Requires improvement

Rotherham Doncaster and South Humber 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)
RXE00	Trust Headquarters - Doncaster	Doncaster Assertive Outreach Team	DN4 8QN
RXE00	Trust Headquarters - Doncaster	Doncaster Recovery Team	DN4 9LJ
RXE00	Trust Headquarters - Doncaster	North Lincolnshire Intensive Community Therapy Team, North Lincolnshire Recovery Team	DN16 2RS

Summary of findings

RXE00	Trust Headquarters - Doncaster	Rotherham Carers Team Support Group, Rotherham Community Therapy Team, Rotherham Recovery Team, Rotherham Social Inclusion Team	S61 1AJ
RXE00	Trust Headquarters - Doncaster	Manchester Early Intervention in Psychosis Service	M40 8WN

This report describes our judgement of the quality of care provided within this core service by Rotherham Doncaster and South Humber 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.

Where applicable, we have reported on each core service provided by Rotherham Doncaster and South Humber NHS Foundation Trust and these are brought together to inform our overall judgement of Rotherham Doncaster and South Humber 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	Requires improvement 
Are services safe?	**Inadequate** 
Are services effective?	**Requires improvement** 
Are services caring?	**Good** 
Are services responsive?	**Good** 
Are services well-led?	**Requires improvement** 

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

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

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

Summary of findings

Contents

Summary of findings

Overall summary

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

- Not all risk assessments were completed, up to date and of good quality. Risk assessments had information omitted and lacked important detail. There were a high number of people with no valid risk assessment. This impacted negatively on the people who use services and staff's safety as current risks were unknown.
- Care plans were not always up to date, holistic or recovery-based.
- Monitoring for physical health issues was inconsistent in some teams which could result in some people's physical health needs not been met. Systems were not in place to monitor service user's physical health check compliance.
- There was a lack of psychological input in some teams. This meant that whilst some people who used services had access to a psychologist, other people did not.
- Information the trust provided showed that mandatory training completion rates were significantly lower than the trust target of 80% for most teams. Although team managers informed us these figures were inaccurate and completion rates were higher, the trust was not able to provide information to confirm this. This meant it was not possible to determine that staff had received the required training to keep people who used services safe.
- On average, only 16% of staff had received an appraisal in the last 12 months. This is not in line with trust policy.
- Staff members not directly working with the team, did not have easy access to information about people when they needed it.
- The poor quality of the IT system had a negative impact on people's care including the ability to provide accurate service user information. The IT system would not allow single changes to any part of the card record such as the risk assessment. It would automatically ask for care plan and CPA review information to be updated. This meant that staff would avoid adding small pieces of information due to the extra amount of work and time this created.
- There was no consistent approach to medication management to support safe practices. There was a lack of oversight regarding medication management and different systems had been allowed to evolve.
- Not all interview rooms were fitted with alarms. This meant that staff were not able to call for assistance if needed which could compromise the safety of staff and people who used services.
- Lone working practices were not consistent and there were some gaps in relation to staff safety. Staff were lone working all day and had no contact with the team until 5pm. This meant there was no assurance regarding staff safety for many hours.

However:

- Managers could employ bank or agency staff when there were staff shortages.
- Incidents were reported in line with the trust's policy.
- We found some areas of good practice, which included effective team working, good links with external organisations, and regular staff supervision.
- Staff were respectful, compassionate and empathic to people who use services. People who use services reported they felt involved in their care and staff were available to them when needed.
- Most staff would recommend the trust to their friends and family as a service to receive care.
- Staff responded to urgent referrals promptly. Staff endeavoured to be flexible in relation to appointment times and dates. Access to consultant psychiatrists was well organised with the availability and flexibility to see service users easily and quickly.
- Detailed information regarding treatment options and care was readily available to service users.

Summary of findings

- Staff handled complaints appropriately. They received feedback from complaints following investigations and subsequent findings.
- Team managers were supportive and available to staff members when needed.

Summary of findings

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

Are services safe?

Inadequate

We rated safe as 'inadequate' because:

- Information the trust provided showed that mandatory training completion rates were significantly lower than the trust target of 80% for most teams.Although team managers informed us these figures were inaccurate and completion rates were higher, the trust was not able to provide information to confirm this. This meant it was not possible to determine that staff had received the required training to keep people who used services safe.
- There was no consistent approach to medication management to support safe practices. There was a lack of oversight regarding medication management and different systems had been allowed to evolve.
- Not all risk assessments were completed, up to date and of good quality. Risk assessments had information omitted and lacked important detail. There were a high number of people with no valid risk assessment. This impacted negatively on the people who use services and staff's safety as current risks were unknown.
- Not all interview rooms were fitted with alarms to ensure staff and service user safety.
- Lone working practices were not consistent and there were some gaps in relation to staff safety. Staff were lone working all day and had no contact with the team until 5pm. This meant there was no assurance regarding staff safety for many hours.

However:

- We found that there was rapid access to a consultant psychiatrist for service users when necessary and that staff could respond promptly to service user need. We also found that managers could employ bank or agency staff when there were staff shortages and that incidents were reported in line with the trust's policy.

Are services effective?

Requires improvement

We rated effective as requires improvement because:

- Staff members not directly working with the team, did not have easy access to information about people when they needed it.
- Care plans were not always up to date, holistic or recovery-based.

Summary of findings

- There was limited psychological input in some teams. This meant that whilst some people who used services had access to a psychologist, other people did not.
- Monitoring for physical health issues was inconsistent in some teams which could result in some people's physical health needs not been met. Systems were not in place to monitor service users' physical health check compliance.
- An average of 16% of staff had received an appraisal in the last 12 months. This is not in line with trust policy.

However:

- We found some areas of good practice that included effective team working, good links with external organisations and regular staff supervision.

Are services caring?

Good

We rated caring as good because:

- We found that staff were respectful, compassionate and empathic to people who use services. People who use services reported they felt involved in their care and staff were available to them when needed.
- Most staff would recommend the trust to their friends and family as a service to receive care.

However:

- We found little evidence of people who use services receiving a copy of their care plan.

Are services responsive to people's needs?

Good

We rated responsive as good because:

- Staff were able to respond to urgent referrals promptly and that staff endeavoured to be flexible in relation to appointment times and dates.
- Access to consultant psychiatrists was well organised with the availability and flexibility to see people easily and quickly.

  Detailed information regarding treatment options and care was readily available to people who use services. Complaints were handled appropriately and feedback to staff was given following investigations and subsequent findings.

However:

- Some teams had waiting lists and access to psychological therapy was not consistent.

Summary of findings

Are services well-led?

Requires improvement

We rated well-led as requires improvement because:

- The poor quality of the IT system had a negative impact on people's care including the ability to provide accurate service user information. The IT system would not allow single changes to any part of the care record such as the risk assessment. It would automatically ask for care plan and CPA review information to be updated. This meant that staff would avoid adding small pieces of information due to the extra amount of work and time this created.
- There was a poor recording system in relation to capturing staff training and data provided was inaccurate. There was no senior management oversight in relation to staff training data.
- There was a lack of oversight regarding medication management and different systems had been allowed to evolve.
- Systems were not in place to monitor the physical health of people who use services.

However:

- Staff acknowledged that team managers were supportive and available to staff members when needed.

Summary of findings

Information about the service

Rotherham Doncaster and South Humber NHS Foundation Trust provided community mental health services to adults of working age in Doncaster, Rotherham and North Lincolnshire.

The service consisted of approved mental health professionals, assessment officers, community psychiatric nurses, consultant psychiatrists, mental health nurses, occupational therapists, psychological therapists, social workers, and support time and recovery workers. The service was divided into three localities, with 19 teams operating from 10 sites. The trust provided information on the roles of each team:

The access teams provided initial assessment of all mental health referrals and identified the needs of the person referred and the most appropriate service for them. They provided a 24 hour, seven days a week service acting on referrals from family, psychiatric and mental health practitioners, or from Accident and Emergency departments.

- The Doncaster access team operated from the Opal Centre based at the Tickhill Road site.
- The North Lincolnshire access team operated from Great Oaks.
- The Rotherham access team operated from Swallownest Court.

The assertive outreach teams were multidisciplinary teams working for the social inclusion of people with severe and long-term mental health problems. They developed and maintained long-term relationships with people who may have a lengthy history of multiple hospital readmissions and who may resist engagement with traditional services.

- The Doncaster assertive outreach team operated from the Opal Centre based at the Tickhill Road site.
- The North Lincolnshire assertive outreach team operated from Great Oaks.
- The Rotherham assertive outreach team operated from Swallownest Court.

The community therapies teams provided short to medium term interventions such as medication management, support and individual psychotherapy to people with mild to moderate anxiety or depression who did not experience psychotic illness.

- The Doncaster community therapies team operated from the East Dene Centre.
- The North Lincolnshire community therapies team operated from 19 Market Hill.
- The Rotherham community therapies team operated from Ferham Clinic.

The intensive community therapies teams provided interventions for people experiencing severe depression or anxiety related disorders including personality disorders, obsessive-compulsive disorders and eating disorders.

- The Doncaster intensive community therapies team operated from the East Dene Centre.
- The North Lincolnshire intensive community therapies team operated from 344 Ashby Road.
- The Rotherham intensive community therapy team operated from Swallownest Court.

The recovery teams provided interventions to people and families who were experiencing psychotic illness, bipolar disorders or major mood disorders.

- The Doncaster recovery team operated from the Stapleton Road Centre.
- The North Lincolnshire recovery team operated from 344 Ashby Road.
- The Rotherham recovery team operated from Ferham Clinic.

The social inclusion teams provided low-level support for people with psychotic illness or mood disorders and focussed on recovery to promote independence and interaction with the local community.

- The Doncaster social inclusion team operated from the Stapleton Road Centre.

Summary of findings

- The Rotherham social inclusion team operated from Ferham Clinic.

The options team provided occupational and vocational recovery through educational courses and practical therapeutic activities.

- The North Lincolnshire options team operated from Sandfield House.

The carers team support group provided advice, advocacy, assessment, education, information, support and training for any individual involved in caring for a person aged 18-65 with mental health problems.

- The Rotherham carers team support group operated from Ferham Clinic.

Rotherham Doncaster and South Humber NHS Foundation Trust also operated an early intervention in psychosis service in partnership with Manchester Mental Health and Social Care Trust. This service provided support, advice and interventions to people aged 14-35 who may be experiencing the early symptoms of a first episode of psychosis.

This was the first comprehensive inspection for this trust and the first time these services had been inspected.

Our inspection team

Our Inspection Team was led by:

Chair: Philip Confue, Chief Executive of Cornwall Partnership NHS Foundation Trust.

Head of Inspection: Jenny Wilkes, Head of Inspections Hospitals Directorate North East, Care Quality Commission.

Team Leader: Jonathan Hepworth, Inspection Manager, Care Quality Commission.

The team that inspected community based mental health services for working age adults comprised: two CQC Inspectors, one CQC pharmacist and four specialist advisors (two mental health nurses and two mental health social workers).

Why we carried out this inspection

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

How we carried out this inspection

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

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

Before the inspection visit, we reviewed information that we held about these services, asked a range of other organisations for information and sought feedback from people who use services at three focus groups.

During the inspection visit, the inspection team:

- visited nine of the community teams based at five separate locations and looked at the quality of the environment
- observed how staff were caring for people who use services
- spoke with 24 people who were using the service and collected feedback from 23 people involved in the service using comment cards
- spoke with the managers or acting managers for each of the teams
- spoke with 34 other staff members including doctors, nurses and social workers

Summary of findings

- spoke with two staff members from an external organisation
- interviewed the locality manager with responsibility for the Rotherham services
- attended and observed three care programme approach reviews, two home visits, one clozaril clinic, one cognitive behavioural therapy session, one wellness recovery and action planning group, and one health promotion event.

We also:

- looked at 33 treatment records of people who use services
- spoke to nine carers of people who were engaged with the service
- carried out a specific check of the medication management at each location where this occurred

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

What people who use the provider's services say

We spoke to 24 people who use services in total, 22 gave positive comments. These included; feeling listened to, having good relationships with care coordinators and overall being happy with their care. People reported that staff were helpful and supportive and treated them with dignity and respect.

Two people gave negative feedback, which included not getting on with their current care coordinator and not being allowed to change to a preferred worker. One person stated that staff were rude and too controlling.

Feedback from a focus group we held in Scunthorpe found one person who described staff from the North Lincolnshire intensive therapy team as variable and not matched to patient need.

Good practice

In Rotherham, the teams had made strong links with third sector organisations. This included developing a “social prescribing” scheme which aimed to help people who use services build informal networks in their community prior to discharge from mental health services.

In North Lincolnshire, the teams were able to refer to a “recovery college” run by the trust to enable people who use services to develop appropriate skills for independent living and to achieve individual goals. Courses available included mindfulness, anxiety management, relaxation, sleep improvement, and meeting people. Staff were proactive in identifying peoples’ needs and referring them accordingly.

Areas for improvement

Action the provider MUST take to improve

- The trust must ensure that systems are in place to collate mandatory training figures accurately.
- The trust must ensure that staff can access information relating to people who use services when required.
- The trust must ensure that all people who use services have an up to date risk assessment and care plan, which accurately reflect their needs’.
- The trust must ensure that medication management practices are in line with trust policy and national guidance in relation to the storage, prescribing, administration and recording of medicines.

Summary of findings

- The trust must ensure that the physical health needs of people who use services are assessed and monitored appropriately and this is evidence in peoples care records.

Action the provider SHOULD take to improve

- The trust should ensure that alarms are available in all interview rooms to make sure staff can call for assistance if required.
- The trust should ensure teams implement the lone worker policy consistently to support staff safety.
- The trust should ensure access to psychological therapies and other specialities within the service, is available to all people who require this intervention.
- The trust should continue to increase the provision of consultant psychiatrist to the Rotherham Social Inclusion Team.

Rotherham Doncaster and South Humber 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
Doncaster Recovery Team	Trust Headquarters
Doncaster Assertive Outreach Team	Trust Headquarters
Rotherham Recovery Team	Trust Headquarters
Rotherham Social Inclusion Team	Trust Headquarters
Rotherham Carer Support Team	Trust Headquarters
Rotherham Community Therapy Team	Trust Headquarters
North Lincolnshire Recovery Team	Trust Headquarters
North Lincolnshire Intensive Community Therapy Team	Trust Headquarters
Manchester Early Intervention in Psychosis Team	Trust Headquarters

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.

Fifty members of staff had completed Mental Health Act (MHA) training. This was 58% of those eligible to attend. Staff we spoke to confirmed training was available and they

had booked onto upcoming training sessions. The trust provided information that confirmed they had scheduled MHA training sessions at various locations in the coming months.

Staff described good working knowledge of the MHA and how to apply it. They showed an understanding of community treatment orders (CTO) and people's rights. Staff explained that people's rights under MHA/CTO were routinely explained to people and recorded on a specific document. The MHA administrator's office sent reminders and prompts to staff to complete these. The MHA administrator also provided advice and guidance to staff regarding legal processes and structures.

People who use services had access to independent mental health advocates provided by Cloverleaf Advocacy throughout the trust area, with the exception of Manchester, where it was provided by Rethink advocacy service. Staff we spoke to understood how to refer people and the reasons around this.

Mental Capacity Act and Deprivation of Liberty Safeguards

All staff had been provided with basic awareness training in relation to the Mental Capacity Act (MCA). This was in the form of a leaflet enclosed with staff payslips and 100% of staff had received this, with the exception of the North Lincolnshire ICT team where the figure was 87%. However, there was no way of knowing if staff had read this or understood the content.

Staff we spoke to were able to describe recent examples of using the MCA and best interest's decisions in their practice and the steps and processes they had used. Staff were able to identify relevant documents where lack of capacity to consent to treatment and other information should be recorded and stored.

Staff explained they could access information and policies in relation to the MCA on the intranet and by flow charts displayed in offices. Staff also had access to approved mental health practitioners in some teams from whom they could seek further advice.

Inadequate

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

None of the services we visited had alarms fitted in the interview rooms, which presented a risk to staff and people who use services as staff were unable to call for assistance if needed. However, all services based at Rotherham had alarms attached to the interview room door key. When activated, an alarm would sound and trigger a light above the door to indicate which room needed assistance. In the North Lincolnshire intensive community therapy team and North Lincolnshire recovery team, staff were provided with mobile panic alarms, which they could activate if necessary in the interview rooms. In the Doncaster assertive outreach team and Doncaster recovery team, staff had no access to any alarms. However, they let each other know if they were expecting any high-risk situations to occur and would see people in pairs if necessary. In the Manchester early intervention team, the vast majority of interactions with people took place in the person's own home or within community settings. Occasionally, for example, once every four to six weeks, people who use services might be seen at the team location and there was one room designated for this which had been risk assessed for peoples use.

There were issues of concern we identified regarding clinic rooms in several locations. In Rotherham, these included;

- out of date stock was left on the floor. This included syringes, blood ampules and needles
- the room was too small and it was not possible to walk around the examination couch.

At the Doncaster recovery team, we found;

- out of date consumables
- unwanted patient medication
- a broken fridge that was not labelled
- depot injections inside the broken fridge.

In North Lincolnshire the clinic room was too small for its intended purpose. There was no clinic room in the Manchester location.

Clinic and treatment rooms were well equipped with the necessary equipment to carry out physical examinations. We found that the clinic rooms were well stocked and well organised with good monitoring of temperature controls. Equipment was well maintained.

All areas were visibly clean and well maintained with well-kept furniture and decoration. At the Doncaster Recovery Team, people who use services' artwork was displayed on the walls.

Safe staffing

Listed below are the whole time equivalent (WTE) staffing establishments for each team.

Rotherham Recovery Team

Establishment levels: qualified nurses or equivalent (WTE) 10

Establishment levels: nursing assistants (WTE) 3

Number of vacancies: qualified nurses or equivalent (WTE) 0

Number of vacancies: nursing assistants (WTE) 0

Staff sickness rate (%) in 12 month period **7%**

Staff turnover rate (%) in 12 month period 0%

Rotherham Social Inclusion Team

Establishment levels: qualified nurses or equivalent (WTE) 11

Establishment levels: nursing assistants (WTE) 4

Number of vacancies: qualified nurses or equivalent (WTE) 0

Number of vacancies: nursing assistants (WTE) 0

Staff sickness rate (%) in 12 month period 1%

Staff turnover rate (%) in 12 month period 33%

Rotherham Community Therapy Team

Establishment levels: qualified nurses or equivalent (WTE) 11

Establishment levels: nursing assistants (WTE) Data not supplied

Inadequate

Are services safe?

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

Number of vacancies: qualified nurses or equivalent (WTE) Data not supplied

Number of vacancies: nursing assistants (WTE) Data not supplied

Staff sickness rate (%) in 12 month period Data not supplied

Staff turnover rate (%) in 12 month period Data not supplied

Rotherham Carers Support Team

Establishment levels: qualified nurses or equivalent (WTE) 3

Establishment levels: nursing assistants (WTE) 0

Number of vacancies: qualified nurses (WTE) 0

Number of vacancies: nursing assistants (WTE) 0

Staff sickness rate (%) in 12 month period Data not supplied

Staff turnover rate (%) in 12 month period Data not supplied

Doncaster Assertive Outreach Team

Establishment levels: qualified nurses (WTE) 7

Establishment levels: nursing assistants (WTE) 4

Number of vacancies: qualified nurses (WTE) 0

Number of vacancies: nursing assistants (WTE) 0

Staff sickness rate (%) in 12 month period 7%

Staff turnover rate (%) in 12 month period 11%

Doncaster Recovery Team

Establishment levels: qualified nurses (WTE) 8

Establishment levels: nursing assistants (WTE) 4

Number of vacancies: qualified nurses (WTE) 0

Number of vacancies: nursing assistants (WTE) 0

Staff sickness rate (%) in 12 month period 3%

Staff turnover rate (%) in 12 month period 6%

North Lincolnshire Recovery Team

Establishment levels: qualified nurses or equivalent (WTE) 7

Establishment levels: nursing assistants (WTE) 2.5

Number of vacancies: qualified nurses or equivalent (WTE) 3 (Social worker posts frozen by local authority)

Number of vacancies: nursing assistants (WTE) 0

Staff sickness rate (%) in 12 month period 10%

Staff turnover rate (%) in 12 month period 43%

North Lincolnshire Intensive Community Therapy Team

Establishment levels: qualified nurses or equivalent (WTE) 10

Establishment levels: nursing assistants (WTE) 9

Number of vacancies: qualified nurses (WTE) **0**

Number of vacancies: nursing assistants (WTE) 0

Staff sickness rate (%) in 12 month period 6%

Staff turnover rate (%) in 12 month period 0%

Manchester Early Intervention Service

Establishment levels: qualified nurses or equivalent (WTE) 17.5

Establishment levels: nursing assistants (WTE) 4

Number of vacancies: qualified nurses or equivalent (WTE) 0

Number of vacancies: nursing assistants (WTE) 0

Staff sickness rate (%) in 12 month period 4%

Staff turnover rate (%) in 12 month period 14%

None of the services we inspected used a recognised tool to estimate the number of staff required for each team. The Doncaster AOT team manager explained that they usually have 12 people allocated to each care coordinator, and the Manchester EIP team manager stated that each care coordinator should have between 12 and 15 people. Other teams mentioned caseload weighting tools and that staffing budgets had been set by senior managers and commissioners.

Listed below are the actual caseload numbers for each care coordinator as of the time of inspection

Average caseload per care coordinator

Rotherham Recovery Team 21

Rotherham Social Inclusion Team 66

Rotherham Community Therapy Team 58

Rotherham Carer Support Team 52

Inadequate

Are services safe?

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

Doncaster Assertive Outreach Team 11

Doncaster Recovery Team 34

North Lincolnshire Recovery Team 23

North Lincolnshire Intensive Community Therapy Team 33

Manchester Early Intervention in Psychosis Team 21

According to the Department of Health, Mental Health Policy Information Guide, 2001, care coordinators were recommended to have a maximum caseload of approximately 35, dependant on complexity and demographics. For early intervention and assertive outreach teams this figure is approximately 12 per care coordinator. Rotherham SIT and CTT both had high caseloads per care coordinator, as did the Manchester EIP team. In the Rotherham SIT, we were told this was due to having a large influx of people who use services into the team. The team manager told us that many people were transferred in from a nurse led clinic and that many people with bi-polar disorder were also transferred from another team due to their capacity issues. Staff described having high caseloads, feeling stressed and some were considering other employment. We spoke to the team manager and the locality manager who explained that various external pressures had impacted negatively on the team resulting in:

- high caseloads of 40-50 or more per care coordinator which is above the Department of Health guidance which is 35 per care coordinator
- staff having to cancel planned visits
- records not being up to date
- a waiting list of 20-25
- approximately 100 people in need of an up to date risk assessment.

In the Rotherham CTT, the team manager told us that many people were waiting for individual therapy and that due to the nature of the work; turn around for this was slow. In the Manchester team, staff felt that they had a higher number of referrals due to the demographics of the area, such as high unemployment, poverty, drugs and other social issues. The team manager also confirmed that the clinical commissioning group had underestimated the number of referrals and ongoing discussing were taking place regarding this. The service had been commissioned to provide support to 116-118 people, whereas that the actual need was approximately 188 people. This impacted on staff's ability to effectively manage peoples care and treatment. In the Rotherham social inclusion team in particular, stress and low morale were affecting staffs wellbeing.

Each team managed and re-assessed caseloads on a regular basis. All staff we spoke with described having supervision, both management and clinical, on a four to six weekly basis. Supervision records and discussions with team managers confirmed this.

Cover arrangements for staff sickness, leave and vacant posts was good in most teams. All team managers interviewed stated they could access bank or agency staff if necessary. However, in the North Lincolnshire Recovery Team, we found three vacant social worker posts were subject to a recruitment freeze by the local authority, which was outside of the trusts control. The Manchester EIP team had employed a full time agency worker to cover five members of staff on maternity leave.

In most teams, a psychiatrist could see a person promptly if required. The exception was the Rotherham SIT. All other teams explained that access to a consultant psychiatrist was available either the same day or within 48 hours. We found that appointments were arranged flexibly and priority was given to the most urgent cases. The Rotherham SIT had a total caseload of 630 people but only one part-time consultant psychiatrist. This is not in line with the Department of Health guidance, which recommends there should be one full time consultant psychiatrist available for approximately 350 people who use services. Staff had raised this issue with the senior management team and it was on the trust's risk register.

Not all staff were up to date with mandatory training, and the recording of compliance rates for training did not always reflect the true figures. We found that data provided by the trust did not match data held locally. The mandatory training figures that fell below 75% were:

Doncaster AOT

- clinical record keeping, 0%
- fire safety, 31%
- fraud, 31%
- health and safety, 44%

Inadequate

Are services safe?

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

- information governance 50%
- moving and handling, 0%
- violence and aggression, 38%

Doncaster Recovery Team

- clinical record keeping, 0%
- conflict resolution, 0%
- corporate induction, 70%
- equality and diversity, 55%
- fire safety, 55%
- fraud, 55%
- health and safety, 65%
- infection control, 55%
- information governance, 70%
- moving and handling, 66%
- resuscitation level 1, 33%
- violence and aggression, 50%

North Lincolnshire Intensive Community Therapy Team

- clinical record keeping, 40%
- conflict resolution, 33%
- corporate induction, 67%
- equality and diversity, 73%
- fire safety, 33%
- fraud, 40%
- health and safety, 53%
- infection control, 20%
- information governance, 47%
- moving and handling, 50%
- resuscitation level 1, 33%
- violence and aggression, 43%

North Lincolnshire Recovery Team

- corporate induction, 14%
- equality and diversity, 71%
- fire safety, 14%
- fraud, 14%
- information governance, 43%
- moving and handling, 57%
- violence and aggression, 50%

Rotherham Community Therapy Team

- clinical record keeping, 47%
- corporate induction, 62%
- equality and diversity, 69%
- fire safety, 69%
- fraud, 37%
- infection control, 33%
- information governance, 44%
- moving and handling, 17%
- prevent level 3, 44%
- resuscitation level 1, 22%
- safeguarding adults level 3, 0%
- safeguarding children level 3, 22%
- violence and aggression 33%

Rotherham Social Inclusion Team

- clinical record keeping, 64%
- conflict resolution, 0%
- domestic abuse, 50%
- fire safety, 64%
- fraud, 45%
- health and safety, 73%
- information governance, 55%
- moving and handling, 64%
- prevent, level 3, 62%
- resuscitation level 1, 40%
- safeguarding adults level 2, 0%

Inadequate

Are services safe?

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

- safeguarding adults level 3, 14%
- safeguarding children level 3, 62%
- violence and aggression, 30%

Rotherham Recovery Team

- clinical record keeping, 65%
- clinical risk assessment 44%
- safeguarding children level 1, 6%
- safeguarding adults level 1, 6%
- safeguarding adults level 3, 33%
- information governance, 65%
- fire safety 71%
- safeguarding children level 3, 56%

Rotherham Carer Support Team

- no data submitted

Manchester Early intervention in Psychosis Team

- safeguarding children level 1, 36%
- clinical record keeping, 74%
- safeguarding adults level 1, 72%
- infection control, 53%
- equality and diversity, 53%
- fraud, 53%

The team managers and the locality managers informed us that these figures were inaccurate and that the true figure of compliance was higher. However, the trust was unable to provide this information to the inspection team to confirm this. Many staff we spoke to explained that they were currently booked on training and that sometimes they accessed training provided by the local authority, which was not captured in the trust's data. Staff at the Manchester EIP team stated that mandatory training was provided locally on specific dates. If they were unable to attend, they needed to travel to Rotherham, which could be problematic and time consuming.

Assessing and managing risk to patients and staff

Doncaster Recovery Team

Approximate number of patient in team 373

Number of patients with no valid risk assessment recorded 119

Number of patients with no risk assessment 68

Number of patient with no crisis plan 352

Doncaster Assertive Outreach Team

Approximate number of patient in team 122

Number of patients with no valid risk assessment recorded 27

Number of patients with no risk assessment 22

Number of patient with no crisis plan 122

North Lincolnshire Recovery Team

Approximate number of patient in team 278

Number of patients with no valid risk assessment recorded 68

Number of patients with no risk assessment 50

Number of patient with no crisis plan 239

North Lincolnshire Intensive Community Therapy Team

Approximate number of patient in team 457

Number of patients with no valid risk assessment recorded 101

Number of patients with no risk assessment 75

Number of patient with no crisis plan 246

Rotherham Recovery Team

Approximate number of patient in team 226

Number of patients with no valid risk assessment recorded 17

Number of patients with no risk assessment 15

Number of patient with no crisis plan 222

Rotherham Community Therapy Team

Approximate number of patient in team 637

Number of patients with no valid risk assessment recorded 226

Number of patients with no risk assessment 96

Number of patient with no crisis plan 383

Inadequate

Are services safe?

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

Rotherham Social Inclusion Team

Approximate number of patient in team 664

Number of patients with no valid risk assessment recorded 186

Number of patients with no risk assessment 66

Number of patient with no crisis plan 551

Rotherham Carers

Approximate number of patient in team 103

Number of patients with no valid risk assessment recorded 88

Number of patients with no risk assessment 88

Number of patient with no crisis plan 5

Manchester Early Interventions Team

Approximate number of patient in team 398

Number of patients with no valid risk assessment recorded Data not provided

Number of patients with no risk assessment Data not provided

Number of patient with no crisis plan Data not provided

Not all risk assessments were updated regularly and this was a problem for all teams especially, Doncaster recovery team, North Lincolnshire ICTT, Rotherham SIT and Rotherham CTT. The access team completed all initial risk assessments, with the exception of the Manchester service. In Manchester, staff inputted their own risk assessments and updated them when necessary. A recent audit conducted by the trust in July 2015, found risk assessments were good overall, but there were issues with the quality of the risk management plans. The audit identified the need for STORM, (risk assessment and risk management) training, which was due to be rolled out in January 2016. Staff told us the audit was also going to be repeated in December 2015. All other teams explained that the process should be that the access team complete the initial risk assessment and that this was expanded upon by the care coordinator and updated when risks change or at least annually. However, all teams described the computer system as difficult for staff to use. For example, boxes did not expand to allow more detailed information to be added and other assessments and care-planning information would unnecessarily require additional updates to be made, making the process lengthy. The Rotherham CTT team manager acknowledged that not all risk assessments were of an adequate standard and that training was needed in this area. This team had a significant waiting list and some people did not have any contact with mental health services during this time. People who use services had been advised to contact the team for support if their needs changed. However, staff were aware that not everyone had the capacity to do this. Some attempt to review the risk assessments of the people who were on the waiting list had been made but this took time. In the Rotherham SIT, the team manager was aware that all risk assessments and other records were not up to date due to a large influx of people who use services to the team. The team manager estimated this could be approximately 100 service users but attempts were being made to review these service users at clinic sessions. Trust data confirmed that the lack of valid risk assessments and crisis plans were an area of concern.

We found that staff had a good understanding of the people they were involved with but that in-depth crisis plans were not developed and information needed by other teams was not available. Teams had good multi-disciplinary team (MDT) working and people deemed to be in crisis or near crisis were discussed in either daily or weekly team meetings. Staff offered advice to one another about crisis management and staff shared information appropriately. Despite this, crisis and contingency plans were poor overall with little information available regarding triggers and coping strategies. This meant that staff outside of the team did not have the necessary information to assist people who were in crisis.

Staff were able to respond promptly to a sudden deterioration in a people's mental health. All staff we spoke to described being able to prioritise their work dependent on need and that support from a consultant psychiatrist was available, if necessary.

Staff demonstrated a good understanding of the safeguarding processes for both adults and children. Team managers we spoke to explained that safeguarding training was available, staff were encouraged to attend and compliance was good. However, trust data supplied for all teams did not reflect this. Rates for adults and children safeguarding training were significantly below trust targets.

Rotherham Recovery Team

Safeguarding Adults Level One Training 6%

Inadequate

Are services safe?

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

Safeguarding Children Level One Training 6%

Rotherham Social Inclusion Team

Safeguarding Adults Level One Training 18%

Safeguarding Children Level One Training 9%

Rotherham Community Therapy Team

Safeguarding Adults Level One Training 20%

Safeguarding Children Level One Training 27%

Rotherham Carer Support Team

Safeguarding Adults Level One Training N/A

Safeguarding Children Level One Training N/A

Doncaster Assertive Outreach Team

Safeguarding Adults Level One Training 12%

Safeguarding Children Level One Training 18%

Doncaster Recovery Team

Safeguarding Adults Level One Training 10%

Safeguarding Children Level One Training 15%

North Lincolnshire Recovery Team

Safeguarding Adults Level One Training 29%

Safeguarding Children Level One Training 29%

North Lincolnshire Intensive Community Therapy Team

Safeguarding Adults Level One Training 27%

Safeguarding Children Level One Training 33%

Manchester Early Intervention in Psychosis Team

Safeguarding Adults Level One Training 36%

Safeguarding Children Level One Training 36%

The senior management team explained that safeguarding training was delivered via a leaflet attached to staff's payslip and therefore the compliance rates were 100%. Staff we spoke to also confirmed training was delivered in a leaflet format. Despite this the trust were unable to produce data to confirm training compliance was 100%.

Safeguarding procedures differed according to the local authority area. Despite this, staff felt the system worked well and there was no confusion regarding roles and responsibilities.

Lone worker practices varied at different locations, although they appeared to be working effectively with some gaps in safety identified. In some teams, the duty worker was responsible for checking that each member of staff had telephoned to say they were safe at the end of each working day. In other teams, administrative staff or team managers had been delegated this role. Staff were also working alone sometimes for a whole day and there was no way of knowing about their personal safety until the end of the working day when they telephoned in. In Manchester, staff wrote their daily visits on a white board that was visible to the admin team. In the Doncaster Recovery Team, staff recorded their daily visits on their outlook calendars. The Rotherham locality manager explained that the lone working procedure had been escalated to the senior management team with a view to improving and simplifying the process for all teams.

Medicines management practice was of variable quality across all teams. We found that medicines were stored securely and dispensed safely in the majority of teams. However, the Doncaster AOT had devised their own medication charts and recording sheets, which were not in line with the trust's format. We found there was no date for the signature of the prescriber and no allergy information had been completed for some people. There were gaps in people's records where staff had not documented that they had delivered medication to people's homes. In the Doncaster Recovery Team, we found evidence of one incident of unsafe secondary dispensing practice by staff who were giving a person their medication on a daily basis in envelopes. There was no care plan or over-arching procedure detailing this practice and it was not possible to locate a list of medication for this particular person. This meant that medication errors were more likely to occur.

We similarly found that there was no consistent approach to completing and recording medicines reconciliation on admission to the service, or clear protocols for stock control and the storage of people's own medicines. There was no oversight of the process and it was not audited. Additionally, it was not possible for the teams to complete clinical audits of prescribing practice because they were unable to identify people's prescribed specific treatments. Doctors supporting the Rotherham recovery team had recognised this and were compiling lists of people who were prescribed high dose antipsychotics with a view to reviewing their treatment.

We saw that on occasion staff at the Doncaster recovery team removed medicines from people's homes for

Inadequate

Are services safe?

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

disposal, or kept individually prescribed supplies of oral medicines at the clinic. There were no records of consent to remove the medicines and of the receipt of the medicines into the clinic or of their safe disposal. This meant that there was no account of the handling of these medicines.

Nurse led clozapine clinics and lithium clinics provided a treatment monitoring service to all people prescribed these medicines. We saw that staff in the clinics also undertook physical health screening with the people who attended. Records of discussions about their treatment and any side effects were recorded. Following an incident last year the trust had implemented a new spreadsheet to support the physical health of people taking clozapine in North Lincolnshire. There were plans in place to roll this out across the trust.

The national audit of schizophrenia 2014 showed that the trust was below average (21%) for the monitoring of five risk factors: smoking, BMI, glucose, lipids, and blood pressure. The trust was developing a physical health and wellbeing strategy to improve physical health monitoring. This had included discussions about the role and responsibilities of primary and secondary care in physical health monitoring, and the interface between inpatient and community services.

In Doncaster, shared care protocols were established and a shared care protocol for lithium had recently been agreed in Rotherham. There were no shared care protocols with GPs in North Lincolnshire. An effective shared care agreement could facilitate transfer of people's treatment from secondary care to general practice, as it provided information on the drug, together with guidance on the prescribing and monitoring responsibilities.

A review completed by the trust in July 2015 had identified that each community team was using different prescription chart documentation. New paperwork to facilitate a more standardised approach was being piloted by the Doncaster access team but had not yet been rolled out across the community mental health teams. Additionally, a programme board and clinical steering group was in place for a clinical systems review but this was in the early stages.

Track record on safety

Over a twelve-month period from February 2014 to March 2015, the trust had recorded 40 serious incidents requiring investigation, (SIRIs) in relation to community mental health services. All had been identified as either unexpected deaths or severe harm. This was 82% of the trusts overall figure for reported SIRI's. The trust had implemented a "sign up to safety" campaign which aimed to reduce the number of suicides and medication errors by learning from events and making changes to practice.

Reporting incidents and learning from when things go wrong

All staff we spoke to had a good understanding of what incidents to report and how to report them. Staff were able to give detailed examples of reportable incidents and could explain which system to use to report them. Data we examined confirmed that staff were reporting incidents in relation to people who use community mental health services.

We found that staff were open and transparent and understood the importance of explaining to people when anything went wrong. Staff discussed several events where mistakes had been made and they had had an open and frank discussion with the person regarding this.

Staff received feedback from investigations of incidents both externally and internally. We found that feedback was delivered within team meetings and in individual supervision. This was evidenced in meeting agendas and from staff interviews.

Changes had been made as a result of feedback from investigations. In Manchester, staff told us about a serious incident that resulted in their involvement in rewriting a trust policy as part of the post incident review.

Are services effective?

Requires improvement

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

Our findings

Assessment of needs and planning of care

We examined 38 care records chosen at random. We found that assessments were comprehensive and completed in a timely manner. All assessments, except for the Manchester EIP, were completed by the access team and contained relevant information to help formulate care needs. Staff we spoke to explained that as further information was discovered they could add this to the assessment information.

Care records did not always contain up to date, personalised, holistic, recovery orientated care plans. Of the 38 care records we looked at, 24 were up to date, ten were personalised, 16 showed some evidence of being holistic, and 16 were recovery-orientated.

All information was stored securely but was not available to staff when they needed it in an accessible form. Most records were stored electronically on a secure password protected database. Some paper notes were also held in Manchester such as letters that could not be scanned onto the electronic system. However, the electronic system used at all other locations, silverlink, was difficult to navigate and important information was hard to find. We found that it was not possible to easily find which people were prescribed anti-psychotic medication and there was no clear guidance on where this information was held. Most staff members had developed their own way of inputting information and the lack of a uniform approach made it problematic for other teams, such as the crisis team, to easily access this information.

Best practice in treatment and care

Medical staff we spoke to explained that they were able to keep up to date with national institute for health and care excellence (NICE) guidance in relation to prescribing medication by having regular supervision and any updates were sent via an email from the trust. Other staff were kept up to date from the nursing consultant and advanced nursing practitioners who discussed and disseminated NICE information to the wider teams. We found that some prescribing was above British National Formulation limits but that service user consent had been sought and closer monitoring provided.

Not all teams were able to offer psychological interventions as recommended by NICE. Most teams were able to identify access to psychology as an area that required improvement. Doncaster AOT only had provision for one hour of psychology per week but people could also access group work for common mental health problems. For more in-depth, individual work, people had to wait over 12 months. There was group work available for those people using the Doncaster Recovery Team but there was no psychology input for one to one work. In the North Lincolnshire Recovery Team, there was some individual work and group work available and the psychologist was able to input into care planning. However, there was a 0.5 whole time equivalent vacancy for a psychologist. In the North Lincolnshire ICT team, cognitive behavioural therapy (CBT) and dialectic behavioural therapy (DBT) were offered but there was a waiting list. In Rotherham SIT, there was limited access to psychology due to a vacancy and in the Rotherham CTT, group work was available but there were approximately 119 people awaiting individual work. In the Manchester EIP, there was access to 0.9 WTE of a clinical psychologist who provided a clinic in the city centre and visited people in their own homes. The psychologist provided CBT, cognitive analytical therapy (CAT) and eye movement desensitisation and reprocessing therapy (EMDR). The service also had a nurse who was trained to deliver CBT. However, people were prioritised in accordance with need and a limited number had access to psychological therapies, as the resource in the team was small. People were also supported to access psychological therapies from other organisations in Manchester.

Most teams were able to offer interventions, which included support for employment, housing and benefits. In the teams based at Rotherham, staff were able to refer people to a third sector organisation, which had been commissioned to provide a social prescribing scheme. The purpose was to offer people opportunities in relation to voluntary work, paid employment, recreational activities and education. Staff members from the Rotherham Social Inclusion Team described being overwhelmed with too many people on their caseload that they did not have time to provide a good quality service to and that interventions relating to housing and benefits were being missed. In Doncaster, Manchester and North Lincolnshire, teams felt they had good links with other agencies and the inclusion of social workers into the integrated teams allowed for social issues to be recognised and interventions offered. In Manchester, the service employed a welfare rights advisor who was able to provide support around housing,

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employment and benefits. However, in the North Lincolnshire Recovery Team, three social worker posts had been frozen by the local authority which was having an impact on the dynamics and resources of the team. However, this was outside of the trusts control.

In the 38 care records we examined, there were only five that contained good evidence of ongoing physical healthcare checks. This means there was a risk that physical health problems were not being identified and risks to people's physical health were being overlooked. This is not in line with the trust's policy, which outlines that staff should ensure all people have had a physical healthcare check and that they should routinely promote healthy lifestyles within their day-to-day practice. The policy also highlighted that regular screening tools should be used to detect side effects from medication. The trust completed an audit of care records approximately 12 months ago and found 49% of care plans did not include information relating to physical healthcare and only 48% of care records contained a side effect monitoring tool. In Rotherham, there was no shared care agreement between the trust and local GPs. Staff were aware that annual physical health checks were not always being completed due to the lack of information regarding who was responsible and a lack of resources available. The trust steering group was working to ensure the physical health screening tool was used consistently within all the teams. People who attended the clozaril and lithium clinics were monitored and physical health was screened. However, other people did not receive this same level of care. The team managers acknowledged this gap and explained they were planning to set up annual physical health check clinics using support workers in the Rotherham community therapy team, and developing a physical health questionnaire in the Rotherham social inclusion team. In Doncaster, there was a shared care agreement with GPs and people had physical health checks by their GP, care coordinators and at care programme approach (CPA) reviews. A support worker was being trained to complete annual physical health checks. Clinics for lithium and clozaril were available and health promotion work had begun regarding smoking cessation and healthy eating. This had been developed after an evaluation of a similar established post in the EIP service. Work was underway with the trust steering group to ensure the trust developed physical health screening tool would be used consistently in all teams . In North Lincolnshire, physical health checks were completed by the GP and health monitoring was provided within clozaril and lithium clinics. In Manchester, a business case had been put to the commissioners to set up a physical healthcare clinic. However, at the time of inspection, the team did not have the facilities to provide ongoing physical health checks and screening. One of the consultant psychiatrists had made links with local GPs and they were carrying out checks.

One main issue that affected all teams, with the exception of the Manchester team, was that it was not possible to clearly identify the current medication prescribed to each person. We found that information was not available within care plans but was contained in correspondence to GPs. However, these GP letters did not always clearly state a full list of a person's medication.

All teams used health of the nation outcome scale to measure severity and outcomes for service users before, during and on discharge from treatment from the service. Other specific outcome measures were used within teams. However, these were dependant on the disciplines within the team. For example, teams that had access to psychology input used specific psychological assessments. Teams that did not have psychology input, did not use these specific assessments. This meant there were inconsistencies across teams in relation to outcome measures used to monitor and review the effectiveness of care and treatment provided.

In Doncaster, staff completed the infection control audit and a prescribing observatory for mental health audit. However, in other teams, there was no evidence of staff involvement in audits.

Skilled staff to deliver care

Not all teams had access to the full range of mental health disciplines required to care for the specific group of people. A lack of psychological input was particularly evident in both Doncaster teams where there was limited psychological provision. In the North Lincolnshire recovery team, there was a shortage of social workers as the local authority had frozen three posts, which was outside of the trusts control. There was also no occupational therapist (OT) in the team and a 0.5 WTE vacancy for a psychologist. In the Rotherham social inclusion team, there was a lack of consultant psychiatrists and an application by the senior management team to employ a full time consultant psychiatrist had been made. In the Rotherham community therapy team and North Lincolnshire intensive community

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therapy team, staffing levels and skill mix were generally good. However, despite this, both teams had a waiting list for treatment. None of the teams had any pharmacy oversight. Staff told us that they could access pharmacist support when advice was needed about specific queries. However, pharmacy support was not integrated into the community mental health teams. For example, in supporting medication reconciliation or review. We were told that very few staff had access to the summary care record, although plans for access were being drawn up.

We found that staff employed were experienced and suitably qualified for their role.

Not all staff had completed the corporate trust induction programme with only 47% of staff being recorded as completing this for the adult mental health services directorate.

We found that staff received regular supervision and were able to attend appropriate team meetings. All staff we spoke to confirmed that they had regular supervision, both clinical and managerial on a monthly basis, and this was evidenced in supervision records. Staff described working in a supportive environment and that they found their team managers approachable. Appraisal rates across teams varied significantly. The lowest rate was 0% for the Rotherham CTT and the highest rate was 53% for Rotherham recovery team. These figures are not in line with trust policy that states that all staff should receive an appraisal annually.

The trust was aware of this and was developing a corporate action plan to address this shortfall

Percentage of non-medical staff that have received an appraisal in the last 12 months

North Lincolnshire Intensive Community Therapy Team 11%

North Lincolnshire Recovery Team 17%

Rotherham Community Therapy Team 0%

Rotherham Carer Support Team 100%

Rotherham Recovery Team 53%

Rotherham Social Inclusion Team 18%

Doncaster Assertive Outreach Team 0%

Doncaster Recovery Team 0%

Manchester Early Interventions Team 45%

However, information provided at a local level by each team manager demonstrated that appraisal rates were higher than those recorded by the trust at governance level. Teams with a higher appraisal rate were,

- Doncaster AOT, up to 85%
- Rotherham Recovery, up to 75%
- Rotherham SIT, up to 20%
- North Lincolnshire ICTT up to 27%

Data we examined also showed that most team managers had booked appointments for individual staff appraisals within the next few weeks or months.

Staff received the necessary specialist training relevant to their role. Staff we spoke to described having good access to additional training such as CBT training, personality disorder training, and other postgraduate courses. Staff stated that they were supported by their managers to develop their skills in areas identified within their supervision and appraisals.

Multi-disciplinary and inter-agency team work

We found that there were regular and effective multi-disciplinary team meetings and that information was shared appropriately. Teams identified which people who use services were in need of extra support and discussions took place regarding how best to support these people. This enabled duty workers to be aware of any current problems and ensured a team approach to individual care and treatment.

Information was not shared effectively between other teams within the trust due to an ineffective record keeping system. The IT system used did not meet the needs of the staff and did not allow information to be easily accessed. The system allowed too many places for information to be stored and there was no consistent approach across teams. The trust had acknowledged this and was making plans to improve this in the future.

There were good working links with primary care, social services and other external organisations. We found that staff had developed good working relationships with other organisations such as GPs, drug and alcohol services, housing departments and child safeguarding teams. Feedback from Aspire Support Agency based in Doncaster,

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described Doncaster AOT as having embedded partnership working and was in frequent telephone contact to ensure that the service delivered was consistent and information shared as was necessary.

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

Fifty members of staff had completed Mental Health Act training in the last 6 months. Staff we spoke to confirmed that the training was available and that they had booked onto upcoming training sessions. Information provided by the trust highlighted that MHA training was being provided in the near future.

Staff described having a good working knowledge of the MHA and how to apply it. There was an understanding of community treatment orders (CTOs), and people's rights. Staff explained that people's rights under MHA/CTO were routinely explained to people and recorded on a specific document. Reminders and prompts to complete these were sent from the MHA administrators' office. The MHA administrator also provided advice and guidance to staff regarding legal processes and structures.

People who use services had access to independent mental health advocates provided by Cloverleaf Advocacy throughout the trust area, with the exception of Manchester, where it was provided by Rethink advocacy service. Staff we spoke to understood how to refer people and the reasons around this.

Good practice in applying the Mental Capacity Act

All staff had basic awareness training in relation to the Mental Capacity Act, (MCA). This was provided in the form of a leaflet enclosed with staff payslips and 100% of staff had received this, with the exception of the North Lincolnshire ICT team where the figure was 87%. However, there was no way of knowing if staff had read this or understood the content.

However, staff we spoke to were able to describe recent examples of using the MCA and Best Interests decisions in their practice and the steps and processes they had used. Staff were able to identify relevant documents where lack of capacity to consent to treatment and other information should be recorded and stored.

Staff explained that they could access information and policies in relation to the MCA on the intranet and by flow charts displayed in offices. Staff also had access to AMHPs in some teams from whom they could seek further advice.

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 observed eight interactions between staff and people who use services. Staff were respectful, and treated people with dignity and compassion. We observed staff demonstrating good listening skills, validating people's feelings and they had trusting relationships whilst being empathic to people's needs. All interventions were safe, caring and supportive, encouraging recovery. Support offered included both emotional and practical interventions.

People who use services reported that staff were helpful and supportive and treated them with dignity and respect. We spoke to 24 people who use services in total and 22 gave positive comments, which included feeling listened to, having good relationships with care coordinators and overall being happy with their care. Two people gave negative feedback which included not getting on with their current care coordinator and not being allowed to change to a preferred worker and one person stated that staff were rude and too controlling.

We found that staff had a good understanding of the individual needs of people and that personalised care was promoted as much as possible. This was reflected in the observations of staff interactions and feedback from people who use services. However, this was not always evidenced in care plans and other relevant documentation.

With regards to confidentiality, we found that this was maintained by safe and secure record keeping and appointments being in private, either in peoples own homes or within clinic environments with separate interview rooms.

The involvement of people in the care that they receive

Although all people who use services (apart from one), explained they felt involved in their care, this was not reflected in care planning records, and only four service users out of the 24 we spoke with could confirm that they had a copy of their current care plan.

Not all care plans contained personalised care or showed any evidence of people's involvement. We examined 33 care records and only six were personalised, 16 were recovery orientated and 11 demonstrated that a copy had been given to the person. However, feedback from the Care Quality Commission (CQC) community mental health patient experience survey, gave positive results in all areas of people's experience including making decisions and agreeing care needs together. The trust scored 7.7 out of 10 for involving people in their care, compared to an England average of 7.4 out of 10.

We spoke to nine carers who all explained that staff were available for them when needed and were responsive to their needs. They described feeling listened to and that they were involved in their relatives' care as much as was reasonably possible. They described staff as kind, caring and helpful and that they had developed good relationships.

The services based in Rotherham had access to Rotherham Carer Support Service. This was also accessible to all carers of people with mental health problems including those not known to services and those with autistic spectrum disorders and organic mental health problems. This service provided carers with carer assessments, information and signposting to other services, advocacy, advice and guidance regarding the carer role and support with education, training, employment and group meetings. In addition to this, the service had also been involved with the training of staff with input from carers at the core of this development.

In all other teams staff completed carer assessments. Within access teams or in the Manchester early intervention team, support workers completed this role. Carers were referred to adult social care if it was felt that a package of care was needed to support the carer further. Carers were also advised to contact local third sector organisations such as MIND or Rethink.

Access to advocacy was available from independent mental health advocates and independent mental capacity advocates, via referral to Cloverleaf Advocacy who also provided more general advocacy services to support people with mental health problems. One person who used services was able to name Cloverleaf as an advocacy service whilst other people stated that they were reliant on their care coordinators to provide this information verbally if necessary. In Manchester, Rethink provided this service.

People who use services were not always able to be involved in decisions about the service or able to help recruit staff. We asked seven people if they had ever been involved in making decisions about the service and only

Good

Are services caring?

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

one person stated that they had but had then declined. We asked 11 people if they had the opportunity to give feedback and six explained they had and five said they did not know how to do this. However, most people stated that they felt able to speak to their care coordinators in the first instance. None of the people we spoke to had been involved in the recruitment of staff. One team manager explained they had involved people who use services in the past.

The trust had implemented a "Your Opinion Counts" survey to capture any feedback from people who use services. However, this was not embedded fully in the teams and was not mentioned by any people we spoke with. Doncaster Assertive Outreach team manager stated that they were trying to gather this information following every care programme approach review.

The CQC community mental health patient experience survey, found that overall the trust was preforming at a level comparable with other similar trusts in relation to peoples experience. However, in some areas the trust were performing above the England average in the following areas:

- care provided being well organised
- agreeing what care will be received
- making decisions together
- medication information being given in an understandable format
- being given help with finding or keeping work
- involving families in peoples' care.

Data provided by the trust's staff survey, the friends and family test, found that staff were 68.4% likely or extremely likely to recommend the trust as a place to work. This was above the England average, which was 61.7%. Staff were also 79.3% likely or extremely likely to recommend the trust as a place to receive care. This was again above the England average of 76.2%.

We received 23 comment cards from people who use community based mental health services for working age adults. Twenty-one of these were positive comments that included staff being helpful, caring, respectful and supportive. People felt listened to and staff responded to them quickly when necessary and could be flexible regarding appointment times. There was one negative comment from a person who felt that there were too many different staff and that there should be more activities available to them.

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

With regards to all community based mental health service for working age adults, the trust was achieving its target of seeing all people within a given timescale from referral to treatment. The target was 95% and the trust was exceeding this with 100% in Doncaster and North Lincolnshire and 99.7% in Rotherham.

The team manager of the Rotherham social inclusion team informed us that there was no target for referrals that had been transferred in from other teams such as the access team. However, the access team did provide all the initial assessments and their target was 14 days.

In June 2015, the Manchester team reviewed 20 cases randomly to check their access and waiting standards. They found that the mean average for length of time from referral to allocation of a care coordinator was 11 days. The shortest time someone had to wait was one day and the longest was 29 days. The target for the team was 14 days.

All teams were able to see urgent referrals more quickly and were able to use appointments flexibly. We found that appropriate duty systems were in place and that staff were usually able to respond within the same working day if necessary. Staff and managers confirmed that in the most urgent cases, people were prioritised for a care coordinator or an appointment with the consultant psychiatrist. This was also reflected in comments made by people who use the service and their carers. However, in some teams this was affecting the ability of staff to see people with non-urgent needs. In the Rotherham SIT, staff expressed concern that they were only able to do crisis management work and that routine appointments were cancelled due to the high caseloads in the team. In the Rotherham CTT, there was a waiting list of approximately 12 months for people to receive one to one psychological therapy. Staff and the team manager acknowledged that seeing the urgent cases more quickly would ultimately mean that other people would wait longer still.

There was clear criteria for offering people a service. Every person had a comprehensive assessment and those eligible for a service were assessed using a "clustering tool", and then referred to the appropriate team for that particular cluster. However, we found that this system was not always flexible enough to meet people's needs. This was particularly evident in the lack of psychological access available in some teams and waiting lists for therapy. However, in the North Lincolnshire recovery team, the team manager identified that although some people had been assessed as needing to be in the intensive community therapy team, it had been agreed that due to good working relationships with their care coordinators and consultant psychiatrists, their needs would be best met within the recovery team. The trust was aware of the problems with delivering care within this structure and plans were being considered regarding moving back to working in larger generic teams.

The Manchester EIP team had a remit to provide a service for a maximum of three years for each person. However, there had been historical problems with discharging people back to local community mental health teams (CMHTs) which resulted in some patients being with the EIP as delayed discharges for up to five years. Although some work had been done to improve this, there were still some problems at the time of our inspection. This issue was on the trust's risk register. The majority of EIP discharges went to primary care and in 2014-2015, 120 people were discharged to their GPs and 38 were discharged to CMHTs.

We observed staff being flexible about appointment times and this was reflected in feedback from people who use the service. Staff gave people a choice of times that suited them and within the clozaril and lithium clinics, people could attend either clinic without difficulty.

The facilities promote recovery, comfort, dignity and confidentiality

For those teams where people were seen on the trust's premises, we found that there were a number of issues relating to the suitability of the environments. In Rotherham, there were sufficient interview rooms and the clinic rooms were well stocked. However, it was not possible to walk around the examination couch due to the small size of the room. In the Doncaster recovery team, there were three interview rooms, which were not enough to meet the need. Staff would often need to find alternative meeting rooms in the local community. In the North Lincolnshire ICT team, we found that the interview rooms were too small with no natural light and a lack of soundproofing. This meant that facilities were not comfortable for the people using them making engagement and treatment more difficult.

Are services responsive to people's needs?

Good

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

We found that all teams had good provision of accessible information regarding treatments, local services, people's rights and how to make a complaint. These were located in waiting rooms and were available in different languages upon request.

Meeting the needs of all people who use the service

All buildings had adequate disabled access, apart from the Doncaster recovery team where the entrance door was too narrow to allow wheelchair access. The team manager explained that the building was leased from the local authority and that it is difficult to obtain funding for building improvements. The service offered appointments at other locations and at people's homes if they were unable to access the building.

Information was available in languages other than English if requested and access to interpreters was available if necessary throughout the service. However, in Manchester, we spoke to one carer who said the service did not provide information in other languages. Another carer we spoke to said they were very happy with the Manchester EIP in this regard. English was not their first language and they said they always received written translated information and information via a translator

Listening to and learning from concerns and complaints

The service had the highest number of service-wide complaints in the trust. Trust-wide, there were 147 complaints in the period from 1 November 2014 to 30 April 2015. In this period, the service recorded 75 complaints, (51%) of which 12 were upheld. The intensive community therapies team received the highest number of complaints within the service with 24 in the last 12 months, of which four were upheld. Those that were upheld, three related to a lack of support and contact with people from the team and one related to a person's family not being given a full explanation of the reasons why the person was not suitable for therapy.

Not all people knew how to complain or give feedback about the service. We spoke to 24 people who use the service and only four were able to say that they understood how to complain about the care they received. However, five did say they felt confident to tell their care coordinators if they were unhappy. Feedback was also sought following group work in the Rotherham recovery team and patient advice and liaison service information given out. Staff stated they receive this information back directly.

Staff we spoke to stated they dealt with complaints by either directing people to use the PALS service or informed their team manager, depending on the nature of the complaint.

Are services well-led?

Requires improvement

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

Our findings

Vision and values

Staff we spoke to described their team leaders as supportive, approachable and available when they were needed. Staff also said that the locality managers were a visible presence and would visit the individual teams. However, managers that were more senior were less visible. Staff knew who the most senior managers were but not all had met them. Staff received a weekly email from the chief executive, which staff said gave helpful information.

Staff at the Manchester EIP told us that the trust senior management team, including the chief executive, had visited them in Manchester.

All staff we spoke to demonstrated a good understanding of the purpose and objectives of their teams. Staff were aware of recovery based approaches and promoting independence. In the Rotherham SIT however, some staff were dissatisfied and felt that they were being pressured by their managers to discharge people unnecessarily.

Good governance

Overall, systems were not effective in ensuring that staff received and were up to date with mandatory training. The training figures provided by the trust did not reflect the actual figures stored at location level. Trust data showed poor compliance with mandatory training however, managers, staff and local data showed mandatory training rates to be higher than those recorded by the trust. The Rotherham locality manager acknowledged this, explaining that not all training was captured by the IT system.

Staff were not able to maximise their time on direct contact with people due to poor IT recording systems. We found that the "silverlink" IT recording system was not suitable for its purpose and was too time consuming. It was not possible to update information on the system without having to update a number of other sections of the system, causing staff to input information that already existed. There were no clearly identified areas within the system to store particular information. It was therefore likely that information would not be available when needed. It was not possible to easily identify people's medication or audit the records for medication purposes. The senior management team agreed that standards of communication needed to improve, especially regarding medication and involving people in their care planning. However, they did not give a timescale for when this would happen.

Systems were effective in relation to incident reporting. We found that appropriate incidents were reported and this information was fed up to the senior management team. Information and lessons learnt were also disseminated in team meetings to the wider staff.

The teams could submit items to the trust risk register. An example of this was the high number of delayed discharges that the Manchester team were carrying because they were unable to discharge people to local community mental health teams. Whilst this situation had improved, there had not been enough time to determine any consistency. Therefore, the item remained on the risk register.

All team managers felt that they had sufficient authority to carry out their roles. They could employ agency or bank staff if necessary without difficulty and they had good administrative support overall.

Leadership, morale and staff engagement

According to the most recent NHS staff survey, 2014/15, 75% of mental health nurses employed by the trust agreed that appraisals were not completed during the last 12 months. This corresponded with trust data on staff appraisal rates.

Sickness and absence rates varied across the teams we inspected. Fifty per cent of teams scored below the England average sickness rate of 4.7%. In the Doncaster AOT, North Lincolnshire recovery and intensive community therapy teams and the Rotherham recovery team, sickness and absence rates were above the England average with the North Lincolnshire recovery team being the highest at 10%. In the Doncaster AOT, the team manager informed us this was due to two members of staff being on long-term sick leave for non-work-related issues. They explained that agency or bank staff were an option but the team were coping well at present and this was unnecessary. In North Lincolnshire, agency social workers were employed to cover the shortfall in staffing and in the Rotherham recovery team and staff had increased caseloads due to staff sickness.

Are services well-led?

Requires improvement

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The NHS staff survey results showed that the trust scored above the England average for staff not experiencing bullying and harassment from patients, relatives or members of the public, and from staff. Staff we spoke with confirmed this was not an issue within the trust.

Staff were aware of the whistle-blowing process and knew they could refer to information on the intranet if necessary.

Staff were able to raise concerns without fear of victimisation. All staff agreed they felt they could confidently raise any issues with their managers and that their managers were available to speak to them when needed. However, in the Rotherham SIT, some staff felt very unhappy with the senior management team and said that managers were not listening to their concerns. Five members of staff explained they were in disagreement with managers regarding the discharge strategy and were feeling pressured to conform in order to reduce caseload numbers. It was staff's perception that managers were blaming them for difficulties within their team, as they were not discharging people quickly enough. Staff explained they felt it was unfair to discharge people inappropriately knowing that they were likely to become unwell fairly soon afterwards. Two members of staff also felt that the planned changes to the team structures were not being explained to staff in a timely way and they felt anxious regarding the uncertainty this created.

Most staff teams described having good morale, job satisfaction and felt empowered within their roles. Staff we spoke to explained that they worked in supportive environments, had mutual support and effective teamwork and enjoy their work. Staff stated they felt involved in decision-making and confident their ideas would be listened to. However, in the Rotherham SIT, some staff felt that morale and job satisfaction was very low. They stated that changes were made to the service without any real input from the affected staff. Staff described having high caseloads, feeling stressed and some were considering other employment. We spoke to the team manager and the locality manager who explained that various external pressures had impacted negatively on the team resulting in:

- high caseloads of 40-50 or more per care coordinator which is above the Department of Health guidance which is 35 per care coordinator
- staff having to cancel planned visits
- records not being up to date
- a waiting list of 20-25
- approximately 100 people in need of an up to date risk assessment.

The team manager explained that those people on the waiting list were not in urgent need and they had a contingency plan that outlined the duty system. They had an approximate wait of around three months to be allocated to a care coordinator. The team manager was aware of the low morale and high stress within the team and stated that this was managed by informal and formal supervision, team meetings, performance management and staff training. They confirmed that there was a trust policy regarding stress at work and that staff could access anti-stress classes. We examined the trust's positive management of pressure/stress in the workplace policy. This stated that team managers should encourage any staff members who were experiencing stress to contact the employee assistance programme. If there had been significant increases in workloads, managers should ensure that staff completed the "iresilience tool" to identify any workplace stress. This information should then be shared with the team manager and used to inform the support that was offered to staff. The team manager should refer staff to occupational health, counselling or specific stress management courses as appropriate. We were not assured that this policy was being implemented.

The locality manager confirmed that there were plans to change the structure of the teams. They told us they were engaging with staff, that staff had been asked for their views, and information had been shared within a newsletter. They went on to say that, emails from staff that had made suggestions about the new team structure had been saved and would be considered. The trust also acknowledged that the structure of the teams required a completed review and they had identified that dividing teams by location instead of diagnosis would allow them to respond to the needs of the local population more effectively.

Staff at the Manchester EIP were dealing with a range of challenging circumstances such as, dealing with people in out of area beds because of local bed issues, staffing pressures, high caseloads and the reduction in voluntary sector services. However, they were working hard and showed a strong determination to keep people who use

Are services well-led?

Requires improvement

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.

services at the centre of plans and to provide them with an effective service. Staff also demonstrated their commitment to team work and we saw many examples of staff being supportive to each other. Overall, this hard work and peer support by staff was reflected in all teams we visited.

Staff were open and transparent and explained to people when something went wrong. Staff gave examples of medication errors and the steps they took to inform other staff, the person and carers. Staff explained that investigations also took place and then lessons learnt were fed back to the team and the wider service.

Commitment to quality improvement and innovation

Staff at the Manchester EIP team were involved in local research projects such as the use of mobile phone applications, drug trials and family intervention projects.

In Rotherham, the teams had made strong links with the third sector and had developed a "social prescribing" scheme which aimed to help people who use services build informal networks in their community prior to discharge from mental health services.

In North Lincolnshire, the teams were able to refer to a "recovery college" run by the trust to enable people who use services to develop appropriate skills for independent living and to achieve individual goals. Courses available included mindfulness, anxiety management, relaxation, improving sleep and meeting people.

This section is primarily information for the provider

Requirement notices

Action we have told the provider to take

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

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Treatment of disease, disorder or injury	Regulation 9 HSCA (RA) Regulations 2014 Person-centred care Regulation 9 (3) (b) Person-centred care How the regulation was not being met; Care plans were not always holistic, person centred or recovery orientated. • Care plans had information missing such as medication was not listed and health information not recorded. • There was little evidence that people had received a copy of their care plans. • The person using the service did not sign care plans. • Care plans did not always contain information in relation to short-term or long-term goals. This meant that the trust was not ensuring people's needs were met or that peoples preferences and views were considered. This was in breach of regulation 9 (3) (b) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Treatment of disease, disorder or injury	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment Regulation 12 (2) (a) Safe care and treatment How the regulation was not being met; Risk assessments were not always reviewed regularly. • Not all people who use services had up to date risk assessments.

This section is primarily information for the provider

Requirement notices

- People that were on waiting lists were not having their risk assessments reviewed.
- There was no clear process or record of peoples physical health checks

This meant that the trust was not effectively assessing the risks to the health and safety of people receiving care and treatment.

This was in breach of regulation 12 (2) (a) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Treatment of disease, disorder or injury	Regulation 17 HSCA (RA) Regulations 2014 Good governance Regulation 17 (2) (b) Good governance How the regulation was not being met; • Teams had developed separate documents for medication charts, which were not in line with the trust's procedures, and had key information missing. • Medication was being secondary dispensed in envelopes to people who use services. • There was no clear system to audit medication. • There was no direct pharmacy support to the teams. • There was no oversight in relation to medication management. • We also found that there was no system in place to monitor and record service user physical health check compliance. • There was no effective process of audits and no systems to drive improvement. This meant that the trust was failing to provide appropriate systems and processes to identify and assess risks to the health safety and welfare of people who use the service.

This section is primarily information for the provider

Requirement notices

This was in breach of regulation 17 (2) (b) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

Regulation 17 (2) (c) Good governance

How the regulation was not being met;

We found that service user information was not accessible to other authorised people as necessary in order to deliver safe care and treatment.

- There was no clear place within the IT system to store specific information such as current medication and physical health needs.
- Staff members had developed their own individual processes for storing information within the system.
- Other staff members needed to spend a considerable amount of time searching for basic information.
- The information recording system did not allow staff to identify people most at risk.
- This allowed for vital information relating to safe care and treatment to be missed.

This meant that the trust were failing to ensure that records were fit for purpose in a way that meets people's needs and keeps them safe.

This was in breach of regulation 17 (2) (c) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

Regulation 17 (2) (d) Good governance

How the regulation was not being met;

We found that there was no effective system in place to ensure that staff were up to date with mandatory training.

- There were different figures for mandatory training provided at trust level and at a local level.
- Training data was not being accurately captured by the IT recording system.
- There was no clear oversight of mandatory training data actions around this.

This meant that the trust was failing to maintain accurate records relating to people employed.

This section is primarily information for the provider

Requirement notices

This was in breach of regulation 17 (2) (d) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.