and staff felt well supported.
- Staff in teams worked collaboratively with a strong team ethic and morale was good throughout. We saw sickness levels were below the national average and staff retention was stable.
- There was an effective system for staff to identify, capture, and manage local risks to the service. Staff submitted their concerns to senior managers to consider adding to the local and trust risk register. We saw that local concerns were included on the risk register.
- The service had a business strategy and project for re-design, which focused on improving the service to older people in the local population. Managers had consulted with staff and taken into account the views of other stakeholders. Staff told us they knew about the proposals and were positive about change.

However,

- All teams had not met the trust targets for mandatory training, staff supervision and appraisal. Compliance rates for some areas of mandatory training were below 75%.

# Summary of findings

## Information about the service

Leeds and York Partnership NHS Foundation Trust provide a range of community based services to patients within the Leeds and York catchment areas. The community-based teams provide services to adults aged 18 years and upwards through three locality hubs situated in the East, West and South areas of Leeds.

- East, North East Community Mental Health team was based at St. Mary's House in Potternewton, North East Leeds.
- West, North West Community Mental Health team was based at St. Mary's Hospital in Armley, West Leeds.
- South, South East Community Mental Health team was based at Aire Court in Middleton, South Leeds.

The community mental health teams focus on those people with the following clinical presentations:

- People with severe and persistent mental disorders associated with significant disability, such as schizophrenia and bipolar disorder
- people with longer-term disorders of lesser severity but who need follow-up
- people with any disorder where there is significant risk of self-harm or harm to others
- people with disorders requiring skilled or intensive treatments such as cognitive behavioural therapy, vocational rehabilitation, and medication maintenance requiring blood tests not available in primary care
- people with complex problems of management and engagement for patients under the Mental Health Act (1983)
- people with severe disorders of personality

The community-based services operate between the hours of 9.00am and 5.00pm, Monday to Friday.

Leeds and York Partnership NHS Foundation Trust was last inspected by the Care Quality Commission in September 2014. This inspection included the community-based mental health services and there were no compliance actions associated with these core services.

## Our inspection team

The team was led by:

Chair: Phil Confue, chief executive of Cornwall Partnership NHS Foundation Trust

Head of Hospital Inspection: Nicholas Smith, Head of Hospital Inspection (North West), Care Quality Commission

Team leaders: Kate Gorse-Brightmore, Inspection Manager, Care Quality Commission

Chris Watson, Inspection Manager, Care Quality Commission

The team that inspected this core service comprised two inspectors, three nurses, one psychologist, one doctor, and an occupational therapist.

The lead inspector for community based mental health services for working age adults was Hamza Aslam.

## Why we carried out this inspection

We inspected this core service as part of our on-going comprehensive mental health inspection programme.

# Summary of findings

## 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 and asked a range of other organisations for information.

During the inspection visit, the inspection team:

- visited three community mental health teams based at St Mary's Hospital, St Mary's House and Aire Court.
- toured the premises and looked at the quality of the environments where staff held outpatient appointments
- undertook 14 observations and observed how staff were caring for patients
- spoke with 28 patients who were using the service and collected feedback from three patients using comment cards.
- spoke with 11 carers or relatives of patients who were using the service
- looked at 41 treatment records of patients which included 25 medication prescription charts
- spoke with 39 staff members; including managers for the services, doctors, nurses, psychologists, occupational therapists, support workers and social workers
- attended and observed four hand-over meetings and three multidisciplinary meetings

looked at a range of policies, procedures and other documents relating to the running of the service.

'Community based mental health services for working aged adults' was an ageless service. This meant teams within the trust had mixed caseloads and worked with older people as well as adults of working age. As a result, this core service report will share similar findings to the 'community based mental health services for older people' report.

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

We spoke to 28 patients using the service, the majority of who were positive about their experiences. They told us about how staff within the community mental health teams were caring, understanding and kind. Patients told us that staff were responsive to their needs and supported them in times of crisis. Staff were flexible in their approach and aimed to support patients in the best way that suited them. This was shared by the carers we spoke with who said that teams worked closely to support families as well as patients. However, we received two negative comments from patients who felt that their care and treatment was poor and staff had not met their needs.

We saw one team had employed patients that were once with the service as volunteers. The volunteers told us how much this opportunity benefited them.

## Areas for improvement

**Action the provider SHOULD take to improve**

- The service should continue to work towards reducing staff caseloads so they align to recommended good practice guidelines.
- The service should ensure that the lone working procedure protects staff safety throughout the day.

# Summary of findings

- The service should ensure all patients receive psychological therapies in a timely manner and within national guidelines.
- The service should ensure that physical health monitoring and recording is consistent across all teams
- The service should ensure that all mandatory training, appraisal and supervision compliance meets the trust targets
- The service should ensure the East, North East team have a system in place to manage premises effectively for the safety of staff and patients.

Leeds and York Partnership NHS Foundation Trust

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

**Detailed findings**

## Locations inspected

| Name of service (e.g. ward/unit/team) | Name of CQC registered location |
|---|---|
| West, North West Community Mental Health Team | Linden House, St Mary's Hospital |
| South, South East Community Mental Health Team | Aire Court Community Unit |
| East, North East Community Mental Health Team | St Mary's House, North Wing |

## 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 Health Act training was part of the trust mandatory training programme with a target of 90% compliance by July 2016; none of the community mental health teams had met the target.

Despite this, staff that we spoke with had a good understanding of the Mental Health Act and how this applied to their everyday practice. They understood the guiding principle of least restrictive care and how to refer patients to the advocacy services.

Where patients were subject to a Community Treatment Order, staff documented capacity and consent in the patients' care records and ensured the associated paperwork adhered to the Mental Health Act. A Community Treatment Order is a legal order, which sets out the terms under which a person must accept treatment whilst living in the community.

Staff had access to Approved Mental Health Professionals and referred to the Mental Health Act office as a central point for advice and administrative support. An Approved Mental Health Professional has the responsibility to coordinate an assessment and demonstrate the principles

of the Mental Health Act. They need to ensure that the person is appropriately interviewed and that if they are admitted to hospital, they are conveyed there in the most humane and dignified manner.

## Mental Capacity Act and Deprivation of Liberty Safeguards

Mental Capacity Act and Deprivation of Liberty Safeguards level two training was part of the trust mandatory training programme. The trust had a target of 90% compliance with mandatory training by 2016 and none of the community mental health teams had met this target.

Staff knew about the trust policy on the Mental Capacity Act and had a good understanding of the Mental Capacity Act and Deprivation of Liberty Safeguards. They gave working examples of how they applied these in everyday practice. The Mental Health Act office also provided advice and administrative support for the Mental Capacity Act, and staff in the community mental health teams referred to them appropriately as required.

Staff considered and documented patients' capacity and carried out best interest decisions in relation to decisions about patients' care and treatment. Staff also sought advice from the Approved Mental Health Professionals about capacity assessments and best interest decisions when needed.

Staff were not able to describe what arrangements the service had to monitor their adherence to the Mental Capacity Act.

Good

# Are services safe?

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

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

## Our findings

### Safe and clean environment

The community mental health teams provided services mainly within community settings such as patients' homes. However, all three locality teams had clinic and treatment rooms available for patients. We saw the environment in which patients were seen was clean and well maintained. General equipment was in good condition and we saw portable appliance testing had been carried out where appropriate. All clinic and treatment rooms had basic physical health monitoring equipment such as height and weight measuring tools.

All the treatment and clinic rooms we saw had a nurse call system. Staff at St Mary's House were provided with personal alarms, which they could activate during a crisis. Aire Court had call points fitted to treatment rooms; both systems alerted the reception area.

Most of the buildings we saw were secure. They had closed circuit television in operation and required keypad entry into the building. However, the building which the East, North East team worked from did not have any surveillance cameras overlooking the reception entrance. In addition, the electric door at the entrance remained opened for a prolonged period. This increased the risk of members of the public and patients entering the building without anyone knowing. The team had reported one incident where a patient who was intoxicated entered the building without anyone granting him access. The manager included this incident on the local risk register and the locality lead put a business proposal forward to have the security of the building addressed. The team had mitigated risk by making staff aware of the issues around accessibility, and having someone in reception at all times to monitor people coming into the building.

Staff were aware of infection control principles. Infection control was a part of the trust's mandatory training and all three community mental health teams had achieved above 85% in this training. Alcohol gel was available at different access points in the buildings.

### Safe staffing

We found overall that staffing levels were sufficient to meet the service needs The provider did not use a staffing tool to estimate the required size of its workforce. However, managers based staffing levels on the population of the areas they covered, patient need, and risk.

Qualified staff across the localities included :

- West, North West locality had 34 qualified nurses and 13 occupational therapists.
- East, North East locality had 22 qualified nurses and nine occupational therapists.
- South, South East locality had 20 qualified nurses and eight occupational therapists.

The community mental health teams were an integrated service and staff carried mixed caseloads. In some cases, staff who had more experience in working with older people had a caseload that reflected their skill set. Each locality had access to a psychiatrist that met the needs of the service. There were dedicated psychiatrists for older people and adults of working age, who specialised in treatment for their particular patient group. Patients had rapid access to a psychiatrist if their mental health was deteriorating. We observed the psychiatrists aimed to support patients in the best possible way that suited them, for example seeing the patients at home because they were too anxious to leave the house. In addition, the teams had support from junior doctors who worked for three months at a time as part of their training. This supported the consultants because junior doctors could facilitate clinics where appropriate

We saw caseloads were high across all the teams. They ranged from 40 to 50 patients per care coordinator. National guidance from the Department of Health in 2002 suggested that average caseload size for community mental health teams should be around 30 to 35 patients per care coordinator. Management did not use a weighting tool to manage caseloads; instead, the clinical leads had oversight and distributed it accordingly. High caseloads were identified on the local risk register. Locality leads told us the caseloads had reduced significantly from 60 to70 patients per care coordinator to 40 to 50 patients. They were committed to continuously improve the efficiency

Good

# Are services safe?

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and quality of the service, whilst maintaining safety. We could not identify any direct impact on patients because of high caseloads. However, staff told us it had an impact on their morale.

There were no patients waiting to be allocated to a care coordinator at the time of the inspection.

The community mental health teams did not use agency staff. Instead, they used regular bank staff, most of who had previously worked for the team. Sickness levels across the teams were low and below the national average of 5%. It was the responsibility of the clinical lead and duty lead to manage appointments during sickness and leave. The clinical leads took responsibility to see patients if other team members were not available or able to cover.

Staff retention across the teams was good. We saw managers undertook active recruitment to develop the workforce through local recruitment days. They had found this to be more successful than recruitment through the corporate trust recruitment arrangements.

Overall training records demonstrated the teams achieved higher than 75% completion for mandatory training, including safeguarding adults 86%, clinical risk 80%, health and safety 88% and infection control 80%. Duty of Candour training had an average of 46%; however, the trust had introduced this training a month prior to the inspection. Examples of training that achieved the trusts 90% target included, Equality and diversity, information governance, child safeguarding level one and two.

### Assessing and managing risk to patients and staff

The trust used the Functional Analysis of Care Environments risk assessment tool. We saw staff started the patient's risk profile at the point of referral, developed it throughout the patient's assessment, and regularly reviewed the risks. Staff at the single point of access noted basic risk information before triaging it to the duty team in the community mental health localities. Duty staff did an initial screening of risk to understand the patient's history, for example contacting external organisations such as probation services, GPs, and social services. All the community mental health teams had a link worker with the police. This meant they had timely access to forensic information about patients.

Staff carried out the formal risk assessment during the initial assessment and completed it within 14 days of referral. We reviewed 43 patient records all of which were up to date and reviewed at appropriate times, for example, when the patients' risk increased.

We observed 'referral meetings' where staff discussed patients they had assessed, and whether they were appropriate for the service. Staff spoke about Initial concerns around risk were and how the team were going to address them, for example, staff facilitating appointments at a trust location. Some staff expressed concerns about teams not always receiving all the relevant risk information for patients at the time of the referral. As a result staff attended assessments in pairs if the patient was unknown to services.

Staff held formulation meetings to review existing patients and discus patients whose risk had changed. Psychology staff attended formulation meetings to support staff in taking appropriate safeguards and interventions.

We saw good use of crisis planning across all three localities. Patients had detailed crisis plans and staff provided patients with a crisis card in case of an emergency. The crisis card contained emergency contact numbers for support.

The localities achieved an average of 86% in completion in adult safeguarding training and over 95% in child safeguarding level one and two. These training modules are important for community teams as they work closely with vulnerable families and young people. Staff were aware of the trust's safeguarding procedures and who to contact if they had concerns. During an observation, a patient who staff considered high risk failed to attend the appointment. We saw the member of staff take prompt action in discussing their concerns with the duty lead, which subsequently led to staff making a child safeguarding alert.

The duty worker was responsible for ensuring all staff were safe at the end of the working day. Staff used a notice board to sign in and out of the office and it was their responsibility to inform the duty worker when they had finished their visits for the day. Staff took other precautions to maintain their safety during the day. For example, if staff were concerned about risks before their visits they asked the duty worker to check on their safety. If they felt in any danger during a community visit, they contacted the duty

Good

# Are services safe?

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worker with a specific code word which alerted the duty worker to take appropriate action. The current method of lone working was sufficient, but meant staff could be left vulnerable whilst on community appointments. In response to this, the teams were piloting an electronic lone working device, which monitored their safety throughout the day

All teams had good medicines management practice which included appropriate storage, transport and administration of drugs.

## Track record on safety

The trust recorded 17 serious incidents requiring investigation across the three community mental health localities since February 2015. The incidents were spread evenly across localities with the South, South East locality receiving five serious incidents and other two localities receiving six. Sixteen of the 17 incidents were patient suicides and the final was an information governance incident. The information we received from the trust did not differentiate the serious incidents between adults of working age and older people. This meant we could not see if the incidents were more frequent with one group of services users to the other.

We saw the locality teams were learning from serious incidents and developing their practice. Discussion after a patient death highlighted the teams felt there could have been better working relationships and improved communication with other agencies involved in patient care. The learning resulted in agencies such as housing attending multidisciplinary meetings more frequently and more collaborative working taking place.

## Reporting incidents and learning from when things go wrong

The trust used the electronic system to record incidents. Clinical leads or locality managers investigated incidents depending on severity. Staff were clear on how to record incidents and we saw appropriate use of the reporting system.

Managers offered staff debriefs after incidents in various ways, which included individual and group sessions. Managers embedded feedback from incidents into the agenda for team meetings where staff discussed learning from incidents.

Staff acknowledged their responsibilities under the Duty of Candour. They understood what it meant and were able to tell us about the importance of being open and transparent towards patients. They understood the process of providing formal apologies when things go wrong. Staff were accountable for their actions, and knew when to take appropriate steps where necessary.

# Are services effective?

Good

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

## Our findings

### Assessment of needs and planning of care

The community mental health teams had a wide ranging referral criteria and accepted most of the referrals for assessment to the service. This meant the teams dealt with a wide range of mental health problems and complexities.

We looked at 41 care records across the three community mental health teams. We found staff completed assessments that were comprehensive, holistic and completed as part of the patient's initial assessment. Staff used an electronic patient records system to record their assessment of patient needs and planning of care. We saw the services stored paper- based information in a locked room. Medical staff recorded their consultations with patients in the paper records. Administrative staff then typed up and stored this information on the electronic system. This system was accessible to all staff via an individual security password, which meant information was stored securely and available to staff when they needed it. Social workers who were also located in the community mental health teams accessed both the local authority and trust electronic patient records system. However some staff were not always clear in navigating through the electronic patient records to access the information they needed about patients' care and treatment.

All 41 care plans we reviewed were up to date and contained information that was personalised and took into account all the needs of the patient including their physical, social, and mental health needs. Staff completed care plans with patients that focused on the patient's goals for recovery. This included plans for staying well and what to do if the patient needed help in crisis.

### Best practice in treatment and care

Staff understood and followed National Institute for Health and Care Excellence guidelines in their practice. Medical staff referred to the Maudsley guidelines when they prescribed medication for patients. For example when medical staff prescribed patients' anti-psychotic medication or Lithium, staff carried out appropriate physical health checks. Staff also liaised with the patient's GP to ensure relevant blood tests and annual health checks were carried out.

Physical health monitoring and recording was inconsistent throughout the teams. Some teams were able to monitor bloods and electro-cardiograms themselves other teams had to rely on primary care services to deliver physical health monitoring.

Staff considered the patients' physical health care needs and referred patients to specialist physical health services such as physiotherapy when required. We saw that staff incorporated patients physical health care needs into care plans and staff discussed patients physical health needs at multidisciplinary meetings. Identified staff took the lead in physical health care and attended clozapine clinics to ensure patients received the appropriate health checks. This included nutritional screening and smoking cessation advice. Patients told us that staff had given them information about their physical health care needs. In recognition of the need to work more closely with general practitioners, managers had recruited a physical health nurse to work in one community mental health team. In recognition of the need to work more closely with general practitioners, managers had recruited a physical health nurse to work in the East, North East community mental health team. Mental Health Community Mental Health Team East North

The community-based mental health services offered patients psychological therapies as recommended by the National Institute for Health and Care Excellence. Staff referred patients for psychological therapies from psychologists such as cognitive behavioural therapy, cognitive analytical therapy, psychotherapy and eye movement desensitisation and reprocessing therapy. Staff in the community mental health teams offered anxiety management techniques and mindfulness.

Patients received support from social workers and the housing and employment support officers for any identified employment, housing and financial problems. Staff referred patients and their carers to a local agency where patients and carers received help and advice for bereavement issues, carer's assessments, and emotional support.

Staff used a variety of recognised rating scales and assessment tools, which measured outcomes for patients. All staff completed the Health of the Nation Outcome Scale, which provided information related to the patients' "cluster" and payment by results framework. We saw this information was used by the creative practitioners to

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Good

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determine patient's clusters and monitor improvements in outcomes. However, staff in the community teams did not routinely record patient reported outcomes such as the Short Warwick-Edinburgh Mental Well-being scale.

Clinical staff collected data for a range of clinical audits including the use of antipsychotic medication in people with dementia, physical health monitoring, and adherence to the Mental Health Act including those patients who received care under a Community Treatment Order. Staff were involved in audits of patients' records and treatment, including audits of the depot medication prescription and recording cards and audits of adherence to the care programme approach.

### Skilled staff to deliver care

All teams had a full range of mental health disciplines, which included medical and nursing staff, occupational therapists, social workers, support staff, and a pharmacist. All teams had access to experienced and qualified staff and we saw that staff had undertaken specialist training appropriate for their role. Staff in the community mental health teams received a wide range of appropriate specialist training to support patients' care and treatment. This included training in the Personality Disorder Knowledge and Understanding Framework Awareness, family therapy, and dementia awareness training.

The trust had a city wide initiative to develop the use of dialectical behavioural therapy and some staff were undergoing training that would enable them to deliver this intervention to patients.

In addition to the corporate mandatory induction, all staff received a local induction when they joined the service. This was a four week programme, which included orientation to the building, policies and procedures and working alongside other members of the team. Managers had recruited a number of newly qualified nurses and had identified mentors to support them in their new roles. One team used creative practitioners to support patients 'discharge. They received an eight week induction that included orientation to community services that patients could access.

Managers ensured staff received regular management and clinical supervision and a yearly appraisal in line with trust policies. In addition staff received peer support and supervision from a range of other meetings. This included focus groups, professional forums, specialist supervision such as child safeguarding and cognitive behavioural supervision and team meetings. We found that the appraisal compliance rates across three community mental health teams ranged from 71% to 97% with the lowest compliance rate in the South team and the highest in the East, North East team. However, the overall compliance rate for all three community mental health teams was 81% which did not meet the trust mandatory target of 90%.

Staff told us they felt the supervision they received from their managers was meaningful and they felt supported in their role. Clinical supervision should be held at least monthly according to the trust policy. We found that rates of clinical supervision varied across the community mental health teams and ranged from 64% to 78%. The team with the highest rate of clinical supervision was the South, South east locality and the lowest was the East, North East locality with 64%. Prior to the inspection the teams did not routinely collect compliance figures for clinical and management supervision. However, the trust had implemented a system in June 2016 to collect this information.

### Multi-disciplinary and inter-agency team work

The teams operated within a multidisciplinary framework and held weekly multidisciplinary team meetings. We observed three multidisciplinary meetings where staff conducted effective and comprehensive discussions about patients' care and treatment. This included changes in presentation, capacity issues, and physical health needs, risk management, safeguarding concerns and carers needs. Staff also met daily where they discussed plans for the day and any changes. Staff felt supported to make decisions about patients care and treatment within these meetings.

Staff worked closely with inpatient services and intensive community teams. We saw good evidence of working with other agencies such as befriending services, Families First and Touchstone. These were all organisations that staff used to help support patients in their recovery. Some staff felt links for services for older people had weakened with the transformation of the teams. However, the service was working to improve this with the role of the creative practitioner, which included developing a strong partnership with other organisations.

Staff gave a range of examples where they worked alongside other teams and agencies, shared information, skills, and worked jointly with patients. For example, the teams shared information with the improving access to

# 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.

psychological therapies staff where appropriate. A worker from Touchstone was working alongside one team for eight weeks to share their dialectical behaviour therapy skills with team members.

The service established three mental health community liaison practitioner roles who were based in local health centres. They worked alongside integrated community teams which included geriatricians, adult social care workers, district nurses and physiotherapists. They also linked with the community mental health teams and provided strong links between the teams and primary care services.

The service established a pilot project to base three mental health community liaison practitioners in local health centres. They worked alongside community teams which included geriatricians, adult social care workers, district nurses, and physiotherapists and linked with community mental health teams. This improved relationships and communication between the teams and supported people to access appropriate services and prevent hospital admission. This improved relationships and communication between the teams and supported people to access appropriate services and prevent hospital admission.

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

Mental Health Act training was part of the trust mandatory training programme. It included two separate training courses, Mental Health Act community level two, and Mental Health Act legislation awareness. The trust had a target of 90% compliance with mandatory training by July 2016. None of the community mental health teams had met the target and reached an overall compliance rate of 75%.

When we spoke with staff, we found they had a good understanding of the Mental Health Act and how it applied to their everyday practice. We saw staff had oversight of patients on a Community Treatment Order and monitored adherence to the Mental Health Act and Code of Practice for those patients.

Staff had access to Approved Mental Health Professionals in the community mental health teams and sought advice and support from them when needed. Staff also referred to the Mental Health Act office as a central point for advice and administrative support.

Staff understood the Mental Health Act and the guiding principle of least restrictive care in the community.

Advocacy information was available for patients in the teams we visited and staff were aware of how to support patients to access advocacy services.

### Good practice in applying the Mental Capacity Act

Mental Capacity Act and Deprivation of Liberty Safeguards level two training was part of the trust mandatory training programme. The trust had a target of 90% compliance with mandatory training by July 2016. The trust reported that the community mental health teams had not reached the target. The overall compliance rate was 72% for all three community mental health teams.

Staff were aware of the trust policy on the Mental Capacity Act and how to access it on the trust's internal network. The Mental Health Act office provided a central point for advice and administrative support for the Mental Capacity Act. Staff also sought advice from the Approved Mental Health Professionals about capacity assessments and best interest decisions when needed.

When we spoke with staff, we found they had a good understanding of the Mental Capacity Act and Deprivation of Liberty Safeguards and gave working examples of how they applied this in their everyday practice. We also saw evidence that staff considered and documented patients' capacity and carried out best interest decisions in relation to decisions about patients' care and treatment.

We reviewed the recording of consent in the care records. Staff always sought consent during initial assessments and we observed staff took time to explain to patients what consent meant and why it was important. We saw three records where capacity was assessed and staff held best interest meetings because capacity was in doubt. This included decisions about medication, finances and the patient's ability to understand conditions under the Mental Health Act.

Staff reflected upon consent and capacity issues during multidisciplinary meetings. Patients told us staff consulted and involved them in decisions about their care and treatment.

Staff were not able to describe what arrangements the service had to monitor their adherence to the Mental Capacity Act.

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

We spoke to 28 patients who were very positive about the services they received. Some of the good practice they highlighted included staff being supportive, kind, empathetic, and responsive. Two patients told us there had been times were communication between them and the service could have been better.

We observed that staff delivered respectful and genuine care. Staff were aware of confidentiality and took steps to protect patients by taking off their identification badges before seeing a patient. It was clear staff had developed positive rapports with existing patients. This created a better working environment for an open and genuine relationship.

Staff were clear about the individual needs of patients and aimed to work in a way that suited them. There was close work with families as well as patients; this was in accordance with the 'Families First' initiative.

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

Patients were involved in the care they received. We reviewed 43 patient records that demonstrated holistic, patient centred care planning. In some cases, staff gave patients booklets, which reflected their care plans in an easy read format. Patients on Community Treatment Orders had their conditions included in their care plans. This was important because it reminded patients what their responsibilities were whilst on a Community Treatment Order. We saw patients, families, and carers were actively involved in care programme approach meetings. We observed one team were liaising with a carer who was in another country as part of caring for their patient.

Patients had access to a local advocacy service. Staff provided patients with information about the advocacy service and information was available in reception areas of all the treatment clinics.

The South, South East community mental health locality had recruited five volunteers who had previously used the service. They worked in the reception area meeting and greeting guests. One of the volunteers told us how important this role was for them and how it had empowered them to work and develop their confidence.

We saw the community mental health teams asked for patient feedback. We saw examples of standard feedback cards at reception areas; however, staff said there was a low response rate and we saw no examples of "you said we did" displayed for patients' information.

# 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

All referrals into the service came via the trust's single point of access and then triaged to the duty team within the community mental health localities. Patients, families, friends, and carers could all access the service via the single point of access. This enabled the service to be more accessible. Referrals were triaged from the single point of access for an assessment from the community mental health team where appropriate.

The duty staff within the locality teams were responsible for screening the referral. Staff assessed all patients within 14 days. Patients who were referred from inpatient settings or the crisis team had to be assessed within 48 hours of referral. The trust target was 80%, however, over the last 12 months the service met 82% of the referrals within this time-frame.

Patients requiring specialist psychological interventions such as cognitive behavioural therapy had to wait 20 weeks. The national recognised target for such treatments is 18 weeks. The teams mitigated risk by offering patients on the waiting list for psychological intervention a crisis card. This meant patients had immediate access to a member of the therapy team. Staff gave patients self-help information leaflets and patients could contact staff for telephone support if they had any short term anxieties.

The trust had implemented a stepped model to build capacity and reduce waiting times. Patients could access up to five sessions of a specialist psychological intervention after their assessment with a wait of three weeks. This short term intervention offered the opportunity for some patients not requiring long term therapy.

Staff discussed each patient assessment in a multidisciplinary meeting to identify whether a package of care could be offered. In some cases, staff referred patients onto third sector or voluntary sector services. Staff formally wrote to all patients to explain the outcome of their assessment. We saw that staff provided crisis numbers and details for support services in the letters.

There were no waiting times for patients to access the services. A member of staff was allocated to a patient following discussion at the multidisciplinary referral meeting. Staff allocated a care coordinator to patients coming from an inpatient setting prior to discharge.

Staff and management across all the localities felt the referral criteria into the service needed to be developed as it was broad. This meant the teams dealt with a wide range of mental health problems and complexities. Staff felt the operational policy did not have clear exclusion criteria to identify which patients were appropriate. The locality managers acknowledged the referral criteria needed developing and work was underway to streamline the services.

Access and discharge across all three localities remained consistent. The locality leads were able to monitor how many people were in the service through the electronic dashboard. Data from these records showed teams received the same amount of referrals a month. For example, the South, South East team were receiving on average 230 referrals a month over the last six months. We did not see any data for how many patients were being discharged back into primary care. However, we could see the total number of patients under the care of each team per month. This figure remained constant over the 12 months, which meant teams were regularly discharging patients. For example the West, North West Team had around 1700 patients under their care per month for the last six months.

We saw the teams were proactive in discharging patients and not keeping them in services for longer than necessary. The clinical leads had oversight of discharge planning and caseloads. In addition, staff were given a week where they could catch up with paperwork and discharge patients who no longer required a service. This "kit kat week" aimed to provide staff with a protected space to complete administration tasks that were delaying discharge.

Crisis services were available for patients through the intensive care service. Staff could refer patients to this service for more intensive daily support, and patients in crisis could contact the service out of hours.

Staff took a proactive approach for patients who missed appointments or assessments. They liaised closely with partner agencies such as GP's, housing, police, and

# Are services responsive to people's needs?

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probation services to make contact with patients. Staff also worked with the families of patients who did not engage; they coached them around coping mechanisms, crisis planning and how best to support the patient.

Patients told us that staff were punctual to appointments and maintained regular contact with them. It was clear they had built good relationships with their service user group. Clinical leads put provisions in place if a member of staff could not make an appointment. The clinical leads decided on whether the appointment had to be rescheduled or facilitated by another member of staff.

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

Patients had access to clinic rooms and consultation rooms. They were well maintained and all had appropriate equipment to support treatments. For example, all the rooms had height and weight measuring instruments to monitor physical health. The consultation rooms had comfortable furnishings and were neutral pastel colours; this promoted a relaxed therapeutic environment.

We saw the teams had access to a range of different sized rooms where they could see patients, some large enough for group work. However, not all the rooms in the West, North West base were appropriate. We saw one room that had no windows, lacked natural lighting, and was very small. We were told this room would only be used as a last resort. In contrast, the South, South East community mental health team had a purpose built building. It had a large, open reception area with bright and comfortable treatment rooms.

Staff in the West, North West, and East, North East localities told us room availability was an issue at times. A booking system was in place to maximise efficiency. In addition, alternative sites across the Leeds district were available for staff to run clinics.

Patients had access to information about their rights, complaints procedures, and advocacy services. Staff reminded patients on Community Treatment Orders about their rights every three months or when appropriate and recorded this information on patients' care plans.

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

All the locations we visited had disabled access points for people who required support around mobility. For example, St Mary's House had a disabled ramp access, and all the treatment rooms were on the ground floor. Aire Court where the South, South team were based had a lift facility for patients wanting to access the first floor group room.

We saw a wide array of information leaflets within the reception areas. The information ranged from support offered by the trust to services within voluntary sectors. The leaflets were not all related to mental health, some were for physical health, sexual health, employment, and housing services. We saw leaflets written in different languages for patients whose first language was not English. For example one leaflet was written in Farsi, which is a language attributed to the Pashtun community. This leaflet was for a support group around mental health.

The community mental health teams had access to interpreters. Staff said this was an important resource due to the demographic of the communities they served.

### Listening to and learning from concerns and complaints

The patients we spoke to understood how to make complaints and felt confident to do so. We saw the teams were learning from complaints and responding to them appropriately. The service received 43 complaints from February 2015 to February 2016. The South, South, East team received seven complaints, the East, North East team received 12, and the West, North West team received 24. These complaints were relative to the size of the teams. The West, North West Team covered the largest area of the three localities. Investigators fully upheld seven of the complaints, partially upheld nine, and seven were still under investigation. No complaints were forwarded to the Parliamentary Health Service Ombudsman.

We found there were no identifiable themes or trends within the complaints.

The community mental health teams had made changes to practice following upheld complaints. We saw an example where a patient was not comfortable with the care coordinator they had and as a result the team found an alternative professional. We saw another example of a patient complaint about how a member of staff spoke to them. Although this complaint wasn't upheld, managers spoke with staff about the importance of communicating with patients effectively.

# 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

In April 2016, the trust launched a consultation process with staff, service users, and other partners to determine a new statement of vision and values. During this inspection a mission statement of a shared purpose, ambition, and values guided the trust.

The purpose of the trust was 'improving health, improving lives'. The stated ambition of the trust was 'working in partnerships, we aspire to provide excellent mental health and learning disability care that supports people to achieve their goals for improving health and improving lives'.

The trust set out their values as;

Respect and dignity - we value and respect every person as an individual. We challenge the stigma surrounding mental health and learning disabilities. We value diversity, take what others have to say seriously, and we are honest about what we can and can't do.

Commitment to quality of care - we focus on quality and strive to get the basics right. We welcome feedback, learn from our experiences, and build on our successes.

Working together - we work together across organisational boundaries to put people first in everything we do.

Improving lives - we strive to improve health and lives through providing mental health and learning disability care. We support and empower people to take the journey of recovery in every aspect of their lives.

Compassion - we take time to respond to everyone's experiences. We deliver care with empathy and kindness for people we serve and work alongside.

Everyone counts - we work for the benefit of the whole community and make sure nobody is excluded or left behind. We recognise that we all have a part to play in making ourselves and our communities healthier.

The trust had introduced a new staff appraisal document that incorporated the vision and values of the organisation. We found that staff had limited awareness of the current purpose, ambition, and values of the trust. However, we found appraisals linked to team goals and staff were more familiar with their local service values and direction of the local service.

Staff at all the teams knew who their local senior managers were and spoke in a positive way about their support and accessibility. Managers told us that they felt well supported had enough authority to do their job successfully.

### Good governance

There were good governance structures and meetings, which linked to the trust governance forums. The service had clear line management arrangements and senior managers met together on a regular basis to discuss service issues.

The service monitored performance through key performance indicators that measured the time from referral to assessment. Clinical staff were actively involved in audits and managers had good oversight of staff performance and other clinical performance via an electronic dashboard. For example, managers could interrogate the system to help them understand mandatory training compliance, sickness, and clinical performance such as rate of admissions and discharges to the service.

Staff received meaningful appraisal and supervision, which supported learning and development and addressed areas of poor performance. The service had not managed to reach the trust mandatory training targets in all areas; however, managers actively supported staff to complete their training, and compliance rates had improved at the time of inspection.

Managers supported staff to take "kit-kat weeks" so that staff could organise their time to complete training and administrative tasks. This meant staff could maximise the time they spent in direct care activity with patients. Staff described this as a helpful method of catching up on the things they needed to do such as completing discharge paperwork and updating their mandatory training.

Staff were confident to raise concerns and report incidents where appropriate. They felt that managers listened to them and took their concerns seriously. We saw that staff concerns were included on the local risk register. Managers investigated incidents thoroughly and ensured they shared any lessons learned across the service. Where staff had been involved in incidents and investigations, managers provided sensitive support to staff.

The community mental health teams had a wide ranging referral criteria and accepted most of the referrals to the

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service. This meant the teams dealt with a wide range of mental health problems and complexities and their caseloads were higher than the recommended Department of Health guidelines.

### Leadership, morale and staff engagement

The teams had low sickness and absence rates and low turnover of staff. Managers supported staff to attend resilience workshops in recognition that the work they did was stressful. Teams were engaged in locality events such as working on patient pathways and consultations about the service re-design project.

There was a strong team ethic at all the services we visited. We saw all staff had effective systems to cover each other during times of absence. We saw a good example of administration staff working together to achieve a team goal to streamline their practices and achieve consistency across the localities.

Most staff were happy with their job despite some concerns about how the service re-design might affect them. Some staff had considered leaving but they were more likely to stay because they hoped for improvements in the services for older people.

Staff knew about and were confident to use the trust whistleblowing policy if needed. However all staff told us they were confident that managers listened to their concerns and dealt with them appropriately. No staff we spoke with had been subject to bullying or harassment and all felt the teams they worked in were supportive of each other.

### Commitment to quality improvement and innovation

The service was committed to improving services whilst at the same time using their resources in the most cost effective way. For example, the trust was undertaking a review of the community mental health services. Two staff led on the project re-designs of the community mental health teams. This was because the service had identified that there was a need to return to a model which delivered a specific older persons service in the community mental health teams. Most staff we spoke with about this were very positive about the future model. They felt the transformation to an ageless community mental health team four years ago had made a negative impact on the service they provided for older people. A review of the community mental health team since the transformation revealed that initially there was a reduction in referrals (about 50%) for people over 65 and a number of experienced staff had left the service. The service adopted continuous improvement methodology as a framework for the service re-design. The project team aimed to have an agreed model by September 2016.

All teams were involved in specific pilot projects which they aimed to share findings across the teams. We saw one team had been involved in a rapid improvement workshop for three days to improve the attendance of people at their first appointment for initial assessment. The aim was to reduce the number of people who did not attend appointments which would help improve efficiency and reduce waste within the team. Another team had used improvement methodology to look at the process of referral to initial contact with the aim that staff made contact with the patient within 14 days. We learned one member of the team was the identified 14 day champion who ensured the team continued to meet the target. One team had been involved with the Families First project and worked effectively with other agencies to ensure support to a service user and their children was delivered in the best way for the family.

The service had recognised the variable waiting times for patients' access to some psychological therapies and had taken active steps to make improvements to this. Psychology staff had produced information leaflets for patients on the waiting list to refer to which included contact numbers for the psychology service. The trust had undertaken a review of the psychology service and the psychologists were due to be integrated into community mental health teams with the aim of improving their accessibility and reduce waiting times for patients.

Staff received specialist training that was linked to the Leeds Institute for Quality Health and Leeds University.