Good

Birmingham and Solihull Mental Health NHS Foundation 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)
RXT	Trust Headquarters	West Hub (Ashcroft)	B18 5SD
RXT	Trust Headquarters	South Hub (Juniper)	B13 8JL
RXT	Trust Headquarters	East Hub (Little Bromwich Centre)	B10 9JH
RXT	Trust Headquarters	Solihull Hub (Maple Leaf Drive)	B37 7JB
RXT	Trust Headquarters	Rare Dementia Service	B10 9JH
RXT	Trust Headquarters	North Hub (Reservoir Court)	B23 6DJ
RXT	Trust Headquarters	Memory Assessment Service	B10 9JH B37 7JB

Summary of findings

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

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

Where applicable, we have reported on each core service provided by Birmingham and Solihull Mental Health NHS Foundation Trust and these are brought together to inform our overall judgement of Birmingham and Solihull Mental Health NHS Foundation Trust.

Summary of findings

Ratings

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

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

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

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

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

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

Summary of findings

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Overall summary

We rated the community based mental health services for older people as **good** because:

- Staff routinely completed and updated patient risk assessments. They developed and recorded crisis plans with patients. This meant there were plans in place to reduce risks if patients were in crisis. Staff had a good understanding of safeguarding and the procedures to keep people safe from abuse. The service carried out regular environmental risk assessments to monitor and improve the safety of buildings.
- The service had clear policies to support staff when they worked alone. Staff were aware of the lone working policy and the procedures to follow if they needed support when working alone. Staff knew how to report incidents and felt able to report concerns.
- Staff knew their patients well. They kept records of patient care and treatment up-to-date, including any changes in circumstances. Staff routinely carried out mental capacity assessments when necessary and supported patients to manage their physical health needs.
- The service worked well with other teams and agencies to enable patients to move between services as their needs changed. Staff communicated promptly and effectively with patients' GPs and other relevant agencies.
- Staff treated patients with kindness, dignity and respect. They routinely involved patients and carers in developing their assessments and care plans. The service was responsive to the needs of patients, carers and care homes. Patients told us they could get appointments when they needed them and doctors were accessible to both staff and patients. They said they could contact their allocated worker if they needed to speak with them. Patients were very positive about the service they received. The trust employed a team to gather feedback from patients and carers and used the information to make improvements to the service.
- Staff had access to regular supervision and there were some opportunities for them to develop their skills and career. They were up-to-date with their mandatory training. Staff had a working knowledge of the Mental Health Act and the Mental Capacity Act.
- Local leaders were visible and accessible to staff. Senior managers sometimes visited the teams.
- Managers carried out regular audits, including audits of patient records. The service recorded referral and discharge data. They used dashboards to inform staff and managers if they were meeting their key performance indicator targets. This meant they could tell how long people waited to be seen by the teams and if staff carried out reviews in a timely manner.

However:

- The service did not have a consistent process to audit safe and secure handling of medicines within the community teams. The trust pharmacy team carried out audits at each site in early 2017 but prior to this, there were gaps of over three years in some teams. There was no effective monitoring of clinic room temperatures in three teams and the clinic rooms in two teams were dusty and cluttered. Staff in most teams told us they believed their caseloads were too high and many told us they felt they needed to work at home, in their own time, to perform essential activities such as updating care plans and risk assessments.
- Caseloads were high and some staff worked unpaid hours to complete essential case recording.
- In some areas of the service, staff told us there were long waiting times for patients to access psychological therapies. The trust told us the longest waiting time was four weeks.
- Most carers and patients did not know how to make a complaint about the service. Despite this, they told us they were sure they could find out how make a complaint if they needed to and were confident they would be listened to.
- Consulting rooms where staff saw patients at the East Hub were very poorly soundproofed which

Summary of findings

meant conversations could be easily overheard. Consulting rooms at the North Hub had glass panels, which meant people using the corridor, could easily look in.

- Some staff felt senior managers did not listen to the feedback they provided about organisational change and they had not received a response when they had used the trust formal feedback process called "Dear John". Three staff said they did not have confidence in the whistleblowing process or in the Dear John process.
- A number of staff felt unsettled about the organisational changes taking place within the trust and this led to a degree of low morale within most teams.

Summary of findings

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

Are services safe?

Requires improvement

We rated safe as requires improvement for the community based mental health services for older people because:

- The service did not have processes in place to ensure the safe management of medication.
- Caseloads were high and some staff said they felt pressure to work in their own time to complete essential recording on the electronic patient record system. Caseloads in the community mental health teams for older people ranged from 29 to 108.

However:

- Staff had a good understanding of safeguarding policies and the procedures to keep people safe from abuse.
- Staff carried out individual patient risk assessments. They updated these risk assessments to reflect important changes in the patients' wellbeing and circumstances.
- Staff provided patients with crisis plans so they knew how to get help when they needed it.
- Staff supported patients with complex needs or crisis situations by engaging the community enablement and recovery team to provide additional support and monitoring.
- Staff knew how to report incidents and most felt able to do so without fear of victimisation.
- Premises used by patients were visibly clean, comfortable and clutter free.
- Staff had a good understanding of infection control measures.

Are services effective?

Good

We rated effective as good for the community based mental health services for older people because:

- Records of patient care and treatment were accurate and up-to-date. They reflected changing patient circumstance and need.
- The service stored confidential personal information securely on a patient database so staff could easily access patient notes to record information.
- We reviewed 39 patient records and all patients had an up-to-date care plan detailing their needs.
- Staff considered patients' physical health needs and supported them to address these either within the team or with their GP.
- Staff supported patients to access specialist group and individual therapies, which were provided by the Older People's Intervention Programme.

Summary of findings

- Mostly, there was good multidisciplinary working within the teams and between services.
- Staff demonstrated a good understanding of the Mental Capacity Act and routinely carried out mental capacity assessments when they were required.
- Staff had a working knowledge of the Mental Health Act.
- The service provided staff with specialist training opportunities to develop their skills.

However:

- In some areas of the service, there were waiting lists of five months for patients to access psychological assessment.

Are services caring?

Good

We rated caring as good for the community based mental health services for older people because:

- Patients and their carers told us that staff treated them with dignity, kindness and respect.
- During the inspection, we saw and heard positive interactions between staff and patients.
- We saw evidence that showed patients and their families had been involved in developing their care plans.
- Staff considered the emotional needs of patients and carers.
- Staff routinely supported carers.
- Staff supported and encouraged patients to move forward with their treatment plans.
- Staff gave patients information about their condition and treatment plans. They routinely addressed patient questions and concerns during home visits and clinic appointments.
- There were independent advocacy services available to support patients and carers when they needed it. These were well advertised in all of the sites we inspected.

However:

- Staff did not routinely signpost carers to the local authority for an assessment of their needs as a carer.

Are services responsive to people's needs?

Good

We rated responsive as good for the community based mental health services for older people because:

- Patients were prioritised based upon their need and risk. All community teams held a daily allocation meeting and had a nominated duty worker to screen referrals.

Summary of findings

- Community team staff saw urgent referrals within the target time of one week and often within a day. Most routine referrals were seen within the target time of four weeks.
- Patients referred to the memory assessment service were contacted within eight weeks and offered an assessment within four to six weeks.
- Patients were able to move through the service as their needs changed. Those seen in the Memory Service were referred to the community mental health team if they needed further support.
- Staff supported patients to access specialist group and individual therapies, which were provided by the Older People's Intervention Programme.
- Staff were flexible wherever possible and appointments could be made to suit the patient and carer. Staff carried out home visits for patients who could not attend clinic appointments and changed the times of clinics so it was easier for patients to attend.
- Patients and staff told us that appointments were rarely cancelled.
- Staff monitored and supported patients who were difficult to engage.
- The service actively engaged with patients and carers to gather feedback about the service they provided. Patient engagement staff routinely attended patient waiting areas to gather their feedback.

However:

- Most carers and patients did not know how to make a complaint about the service. Despite this, they told us they were sure they could find out how make a complaint if they needed to and were confident they would be listened to and taken seriously if they did make a complaint.
- Consulting rooms at the North Hub had glass panels in the doors and we saw people looking into the rooms. This meant that patients' dignity and privacy could be compromised.
- Consulting rooms at the East Hub were poorly soundproofed, so conversations could be overheard. This meant that patients' dignity and privacy could be compromised.

Are services well-led?

Good

We rated well-led as good for the community based mental health services for older people because:

- Staff were aware of the trust's vision and values.
- Local leaders were visible and accessible to staff.

Summary of findings

- Senior leaders occasionally visited the teams and staff were aware that the chief executive routinely and randomly visited sites across the trust.
- Managers made sure that staff had regular supervision and annual appraisals. They addressed performance issues when they needed to and supported staff with the sickness policy.
- Managers monitored staff compliance rates with mandatory training. Staff were sent electronic reminders when mandatory training modules were due for renewal and supervision was routinely used as a forum to discuss training needs.
- Staff were committed and engaged with their roles.
- Staff said lessons learned from incidents were shared throughout the teams and the trust in business meetings.
- Patients were encouraged to provide feedback about the service via questionnaires, after consultations and at focus groups.

However:

- Staff reported that morale was low in most teams, which they said was due to organisational change and a perception of high caseloads.
- Not all staff were confident they could report concerns and use the whistleblowing process without the risk of recrimination.
- Some staff felt senior managers did not listen to the feedback they provided about organisational change and developments within the service.

Summary of findings

Information about the service

Birmingham & Solihull Mental Health NHS Foundation Trust provides specialist community mental health services to meet the needs of adults over 65 years of age and anyone suspected as requiring diagnosis and support for dementia. Services provided include routine and urgent assessment, memory assessment, and ongoing treatment and review. Services are provided depending upon clinical commissioning group (CCG) and geographical boundaries.

There are five teams providing a community mental health service for older people across Birmingham and Solihull. Older adults requiring specialist mental health services are referred into the service by their GP. Referrals are made to a central referral point called the single point of access, who then allocate them to the most appropriate team, either a community mental health team, the rare dementia service or the memory assessment service. Access to the service is determined by the needs of the individual as well as their age. People of all ages can access the community teams and the memory assessment service if they require a dementia diagnosis or dementia related support.

The memory assessment service provides an assessment and diagnosis service to people suspected of having dementia and signposts them to sources of support following diagnosis. The services are provided through partnership arrangements between Birmingham & Solihull Mental Health NHS Foundation Trust and the Alzheimer's Society. The community teams manage prescribing arrangements for dementia medication.

The service operates from five hubs; North, South, East, West and Solihull. The memory assessment service operates from the hubs. The rare dementia service is based at the East Hub.

The older people's community mental health service had established new ways of working at the time of our inspection. The trust had made changes to the way they were delivering the service. They had been running the service from hubs for approximately one year, had issued staff with laptops and tablets to enable more agile working and had recently made the decision to remove the role of support workers from the teams and introduce physical health care support workers.

Our inspection team

Chairperson: Michael Tutt, Non-executive Director, Solent NHS Trust.

Head of Inspection: James Mullins, Care Quality Commission

Team Leader: Kenrick Jackson, inspection manager, Care Quality Commission

The team that inspected this core service comprised: three inspectors and a range of specialist advisors. The specialist advisors included mental health nurses, a psychologist and a psychiatrist.

Why we carried out this inspection

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

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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, we reviewed the information that we held about community based mental health services for older people and we asked the trust to provide us with detailed information about the service.

During the inspection visit, the inspection team:

- visited the memory assessment service, the rare dementia service and five community mental health team hubs to look at the quality of the environment and observe how staff were caring for patients
- spoke with 13 patients who were using the service
- spoke with 12 carers of patients using the service
- spoke with one carer and one patient who had recently been discharged from the service
- collected feedback from one patient using comment cards
- attended and observed seven patient home visits and five clinic appointments in two clinics
- attended and observed three allocation meetings and a multidisciplinary team meeting
- spoke with the managers or acting managers for each of the teams
- spoke with 44 other staff members; including administrators, occupational therapists psychologists, doctors, nurses, a student nurse and a physical health care support worker
- gathered feedback from 10 care homes, two GP practices and a day centre
- looked at 36 patient records and looked in depth at the treatment journeys of four patients
- carried out a specific check of medication management in the community mental health teams
- looked at a range of policies, procedures and other documents relating to the running of the service.

What people who use the provider's services say

We spoke with 13 patients who were using the service, to gather their feedback. We received and reviewed one comment card. We spoke with 12 carers of patients using the service to gather their feedback. We carried out one telephone interview with a patient who had recently been discharged from the service and one telephone interview with a carer of a patient who had recently been discharged from the service. Altogether, we looked at feedback from 28 patients and carers.

We visited one care home and carried out telephone interviews with nine other care homes, two GP practices and one day centre that supported patients using the service.

Overall, patients and carers were very positive about the care and support they received from the service. We received many positive comments about individual staff members who patients and carers felt were supporting them extremely well.

Patients and carers told us staff treated them with kindness, were always polite and were respectful. They told us they believed staff were genuinely interested in their needs and their wellbeing. They told us they could contact their worker when they needed to and got a timely response if their worker was not immediately available.

Patients and carers felt listened to and included in their care. They felt they were offered choices about their care

Summary of findings

and treatment. Almost all patients had copies of their care plans or remembered seeing one. Patients and carers knew who to contact if they needed support and had a telephone number to call if they needed help out of normal office ours.

Patients said if they had relatives and wanted them involved in their care, staff did this. Carers said communication with staff was very good and they always felt informed and kept up–to-date.

Almost all of the patients and carers we spoke with were unaware of the complaints process. However, they all felt they would be able to find out how to complain if they needed to. Everyone we spoke with said they had not had any reason to complain but felt confident that they would be listened to and taken seriously if they did.

Patients were routinely supported and encouraged to provide feedback to the trust about the service they received, but most did not recall doing this. During the inspection visit, we saw staff from the patient engagement team engaging with patients in waiting rooms.

Overall, patients and carers said they were very happy with the support provided to them and staff were responsive to their needs.

Almost all the care homes and GPs we spoke told us they received a good service from the community teams, the rare dementia service and the memory assessment service. Several care homes were highly complementary about the support they received from one of the doctors.

Good practice

The trust website provided useful information for patients and for GPs, about how to refer patients to the memory assessment service. There was also a useful presentation GPs could download called “Dementia Recognition and Diagnosis in Primary Care”.

The memory assessment service was accredited with the Royal College of Psychiatrists. It worked closely with the Alzheimer’s Society who they commissioned to provide follow-up support and information along with information about local sources of support.

The service had a care home liaison team, which supported care home staff to positively manage patient need before reaching a crisis point, therefore reducing the risk of placement breakdown.

Patients could access a wide variety of group therapies to support their wellbeing and recovery.

Areas for improvement

Action the provider MUST take to improve

Action the provider MUST take to improve

- The trust must ensure that they have processes in place to monitor and support the safe and secure handling of medicines.
- The trust must ensure that staff caseloads are manageable.

Action the provider SHOULD take to improve

Action the provider SHOULD take to improve

- The trust should address waiting times where there are waiting lists for patients to access psychological therapies.
- The trust should consider how they demonstrate to staff that they listen to staff feedback, particularly during times of reorganisation.
- The trust should ensure that staff feel able to report concerns and use the whistleblowing process without fear of recrimination.
- The trust should ensure that staff offer to refer carers to the local authority for an assessment of their needs under the Care Act 2014.
- The trust should ensure all consulting rooms where staff see patients provide facilities which promote dignity and privacy.

Birmingham and Solihull Mental Health NHS Foundation 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
West Hub (Ashcroft)	Trust Headquarters
South Hub (Juniper)	Trust Headquarters
East Hub (Little Bromwich Centre)	Trust Headquarters
Solihull Hub (Maple Leaf Drive)	Trust Headquarters
Rare Dementia Service	Trust Headquarters
North Hub (Reservoir Court)	Trust Headquarters
Memory Assessment Service	Trust Headquarters

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.

- All relevant staff had undertaken training on the Mental Health Act as part of their mandatory training. Compliance rates across the service for January 2017 were 97.3%.

Detailed findings

- Staff demonstrated a working knowledge of the act in relation to their patients. Staff knew where to get further information and help if they needed it.
- Across the service, there were eight patients who were subject to a Community Treatment Order. Paperwork was stored effectively and staff were aware of their professional responsibilities.
- All but one member of staff knew how to access an independent advocate for patients who might need one.
- All the sites displayed information for patients about local advocacy services in the area.

Mental Capacity Act and Deprivation of Liberty Safeguards

- Staff had undertaken training in the Mental Capacity Act as part of their mandatory training schedule. They were provided with a refresher session every three years. Compliance rates across the service for January 2017 were 98.1%.
- All the staff we spoke with had a working knowledge and understanding of the Mental Capacity Act. They understood the presumption of capacity and could give examples of supporting patients to make decisions.
- Most staff routinely undertook mental capacity assessments when they were necessary and recorded them on the electronic patient record system, in the designated area. They referenced this in the daily care records.
- We saw examples of staff being involved in best interest meetings for patients when these were required.
- Staff did not routinely record advanced decisions regarding patient care and treatment but were aware they could support patients with this. The patient record system prompted staff to discuss advance decisions.
- No patients were reported as being subject to a community Deprivation of Liberty Safeguards authorisation.
- Staff gave patients using the memory assessment service information about the legal options available to them to support them with making decisions in the future, such as Lasting Power of Attorney. Lasting Power of Attorney allows people to identify someone they want to make important decisions for them in the future, when they might lack the mental capacity to make the decision themselves.

Requires improvement

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

- Patient areas were visibly clean, well-ordered and clutter free. During the inspection, we saw domestic staff carrying out routine cleaning. Patients and carers told us the sites were always clean when they used them. Work place risk assessments showed when domestic staff would carry out a deep clean of areas such as communal staff fridges
- Infection prevention and control procedures were visible and there were hand washing opportunities at all sites. Sanitising hand gel dispensers were available and staff had access to mobile hand sanitising supplies, aprons and gloves when working in the community. The service undertook regular hand washing audits.
- All but one of the Hub sites had a clinic room where staff could carry out patient consultations and perform physical health checks if required. Apart from the Solihull and East Hubs, clinic rooms were visibly clean, well ordered and clutter free.
- Not all clinic rooms contained an audit checklist for cleaning, temperature monitoring (room and fridge where applicable), infection control and equipment maintenance. There was little evidence that staff completed these checks routinely and effectively.
- The service had a process for carrying out electrical appliance safety checks. We looked at a sample of electrical equipment, which had all been safety tested and displayed the date when it was due to be re-tested. Managers reminded staff in team meetings that they were not to use electrical items which had not been tested.
- When seeing patients on site, staff had access to personal alarms or room activated alarms at all sites except the North Hub. Alarms were routinely tested to ensure they worked effectively. The North Hub had closed circuit television cameras installed. However, the door to the corridor where patient consulting rooms were situated was not protected with a staff operated lock. This meant people could potentially enter the corridor from the waiting area. Staff at the North Hub were not provided with room activated or personal alarms. They would need to operate the alarm linked to their mobile telephone if they were at risk. This could cause a delay in them receiving assistance in an emergency.
- Managers carried out routine assessments of the environment. However, they did not all complete the risk matrix or target dates for completion of actions. This meant it was not always possible to determine the level of risk or when, and by whom, the identified actions to address the risks would be completed.

Safe staffing

- Depending upon individual complexity, the service supported some patients under the Care Programme Approach and some under the locally termed “care support”. Patients with a lower level of need or complexity were supported on care support. Not all members of the multidisciplinary team felt they should take on the role of care co-ordinator under the Care Programme Approach.
- A number of staff in the community mental health teams told us their caseloads were not manageable and they felt they needed to work from home, outside of office hours, to complete their essential recording. These staff told us their caseloads were in excess of 40 patients on the Care Programme Approach plus additional patients, who staff were supporting on the lower level care support system. The Department of Health’s Mental Health Policy Guidelines - Community Mental Health Teams (2002) recommends that full time care coordinators carry a maximum of 35 patients on the Care Programme Approach. The trust also recommended a maximum caseload of 35 for full time staff. Trust figures showed that, at the time of inspection, average combined caseloads for care coordinators of Care Programme Approach and care support patients ranged from 29 in the West Hub to 108 in the North Hub. The average combined caseload for care coordinators was 75.
- Local managers were aware that staff were reporting they felt pressure with the workloads and we saw this

was recorded in supervision records. The Solihull Hub had been able to employ temporary nursing staff from an agency to support with the pressure. However, the West Hub had been told they were over staffed with Band 6 nurses. All teams felt that losing the health care support worker roles from the teams had a negative impact upon them. Managers accepted there was a perception amongst staff of high caseloads and they were reminding staff not to work unpaid hours from home.

- The trust used a formula to determine staffing levels required within the service. The formula used the number of referrals and the percentage of patients on the Care Programme Approach to determine the number of nurses required to staff the team. Managers felt the system worked well overall.
- The service had a low vacancy rate of 1% for the year ending November 2016.
- Figures provided by the trust for November 2016 showed the memory assessment service had25.3 whole time equivalent (WTE) staff and 2.5 vacancies. The West Hub had 14.8 WTE staff. They had no vacancies and were overstaffed by 1.1. The Solihull Hub had 14.5 WTE staff. They had a 5.5% vacancy rate, which represented a 0.8 vacancy. The South Hub had 12.1 WTE staff. They had a vacancy rate of 25.6%, which represented 3.1 vacancies in November 2016. At the time of the inspection, the team had vacancies for a Band 6 nurse along with a half time psychologist and a half time administrator. The North Hub had 13.3 WTE staff. They had a vacancy rate of 6.8%, representing a 0.9 vacancy.The East Hub had 18.5 WTE staff. They were overstaffed by two posts in November 2016. They had one vacancy for a physical health care support worker at the time of our inspection. The rare dementia service had 5.2 WTE staff. They had a vacancy rate of 5.8%, which represented a 0.3 vacancy.
- Sickness and staff turnover rates across the service were low. Sickness in the memory assessment service was 1.6% and two staff left the team between February and April 2016. The sickness rate was 0.5% in the West Hub and no staff left between March and November 2016. The highest level of sickness was in the Solihull Hub, at 8.2% and two members of staff left between August and October 2016. There was no sickness in the rare dementia service, the South Hub or the North Hub. One person left the North Hub team in March 2016 but no one left the rare dementia service between May and November 2016 The sickness rate for the East Hub was 1.1% and no staff left the team between May and November 2016. There was only one agency nurse working within the service, at the Solihull Hub and they were planning to engage another one to manage caseloads. There was a vacancy for a speciality and associate doctor in the service, which was filled by a locum doctor at the time of the inspection. There were also two locums in junior doctor roles.
- Patients and staff told us they could speak with a doctor when they needed to.
- Records showed that staff had completed and were up-to-date with their mandatory training. The trust set a compliance target of 85%. Across the service, the teams exceeded this target, achieving a compliance rate of 96.2%. Mandatory training included personal safety, equality and diversity, safeguarding, the Mental Health Act, fire safety, health and safety, the Mental Capacity Act and information governance. Suicide training had recently been introduced as a mandatory training module for clinical staff and non-clinical staff had been encouraged to complete it. Staff and managers were sent email alerts advising them when specific training was due to be renewed. Managers monitored staff compliance with mandatory training and the supervision record automatically transferred staff training data to aid discussion.

Assessing and managing risk to patients and staff

- We looked at 39 patient records and found that staff had routinely carried out risk assessments and updated them regularly.
- Staff triaged and allocated patients based upon their risk and need. This meant they saw the patients with the greatest needs and the highest risks more quickly.
- The memory service was a diagnostic and signposting service so did not carry out full risk assessments. However, when they identified risks or safeguarding concerns, staff acted on these appropriately. They also worked with the Hubs for patients with complex risk needs.
- Staff supported patients to develop crisis and contingency plans. Patients could access crisis support

Requires improvement

Are services safe?

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

from the Home Treatment Team outside of normal office hours. This was a relatively new route of supporting patients within the service and staff told us they thought it had been a helpful introduction for their patients. Staff supported patients to identify both the early warning signs that their mental health might be deteriorating as well as the protective factors that helped keep them well. The trust told us that 91% of patients under the Care Programme Approach and 81% of patients on care support had crisis support plans in place. All of the records we inspected had a crisis support plan in place and patients told us they knew who to contact for crisis support.

- Staff received safeguarding training and they knew how to make an alert. They knew how to report concerns and knew where to get specialist advice if they needed it. Staff said their local safeguarding team at the trust were very supportive. We looked at a sample of patient records, which showed that staff recognised and effectively dealt with safeguarding concerns. The service routinely worked with the local authority to support patients where there were safeguarding concerns.
- To support the safety of staff working alone in the community, the trust had a lone working policy. They also provided staff with mobile telephones. Staff were clear about the policy but some managers said staff were not keen to use the alert system that they activated with their mobile telephone. When we asked staff and managers to tell us how the system worked, we were given a number of different responses. However, managers told us they were assured the system worked and it was a useful additional tool for their staff to use when lone working. However, usage of the devices across the trust was low at only 15% in August 2016 and 9% in September 2016.
- The service did not have an embedded system to monitor the safe storage of medication. The teams we visited did not routinely store medication in their medicines fridges but all had fridges, ready for use. The West Hub monitored fridge but not room temperatures. The North and East Hubs routinely monitored and recorded fridge and room temperatures. The East Hub had introduced a recording and monitoring system shortly before the inspection. The Solihull Hub had a new fridge but no system of monitoring and recording the roomtemperature and no protocol to advise staff what to do in the event that temperatures rose above the recommended levels. The South Hub was not monitoring and recording room temperatures prior to the audit in January 2017. The East Hub was the only team to routinely complete a medicines stock list. Three of the teams had no safe operating procedures for staff to refer to. We found out of date medication at two sites, which staff acknowledged and dealt with. We also found out of date syringes. We found one site held blister pack medication for a patient but there was no audit trail to account for it.
- Most medication administration was given by the community teams, in the form of depot injections to patients living in their own homes. There were processes in place to safely transport these medicines. Two staff had signed medication administration cards in all but one of those we checked.

Track record on safety

- The service reported no serious incidents between March 2016 and February 2017.
- Managers discussed trust wide serious incidents in their service meetings.

Reporting incidents and learning from when things go wrong

- Staff knew what type of incidents they should report and how to report them. They used an online incident reporting system, which they were confident to use. Managers reviewed incidents.
- Managers told us the trust shared information with staff about lessons learned when things had gone wrong. We looked at a random sample of minutes from team meetings across the service and found that learning from incidents was not a standard agenda item for all of the teams. Staff told us that they were kept up-to-date with lessons learned in their regular team meetings and in emails. There was also a trust wide event in July 2016 and the trust intranet informed staff about learning from incidents.
- Staff could give examples of change the teams had put in place following learning from incidents. Staff also said they had access to support and debriefs after incidents.

Are services effective?

Good

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

Our findings

Assessment of needs and planning of care

- Staff carried out comprehensive assessments of patients' needs. The assessments were holistic in all of the 39 records we looked at. This meant staff looked at patients' social and physical health care needs as well as their mental health needs. The assessments were person centred and meaningful to patients in all of the records we reviewed. They reflected patient views and were written in a way which was accessible and free of jargon. Staff also considered the needs of carers. Staff were prompted by the assessment tool to include information about advance decisions but none of the patients had provided any advance decision information in the sample of records we looked at.
- In all of the records we looked at, each patient had a care plan, which reflected their assessment of need. Staff had recorded when they offered patients a copy of their care plan and if the patient had accepted or declined to receive a copy. Care plans were up-to-date and linked to risk assessments.
- The memory assessment service was a diagnostic and signposting service so did not develop care plans for patients.
- Staff had considered and addressed patients' physical health needs in every record we reviewed. Staff routinely considered patients' physical health during their ongoing involvement. Staff liaised with GPs and other health professionals in order to support patients to manage their physical health as well as their mental health. We saw examples of staff referring patients to specialist sources of support when required.
- The trust was developing the role of physical health care workers within the teams. This was a new role within the service. Supporting patients to manage their physical health was a priority the trust had identified as part of the quality goals. The trust had allocated each hub a different number of physical health care support workers and nurses. West and North Hub were each allocated and had recruited two nurses and two health care support workers. South Hub was allocated four health care support workers and two nurses, all of whom had been recruited. East Hub was allocated two health care support workers, one of which was in post and the vacant post was awaiting recruitment. Solihull Hub was allocated one health care support worker for 30 hours per week and one nurse, which was being advertised at the time of the inspection
- Staff stored patient information on a secure electronic database. Staff could access the database easily and in a timely manner. The West Hub still had some paper documents, which they were in the process of transferring to the electronic patient record system. All the teams had administrative support to enable them to transfer any paper documents, such as letters, to the electronic patient record system and this was done without delay.

Best practice in treatment and care

- We saw evidence that staff considered National Institute for Health and Care Excellence (NICE) guidelines when making treatment decisions. These included specific dementia examinations such as the Addenbrookes Cognitive Examination – Revised tool. Staff followed NICE guidelines for cognitive enhancers (drugs or therapies that may enhance memory). Staff were able to access NICE and British National Formulary prescribing guidelines. Some teams included nurse prescribers. Doctors and nurse prescribers prescribed medicines in line with guidelines.
- Staff routinely supported patients to access external sources of help to deal with housing, employment and welfare benefits issues.
- The service was developing the role of physical health care workers within the community teams and a physical health care link worker in the rare dementia service. Staff also ensured that patients were supported by their GP to have regular physical health checks and monitoring.
- Staff used recognised assessment tools such as Hospital Anxiety and Depression Scale (HAD), Goal Attainment Scaling (GAS) and the Generalised Anxiety Scale in older adults (GAD). Psychology and occupational therapy staff also completed specialised assessments. The rare dementia service used guidelines for behavioural and psychological symptoms in dementia (BPSD).

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- The rare dementia service were completing a self-assessment for the "Triangle of Care". The Triangle of Care is a therapeutic alliance between patient, staff and carer, that promotes safety, supports recovery and sustains wellbeing.
- Staff also completed Health of the Nation Outcome Scales (HoNOS). This scale measures the health and social functioning of people with severe mental illness and is recommended by the English National Framework for Mental Health and by the Department of Health working group on outcome indicators for severe mental illnesses.
- In line with the National Institute for Health and Care Excellence (NICE) guidelines, patients had access to psychological therapies. Psychologists were able to offer advice to other disciplines within the teams and supported staff with formulations. Therapeutic groups were provided for patients in collaboration with other teams and external agencies. The Older People's Intervention Programme ran the majority of groups. Staff could refer patients to the programme if they felt attending a group would be of benefit to the patient. The Older People's Intervention Programme provided between 5-10 groups across the city each day with 6-10 participants in each group. One group was specific to patients who spoke Asian languages. Additionally, the West Hub delivered a weekly rolling programme of two groups; compassion focussed therapy and mindfulness. Staff also encouraged patients to attend the Recovery College for All.
- Patients using the memory assessment service could access a variety of specialist groups: cognitive stimulation, memory management, mild cognitive impairment and a memory self-management programme (a collaborative patient and carer group). These groups were run on a rolling programme. Additionally, the service provided a men's reminiscence group, working in collaboration with local football clubs, to promote memory stimulation relating to specific football clubs.
- Patients with a functional diagnosis could access a wide variety of group therapy sessions including: wellness recover, sleep well, self-esteem, anxiety management and lifestyle matters.
- Staff were able to participate in clinical audit. The service routinely carried out audits of infection prevention and control, patient records, and the numbers of patients who did not attend booked appointments.
- The trust pharmacy team did not make regular monitoring and support visits to the Hubs. The staff we asked were unsure how often a member of the pharmacy team attended their site. Pharmacy had visited and audited for safe and secure handling of medicines processes at each site in early 2017. However, prior to this recent audit, they could not provide evidence that they regularly visited and audited all of the community teams.
- The Solihull Hub had been audited in April 2016 however, the Community Team Audit Checklist was unsigned and the action plan was blank. The 2016 audit showed that the Solihull Hub were non-complaint with audit trails for patient medication that staff brought into the site to dispose; non-complaint with stock list of its medicines and non-compliant with room temperature control monitoring. When the Solihull Hub was next audited in 2017, they remained non-complaint with the monitoring of room and fridge temperatures but had installed a new medicines fridge and ordered a room temperature thermometer. There were no records of the North and South Hubs having been audited by the pharmacy team prior to January 2017. The East Hub was previously audited in February 2013 and found non-complaint in four areas. The West Hub was last audited in December 2014 and found to be non-compliant in four areas.

Skilled staff to deliver care

- The community teams included managers, senior practitioners (a nurse or an occupational therapist) physical health care support workers and nurses, administrators and doctors. The service employed psychologists, most of whom worked part time across the teams and the memory service. They provided psychological assessment and support. All the teams had a mix of staff from different grades and different disciplines.
- The service also had five Admiral Nurses. Admiral Nurses give practical, clinical and emotional support to families living with dementia. They are trained, developed and

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supported by the charity Dementia UK but were employed by the trust.In the seven months leading up to the inspection, the Admiral Nurses had an average caseload of 43 carers each.

- New staff and students underwent an induction before they took up their role and responsibilities in the teams. Practice placements were offered within the service for medical and nursing students. Administrators supported staff with the induction process.
- Staff were able to undertake further training to equip them in their role. There were opportunities to become nurse prescribers and advanced nurse practitioners. Occupational therapists could train in Assessment of Motor and Process Skills (AMPS). Staff and managers considered training and development needs in the supervision and appraisal process. However, some nursing staff felt opportunities for career development had been limited because the trust had reduced the number of Band 6 nurse roles within the service.
- Staff had received an annual appraisal within the last 12 months and received regular individual supervision. The trust set a compliance rate of 85% for annual appraisals. Appraisal rates across the service exceeded the trust target, at 88.3%. Staff received regular management supervision every six to eight weeks, which managers recorded on a trust database. Management supervision records we looked at were comprehensive. Staff also received clinical supervision within their professional discipline. All doctors working within the service had been revalidated.
- When managers identified performance issues within their teams, they were able to address them. There was a human resources service within the trust, to support managers and staff.

Multidisciplinary and inter-agency team work

- Staff shared information and worked effectively together. We attended and observed three allocation meetings and a multidisciplinary team meeting. Staff from the different disciplines worked well together. Staff showed each other mutual professional respect. Their working relationships were effective and positive. However, not all doctors routinely attended the allocation meetings and team meetings. Staff in the rare dementia service and the memory assessment service worked closely as a multidisciplinary team.
- Staff routinely advised GPs of patient assessment outcomes. The service was developing further contact with GP surgeries by attending practice meetings. We spoke with two GP practices who provided positive feedback about the service they received. The trust website provided information for GPs about how to refer patients to the service and it provided information that GPs could give to patients. There was also a useful presentation GPs could download called "Dementia Recognition and Diagnosis in Primary Care".
- The memory assessment service worked closely with voluntary sector agencies to develop post diagnostic support for patients and carers. The service had arrangements with the local Alzheimer's Society to provide patients and carers with information and access to sources of support.
- We spoke with ten care homes and a day centre to gather feedback about how the service supported their service users. They were very positive about the support received from the East Hub. One care home said doctors would hold reviews and patient meetings at the care home which meant they could fully participate. Care homes were very positive about the prescription service for residents' dementia medication and the speed with which the teams responded to their requests for support. They were particularly pleased with the support doctors gave them to reduce patients' medication and avoid the use of anti-psychotic medication.Care home feedback about the Solihull Hub showed that staff were all kind and respectful in their interactions with patients. They were particularly complimentary about some of the community team nurses who they felt were very responsive. However, they often had to wait between six and eight weeks before a doctor came to see the resident. One care home said they could not directly contact the team and felt blocked by reception staff who were not always helpful. They also said the telephone would ring for a very long time before staff answered it and doctors did not hold reviews or patient meetings at the care homes. We spoke with a local GP practice who told us that they had developed very good working relationships with the Solihull Hub staff and routinely attended practice sharing meetings to look at ways of supporting patients with highly complex needs. Care home feedback about the West Hub said they did not receive a swift and efficient repeat prescription service for residents'

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dementia medication but they were complimentary about the support they received from some of the doctors. However, they said one doctor would not support care home staff to carry out a complex mental capacity assessment for a resident, which left them feeling unsupported. They also said that not all nurses spoke in a kind way when giving some patients their injections. One care home said reception staff at the West Hub did not make them feel welcome when they telephoned to ask for support to resolve issues with repeat prescriptions. The same care home said the repeat prescription service at the South Hub was very efficient and effective and if there was a problem, reception staff would sort out any problems immediately.

- None of the teams displayed the contact details for the pharmacy team in their clinic rooms or medicines areas.

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

- All staff had undertaken training on the Mental Health Act as part of their mandatory training. In January 2017, compliance rates for the training, across the service, were high at 97.3%. Staff demonstrated a working knowledge of the Mental Health Act in relation to their roles and stored Mental Health Act paperwork effectively. Staff knew where to get further information and help if they needed it.
- There were eight patients across the service who were subject to a Mental Health Act Community Treatment Order. Paperwork was stored effectively and staff were aware of their professional responsibilities.
- All but one member of staff knew how to access an independent advocate for patients who might need one. All of the sites displayed information for patients about advocacy services.

Good practice in applying the Mental Capacity Act

- Staff had undertaken training in the Mental Capacity Act as part of their mandatory training schedule. Compliance rates for the training were high, at 98.1%. They received regular training updates.
- All the staff we spoke with had a working knowledge and understanding of the Mental Capacity Act. They understood the presumption of capacity and could give examples of supporting patients to make decisions.
- Staff routinely undertook mental capacity assessments when it was necessary to do so and recorded them in the electronic patient record system. One member of nursing staff said that it was only doctors carried out capacity assessments. One care home said they struggled to get support from the service to assess the mental capacity for a patient with complex needs.
- We saw examples of staff being involved in best interest meetings for patients when these were required.
- Staff did not routinely record advanced decisions regarding patient care and treatment but were aware they could support patients with this. The electronic patient record prompted staff to ask patients about advanced decisions.
- Patients using the memory assessment service were given clear information about the legal options for supporting them to make decision in the future, when they might lack capacity, such as Lasting Powers of Attorney.

Good

Are services caring?

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

Our findings

Kindness, dignity, respect and support

- We observed 12 staff and patient interactions during home visits and clinic appointments. We observed a number of interactions in reception areas and heard staff speaking with patients and carers on the telephone. Staff spoke respectfully about patients and showed understanding and compassion during home visits and clinic appointments. Staff treated patients with kindness and respect. They used a person centred approach when communicating with their patients. Staff discussed treatment options and encouraged patients to engage in their assessments and appointments.
- Staff demonstrated skills in active listening and showed positive encouragement when communicating with patients and carers. They validated patients' feelings. They actively listened to the opinions, questions and wishes expressed by patients and carers.
- We spoke with 13 patients and asked them about the care and treatment they received from the service. All the patients were positive about the care and treatment they had received from the service. Patients described staff as friendly, kind, helpful, respectful and polite.
- Staff were committed to providing good patient care. They showed a good understanding of the needs of individual patients. We spoke with nine care homes and a day centre. They all told us that trust staff knew their patients well.
- Both clinical and reception staff were responsive to patients' needs. We observed kind interactions between them. Staff answered telephones swiftly and effectively. One care home said they did not always find reception staff helpful. However, we observed reception staff greeting patients and carers warmly and efficiently.

The involvement of people in the care they receive

- Patients and carers felt listened to and included in their care. They felt they were offered choices in relation to their care and treatment. Some patients had copies of their care plans and a number remembered having a copy. We saw that staff recorded when they had offered people a copy of their care plan and if the person had declined to have one.
- Most patients said that their relatives were involved in their care if they wanted them to be. We spoke with 12 carers of people using the service. Carers said communication with the service was very good and they were really happy with the support provided to them and the person they cared for.
- Staff did not routinely support patients to make an advanced decisions, which would have included their wishes should they become more unwell or need to be admitted to hospital. However, the memory assessment service routinely offered patients information about Lasting Power of Attorney and how to live well with dementia.
- The trust set a standard for all patients to receive a review of their care every six months or sooner if required. This was for patients under the Care Programme Approach and care support. Patients and carers were not routinely involved in regular multidisciplinary meetings but were involved in their regular reviews.
- Staff considered carers' needs and supported them within the team. Carers could attend groups run by the service across the city. Carers we spoke with were very positive about the support they received from the Admiral Nurses and the other staff in the teams. Overall, carers told us that they found staff very supportive. However, staff did not routinely refer carers to the local authority for an assessment of their needs under the Care Act 2014.
- Patients had access to a variety of advocacy and support services, which were well displayed in all patient areas. The memory assessment service provided patients with a lot of useful information. Community staff also provided patients with information packs containing useful local information. The Solihull Hub had worked in collaboration with the local Clinical Commissioning Group and the local authority to develop brightly coloured patient folders which contained useful information from statutory and voluntary sector organisations.
- Patients were able to give prompt feedback about the service they had received using satisfaction surveys and questionnaires. They were available in a variety of formats. There were also tablet computers that staff could take out into the community. Staff from the

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patient engagement team routinely visited the Hubs and talked with patients to gather their feedback. We returned to the Hubs, unannounced, a week after the initial inspection visits. The patient engagement team were speaking with patients and carers during our visit.

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

- The service triaged all referrals to determine who was at most risk and should be seen most quickly. Staff saw the most urgent referrals within one week, often within a day. The Hubs all provided a duty service in order to triage referrals and support patients most in need. Routine referrals were seen within four weeks. Average referral to initial assessment times across the service ranged from 17 to 30 days. The trust provided referral data for the North, West and South Hubs for December 2016 to February 2017. This showed that most referrals into these teams, 457, came from GPs who used the single point of access route. Each team also took between 50-60 internal referrals and transferred on average of 19 patients between teams. The trust was not able to provide data to show how long patients waited from their initial assessment to the onset of their treatment. However, they told us there were no waiting lists.
- The service gathered data on the number of patients who did not attend for their planned appointments. We looked at this data for the Hubs from April 2016 to February 2017. The North Hub showed the biggest improvement on reducing the number of patients who did not attend for their appointments. Their average monthly rate for the year ending 2015-16 was 10.6% but the team managed to reduce this to 9.2% in the 11 months leading up to the inspection. The North Hub were proud of this achievement and said the improvements were as a result of them moving the time of clinic appointments, from mornings to afternoons. The other Hubs reduced their rates from between 0.1 - 0.5% with the exception of the East Hub, which saw a small rise of 0.2%. However, at 5.8%, the East Hub had the lowest rate of patients who did not attend for planned appointments. When patients did not attend their planned appointment, staff followed this up. They made attempts to engage with patients who needed a more assertive approach to manage their mental health.
- Patients referred to the memory assessment service were contacted by the team within eight weeks and offered an assessment within four to six weeks. They were initially seen at home for a pre-assessment counselling appointment.
- Between May 2016 and February 2017, the Memory Service saw an average of 334 patients each month. The Hubs saw an average of; East, 418; North, 460; Solihull, 377; South, 386; and West, 440. The rare dementia service saw an average of 58 patients each month.
- On average, between October 2016 and February 2017, patients used the rare dementia service for 760 days. Between May 2016 and February 2017, patients used the community teams for an average of 381 days.
- All of the community teams could arrange short notice urgent appointments for patients. This meant that patients were able to see staff when they most needed to. For patents requiring additional monitoring and support, the teams could refer to the community enablement and recovery team. This team provided additional home visits to patients who presented with complex needs or required additional support to guide them through a period of crisis.
- Staff reported good relationships with social care colleagues. However, most staff said that there could be delays obtaining social care support for their patients. They said they often had to make follow up calls to pursue referrals and had to retain patients on their caseloads, who they could otherwise have discharged, due to delays in obtaining social care support.
- Not all teams included a psychologist. The East and South Hubs had waiting lists for psychology assessment and intervention. The trust told us that there was no waiting list for psychology at the West Hub. Patients could access psychosocial therapies from the Older People's Intervention Programme team. They provided group work and time limited therapies across the geographic area, usually near to one of the hubs. Community team staff made referrals to the Older People's Intervention Programme who then carried out their own assessment to determine if the patient would benefit from their service. They provided a wide range of therapies across the city.

The facilities promote recovery, comfort, dignity and confidentiality

- Community teams had access to rooms to see patients when they needed to. Almost all rooms were private and appeared to be comfortable. However, consulting rooms used by the East Hub had poor soundproofing, which meant that conversations could be overheard. The

Are services responsive to people's needs?

Good

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

consulting rooms at the North Hub had glass panels in the doors. These rooms were situated on a busy corridor and during the inspection, we saw people looking in at the windows. This could compromise the privacy and dignity of patients using the consulting rooms, particularly as the rooms contained equipment for staff to measure a patient's weight, height and blood pressure because there was no clinic room at the North Hub. At the time of the inspection, staff told us the service was in the process of developing a room specifically to undertake physical health checks for patients. .

- Information about local support services and mental health conditions were on display in waiting areas. All sites displayed local information for patients regarding advocacy services, social activities and support groups.

Meeting the needs of all people who use the service

- People with mobility issues and those who used wheelchairs could access all the community team premises. Consultation rooms were provided on the ground floor and had enough room to accommodate people using mobility aids or wheelchairs. All sites had wheelchair accessible toilets with patient assistance alarms fitted.
- Information leaflets and leaflets about local services and mental health issues were available in a range of different languages, but almost all that were on display were in English. Staff could easily access interpreters and leaflets in other languages when they needed them. Staff had a list in a variety of languages which patients and carers could point to and identify the language they would find most useful. Staff could then access leaflets in the required language. Some teams had staff who spoke more than one language. When the teams lost their health care support workers, the West Hub lost a worker with a second language who had often supported staff to overcome language barriers. A number of staff told us they felt this was a great loss to the whole team.

Listening to and learning from concerns and complaints

- Information on how to complain was displayed in waiting areas where patients could see it. Staff were confident that they could support patients to make a complaint and knew that the Patient Advice and Liaison Service (PALS) would support patients with the process. Details of PALS were displayed in patient areas. Almost all patients and carers told us that they were unaware of the complaints process and had not been specifically advised how to make a complaint. However, they told us that they would be able to find out how to make a complaint and they all felt confident that if they had cause to complain, they would be listened to and taken seriously by staff. The service as a whole received only a small amount of complaints. Most complaints were dealt with centrally by the trust, which meant that local managers were not always made aware of them at an early stage. However staff were interviewed as part of the complaints investigation process and feedback from complaints investigations including lessons learnt was shared with teams.
- Patients had complained about being cut off when telephoning into the Solihull Hub, so staff put in place measures to try and prevent this from happening.
- The Solihull and North Hub had changed the times of clinic appointments as a result of patient feedback. Staff felt moving appointments to an afternoon was more convenient for patients and their carers. The North Hub staff believed this change had reduced the number of patients who did not attend for planned clinic appointments.
- When we visited the teams, we saw many compliments and thank you cards. Most were from students who had experienced a good placement within the teams but some were from patients and carers. We saw a family delivering a thank you gift to staff during the inspection visit.

Are services well-led?

Good

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

Our findings

Vision and values

- Staff understood the visions and values of the organisation. They were committed to providing good quality care for patients and supporting carers.
- Senior managers occasionally visited the community teams and staff were aware that the chief executive randomly visited services in the trust. Staff could give examples of senior trust leaders visiting their teams. Some staff told us they felt senior managers did not listen to the feedback they provided.

Good governance

- Local managers met regularly to discuss issues that affected their local teams and the service. New arrangements were in place following the most recent reorganisation and managers were not clear what the new meeting structures would look like. We looked at a sample of minutes from the meetings in late December and early January 2017. These showed that managers discussed serious incidents, complaints and lessons learned. Staff told us they were kept informed about incidents and lessons learnt in their business team meetings. However, not all the minutes from the meetings evidenced these discussions had taken place. The only teams routinely doing this were the rare dementia service, the memory assessment service and the South Hub.
- The service routinely carried out audits of infection prevention and control, patient records, and the numbers of patients who did not attend planned appointments. However, the pharmacy team did not carry out regular audits of medicines management within the community teams.
- There were high compliance rates of mandatory training, supervision and appraisals across the service. Staff had access to learning and development opportunities within the trust but some staff said their development opportunities were restricted following the reorganisation of the service because there were fewer opportunities for progression. One member of staff said they were reluctant to apply for the training they needed because the trust needed to save money.
- There were a range of administrators across the service and they supported staff and managers to deliver effective care and support to patients by booking clinics, sending out letters, appointments and greeting patients when they visited the sites. There were opportunities for apprentice administrators to develop a career in the field.
- Managers recognised and effectively dealt with any staff performance and sickness issues. They were supported by trust policies and procedures.

Leadership, morale and staff engagement

- Sickness and absence rates across the service were low.
- There were no reported cases of harassment and bullying within the teams but one member of staff refused to comment when asked about this.
- Staff knew about the whistleblowing process. All but three members of staff said they felt able to raise concerns without the fear of victimisation. One of these, said they were unsure if they would use the whistleblowing policy because a member of staff who had used it, had a bad experience.
- Overall, morale in the community teams was low but good in the rare dementia service and the memory assessment service. A number of staff told us they had been unsettled and anxious during the latest reorganisation. They had been told about plans which the trust intended to introduce, and some of these plans had made staff anxious. However, the trust did not implement all of the plans, which then left staff fearful and mistrustful. The distances some staff had to travel to visit patients, meant they could be away from their base for most of the working day. This was particularly evident for staff in the West Hub because staff had to travel to patients who lived near to the Solihull, South and East Hubs. The West Hub had been told by the trust that they were overstaffed with Band 6 nurses and would need to replace them with lower grade staff when a vacancy arose. Staff in the community teams were unhappy they had lost their health care support workers. They did not feel the introduction of the physical health care workers would compensate for the loss of health care support workers in their teams. Overall, these issues impacted on morale in the community teams.

Are services well-led?

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- Staff told us they felt good about their jobs and were supportive of each other. A number of staff told us their local managers were supportive. However, five members of staff felt there were excessive levels of stress associated with their workloads and they felt obligated to work at home, outside of office hours. Two members of staff told us they regularly worked more than two hours a night when they got home.
- Staff understood the duty of candour. This means they knew to be open and transparent with patients if something went wrong.
- The trust had an electronic staff feedback system, which enabled staff to contact the chief executive. The trust called this system "Dear John". Staff told us they had no faith in the "Dear John" system. One member of staff told us they felt the service was advertised to them as confidential, but when someone in the team had used it, there were repercussions. Two other staff told us they had used the Dear John process but had never received a reply.

Commitment to quality improvement and innovation

- The trust was developing new ways of working. They called this New Dawn. Community team staff had been issued with laptops as part of the programme. This gave staff the opportunity to work from locations outside of their office base. The trust had dedicated "hot desks" in most bases, which meant that if staff were near to a base which was not their normal place of work, they could work from a dedicated space. This could reduce travel time and increase flexibility for staff.
- The memory assessment service was an accredited member of the Royal College of Psychiatrists' Centre for Quality Improvement Memory Service National Accreditation Programme (MSNAP). The Memory Services National Accreditation Programme works with services to assure and improve the quality of memory services for people with dementia or memory problems and their carers. It engages staff in a comprehensive process of review, through which good practice and high quality care are recognised. The programme also supports memory services to identify and address areas for improvement.Accreditation of the programme aims to assure staff, service users and carers, commissioners of the service being provided. The service was in the process of applying to be re-accredited which was due in April 2017.
- The service was involved in a National Institute for Health Research funded research programme with a local university: "How does patient care affect family carers' lives?".

This section is primarily information for the provider

Requirement notices

Action we have told the provider to take

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

Regulated activity	Regulation
Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment The service did not ensure that there were effective processes in place for the safe and secure handling of medicines. Processes for the recording and monitoring of fridge and room temperatures were not embedded within the service. Some teams had out of date medication. Two clinic rooms were dusty and cluttered. There were no stock lists of medication held on site. The pharmacy team did not carry out regular monitoring of the safe and secure handling of medicines across the service. This was a breach of Regulation 12 (2)(d) (e) (g)

Regulated activity	Regulation
Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 18 HSCA (RA) Regulations 2014 Staffing Caseloads in the community mental health team hubs were high. Some staff reported that they worked in their own time to complete essential case recording. This was a breach off Regulation 18 (1) (2) (a)