Good

Mersey Care NHS 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)
RW445	Arundel House	Arundel House	L15 2HE
RW425	Ferndale Unit	Ferndale Unit	L9 7AL
RW400	Trust HQ Princes Dock	Kirkby CMHT	L33 0YE
RW400	Trust HQ Princes Dock	Moss House	L19 2NA

This report describes our judgement of the quality of care provided within this core service by Mersey Care 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 Mersey Care NHS Trust and these are brought together to inform our overall judgement of Mersey Care 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	Good
Are services safe?	Good
Are services effective?	Good
Are services caring?	Good
Are services responsive?	Good
Are services well-led?	Good

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

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

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

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

Summary of findings

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Overall summary

Overall, we rated community based mental health services for adults of working age as good because:

The CMHT's at Arundel, Kirkby and Moss House had safe and clean environments. Clinical rooms were sufficiently equipped and the equipment was generally well maintained. Staff adhered to infection control requirements and good practices in medicines management. Staffing levels ensured people using the service received safe care. All the CMHTs visited, managed vacancies and sickness to ensure there was minimal impact for people using the service. Staff assessed and managed the risks of people. These were reviewed regularly. Staff discussed crisis plans with people and included them in their care packages. Staff were knowledgeable in safeguarding requirements. Staff reported on incidents and lessons learnt, were shared across the teams at location level and trust wide.

Peoples' needs were assessed to enable staff to plan their care with a holistic and recovery focused approach. The CMHT's had access to a full range of disciplines. Staff were well supported, appropriately trained and able to develop their roles. The CMHT's held effective and regular multi-disciplinary meetings. There were good links with social services, inpatients settings and crisis provisions to ensure good care. Staff adhered to the Mental health Act 1983 (MHA) and the MHA Code of Practice and demonstrated good practice in applying the Mental Capacity Act (MCA) 2005.

Staff were kind and respectful to people using the services. Staff actively involved people in developing and reviewing their care and maintained people's confidentiality. Staff also made sure that their families and carers were involved when this was appropriate.

Staff saw referrals within the trust targets. There was a clear process to discuss steps to be taken for people who found difficulty in engaging with the service. Inpatient discharges into the community and discharges from community services were planned and consultant led, with care co-ordinator involvement. Information was available to people and accessible in varying formats and languages as needed. People using the service knew how to complain and learning from complaints was discussed within staff teams.

Staff knew the trust's vision and values and felt these were embedded into service delivery. Morale within teams was generally good and staff felt supported by management. Staff had opportunities to develop and were encouraged to do so. Managers had sufficient autonomy and support for their roles. Staff had attended trust wide events learning from incidents.

However,

- The trust's Lone Working Policy lacked detail on how regularly checks should be made to account for workers on community visits and who should conduct these checks.
- People using the service had limited psychological interventions and with long waiting lists for psychotherapy.
- Teams had not been subject to audits to ensure the MHA was being applied correctly in relation to community treatment orders (CTOs).
- Some managers reported that systems for reporting training, supervisions and appraisals were not robust.

Good |

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Summary of findings

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

Are services safe?

Good

We rated safe as good because:

- The CMHTs at Arundel, Kirkby and Moss House had safe and clean environments. Clinical rooms were sufficiently equipped and the equipment was generally well maintained. Staff adhered to infection control requirements and good practices in medicine management.
- Staffing levels ensured people using the service received safe care. All the CMHTs visited managed vacancies and sickness to ensure there was minimal impact for people using the service.
- Staff assessed and managed the risks of people. These were reviewed regularly. Staff discussed crisis plans with people and included them in their care packages. Staff were knowledgeable in safeguarding requirements.
- Staff reported incidents and lessons learnt were shared across the teams at location level and trust wide.

However,

- The trust's Lone Working Policy lacked detail on how regularly checks should be made to account for workers on community visits and who should conduct these checks.

Are services effective?

Good

We rated effective as good because:

- Staff assessed peoples needs and planned their care with an holistic and recovery focused approach. Care plans were generally up to date and individualised. Staff encouraged activities to promote social functioning and there were a variety of groups available which were delivered by the teams. Staff were able to access information needed to deliver care from a trust wide database.
- Staff followed guidance for prescribing and offered interventions to support housing, employment and benefit needs. Staff explored physical health needs for people and were developing relationships with general practitioners (GP) to ensure health checks were carried out.
- The CMHTs had access to a full range of disciplines. Staff were well trained and were able to access additional training to

Summary of findings

develop their roles. Teams attended weekly meeting and received regular supervision. The trust had introduced a new appraisal system and management were progressing in the achievement of ensuring all staff had appraisals.

- Staff attended effective and regular multi-disciplinary meetings. The CMHT's had good links with social services, inpatients settings and crisis provisions to ensure a persons care was seamless.
- Staff adhered to the MHA and the MHA Code of Practice and demonstrated good practice in applying the MCA.

However,

- Despite figures showing that use of the outcome measure Health of the Nation Outcome scale (HoNOS) stood at 90% compliant, staff were not able to clearly explain the approaches they used to monitor outcomes.
- Staff had variable working links with GPs across the services which could compromise a multi-disciplined approach to someone's care in some areas.
- Teams had not been subject to audits to ensure the MHA was being applied correctly .
- Staff and people using the service had limited awareness of access to IMHA services.

Are services caring?

Good

We rated caring as good because:

- Staff were kind and respectful to people using the services. Staff actively involved people in developing and reviewing their care and maintained people's confidentiality. Staff also made sure that families and carers were involved when this was appropriate.

Are services responsive to people's needs?

Good

We rated responsive as good because:

- People were seen within trust target times. There was a clear process to discuss steps to be taken for people who found difficulty in engaging with the service. Inpatient discharges into the community and discharges from community services were planned and consultant led with care co-ordinator

Summary of findings

involvement. Information was available to people and accessible in varying formats and languages as needed. People using the service knew how to complain and staff learning from complaints was discussed within teams.

- People using the service had limited psychological interventions and with long waiting lists.

Are services well-led?

Good

We rated well-led as good because:

- Staff knew the trust's vision and values and felt these were embedded into service delivery. Morale within teams was generally good and staff felt supported by management. Staff had opportunities to develop and were encouraged to do so. Managers had sufficient autonomy and support for their roles. Staff had attended trust wide events learning from incidents.

However,

Some managers reported that systems for reporting training, supervisions and appraisals were not robust

Summary of findings

Information about the service

The community mental health teams (CMHTs) in Mersey Care NHS Trust work with adults who have severe and enduring mental health problems. They also work with those with less severe illness, who have not responded to interventions provided by primary care services. They offer services to individuals with severe and complex mental and behavioural disorders. Services offered to individuals are provided in the most appropriate setting primarily within the individual's own home.

They aim to:

- Enable individuals to achieve the highest level of functioning possible in the least restrictive setting.
- To prevent unnecessary hospitalisation.
- To facilitate more rapid discharge from an inpatient setting.

There are nine CMHT's operating within the trust. We inspected four of the locations as follows:

- Arundel CMHT at Baird House. This service relocated five weeks prior to our inspection. The service works with approximately 1300 people. Around a third of people were on a care programme approach (CPA) and 12 people were on stepped up care. Stepped up care offers intensive treatment to those in crisis.
- Ferndale CMHT was in the process of moving premises. At the time of our inspection they were working with just under 2000 people. 450 of these were on the CPA and 20 on stepped up care.
- Kirkby CMHT were working with approximately 490 people, with approximately a third on the CPA.
- Moss House CMHT were providing care for approximately 1000 people with approximately a third on the CPA and ten on stepped up care.

Our inspection team

The team that inspected community-based mental health services for adults of working age consisted of 9 people: two experts by experience, one inspector, one inspection manager, one Mental Health Act reviewer, two mental health nurses, one psychologist and one social worker.

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 using the services.

During the inspection visit, the inspection team:

- visited four community mental health teams.
- spoke with 49 people who were using the service.
- spoke with the managers for each of the locations visited.

Summary of findings

- spoke with 52 other staff members; including doctors, nurses, social workers, support staff, psychologists and psychiatrists.
- attended and observed five multidisciplinary team meetings (MDT's), one team meeting, two service user groups, one GP liaison meeting, two referral meetings, two stepped up care meetings and five care programme approach (CPA) meetings.
- attended and observed 20 community visits.

We also:

- collected feedback from people using comment cards.
- looked at 78 treatment records of people using the service.
- looked at a range of policies, procedures and other documents related to the running of the service.

What people who use the provider's services say

We spoke with people and their relatives and carers. Most were positive about their experience of care received by the CMHTs. They told us:

- Staff promoted independence without being intrusive.
- Staff supported them and helped them understand their illness and how to manage it.
- Staff were respectful and polite.
- Staff were responsive at times of need.

We were also told that staff were only able to provide crisis management and there was limited time to provide preventitive care.

Good practice

Areas for improvement

Action the provider SHOULD take to improve
Action the provider SHOULD take to improve

- The trust should ensure that the Lone Working Policy specifies how regularly and who is required to check all staffs' safety following visits.
- The trust should ensure psychology and occupational therapy is accessible and embedded into treatment provision.
- The trust should conduct regular audits to ensure that the MHA is being applied correctly and that people's rights are protected.
- The trust should ensure managers have clear oversight of staff training, supervision and appraisal.

Mersey Care NHS 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
Arundel House	Arundel House
Ferndale Unit	Ferndale Unit
Kirkby CMHT	Trust HQ
Moss House	Trust HQ

Mental Health Act responsibilities

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

Staff demonstrated an awareness and understanding of the Mental Health Act and the MHA Code of Practice. They were able to tell us what was required particularly in relation to community treatment orders (CTOs). Staff adhered to treatment and capacity requirements. However, it was difficult to identify people who were on CTOs from the records. The CMHT's or the wider trust had not conducted any recent audits to ensure that the MHA was being applied correctly.

Staff had limited awareness of access to IMHA services. Some people using the services told us they had been referred to the trust's patient advice and liaison service (PALs). Moss House CMHT had IMHA information on display. However, none of the records we viewed included evidence to show how people had been supported to engage with advocacy services. Staff we spoke with could not provide examples where they had supported people to access advocacy services.

Detailed findings

Mental Capacity Act and Deprivation of Liberty Safeguards

Staff had received training in the Mental Capacity Act and had availability to trust leads if they required any further guidance. The records we looked at showed evidence of informed consent and assessment of mental capacity. Staff completed capacity assessments on a decision specific basis for significant decisions. For example, we saw that a nurse had carried out a capacity assessment relating to financial exploitation involving telesales and cold callers; the outcome was that the person had capacity.

Staff worked with the family to ensure preventable measures were in place. Approved Mental Health Professionals (AMHPs), social workers and consultants from within the teams undertook best interest assessments.

Good

Are services safe?

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

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

Summary of findings

Our findings

Safe and clean environment

- Staff conducted the majority of their appointments at peoples' homes. Where appointments took place at service locations, staff had access to panic alarms when seeing people at the service locations. Staff ensured that all people entering the locations were authorised to do so. There were sign in and out books used to account for people in the event of emergencies.
- Clinic rooms were adequately equipped at Kirkby, Moss House and Arundel CMHT's. Equipment was well maintained and in date. The CMHT at Ferndale were due to relocate the day following our inspection, we therefore did not inspect the environment or equipment. Locations were clean and clutter free.
- Staff adhered to infection control principles. There were antibacterial gels suitably located; gloves were available where required and clearly labelled sharps bins were available.
- At Moss House, staff had not taken fridge temperatures on three occasions during May. The clinic room temperature had been recorded on three occasions as being over 25 degrees. There was no record of what action had been taken to ensure that medicines were safe to be given.

Safe staffing

- The trust used a tool to establish the numbers of qualified nurses and nursing assistants required for each team. All locations visited has sufficient establishment levels. Managers, staff, people using the service and records confirmed this.
- At the time of our inspection, we found that there were a small number of vacancies. Where there were vacancies this was being managed and did not impact on the quality of services. There was a band 8 manager's post vacant at Arundel; this had been recruited to with a new manager appointed awaiting a start date. The deputy was covering the interim period. Ferndale CMHT had two psychologists on maternity leave. One remaining psychologist was covering this role. Moss House CMHT had three qualified nurses' vacancies that were in the recruitment process; the team were covering these roles until the roles were filled. Kirkby had a vacant deputy manager's role; the deputy seconded in from social services was covering this work.
- There were low levels of long term sick. Staff, people using the service and records showed us that this was not impacting on the safety of staff or people using the services.
- There was no average caseload across the CMHTs we visited. Staff were allocated their caseload in accordance with their experience, skills, availability and complexity of need. Caseloads varied from 20 to 35, the largest caseloads being at Arundel. There were no waiting lists for allocation to care co-ordinators at the locations we visited.
- There was rapid access to a psychiatrist for people who required it. Psychiatrists were part of all the teams we visited and were based at each location.
- The trust had identified mandatory training for staff. The majority of staff were up to date with their mandatory training. Where training had expired, there was evidence that refresher dates had been booked. Staff at Arundel CMHT were below the 95% compliance rate for training in basic life support. This was at 70% compliance with actions to ensure its increase.

Assessing and managing risk to patients and staff

- The assessment or access team initially saw people newly referred to the service. Staff from these teams conducts an initial risk assessment which was electronically available for the CMHTs. Staff then assessed peoples' risks on each visit, when there were changes or at CPA reviews. Mostly risk assessments were thoroughly completed, detailed and up to date. All risk information was updated and recorded in detail at Ferndale and Kirkby. However, two out of the ten records seen at Arundel CMHT had not been updated in relation to recent changes in presentation. One of these

Good

Are services safe?

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cases involved a serious event, driving without a valid licence, which was not reflected on the risk assessment. People using Moss CMHT all had updated risk assessments. However on one of these records, staff had not included a recent self-harm incident in the risk assessment.

- Care plans included contingencies for people experiencing a crisis. This included where to go for support depending on the time of day and who to contact. Staff discussed these plans with people during appointments. We observed two visits where staff were discussing strategies to manage risk taking behaviours and actions to be taken if a crisis occurred.
- In Kirkby, domestic violence leaflets were located in the toilets used by people using the service. This enabled those experiencing domestic violence to access support information discreetly which would be unsafe or difficult to discuss at any other time if the abuser was present.
- Staff had received training in safeguarding adults and children. Staff demonstrated a sound understanding of how to recognise potential safeguarding issues and how to act on concerns. Each team had a safeguarding ambassador. Social workers, embedded into each team, took the lead in co-ordinating and investigating safeguard concerns. Procedures for identifying, reporting, investigating, recording and acting upon safeguarding concerns were robust. Team managers had good oversight of the safeguarding issues currently being investigated. Safeguarding issues were a standing item on all team agendas.
- The trust had a lone working policy in place; staff were following this at each location we visited. However, the policy was unclear on individual responsibilities and did not require staff to report their safety following each visit. Staff at each location signed out and ensured the service had information on their appointments. Checks on staff's whereabouts were not carried out until the end of each day and it was unclear who would conduct these checks. Therefore if staff had multiple back to back visits, it would not be known if the staff member was safe until the end of their scheduled appointments. Staff did inform us that if there were identified safety risks, or if the person was not known to the service, then they would ensure two members of staff attended the appointment. Staff also used a specific phrase that could be texted or telephoned if they were in danger and able to do so.
- Medicines were stored securely and in date. Staff kept medication cards fully completed with doses, signatures and dates. Staff ensured medications were entered onto the electronic records. All four locations visited had recently undertaken a medications standards review. The review identified that a second member of staff was required to sign for the administration of the medication and this was not happening. Managers had escalated this within the trust to be revised as the policy did not consider how this could be applied within a community setting.

Track record on safety

- There had been eight serious incidents under investigation in the last 12 months across the teams we inspected.
- Arundel CMHT had one serious untoward incident relating to self-harm. Ferndale CMHT had three suspected suicides and Moss CMHT had four suspected suicides. The trust had, or was in the process of investigating these. From the data available to us, we are unable to tell if these fell above or below national figures.

Reporting incidents and learning from when things go wrong

- Staff told us they knew what constituted an incident and how to report it. Staff recorded incidents on the electronic system which ensured management were able to consider themes and to decide on whether wider investigation required and at what level.
- Team meetings, MDTs and supervisions were used to discuss feedback from internal incidents and lessons.
- Trust wide learning from incidents was shared in events called "Dare to Share" and "Oxford Learning Events". Various staff from the CMHTs we visited had attended these trust wide events which shared incident finding and lessons learnt. They told us the events were good leaning and reflective practice.

Good

Are services safe?

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

- Staff received de-brief and support after serious incidents. Staff told us of a suicide at Arundel which was unexpected and how they were supported through this and given the time to talk about it.

Are services effective?

Good

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

Summary of findings

Our findings

Assessment of needs and planning of care

- The trust's Assessment or Access teams carried out assessments to determine the suitability of people for treatment in the community. The assessments of those people were electronically sent to the relevant CMHT. Daily meetings then took place with clinical teams including the consultant psychiatrists to determine their care.
- People in crisis requiring more intensive treatment were put on Stepped Up Care packages which could entail up to two visits a day. The daily clinical meetings were used to discuss their continued assessment of needs and the planning of their care.
- The records reviewed did not clearly detail initial referral dates and dates referred to the CMHT's. However, staff and people using the service told us, and records confirmed they were seen in a timely manner.
- We examined the care plans of 38 people using the service. Care plans were mostly up to date and generally holistic and recovery orientated. Staff updated ten of the twelve care plans seen at the Kirkby CMHT. All had evidence of a holistic approach involving community support groups and recovery colleges. The two records not updated, did however reflect the person's current situation, but had no record to show that they had been reviewed within the identified time frame. The care plans seen for people using the Kirkby CMHT, all reflected personal involvement and a hope for a better future.
- At Moss House CMHT the six care plans we reviewed showed inconsistent quality. Two of the six care plans looked at were not updated to reflect current medications. Three of the records were not recovery orientated.
- At Arundel CMHT care plans showed that staff had discussed other support and activities. Two out of the ten records looked at were not updated.
- At Ferndale CMHT the care plans were of a good quality with people using the service at the centre of care. Care plans demonstrated a holistic approach with multi-agency involvement.
- When we observed care, we saw that staff engaged people using the service in the planning of their personal care. This was evident in personalised care plans.
- The Ferndale unit had a personality disorder lead who assisted staff in ensuring care plans reflected the specific needs of people with this disorder.
- Staff encouraged people to engage in group activities to promote social functioning. Groups available included an established allotment group at Kirkby, walking groups from Moss House and Arundel and arts groups.
- Staff used a trust wide database to store and maintain records relating to people's care and treatment. Teams could access records from other trust services which meant that accurate up to date information was available to all staff. Social workers seconded into the CMHT's also used the local authority's database system and this information was available to trust staff as needed.

Best practice in treatment and care

- There was generally a lack of psychotherapy interventions available for people. Staff were only able to deliver limited cognitive behavioural therapies for people on their case load. The pathway was to refer people to the trust wide provision for psychotherapy which entailed long waiting times.
- Staff incorporated interventions for employment, housing and benefits into appointments and care plans. For example, we observed a visit to a person using the service at Ferndale CMHT who had attended an interview for employment the same day. The interview was a result of agreed interventions for employment. The visit was to ensure the person's mental health was stable following the interview. Moss House and Kirkby CMHT's had dedicated worker for housing, employment and education.
- Staff reviewed physical health needs at all locations. However, the success rate of ensuring physical health checks were conducted and recorded was variable, depending on location and relationships with GPs. The

Are services effective?

Good

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

GP liaison worker at Kirkby had established effective relationships with the local GPs. Staff accompanied people to the GP surgeries for the checks to be done. If this was not possible, a nurse from the CMHT would conduct the check and report back to the GP. All the records looked at from Kirkby CMHT showed that staff had explored physical health needs. Staff also followed up appointments related to a person's physical health. Staff from Moss House CMHT, recognised physical health needs, however these were not always pursued. For example, we observed the records of someone on an anti-psychotic who was identified as being clinically obese. However, there was no follow up action recorded.

- The trust used the mental health clustering tool to rate the care needs of a person using services. However, the access and assessment teams conducted this assessment. Staff from the CMHT's were vague in their understanding of the use or the application of this tool. We were told that a person's progress and outcome was generally measured using the CPA reviews, which were conducted every 3 to 6 months. We also saw sporadic use of outcomes being measured by recovery stars and the Health of the Nation Outcome Scale (HONOS). Despite figures showing that the use of the outcome measure HONOS) stood at 90% compliant, staff were not able to clearly explain the approaches they used to monitor outcomes.
- There was no routine use of a tool to monitor side effects for people on antipsychotics. The Liverpool University Neuroleptic Side Effect Rating Scale (LUNSERS) was used on some instances however this was not consistent.
- All four CMHTs visited had recently participated in a medication audit the month prior to our inspection. Staff from Kirkby had responded to findings from this audit by ensuring peoples photographs were attached to medication cards. There had also been a clozapine monitoring audit at Moss House and Arundel CHMTs. All services were in the process of introducing a care co-ordinators audit tool to use during supervisions. In three of the services we visited this was already being used to improve quality of documents. It had not yet been implemented at Moss House.

Skilled staff to deliver care

- Staff working in the CMHTs came from a variety of disciplines, including psychiatrists, psychologists, occupational therapists, nurses, social workers and support workers. Teams included practitioners specialising in dual diagnosis, personality disorders, employment, GP liaison and housing. Kirkby had a smaller team mix which did not include an occupational therapist. However, this role was absorbed by nurses and support workers to enable activities. Although psychologists and occupational therapists were mostly included in teams, their ability to provide an effective service was compromised by their availability. For example, the occupational therapist at Moss House did not have the capacity to ensure a people's needs in relation to occupational activity were assessed in depth.
- Staff were appropriately qualified and able to undertake continuous professional development and specialist training to their role. For example, a nurse from Arundel was trained in phlebotomy and ECG to carry out physical health checks. Nurses from Kirkby had trained to deliver smoking cessation and a nurse from Ferndale had trained to specialise in looking after people living with a personality disorder.
- Staff attended regular team meetings with standing agenda items, ensuring they kept up to date with service and trust activity. The meetings also shared lessons learnt, good news stories and areas for improvement.
- Staff were mostly supervised regularly and also told us they received regular informal supervision, additional to their six weekly formal meetings. A new social worker in the Kirkby CMHT received 15 minutes of supervision on a daily basis during their induction period. The clerical staff at Kirkby received irregular supervision as line management outside the location provided this. However, we were told that they felt well supported by staff and management within Kirkby CMHT.
- The trust had introduced a new appraisal system for staff. The expectation was for at least 50% of staff to have received their appraisal by the end of June. Kirkby CMHT had achieved this at the time of our inspection. The other three locations were working towards this target.

Are services effective?

Good

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

- At the time of our inspection, senior staff told us they were addressing poor performance with one member of staff in line with the trust's people management policies.

Multi-disciplinary and inter-agency team work

- Nurses, consultants, social workers, and on some occasions occupational therapists attended multi-disciplinary team (MDT) meetings. The consultant psychiatrists led the meetings which were regular and effective. We observed five MDTs across all four CMHT's. All staff attending engaged in discussions relating to individual peoples' needs, risks, contingency plans, overdue CPA reviews and safeguarding. The meetings were at least weekly and more regularly for people on' stepped up' care. At Ferndale CMHT, the person using the service was invited to attend their own stepped up care meeting.
- Staff ensured an effective handover for people due to be discharged from an inpatient setting. For example, we observed an MDT meeting at the hospital to discuss a person on the ward due to be discharged to community services. A member of staff from the Kirkby CMHT attended the meeting to plan onward care. The meeting, led by the hospital psychiatrist, was recovery focused and respectful of the person's choices.
- There was an absence of psychology input at all MDTs.
- The CMHTs had particularly good links with social services due to seconded social workers being embedded into teams. There were also good links with drug and alcohol services, Sure Start centres and carer's services.
- Staff from the Kirkby CMHT had developed effective links with the GPs in their area. This was not so evident at Moss House, Arundel and Ferndale. This could compromise the ability to develop comprehensive wrap around care packages involving both primary and secondary care.
- People presenting in crisis outside of the normal working hours of the CMHTs were advised to attend the accident and emergency departments. They were initially assessed in A & E where a decision would be made to seek an inpatient bed. Alternatively they would refer to assessment or access teams for an appointment next working day, or contact the CMHT to action. There were effective electronic systems in place to ensure these handovers.

Adherence to the MHA and the MHA Code of Practice

- Staff demonstrated an awareness and understanding of the Mental Health Act and the MHA Code of Practice. They were able to tell us what was required, particularly in relation to community treatment orders (CTO's). Records we looked at showed treatment and capacity requirements were adhered to. However, it was difficult to identify people who were on CTOs from the records.
- The CMHTs or the wider trust had not conducted any recent audits to ensure that the MHA was being applied correctly.

Good practice in applying the MCA

- Staff had received training in the Mental Capacity Act and had access to trust leads if they required any further guidance.
- The records we looked at showed evidence of informed consent and assessment of mental capacity.
- Staff completed capacity assessments on a decision specific basis, for significant decisions. For example, we saw that a nurse had carried out a capacity assessment relating to financial exploitation involving telesales. The outcome was that the person had capacity. However, staff worked to ensure they were supported and protected.
- Approved Mental Health Professionals (AMHPs), social workers and consultants from within the teams did best interest assessments.
- Staff had limited awareness of access to advocacy services. Some people using the services told us they had been referred to the trust's patient advice and liaison service. Moss House CMHT had IMHA signage on display. However, none of the staff we spoke with or records that we reviewed, provided evidence of how a person had been supported to engage with advocacy services.

Good

Are services caring?

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

Summary of findings

Our findings

Kindness, dignity, respect and support

- Staff appeared interested and engaged in providing good care to people. We observed staff showing a caring attitude and enthusiasm to help others whilst understanding their individual needs. They talked about people using the service in a respectful manner.
- People using the service and their carers told us that staff treat them with dignity and respect and we saw this when we observed care being delivered.
- Staff took measures to ensure people's confidentiality was maintained. Records were electronically stored requiring password access and waiting areas were of an adequate size to ensure discretion when people phoned the services.

The involvement of people in the care they receive

- People were involved in their care plans. People told us they felt listened to in decisions relating to their care. We observed staff discussing interventions with people and giving them choices. Staff gave people copies of their care plans and printed information on their treatment choices.
- Staff included families in someone's care if consent was given and completed carers' assessments as required. Family workers worked closely with Sure Start centres and Barnados. Staff from the CMHTs had co-produced a support pack for the families of people using community mental health services. At Moss House CMHT, we observed the use of a booklet developed for children when their parents go into hospital to help to understand what is happening.
- Staff did not routinely give people information to enable them to access advocacy. This was particularly apparent for people whose CTO were due to end. However, we did observe staff discussing advocacy support in MDT meetings at the Arundel CMHT.
- Some people using services had been trained to participate on recruitment panels enabling them to be involved in decisions about their service. However, although this training had occurred, their involvement was not consistent. There was also no evidence of forums for people using the service to feedback or provide ideas.
- Each CMHT were required to provide a minimum of 12 service user feedback surveys each month. All services met these targets and the surveys were collated to provide feedback.
- The Community Mental Health Patient Experience Survey showed that the trust scored better than most other trusts for the questions: 'Were you involved as much as you would want to be in discussing how your care is working?', 'Did you feel that decisions were made together by you and the person you saw during this discussion?', 'Were you involved as much as you wanted to be in discussions about which medicines you receive?' and 'Have NHS Mental Health services involved a member of your family or someone else close to you as much as you would like?'.

Good

Are services responsive to people's needs?

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

Summary of findings

Our findings

Access and discharge

- The CMHTs operated from 9am until 8pm. People in crisis outside these hours attended the accident and emergency departments where their level of need would be initially assessed. This would then result in an inpatient bed, a referral to the CMHTs for the following day, or referral to the assessment or access teams. The CMHTs had a target to ensure all referrals received were contacted within 48 hours and seen within 72 hours. All the CMHT's achieved this target and mostly saw a person within 24 hours of the referral.
- GP referrals for people to mental health services were via the access and assessment teams. These teams' ensured people were suitably referred to the appropriate service.
- There were effective arrangements in place to ensure continuity of care when people required hospital admission. Staff visited people from their caseload that had been admitted to hospital and attended inpatient discharge meetings in preparation for their discharge.
- Staff discussed people who were difficult to engage, or who had not attended appointments at MDT meetings. We observed pro-active approaches to re-engage people and a clear process for discharge, if appointments continued to be missed. This involved communication with the person's GP.
- There were long waiting lists for people requiring psychotherapy. Staff were only able to offer brief cognitive behavioural therapy; the pathway for comprehensive therapy was through a trust wide provision. Waiting lists for this were up to one year. This was particularly the case for people requiring psychological intervention for personality disorder and family interventions for psychosis.
- The consultant agreed all discharges. We were told that in some cases, GPs would not take over the management of people's care if they were deemed appropriate to be discharged from community mental health services and still requiring depot injections.

The facilities promote recovery, comfort, dignity and confidentiality

- The facilities in Kirkby and Arundel CMHT's were spacious, fresh and welcoming. Kirkby CMHT had displayed art work from people who had used the service. However, consulting rooms in Moss House were worn and bare and did not promote comfort or recovery. We did not inspect the facilities at Ferndale CMHT due to their very imminent relocation.
- Information available included treatments, local services, groups, parenting and how to complain. Information was mostly easily accessible. However, Kirkby CMHT displayed what information could be obtained but people were required to request this at reception which may deter some people.
- However, Moss House CMHT had a toilet in their waiting area which could not be locked.

Meeting the needs of all people who use the service

- All the CMHTs visited had access for people living with disabilities.
- Staff knew how to access interpreters for non-English speaking people and sign language services for people with hearing impairment.
- The trust had an Equality and Diversity lead who provided support to translate written information into braille, languages other than English and to convert information into an easy read format if required.
- The CMHT in Arundel has recently relocated. It was located on a business park which was not easily accessed from public transport. However, the trust were in the process of introducing small community hubs, mainly located in primary care settings, which would ensure people could better access the locations.

Listening to and learning from concerns and complaints

- People knew how to make a complaint and told us that they felt they would feel listened to if they did so.

Good

Are services responsive to people's needs?

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

- Staff told us they always tried to address people's concerns informally as they arose and believed complaints were positive in improving services.
- Complaints were a standing item on team meetings and MDT meetings which supported learning.
- Moss House CMHT had a suggestion box in the waiting area however there was no immediate access to pens or paper for this.
- Complaints from people using Arundel CMHT had increased since their relocation due to difficulties in locating and accessing the service. Staff had responded to these complaints by issuing information on bus routes and maps and by collecting people for their first appointments at the new location.

Are services well-led?

Good

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

Summary of findings

Our findings

Vision and values

- The trust's vision and values were evident and on display in the CMHTs. Staff attended trust road shows on visions and values considered they understood them. The values were also embedded into staff appraisals.
- Staff knew who senior managers within the trust were. The trust used a direct email address encouraging staff to ask questions to the chief executive. We were told of two occasions were staff had done this, both receiving a prompt response and follow up.
- We observed side by side care in action, evidencing the trust's perfect care philosophy at work.

Good governance

- Staff received mandatory training, supervision and were in the process of a new appraisal system. However, managers told us that oversight of this was sometimes difficult as the trust wide information they received was not always solely specific to their teams or in a consistent format.
- Incidents were reported and investigated appropriately. Lessons learnt from local incidents and trust wide incidents were shared and cascaded to staff levels.
- Managers had sufficient authority and also had the ability to submit items to the trust risk register.
- There was limited staff participation in clinical audits.

Leadership, morale and staff engagement

- Staff knew how to access the whistleblowing procedure if needed and felt confident that they could use this without repercussions if needed.
- We were told of historic incidents of bullying within a CMHT visited; the manager had effectively dealt with these incidents.
- There was mostly high morale among staff teams. Staff felt included and connected with good management visibility and support. The clerical support staff at Kirkby were fully integrated into the team with their contributions supported and valued. However, there was evidence of less effective team functioning at Moss House CMHT. Some staff told us there was a gap between management and operational staff and the occupational therapists and psychologists did not feel their roles were valued with the whole trust. The focus group further supported this view. Psychologists described low morale. The trust had just employed a Head of Psychology to boost leadership for this discipline.
- Staff had opportunities for leadership development. Managers had attended leadership training and courses on resilience and change. Managers then encouraged others in their team to participate in leadership development.

Commitment to quality improvement and innovation

- The CMHTs had registered with the trust's perfect care initiative. Their direction being to improve learning from incidents as a whole CMHT.
- Staff had attended the trust's events aimed at learning from incidents across the trust.