

Requires improvement 

Solent NHS Trust

Community-based mental health services for older people

Quality Report

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Locations inspected

Location ID	Name of CQC registered location	Name of service (e.g. ward/unit/team)	Postcode of service (ward/unit/team)
R1CF2	St James Hospital	Langstone Centre Older person community mental health team	PO4 8LD

This report describes our judgement of the quality of care provided within this core service by Solent NHS 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 Solent NHS Trust and these are brought together to inform our overall judgement of Solent NHS 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?

Requires improvement



Are services effective?

Requires improvement



Are services caring?

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

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Summary of findings

Overall summary

We rated older people's community mental health services as requires improvement because:

- The staff member who managed the memory service had a caseload of over 600 patients. Therefore, patients did not receive six monthly reviews of their medication in line with national guidance.
- Staff did not follow the trust's policies and procedures when managing medicines. Therefore, staff did not manage medicines in line with current legislation and guidance, including those related to storage and transportation.
- Staff told us that they managed risk and investigated incidents. However, at the time of the inspection staff could not provide any records of risk assessments, incident reports or audits of these records. Therefore, it was difficult to see how staff reported incidents, what action they took and whether staff learnt any lessons as a result.
- Electronic care records were of inconsistent quality. We viewed 10 records which had no evidence of patient involvement, capacity assessments that were incomplete and no evidence that the patients had received copies of their care plans

- Care records did not describe how staff involved patients in making decisions about their care
- Seventy Eight percent of staff in this service had completed statutory and mandatory training. However, the trusts target for completion was 85%
- The clinic did not have hand-washing sinks in the consultation rooms so that they could wash their hands between consultations.

However:

- The service had access to administrative support and legal advice on implementation of the Mental Health Act and the Code of Practice from a central team.
- Staff were aware of the Mental Capacity Act and how to report Deprivation of Liberty Safeguards (DoLs). Although at the time of the inspection, nobody was subject to a DoLs.
- We observed a patient assessment and saw that staff treated the patient and their carer with kindness.

Summary of findings

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

Are services safe?

We rated safe as requires improvement because:

- Staff did not always carry out physical health monitoring in line with National Institute for Health and Care Excellence Guidelines.
- The temperature in the clinic room was not controlled so staff could not monitor the temperature medicine was stored at. Some medicines needed to be stored within a specific temperature range or the medicines may not be effective.
- The service did not have a system in place to check if staff had completed medicines competencies. Staff carried medicines to patient's homes in transportation bags. However, these were not locked which presented a risk of them being easily stolen.
- There was limited resuscitation equipment in the clinic building at St James Hospital and no records of the regular monitoring of equipment.
- Environmental audits had been carried out by the trust. However, managers and staff within the service were not aware of them or any actions that needed to be taken.
- Despite having, a system for calculating safe staffing levels on shift the community team told us their current caseload was between 40 to 60 so they were not able to see all patients regularly.

However:

- All staff had a good knowledge of safeguarding adults. However, several staff were still to complete their training at the time of the inspection.
- The service had a buddy system in place to help keep staff safe when they were working in the community on their own.

Requires improvement



Are services effective?

We rated effective as requires improvement because:

- The quality of recording within the electronic care records was inconsistent and staff did not always record important information.
- Not all patients on anti-psychotic medication received an annual physical health check.

Requires improvement



Summary of findings

- The memory clinic did not follow national guidance from the National Institute for Health and Care Excellence in assessing and starting anti dementia medication.
- We saw no evidence of staff monitoring clinical outcomes in patient care plans.
- At time of the inspection, only 46% of staff had completed Mental Capacity Act training.

However:

- The service had access to administrative support and legal advice on the use of the Mental Health Act and its Code of Practice from a central team.
- Staff knew how to access independent mental health advocates ensuring the advocates could represent patients' rights.
- Staff were aware of the Mental Capacity Act and how to report Deprivation of Liberty Safeguards (DoLs).

Are services caring?

We did not provide a rating for caring, as we were unable to speak to patients and fully observe how staff delivered care. We found the following areas of good practice:

- We observed warm interactions with a patient and carer in the clinic setting and staff demonstrated professionalism.
- We spoke with one patient and their carer, they were very positive about the treatment they received and described staff as very helpful friendly and polite.

However, we also found areas that the service provider could improve:

- There was little documented evidence that patients were involved in developing their care plans and there was little evidence that patients choices and preferences had been taken in to account.

Are services responsive to people's needs?

We rated responsive as good because:

- Patients were seen within six weeks of referral in accordance with the guidance from the National Institute for Health and Care Excellence.
- The team took a proactive approach to re-engaging with people who do not attend appointments.

Good



Summary of findings

- The waiting areas and clinic rooms were welcoming and comfortable in the location where the trust had based the community older people's team.
- We saw the information pack that staff gave to people using the memory clinic. It contained a good range of literature, including information how to complain.
- We observed some examples of reasonable adjustments that staff had made so there was disabled access.
- The carer we spoke with told us they knew how to complain. They were able to describe the complaints procedure and all said they felt confident that staff would act upon this if needed.

However:

- Staff told us that the service did not collect patient feedback at a local level.
- Manager could not provide figures for waiting times for therapies such as cognitive behavioural therapy.

Are services well-led?

We rated well led as requires improvement because:

- The manager for the service was not available on the day of the inspection and the modern matron had difficulty finding any information that we requested from them. It was therefore difficult to evaluate the effectiveness of the systems used to evaluate and monitor the quality of care delivered.
- We did not see any evidence of learning from incidents that had occurred.
- At the time of the inspection, staff morale was low. Staff expressed concerns about the plans to relocate the community teams.
- Staff told us they knew how to raise any whistleblowing concerns. However, they were not sure about what actions the trust would take or how senior managers would react to any whistleblowing concerns raised.
- Managers did not link staff job plans to the appraisal and supervision process. Staff we spoke with told us there were limited opportunities to undertake leadership development from the training department.
- Staff we spoke with told us they did not collect feedback from patients and could not evidence any changes to service because of patient involvement.

Requires improvement



Summary of findings

However:

- Staff were aware of the trust vision and values.
- We saw good safeguarding practice and staff with skills and knowledge in how to make appropriate referrals.

Summary of findings

Information about the service

St James Hospital was the registered location from where Solent NHS trust provided a range of community-based mental health services for older people. The service included a community team that served the city of Portsmouth. The team worked between 9am and 5pm, Monday to Friday and provided assessment and ongoing therapeutic work. There was also an intermediate care team that worked seven days a week from 9am to 5pm. Staff in this team worked with patients who had more

complex needs. In addition, the service offered access to a memory-monitoring clinic. This service provided follow up appointments and monitoring of patients medicines and included home visits when appropriate.

CQC had previously inspected the older people's community mental health team on the 1 June 2014 and found no breaches of regulations.

Our inspection team

The inspection was led by Joyce Frederick, Head of hospital inspection.

The team that inspected this core service comprised: one Care Quality Commission (CQC) inspector, a registered nurse with a specialist interest in dementia and a retired consultant psychiatrist.

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 this service, asked a range of other organisations for information and sought feedback from staff at a focus group.

During the inspection visit, the inspection team:

- Visited the community team at St James hospital site and looked at the quality of the clinical environment.

- Spoke with a patient and their carer that attended the memory service clinic. However we were unable to undertake any visits to patients in the community at the time of the inspection
- Spoke with the manager who had overall responsibility for this service
- Spoke with 14 other staff members; including consultants, doctors, nurses, medical secretaries and social workers
- Observed a multidisciplinary meeting
- Looked at 17 prescription records
- Reviewed care records for 10 patients who used this service
- Reviewed the medicines management within the service
- Looked at a range of policies, procedures and other documents relating to the running of the service

Summary of findings

What people who use the provider's services say

We spoke with one person who used the memory clinic and their relative. They were very positive about the treatment that they received. They described the staff as friendly, kind, helpful, respectful and polite. Their carer felt listened to and included in their care. They felt staff offered choices in relation to their care and treatment. The carer said communication with the community team

was very good and they always felt informed. They said staff contacted them when there were any concerns to share. The patient told us they felt that staff responded to their needs. The carer that we spoke with was aware of the complaints process. They had not had any reason to complain but felt confident that they would be listened to and taken seriously if they did.

Areas for improvement

Action the provider **MUST** take to improve

- The provider must carry out physical health checks in line with the national guidelines.
- The provider must review the caseloads of staff in the memory assessment service to ensure staff are able to review patient's medication six monthly in line with national guidance.
- The provider must follow policies and procedures about managing medicines in line with current legislation and guidance, including those related to storage and transportation.
- The provider must ensure the leaders and manager of the service have access to appropriate policies, procedures and documentation in order to be assured of the effective management of the service.

Action the provider **SHOULD** take to improve

- The provider should ensure managers and staff within the service are aware of aware of the risks of the environments they deliver services from to patients and carers attending clinics.
- The provider should ensure that there is appropriate resuscitation equipment in the buildings from which sees patients in clinics and that regular checks on equipment is carried out.
- The provider should take every reasonable step to provide opportunities to involve people in making decisions about their care and treatment, support them to do this and record it in patient notes.

Solent NHS Trust

Community-based mental health services for older people

Detailed findings

Locations inspected

Name of service (e.g. ward/unit/team)

Name of CQC registered location

Langstone Centre older person community mental health team

St James Hospital

Mental Health Act responsibilities

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

- Registered nurses had received MHA training during their registration and one staff member had training in Section 117 of the Act. Section 117 places a duty on health and social services to provide aftercare services to patients who have previously been detained under the Mental Health Act.

- Staff demonstrated a good working knowledge of community treatment orders. At the time of our inspection, there were no patients subject to these orders.
- Patients were signposted to appropriate local advocacy services. Staff gave information to patients telling them how to access an advocate if they needed additional independent support.

Mental Capacity Act and Deprivation of Liberty Safeguards

- Staff had knowledge around the Mental Capacity Act (MCA). The consultants were Deprivation of Liberty Safeguard (DoLS) assessors and all of the staff we spoke with understood what the Act was.
- There was a policy on MCA including DoLS. Staff told us they could access this through the trust's intranet

Detailed findings

- We observed staff discussing the assessments of patients who might have impaired capacity at a multi-disciplinary meeting. Staff covered mental capacity and consent to treatment in initial assessments. Staff

documented consent to treatment in the care records that we viewed. However, we did not see examples of decision specific mental capacity assessments. For example, living arrangements and managing finances.

Are services safe?

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

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

Our findings

Safe and clean environment

- The trust based the community team in the Langston building at St James Hospital. The main reception area was spacious and not carpeted to reduce trip hazards. environmental audits had been carried out by the trust but managers and staff within the service were not aware of them or any actions that needed to be taken.
- There was an alarm button on the electronic computer system in the reception area. However, reception staff told us they did not know if it worked. A manager told us that the supplier of the alarm system completed an audit of the use of alarms every 6 months. However, they did not have documentation to support this. Staff said the provider issued community staff with alarms. However, a manager told us that not all staff had activated them. In addition, the community psychiatric nurses operate “buddy”, this was a buddy system where staff reported to each other there daily appointments and whereabouts. Staff told us this formed part of the lone working policy.
- The small clinic room was clean and tidy. The clinic room had access to an electrocardiogram (ECG); this is a simple test used to check a person’s heart’s rhythm and electrical activity. The trust provided older style sphygmomanometers, an instrument for measuring blood pressure. These were available to take out by staff for home visits. However, there was limited resuscitation equipment in the clinic building at St James Hospital and no records of the regular monitoring of equipment
- The Patient-Led Assessment of the Care Environment (PLACE) score for St. James Hospital was 99%. The reception area and toilets appeared clean. Staff told us that cleaning contractor’s complete general public areas and staff clean clinical areas above floor level. However, cleaning schedules were not available on day of inspection.
- We observed nursing staff working in consultation areas, they wore a uniform that was above the elbow and we observed the use of antibacterial hand wipes. We spoke with the link nurse for infection control. The nurse showed us the trusts on line hand hygiene policy dated May 2016. We observed a notice on the environmental

tour which indicated that taps should be flushed weekly in this service to monitor legionella. However, we did not see any evidence that staff completed this. We asked the manager for audits regarding infection control; these should have included cleaning records, the hand hygiene competencies completed annually for all clinical staff and twice-yearly hand hygiene observational audit. However, the audits were not available on the day of inspection. The clinic had no hand-washing sinks in the consultation rooms, the only sinks we saw were in the toilets. We could not identify any clear trust policy that would indicate it is compulsory to have a hand wash sink in the consultation rooms. However, this was an aim in one of the trust reports. The trust’s mandatory training included infection prevention control. However, records showed that only 60 % of staff in this service had completed the training.

Safe staffing

- A business continuity plan, dated December 2015, covered the minimum number of staff required, disruptions to the location, information technology issues and arrangements staff should make in the event of a major incident. There was a clear action plan that included the minimum number of staff required in adverse circumstances. For example, two band six nurses for the community mental health team and two for the intermediate care team plus one medical practitioner and one administrator. If a manager could not provide this, they could request staff from a nearby ward to support them.
- The manager told us there was a system for calculating the establishment levels of staff required on shift. This system estimated that one whole time equivalent (WTE) staff member would be available for work for 220 days per year. Staff took the number of service users, the anticipated caseload and the number of WTE staff and calculated the number of staff required for the older people’s community mental health team. The staffing was 11 qualified nurses (WTE) and two (WTE) support workers. At the time of the inspection, there was one vacant position for a registered nurse, this was due to maternity leave and there were no plans to replace the post, as the service reduced hours of operation from

Are services safe?

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

8am to 10pm to 9am to 5pm from Feb 2016. There were no vacancies for support workers. The trust reported staff turnover rate was 8% within the older people's community mental health teams (CMHT), compared to the overall trust rate of 15%. Staff sickness was 1% as of June 2016. The team did not use bank or agency staff. A review of the staffing rotas showed that all shifts achieved minimum establishment levels. In the event of sickness staff would usually rearrange visits unless they are a priority then they would ask another team member to take them on. Administrative staff checked staffing levels every day. However, the system appeared not to be effective in identifying appropriate caseloads as staff in the community team told us current caseloads were between 40 to 60 patients. Therefore, they were not able to see all patients regularly and staff had to prioritise cases.

- The trust had a core programme for mandatory training, which included safeguarding adults, safeguarding children, equality, diversity and human rights, information governance and hand hygiene. The trust did not include the Mental Health Act (MHA), the Mental Capacity Act (MCA). The trust reported the overall compliance for mandatory training is 86%. However, the team had achieved 78% compliance overall. Five of the training courses achieved 69% or below, this includes mental capacity act (46%), safeguarding adults (62%), fire safety, health and safety and infection control 69%. Both the community team and the intermediate care team failed to achieve above the 75% benchmark only achieving 62% and 70% respectively for the safeguarding adult's course.

Assessing and managing risk to patients and staff

- Two nurses screened and assessed referrals for risk. The nurses would then allocate the patient to a relevant team based on their needs.
- We reviewed the care records of 10 people who used the service and found each had a risk assessment and risk management plan in place. Staff completed these as a part of the initial assessment process. Staff could arrange emergency appointments and access a consultant psychiatrist at short notice if required. However, staff did not review risk assessments regularly and care records did not contain crisis and contingency plans.
- We spoke with four members of staff specifically about safeguarding. Staff told us what they would do and who they would contact if they had concerns about a patient. The information given was in line with their role responsibilities. An example given included a patient at risk of suicide.
- Staff told us they sent an email to the manager notifying them when the staff had submitted a safeguarding referral. The manager would then arrange to speak with that member of staff. However, when we asked the manager how many safeguarding referrals may pass through the service, they told us that there was an agreement with social services to keep those figures and that they were unable to tell us at the time of the inspection. This meant staff could not monitor the outcome of safeguarding investigations.
- The Policy for Security and Management of Violence and Aggression (2016) indicates that there should be a local lone working risk assessment and management plan. Staff should also have suitable training to manage challenging situations within their working environment and training on how to report incidents. However, staff could not show us the local lone working procedure. We discussed this with the manager who informed us that the trust issues all staff with alarms and when staff activated them, the information goes to a call centre that sends appropriate help. Staff told us they had telephones, a buddy system and that managers expected staff to keep their appointment diaries up to date and accessible to others. However, staff could not evidence this on the day of the inspection. This meant staff could not be sure if they were safe when out on visits.
- Staff stored depot medicine in drug cupboard secured to a wall in a clinic room. Staff took medicines to patients' homes in non-lockable bags. A staff member told us that some nurses chose to purchase a padlock at their own expense. However, this was not in line with trust policy. We found two different depot prescription charts in use, one titled Solent NHS Trust and the other Portsmouth NHS Trust. Staff said this was confusing and meant that staff could make a mistake when administering medicine. Staff said the Solent form gave specific columns for a number of physical health measures. For example, a person's blood pressure, pulse, body mass index. The older form had a table to

Are services safe?

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record pulse, weight and any concerns. We reviewed 14 depot cards and found that staff had not completed the sections on Mental Health Act status. In nine patient cards, staff had not recorded patient's capacity, in seven of the cards, staff did not record physical health measures and in the other seven cards, information was limited. This meant the trust was not meeting the psychosis and schizophrenia in adults, prevention and management NICE guidelines CG178 on physical health monitoring. This guidance says providers must routinely monitor weight, and cardiovascular and metabolic indicators of morbidity in people with psychosis and schizophrenia

- The contents of first aid boxes included bandages, plasters and wipes. Staff did not know whose responsibility it was to check this. We did not see any audit records for checking the first aid boxes or hazard risk assessments in place.
- Staff did not evidence assessment of medicines competencies. Some intramuscular, anti psychotic medicines are based in nut oil. The staff did not have the procedures in place to manage risk of allergies. The clinic did not have a fridge to store medicines for intramuscular depots and Risperidone, which meant medicines were not stored in line with protocol. For example, the entire pack should be stored in a refrigerator at 2oC to 8oC and monitored with a Max/Min

thermometer. The clinic room had no access to natural light and there was a lack of adequate ventilation and staff did not control temperatures, this meant medicine could be exposed to temperatures above 25°C.

Track record on safety

- The trust did not report the number of serious Incidents in last 12 months before the inspection took place. At the time of the inspection, staff could not provide information about adverse events that were specific to this core service or Information about improvements in safety that was specific to this service. However, the manager told us they met with the risk team and governance lead on monthly basis to look at thematic reviews. They also met with clinical director for mortality reviews (reviews for unexpected deaths). However, we did not see any minutes from these meetings on day of inspection.

Reporting incidents and learning from when things go wrong

- At the time of the inspection, the manager was unable to show us records of complaints. There was no evidence to demonstrate that incidents were discussed with staff or that learning took place. However, staff clearly understood the concept of being open and honest.

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

- Two nurses triaged new referrals daily. If patients had medical complexity, staff referred them to the doctors for further assessment, which could be at home or in outpatients. We observed assessments including mini mental state examination (the most commonly used test for complaints of problems with memory or other mental abilities) to a very high standard.
- The GPs had usually performed routine blood checks prior to referral. However, if this had not been completed a nurse would prompt staff to do so at the triage stage. Staff completed Electrocardiogram (ECG) in the clinic and faxed the results to cardiology if there was a concern. The cardiac department faxed back with a comment. This meant staff did not delay prescribing anti-dementia drugs.
- When a patient attended the clinic, staff created their care plan on a letter and sent it to the patient and their GP for information. Staff confirmed this was the core assessment letter. When staff visited patients at home, they completed the care plan template on the electronic recording system.
- We viewed 10 care records. The quality of recording in all 10 was inconsistent. This included 10 records that had no evidence of patient involvement, mental capacity assessments were incomplete and there was no evidence to say that the patients had received copies of their care plans. Staff tended to record information in progress notes. This meant that agency staff did not have easy access to information relating to care, treatment and risk relating to patients. However, all records had clear goals set for patients to achieve.

Best practice in treatment and care

- A consultant described some difficulties with physical health care monitoring for community patients. Staff told us general practitioners would not do routine monitoring for patients under the age of 75. The manager told us that physical health care monitoring had become a priority for the Trust. However, at the time of the inspection we saw no evidence that patients on anti-psychotic medication received an annual

physical health or priority plans. The service had one nurse in the intermediate team who can take bloods if the nurse was not available patients had to wait to have bloods taken.

- Staff did not refer to the Department of Health's document 'nothing ventured nothing gained', which provided guidance on best practice in assessing, managing and enabling risk for patients living with dementia.
- Staff told us they had access to psychological therapy. However, staff could not provide any figures on waiting times for therapies such as cognitive behavioural therapy. Another staff member told us staff would advise patients to self-refer to talking change and the trust would fund this.
- Staff used recognised rating tools. Nursing and medical staff told us they used the health of the nation outcome scales (HoNOS), the mini mental state examination (MMSE) and the (ACE) to monitor outcomes in memory and cognition. However, staff told us that they completed the HoNOS for clustering patients' needs as this was part of the payment by results funding requirements and staff had not recorded outcomes from these tools in patient care plans.
- The service participated in the national Prescribing Observatory for Mental Health (POMH-UK) audit of antipsychotics prescribed in Dementia. We looked at the trust's clinical risk assessment and management procedure policy. The policy stated that all service users would have a risk assessment and care plan documented in the relevant part of the electronic records system. Staff completed this at the first point of contact. Staff informed us that they audited the care programme approach, (this is a way that services are assessed, planned, co-ordinated and reviewed for a patient) in April 2016. Staff said they reviewed 20 patient files. Staff told us the percentage of patients that had reviewed and in date care plans, was below the trust's target of 85%. We saw that managers had put up laminated posters reminding staff of the risks to the service. However, we could not verify this information as the manager could not find the correct audit data on the trust's electronic system on the day of the inspection.

Skilled staff to deliver care

- The team had a range of mental health disciplines to care for the patient group. This included trained

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.

occupational therapists, an occupational therapists assistant, one part time psychologist, part time student psychologist, one full time equivalent social worker, 14 registered nurses, support workers. One junior doctor, one specialist doctor within the intermediate care team, four consultants, three full time equivalent medical secretaries, two full time equivalent administration and one bank administration staff, two student nurses and there was a nurse prescriber in the team.

- The trust policy for supervision was a minimum of one hour per three months. Staff told us that the community and intermediate care teams had supervision more frequently, for example four to six weekly. The trust had raised a red flag on the electronic system previously; this meant that the service had not met the trusts standard for supervision. However, records showed that the trust had removed the flag as the team had now met the trusts standard of 95%. At the time of the inspection, the manager did not have a record of who had undertaken an appraisal. However, they showed us their email inbox with completed appraisals. These appraisals reflect the key performance indicators and the trust values.
- Staff described the additional training they had undertaken. Staff said access to professional training had improved since the manager had started. Additional training included mindfulness from a local hospice and two days training on long term conditions. The trust holds a journal club at St James Hospital; this was open to all medical staff that had an interest in the subject. In addition, there are meetings at Queen Alexandra Hospital. However, consultant's report that it is more difficult to get funding for National Conferences.

Multi-disciplinary and inter-agency team work

- The intermediate care team held a daily handover at 9am to discuss patient progress in the previous shift. Staff told us that a consultant attended these handovers

on Tuesday and Thursday for case management reviews. Staff also attended a monthly meeting with the community mental health team to discuss patients' needs as part of joint working.

- We observed a multi-disciplinary meeting of the Portsmouth Central Team that included a consultant, nurses and support workers. Staff discussed patients in detail and with respect. Staff presented a holistic assessment of need and risk and supported by concise action plan.
- Staff said they had good links with district nurses who supported patients in their own homes. We saw evidence of this in the patient's progress notes.
- We saw evidence of consent to treatment. Staff attached copies of consent to treatment forms to medication charts where applicable. The service had access to administrative support and legal advice on implementation of the Mental Health Act and its code of Practice from a central team.

Good practice in applying the Mental Capacity Act

- The consultants were Deprivation of Liberty assessors (DoLS) and all of the staff we spoke with understood what the Mental Capacity Act.
- There was a policy on MCA including DoLS, staff told us they could access this through the intranet. We observed staff assessing patients who might have impaired capacity at an multidisciplinary team meeting, staff recorded the information in the electronic notes. However, the patients were not present at this meeting.
- We saw evidence that staff managed applications for DOLs well in Portsmouth. However, the clinical director informed us that this was problematic in Havant (Portsmouth GP) as this came under Hampshire county council and there were delays of 3-6 months for DoLS assessments to take place.

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

- The interactions that we saw between staff and patients were positive. We observed an assessment of a patient and during this time the staff member listened to the patient and their carer. They treated them with respect and allowed them time to ask and respond to questions. We spoke to a carer who told us they were involved in their family members care and felt supported. The patient we spoke with told us they liked the staff and that they were always nice to them.
- We attended an MDT meeting of the Portsmouth Central Team. Staff present included a psychiatrist, community psychiatric nurses and a support worker. Staff told us these meetings happened weekly.
- We observed staff interacting with patients on the phone; staff attitudes were responsive and respectful. Staff gave clear explanations, they were helpful, unhurried and took time to explain recent communication.

The involvement of people in the care that they receive

- At the time of our inspection, there was no formal patient involvement within the team. For example, patients did not have the opportunity to help recruit staff. Patients said they were not aware of any plans the trust may have had to increase user involvement in the future.
- The carer that we spoke with had an understanding of the care that staff provided their family member. However, the family member told us they did not receive copies of any care plans and staff confirmed that they did not send care plans to patients routinely.
- We spoke to a carer who told us that physical health care services and adult social care services did not inform mental health services of their family member's progress. They felt this was providing inconsistent care for their family member.

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

- Staff made first contact with the patients on the day of the referral and all patients referred by their general practitioner (GP) were seen and treatment was initiated within 6 weeks in line with national guidance. Patients and carers could also self-refer to the service. However, staff triaged these referrals and they may not have been seen within the six weeks if staff felt it was not appropriate. Staff told us this did not apply to the memory service as high caseloads meant that patients could not be seen within the six week period.
- Two community psychiatric nurses triaged referrals every day during a protected time slot. Staff allocated patients to the intermediate care team or for a home visit dependant on the patient's need. If the patient did not need the service, staff sent the referral to the community mental health team or back to the GP with information about more appropriate services.
- Staff told us if they had an urgent call from a patient the team member typed it up as a message on the electronic record system and a nurse is informed. They did not place the referral for triage and a nurse will respond to the call immediately. We saw evidence of this in the notes where staff saw a patient the same day to conduct a Mental Health Act assessment and the consultant admitted the patient to hospital the next day.
- The team took a proactive approach to re-engaging with people who did not attend appointments. Staff wrote to the General Practitioner and the patient offering another appointment. However, staff told us they have no written protocol to follow for this, which meant staff had to make a judgement as to how many appointments staff offered patients. Staff postponed or moved appointments due to staff sickness or attendance at the coroner's court. Staff said they would telephone the patient first and send the agreed appointment out in a follow up letter. We asked the manager about data for patients that did not attend appointments. However, they could not provide any on the day of the inspection.

The facilities promote recovery, comfort, dignity and confidentiality

- The waiting areas and clinic rooms were welcoming and comfortable. We saw an information pack for the memory clinic that that patients received. This contained a good range of literature, including information how to complain.
- We observed staff respecting patient confidentiality, this included staff putting information relating to patient care in the confidentiality waste. We did not observe any visual display units with patient data left unattended. Care records were stored electronically and these were password protected.

Meeting the needs of all people who use the service

- We observed some examples of reasonable adjustments made so that disabled people can access and use services on an equal basis to others. For example, the service had an automatic door, a ramp and colour coding (dark green) on hand rails in patient toilets. However, the service did not display openly information in other languages or easy read and clinic rooms were too small to accommodate wheelchairs users. However, some consultation rooms we viewed were small, this meant patients using wheelchairs could not access them.
- Admin staff explained they could have arranged for translators before consultant appointments if a patient needed one, we saw a loop Induction system along ceiling and staff told us they had access to information on the intranet in easy read format. However, when we asked if we could see this, the staff member could not find it.
- One nurse led the memory service and provided monitoring for patients on anti-dementia medicines. Staff told us the current caseload is 613 and staff could not carry out that patient reviews within the expected six monthly periods. This meant staff did not follow NICE guidelines in assessing and starting anti dementia medication.
- Managers could not provide any figures on waiting times for therapies such as cognitive behavioural therapy. Staff told us that due to long waiting lists, they would advise patients to self-refer to an organisation called talking change and the trust would fund this.

Are services responsive to people's needs?

Good 

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

Listening to and learning from concerns and complaints

- There were three formal complaints in the previous year. The trust reported that they had not upheld any of them. The theme included clinical treatment, policy decisions and appointment issues. We saw evidence of learning in relation to formal complaints from the information submitted by the trust. For example, in one complaint there was a concern regarding communication and clinical treatment. The investigation accepted that there had been issues around communication and there was a signed final response from the Chief Executive Officer apologising for experience.
- Carers told us they knew how to complain. They were able to describe the complaints procedure and said they felt confident that staff would act upon this if needed. Staff we spoke with described the complaints procedures and felt that the service was very open with families, bringing any issues to their attention in a timely way. However, we did not see any evidence of this at the time of the inspection.

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 could describe the trusts values and vision and felt this was in line with their clinical practice. However, staff said they did not know if any team objectives had been set against the organisations values.
- Staff knew who trust senior managers were. They told us they received emails from them with information updates. One staff member said they had met the chief executive at a meeting but could not recall if they had visited the service. They also told us that the manager visited regularly. Some staff felt that it was hard to attend daytime meetings due to workload so welcomed some evening events the trust had arranged.

Good governance

- Staff told us they knew how to report any concerns they had. However, staff said they had a new manager who was on annual leave and they did not know how that manager would be address concerns at a local team level yet. Staff we spoke with also said they did not know what actions the Trust would take or how senior managers would react to any whistleblowing concerns.
- We spoke with a consultant who told us they had found their responsibilities extremely stressful at times, as they had clinical responsibilities for community mental health teams (CMHTs) in North and South Portsmouth. Staff told us the trust reduced staff roles within the service. Staff said they were concerned about their jobs and that although they could not articulate the impact on service users they felt that it was additional pressure on the community team.
- Staff in the memory clinic told us they had raised concerns about the caseload within their supervision and felt their manager had not addressed it. The manager had not planned with them how they could manage the risk and the staff member said they did not know if the manager had entered the information onto the trusts risk register.
- Staff we spoke with told us there were limited opportunities to undertake leadership development from the training department. They attributed this to tightened budgets across the service. Staff we spoke with told us they felt services changed around them rather than being specifically involved.

- At the time of the inspection, the manager had left the trust and the newly recruited manager was on annual leave. The manager overseeing the service had not prepared for the inspection and had difficulty finding requested information. For example, data including clinical audits, risk assessment and team meeting minutes.
- At the time of the inspection, staff morale was low. Staff expressed concerns about the plans to relocate the community teams. Staff said the trust has made many changes and there is concern that the trusts future vision is to amalgamate older peoples mental health into adult services to create an “ageless service”. Senior staff told us they could input into these plans if they wanted to.
- The clinical director expressed concerns that the new team base will be a lot smaller. There will be hot desking, this means staff will not have a dedicated desk and staff will not have individual office space. Staff raised concerns about how they would ensure confidentiality while sharing an office. A consultant informed us that they had submitted his concerns to the senior management team. However, the trust said there is pressure to reduce services from the St James site.
- Staff said they did not know if a local manager would inform patients of any incidents or changes to the service. However, they were aware of the duty of candour and said this information would come from the trust.

Leadership, morale and staff engagement

- We saw good safeguarding practice and staff with skills and knowledge in how to make appropriate referrals. Mandatory training is on line and we saw a training matrix covering equality and diversity, mental capacity act, clinical governance, resuscitation, safeguarding, and infection control. Staff received an electronic warning by email if a training topic is overdue. Seventy eight percent of staff in the service had completed this training.
- The trust had raised a red flag on the electronic system previously; this informed managers that that the service had not met the trusts standard for supervision. However, records showed that the trust had removed the flag as the team had now met the trusts standard of 95%. At the time of the inspection, the manager did not

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.

have a record of who had undertaken an appraisal.

However, they showed us their email inbox with

completed appraisals attached. These appraisals reflect the key performance indicators and the Trust values.

- We saw evidence that staff collated information for key performance indicators on the service for use at Trust level. For example, sickness levels on a monthly basis and budget targets. However, at a local level staff could not evidence data including audits, risk register or team meeting minutes this meant it was difficult to evaluate the effectiveness of monitoring of quality assurance at a local level.
- Staff described the additional training they had undertaken. Staff said access to professional training had improved since the manager had started. Additional training included mindfulness from a local hospice and two days training on long term conditions. This supported the trusts objective to ensure patients physical health becomes an increasing focus for team.
- Staff told us they had no written protocol for re engaging patients who had not attended appointments. We asked the manager about data for patients that did not attend

appointments. However, they could not provide any on the day of the inspection. This meant staff had to make a judgement as to how many appointments staff offered patients before they discharged them.

- Managers could not evidence how they resolved problems at a local level. Staff told us there had been no incidents that met the 'duty of candour' regulations within the older peoples' community mental health teams. We spoke with one member of staff who clearly understood the concept of duty of candour. However, they could not evidence that they learned from incidents, as this information was not available.

Commitment to quality improvement and innovation

- Staff told us they are involved in areas of innovation. For example, The MARQUE project: Managing Agitation and Raising Quality of Life. A project to improve quality of life in people with moderate or severe dementia living in care homes-training video and collaboration with University of Southampton on inflammatory changes in dementia.

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

Assessment or medical treatment for persons detained under the Mental Health Act 1983
Diagnostic and screening procedures
Treatment of disease, disorder or injury

Regulation

Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment

We found that the provider did not follow policies and procedures about managing medicines in line with current legislation and guidance, including those related to storage and transportation. Staff transported medicines in unlocked cases to patient's homes.

We found that the Staff did not always carry out physical health monitoring in line with National Institute for Health and Care Excellence Guidelines

This is a breach of regulation 12 (1) (2) (g)

Regulated activity

Assessment or medical treatment for persons detained under the Mental Health Act 1983
Diagnostic and screening procedures
Treatment of disease, disorder or injury

Regulation

Regulation 17 HSCA (RA) Regulations 2014 Good governance

The provider must ensure the leaders and manager of the service have access to appropriate policies procedures and documentation in order to be assured of the effective management of the service.

This is a breach of regulation 17(2)(d)

Regulated activity

Assessment or medical treatment for persons detained under the Mental Health Act 1983
Diagnostic and screening procedures
Treatment of disease, disorder or injury

Regulation

Regulation 18 HSCA (RA) Regulations 2014 Staffing

This section is primarily information for the provider

Requirement notices

The provider operated the memory assessment service at very high capacity. The staff member leading the clinic had a caseload in excess of 600 patients. We saw that staff had missed patient's six month reviews.

This is a breach of Regulation 18 (1)