Good

Leeds and York Partnership NHS Foundation Trust

Community-based mental health services for adults of working age

Quality Report

Leeds and York Partnership NHS Foundation Trust
Tel: 0113 305 5000
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Locations inspected

Name of CQC registered location	Location ID	Name of service (e.g. ward/ unit/team)	Postcode of service (ward/ unit/ team)
Trust Headquarters	RGD01	Assertive Outreach Team, Leeds	LS14 1PP
Trust Headquarters	RGD01	Assertive Outreach Team, York	YO30 6AS
Trust Headquarters	RGD01	Aire Court Intensive Community Service, Leeds	LS10 4BS
Trust Headquarters	RGD01	Linden House Community Mental Health Team, Leeds	LS12 3QE
Trust Headquarters	RGD01	Millfield House Community Mental Health Team, Leeds	LS19 7LX
Trust Headquarters	RGD01	Hawthorne Intensive Community Service, Leeds	LS12 3QE
Trust Headquarters	RGD01	South West Community Mental Health Team, York	YO30 7BY

Summary of findings

Trust Headquarters	RGD01	North East Community Mental Health Team, York	YO30 7BY
Trust Headquarters	RGD01	Liaison Psychiatry Service for Older People, Leeds	LS9 7TF

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

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

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

Summary of findings

Ratings

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

Overall rating for Community based mental health services for adults of working age	Good 
Are Community based mental health services for adults of working age safe?	Good 
Are Community based mental health services for adults of working age effective?	Good 
Are Community based mental health services for adults of working age caring?	Good 
Are Community based mental health services for adults of working age responsive?	Good 
Are Community based mental health services for adults of working age 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

Over the past twelve months, some of the community mental health team (CMHT) services had experienced significant changes due to the transformation of community services which the trust had implemented to improve access to the service. This had involved the introduction of a, 'single point of access' (SPA) to manage and prioritise all new referrals into the service. We found the SPA was embedded, effective and responsive in prioritising patients' needs. Some patients reported difficulties in accessing the CMHTs as the trust had reduced the number of CMHTs as part of the transformation process. However, we found the teams had developed and implemented pro-active, flexible approaches to working with patients to make sure their needs were being met.

The teams completed comprehensive assessments of patients' needs which included their social, occupational, cultural, physical and psychological needs and preferences. We found some good examples of how teams ensured the physical health care needs of patients were being met.

All the teams worked in line with the principles of the recovery model. This was evidenced by the team's focus on supporting patients to remain within the community and facilitating the early discharge of patients from hospital where possible.

There was good evidence of effective multi-disciplinary team (MDT) team working across the service and with partner organisations external to the trust. The teams provided a range of activities and therapeutic interventions to patients to support their recovery in line with best practice guidance.

At a local level, we found staff were clear about the direction and vision of the team they worked in. However some teams felt a disconnect from the wider trust. The trust had implemented a range of initiatives to improve engagement with these teams to address this issue.

The teams were committed and motivated to improve their service through the process of clinical governance and were at different stages of embedding this in clinical practice. They had established team, formulation and supervision meetings to support them with this process. We found some good examples of how teams had pro-actively sought feedback from patients, stakeholders and carers through the use of audit and used this information to improve services provided.

We gathered information from a range of sources to gain feedback from patients and their carer's about their experiences of using the service provided. All the patients and carers we spoke with reported they were happy with the service they received and that staff treated them with respect and kindness. The teams involved patients and carers in all aspects of their care. From our observations, we saw that staff were sensitive and respectful of patient's wishes and were committed to providing personalised care based upon the needs of patients.

Unlike in Leeds, the York services did not have intensive community service's (ICS) or liaison psychiatry service for older people. This could result in patients' staying in hospital for longer than was necessary.

We found at Hawthorne ICS, there was a lack of monitoring with regards to access to the building and staff were not using the personal alarms provided.

There were inconsistencies across teams regarding the completion of mandatory training and appraisals which was particularly low in some teams. This had been escalated onto the trust's risk register and there was an action plan in place to address this issue.

Most staff had not accessed training in the Mental Capacity Act 2005 as this was not compulsory although the trust had plans in place to ensure staff received this training. We found inconsistencies in staff understanding of the application of the MCA. In the case records we looked at we found evidence that capacity was considered and recorded. However, some documentation in relation to community treatment orders (CTOs) was not detailed enough.

Summary of findings

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

Are services safe?

Good

Overall, we found the service had effective systems in place to keep people safe. However, we did find at Hawthorne ICS that there was a lack of monitoring with regards to access to the building which could place staff or others at risk. We also found that staff were not using the personal alarm system at this location which meant there could be a delay in staff raising and responding to the alarm if an incident occurred.

The teams had sufficient numbers of staff to provide the care that patients needed, although case-loads of staff within the CMHT's had increased due to some staff leaving. The trust had developed an action plan to address this. This included the on-going recruitment of new staff. Staff told us this was effective and had improved this situation.

Overall, we found that patients risk assessments were comprehensive and holistic. Where a risk had been identified, there was a plan in place to reduce or manage the risk to make sure patients were safe. Staff were knowledgeable about their responsibilities regarding safeguarding and the process for reporting safeguarding concerns.

The number of incidents and safeguarding referrals which the service had made was within expectations when compared with similar services. Staff told us they received feedback from these and 'lessons learnt' to improve services.

We found inconsistencies across teams regarding the completion of mandatory training. This had been escalated onto the trust's risk register and there was an action plan in place to address this issue.

The service had a lone working policy and procedure in place which was reported by staff to be working well.

The teams had suitable arrangements in place for the management of medicines.

Are services effective?

Good

All the teams worked in line with the principles of the recovery model. This was evidenced by the teams' focus on supporting patients to remain within the community and facilitating the early discharge of patients from hospital.

The teams completed comprehensive assessments of patients' needs which included their social, occupational, cultural, physical and psychological needs and preferences. We found some good

Summary of findings

examples of how teams ensured the physical health care needs of patients were being met. For example; both of the AOT teams escorted patients to their general practitioner if required to ensure they received their annual health check.

The teams provided a range of activities and therapeutic interventions to patients to support their recovery in line with best practice guidance. There was good evidence of effective multi-disciplinary team (MDT) team working across the service. Teams had also developed good working relationships with third sector organisations.

Teams were committed to adhering to the 'least restriction principle' in line with the MHA Code of Practice. We did find that documentation in relation to CTO's was not detailed enough. Staff had not received training in the Mental Capacity Act (MCA). We found inconsistencies in staff understanding in the application of the MCA. The trust had plans in place to address this.

We found significant differences in the number of staff who had received a staff appraisal in the previous 12 months within the teams as per the trust's policy which the trust was aware of and addressing.

Are services caring?

Good

We held a series of focus groups and listening events prior to and during our inspection to gain feedback from patients and carers about their experiences of using the services. During this inspection, we spoke with 25 patients, four carers and reviewed the comment cards we received back from patients and carers. We also observed two handovers, three CPA/MDT meetings and one initial assessment of a patient.

All the feedback we received was very positive. Patients and carers all reported they were happy with the service they received and that staff treated them with respect and kindness.

We found good evidence within all the teams we visited of how staff had pro-actively involved patients and family members in all aspects of their care. From our observations, we saw that staff were sensitive and respectful of patients' wishes and were committed to providing personalised care based upon the needs of patients.

Are services responsive to people's needs?

Good

The trust had introduced a single point of access (SPA) into the service as part of the transformation of community services 12 months ago to improve response times to referrals. We found that services had good systems in place to triage patients' needs based upon their individual risks. This enabled the teams to prioritise response times based on patients' risks and needs. We found

evidence which demonstrated that the system was effective and responsive. As part of the transformation of CMHTs, the trust had implemented an 'ageless' service which was based upon providing care to meet patients' needs rather than being based on the patients' age. The CMHTs had split the teams into each of these pathways to enable staff to develop specialist skills and knowledge relevant to the pathway they were working with.

The patients CPA care co-ordinator remained consistent throughout the patient's admission and discharge from hospital. This meant that the discharge process was seamless and patients received continuity of care.

We found some good examples of how teams had worked pro-actively in providing a flexible approach to meet individual needs and promote access to the services. One team for example; met patients at a community based dementia café' as a social event to enable patients to access a nurse in a more informal, less stressful environment.

The teams had access to translators through a service called Language Link. Staff told us they could access leaflets in different formats and languages through the trust's diversity team if required.

Overall, staff we spoke with were able to explain the complaints procedure and action they would take in line with trust policy if someone wished to make a complaint.

Unlike in Leeds, the York services did not have intensive community support teams or liaison psychiatry service for older people which could result in patients' staying in hospital longer than was necessary.

Are services well-led?

Good

Despite some of the teams experiencing significant changes over the past year due to the transformation of community services which the trust had implemented; we found that morale among staff was high. Staff were positive about their experience of working within the teams and told us they felt supported by their colleagues and managers. All staff stated they felt able to raise concerns to their management team and were confident they would be listened to.

At a local level, we found staff were clear about the direction and vision of the team they worked in. However, some teams felt disconnected from the wider trust. The trust had implemented a range of initiatives to improve engagement with these teams to address this issue.

We found the teams were committed and motivated in improving their service through the process of clinical governance. The teams

Summary of findings

were at different stages of embedding this in clinical practice. The teams had established team meetings and supervision meetings in place to support them with this process. We found some good examples of how some teams had pro-actively sought feedback from patients, stakeholders and carers through the use of audit and used this information to improve services provided.

The teams were committed to developing and improving the service provided and we found some excellent examples of how they had achieved this through working with partnership organisations.

Summary of findings

Background to the service

Leeds and York Partnership Trust provide a range of community based services to patients within the Leeds and York catchment areas of the trust. The trust reviewed all of its community based teams 12 months ago as part of a transformation of community mental health services project. As a result of the project, the trust informed us that all the community based teams now provided an, 'ageless' service based on individual's needs rather than their age with the exception of the liaison psychiatry service for older people (LPSOP) based in Leeds .

These teams have not been inspected before by the Care Quality Commission. During our visit to the trust, we visited a sample of these teams. The teams we visited were;

Assertive Outreach Team (AOT)

The trust has two assertive outreach teams (AOT) based in York and Leeds which provide mental health services to patients. The AOT team is recovery orientated and offers intensive and longer term support tailored packages of care to patients who have struggled to engage with services. The service is available to people aged 18 or over and operates from 8.00am-8.00pm Monday to Friday and 9.00am-5.00pm on weekends and bank holidays.

Community Mental Health Team (CMHT)

The community mental health teams work with patients with a wide range of mental health difficulties and help patients to cope with periods of mental illness and severe distress. They offer support to those patients with a GP who require short term interventions alongside those requiring longer term care planning, supporting them to stay out of hospital where possible. The service is available to people aged 18 or over and operates Monday to Friday between 9am-5pm.

Intensive Community Service (ICS)

The trust has three ICS teams which are based in Leeds. The teams provide intensive short term crisis support for patients experiencing severe mental health problems who would otherwise be in hospital. The teams provide a service from 8am-9pm seven days a week. The teams aim to facilitate the early discharge of patients from hospital or prevent patients been admitted to hospital by providing either home or unit based support and treatment.

Liaison Psychiatry Service for Older People (LPSOP)

The team is based at St. James's Hospital in Leeds. It provides advice, training and support to teams within the acute hospital in relation to patients they are caring for who may have mental health problems and who are aged 65 years or over. The team carry out assessments and evaluations of patients who may have a mental illness and provide advice to staff about how best to meet the needs of patients during their stay in hospital and throughout the discharge planning process. The service operates between 9am-5pm seven days a week.

Our inspection team

Our inspection team was led by:

Chair: Michael Hutt, Chief Operating Officer, Cumbria Partnership NHS Foundation Trust

Team Leader: Jenny Wilkes, Head of Inspection – Hospitals Directorate (Mental Health), Care Quality Commission

The team included an inspection manager, a Mental Health Act reviewer, a pharmacist inspector and an analyst. We also had a variety of specialist advisors which included senior nurses, social workers, and senior managers.

Why we carried out this inspection

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

Summary of findings

How we carried out this inspection

During this inspection we spoke with 25 patients, four of whom we visited in their homes. We spoke with 50 members of staff from a range of disciplines and roles. We looked at 37 care records of which we case tracked seven.

We also spoke with four carers or relatives. We attended two handovers, three CPA/MDT meetings, one initial assessment of a patient, a clinical supervision session and one team meeting.

What people who use the provider's services say

We held a series of focus groups and listening events prior to and during our inspection to gain feedback from patients and carers about their experiences of using the services. During this inspection, we spoke with 25 patients, four carers and reviewed the comment cards we received back from patients and carers. We also looked at the results of some audits which the trust and teams had sent to patients and carers.

All the feedback we received was positive. Patients and carers all reported they were happy with the service they received and that staff treated them with respect and kindness.

Good practice

Staff within the assertive outreach teams escorted patients' to visit their general practitioner if required to ensure they received their annual health check.

Staff met patients at a community based dementia café as a social event to enable patients to access a nurse in a more informal, less stressful environment.

At Linden House, the team had established a specialist training link with Leeds bereavement forum specifically in relation to dementia.

In York, the CMHT's had developed excellent partnership working with York St John University through the, 'Converge' partnership. Converge provides support and access to courses specifically designed for people who use mental health services.

Areas for improvement

Action the provider MUST or SHOULD take to improve

Action the provider SHOULD take to improve

The trust should ensure effective monitoring arrangements are in place at Hawthorne ICS for people accessing the building.

The trust should ensure staff at Hawthorne ICS are using the personal alarm system provided.

The trust should ensure care plans for patients subject to community treatment orders (CTO) provide sufficient details about the conditions relating to the CTO and ensure consent to treatment forms are regularly reviewed and reflect current medication prescribed to patients.

The trust should ensure that staff receive mandatory training and appraisals as per trust policy.

Leeds and York Partnership NHS Foundation Trust

Adult community-based services

Detailed findings

Locations inspected

Name of service (e.g. ward/unit/team)	Name of CQC registered location
Assertive Outreach Team, Leeds	Trust Headquarters
Assertive Outreach Team, York	Trust Headquarters
Aire Court Intensive Community Service, Leeds	Trust Headquarters
Linden House Community Mental Health Team, Leeds	Trust Headquarters
Millfield House Community Mental Health Team, Leeds	Trust Headquarters
Hawthorne Intensive Community Service, Leeds	Trust Headquarters
South West Community Mental Health Team, York	Trust Headquarters
North East Community Mental Health Team, York	Trust Headquarters
Liaison Psychiatry Service for Older People, Leeds	Trust Headquarters

Mental Health Act responsibilities

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

Staff we spoke with understood their responsibilities with regards the Mental Health Act. However, we found examples at Millfield House and the AOT in Leeds where some care plans for patients' subject to community treatment orders (CTO) did not provide sufficient details about the conditions relating to the CTO and some consent to treatment forms were not in date. At Linden House, we found a risk assessment in one patient's record which did not indicate that the patient was subject to a CTO although staff confirmed they were.

Detailed findings

Mental Capacity Act and Deprivation of Liberty Safeguards

We found that most staff had not received training regarding the Mental Capacity Act (MCA) and Deprivation of Liberty Safeguards (DoLS) as this was not part of the mandatory training provided by the trust. The director of nursing told us that this would be incorporated within the mandatory training matrix. We found inconsistencies in staff understanding of the application of the MCA however, in the case records we looked at we found evidence that capacity was considered and recorded. Staff were aware that information was available on the trust website and how to access this.

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

Overall, we found the service had effective systems in place to keep people safe however; we did find at Hawthorne ICS that there was a lack of monitoring with regards to access to the building which could place staff or others at risk. We also found that staff were not using the personal alarm system at this location which meant there could be a delay in staff raising and responding to the alarm if an incident occurred.

The teams had sufficient numbers of staff to provide care patients needed although case-loads of staff within the CMHTs had increased due to some staff leaving. The trust had developed an action plan to address this which included the on-going recruitment of new staff. Staff told us this was effective and had improved this situation.

Overall, we found patients' risk assessments were comprehensive and holistic. Where a risk had been identified, there was a plan in place to reduce or manage the risk to make sure patients' were safe. Staff were knowledgeable about their responsibilities regarding safeguarding and the process for reporting safeguarding concerns.

The number of incidents and safeguarding referrals which the service had made was within expectations when compared with similar services. Staff told us they received feedback from these and 'lessons learnt' to improve services.

We found inconsistencies across teams regarding the completion of mandatory training. Attendance for safeguarding and the prevention and management of violence and aggression was particularly low in some teams. This had been escalated onto the trust's risk register and there was an action plan in place to address this issue.

The service had a lone working policy and procedure in place which was reported by staff to be working well.

The teams had suitable arrangements in place for the management of medicines.

Our findings

Safe and clean environment

The team locations we visited were clean and generally well maintained however; we found that Millfield House was in need of refurbishing. The manager informed us the trust had plans for the necessary work to be completed between October and December 2014.

The community mental health teams (CMHT) and assertive outreach teams (AOT) staff told us they generally visited patients within their own homes or an alternative community setting. The teams had rooms available at their team bases where they could see patients in private if required or for specific group activities. There were effective systems in place for monitoring and recording who was in the buildings at all times.

The intensive community service (ICS) provided support and treatment for patients at the team location. Patients could spend several hours at a time within these locations. At Hawthorne ICS, the building had three different doors in which access to the building could be gained. There was a board in reception which patients were expected to 'sign in' on upon their arrival. This area was not always supervised by staff. The building had several unlocked rooms which were not within sight of staff at all times. Due to the open nature of the building, it would not be possible for staff to be certain at all times who was in the building as anyone could access the building unsupervised. There were alarms in some of the rooms but not all of these were working. Staff told us they had been provided with two personal alarms which staff could use if they were using a room where the alarm did not work. The alarms were also to be used if staff were using a room that was isolated from the main hub which included the clinic room. However, staff on duty were not sure where the alarms were and told us they were never used. This meant there may be delays in staff receiving assistance in the event of an emergency which could place themselves or others at risk. The lack of an effective system for monitoring access to the building could also place staff or others at risk for instance in the event of a fire.

Good

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All the other teams we visited had alarm systems in place which staff could use to call for assistance if required. However, we were told by staff at York CMHT hub that the alarm system there was not reliable. The manager informed us this risk had been escalated onto the trust's risk register and that fob alarms had been ordered for staff to manage this risk.

The teams had suitable arrangements in place for the management of medicines. This included the receipt, storage, administration and recording of medicines.

All the teams had access to the necessary personal protective equipment to reduce the risk of infection. Training records showed that the majority of staff within the teams had completed mandatory training in infection control and prevention.

Safe staffing

The teams used a caseload management tool to establish caseload sizes for each member of staff in line with the trusts' 'caseload management tool' policy (2010). The policy described in detail the formula which should be used for caseload weighting which was risk based. This tool was used in practice to determine the number of patients each staff member should have on their caseload to enable them to effectively meet individual patient's needs.

We found in the assertive outreach teams that this tool was used effectively and caseloads were 'capped' to ensure they were manageable for staff.

However, staff within the CMHT's told us that their case loads had increased since the transformation of services from between 30-35 to over 50 in some cases. This figure is above the Department of Health 'Policy Implementation Guide' for CMHT's (2002) which recommends caseloads of no more than 35. Staff told us the increase in caseloads was largely due to some staff leaving during the transformation process.

In the York CMHT hub and Millfield House in Leeds, staff told us that many of the staff who had left the service since the transformation had worked in the older people's CMHT. This had left a deficit in staff who had the appropriate specialist skills and knowledge to deliver care and treatment to older patients. In response to this, the managers had undertaken a staff skills and training audit to identify what training was required to ensure that the teams were able to meet the needs of older patients.

This issue was recognised and acknowledged by the trust and had been placed on the trusts risk register with an action plan to address this deficit. The action plan included the on-going recruitment of new staff which staff reported was improving this situation. Managers told us staff skill mix was also considered as part of the recruitment of new staff to manage the deficit identified.

Each team had access to a consultant psychiatrist and approved mental Health professional (AMHP) when required. This meant that community staff had access to medical input and could access timely Mental Health Act assessments.

The trust may wish to note that the 'caseload management tool' policy (2010) required reviewing in July 2011.

Assessing and managing risk to patients and staff

The teams used a FACE risk assessment tool to identify patient risks. This assessment tool is nationally-accredited by the Department of Health. Overall, we found the risk assessments were comprehensive and holistic. They included the patients' risks to self, others and identified if they were at risk of exploitation or were vulnerable due to their mental health needs. Where a risk had been identified, we found good evidence that management plans, including relapse prevention plans, had been developed. There was evidence of family and patient involvement in developing these particularly in the AOTs. We did find some plans at Millfield House however, which were lacking in sufficient detail.

We looked at the training records of the teams in relation to clinical risk training provided by the trust. With the exception of York North East CMHT, where almost all of the team had completed this training (32 out of 35 staff completed), 50% or less of staff in the other teams had done so. The director of nursing told us that the training had been evaluated and reviewed in the last year and a new, 'bespoke' training was in the process of been rolled out to the teams as a result of the outcome of the evaluation.

Staff we spoke with were knowledgeable about their responsibilities regarding safeguarding. The trust's policies and procedures were accessible on the trust's own intranet site. Some staff gave examples of safeguarding concerns they had reported and described the process for completing this. Staff reported there were also good

Good

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relationships and accessibility to the police. They reported they had an opportunity to discuss safeguarding during multi-disciplinary team meetings and during supervision meetings with managers to share learning.

We observed a handover at York AOT during which a potential risk to a patient from their partner was identified and discussed within the team. A team decision was made to refer these concerns to the local safeguarding authority as per trust policy. The team agreed a plan to monitor the situation and minimise any potential risk to the patient. We looked at the staff safeguarding training matrix which the trust provided. With exception of the York North East and AOT teams, we found safeguarding training was poorly attended, with a third or more staff in the other teams not having completed this training.

The service had a lone working policy and procedure in place which was reported by staff to be working well. We saw the whereabouts of people recorded when out of office and the duty clinical lead was responsible for ensuring those out had returned safely. In the York hub, the teams had implemented a new tracking system for staff movement. This was developed to manage the whereabouts of staff from the five teams which had merged into one team to ensure staff safety whilst enabling staff to work flexibility due to the larger geographical location the team now covered. This included the duty clinical lead contacting staff if they were going straight home from their last visit of the day to make sure they were safe.

Staff told us they would undertake joint visits if a safety risk was identified. This could be a risk in relation to a patient or the location in which the visit was taking place. Consideration was also given to vehicle safety.

We looked at the staff, 'prevention and management of violence and aggression (PMVA) training matrix the trust provided. With the exception of the AOTs in York and Leeds, we saw that attendance at this training was low in all the other teams. The lowest figures were within the West North West team in Leeds with 19 staff out of 50 not being in date, York South CMHT where16 staff out of 52 had not completed and in the South Leeds CMHT where 16 staff out of 24 had not completed the training.

This meant that large numbers of staff within the service had not received the mandatory training required to equip them with the skills to safely 'breakaway' from a situation where there was an imminent threat to their personal safety.

Reporting incidents and learning from when things go wrong

Since 2004, trusts have been encouraged to report all patient safety incidents to the national reporting and learning system (NRLS) and since 2010, it has been mandatory for them to report all death or severe harm incidents to the CQC via the NRLS. An analysis of the number of incidents reported to the NRLS, against the number of incidents expected to occur at a trust, based on the number of bed days, can indicate any potential under-reporting. There were 10 incidents reported by the trust to the NRLS between April 2013 and March 2014 which had occurred within the CMHT's. This number is within expectations when compared with similar services.

Staff within all the teams were able to explain the procedure for reporting any incidents which may occur and their responsibilities in relation to reporting. The trust had a paper based reporting system for incidents. The director of nursing told us that the trust were in the process of implementing an electronic based system called 'Datix' trust wide. All incidents were signed off by a clinical lead before being submitted through the trust. A common theme staff reported was they did not have access to any aggregated information from incidents or safeguarding referrals they had made within the teams or directorate. This meant it was not possible for teams to gain an overview of these for analysis to identify any trends. The director of nursing told us the implementation of the Datix system would provide managers and teams with this information in 'real time'.

Staff told us they received feedback from incidents which had occurred trust wide through a new 'lessons learned' newsletter which they discussed within supervision, formulation and MDT's meetings. We found evidence that practice had changed within the teams in response to lessons learnt. For example; staff at Aire Court ICS told us they now proactively sought information and corroboration from family members where possible which was learning from a serious incident which had occurred within the trust.

Good

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One member of staff told us “I feel as a team and as an organisation, we are open and accept where we have issues. We do respond to incidents and share learning."

The trust had a ‘whistleblowing’ policy in place which staff were aware of. The policy provided detailed information to guide staff on how they could raise and escalate concerns within the trust anonymously if they wished to do so.

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

All the teams worked in line with the principles of the recovery model. This was evidenced by the teams focus on supporting patients to remain within the community and facilitating the early discharge of patients from hospital.

The teams completed comprehensive assessments of patient's needs which included their social, occupational, cultural, physical and psychological needs and preferences. We found some good examples of how teams ensured the physical health care needs' of patients were being met. For example; both of the AOT teams escorted patients to their general practitioner if required to ensure they received their annual health check.

The teams provided a range of activities and therapeutic interventions to patients to support their recovery in line with best practice guidance.

There was good evidence of effective multi-disciplinary team (MDT) team working across the service. Teams had also developed good working relationships with third sector organisations.

Teams were committed to adhering to the 'least restriction principle' in line with the MHA Code of Practice. We did find that documentation in relation to CTO's was not detailed enough.

Staff had not received training in the Mental Capacity Act (MCA). We found inconsistencies in staff understanding of the application of the MCA. The trust had plans in place to address this.

We found significant differences in the number of staff who had received a staff appraisal in the previous 12 months within the teams as per the trust's policy which the trust was aware of and addressing.

Our findings

Assessment of needs and planning of care

We looked at 37 care records across the service. We found that each patient had a comprehensive assessment completed as part of the assessment process which included patients' social, occupational, cultural, physical and psychological needs and preferences. The teams also used a range of multi-disciplinary assessment tools to assess patient's needs, monitor progress and promote their recovery. These included: Health of the Nation Outcome Scale (HoNoS) and a range of specific psychological assessments.

All the care records we looked at included a FACE risk assessment and relapse prevention plan. These plans provided specific details of interventions which should be put in place, if the patient's mental health deteriorated to prevent a relapse of their illness. A care plan was developed with the patient to meet their identified needs under the framework of the Care Programme Approach (CPA). This is a particular way of assessing, planning and reviewing someone's mental health care needs. The care plans we looked at were centred on the needs of the individual patient. The majority of patients we spoke with both within the focus groups and during our visit to the teams told us they had been involved in developing their care plans with staff.

We found evidence within the care records that patient's carers and advocates were involved as appropriate and according to the patient's wishes. Carers we spoke with confirmed this. We saw evidence to show that staff proactively engaged with carers by offering carers' assessments to identify carers' needs and assist them to access any support they may need.

Best practice in treatment and care

We found evidence which demonstrated the teams had implemented best practice guidance within their clinical practice. This included the establishment of new groups to promote the implementation of the National Institute of Clinical and Health Excellence (NICHE) guidance for the psychological treatment of a range of mental illness conditions such as psychosis, depression, anxiety and bipolar disorder. The teams also provided a range of activities and therapeutic interventions to patients to support their recovery. These included both group and individual interventions.

The assertive outreach teams had undertaken an audit to measure the frequency and duration of admissions to hospital for patients both before and after they had received input from their teams. The results of the audit showed a reduction in both the frequency and duration of

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.

admissions to hospital for patients who received care from the AOT teams. This reflected findings for the trust from the Information Centre for Health & Social Care (ICHS), which measured how the trust compared with similar trusts in relation to re-admission rates within 30 days of discharge. The latest figures for November 2012 to October 2013 showed that the trust had lower than expected re-admission rates in comparison to similar trusts. Information from the Department of Health, Mental Health Minimum Data Set (MHMDS) for November 2012 to October 2013 also showed that the percentage of readmissions within 7 days of discharge and the rate of Community Treatment Order recalls to hospital were both within expectations in comparison to similar trusts. Information provided by the National Health Service Litigation Authority (NHSLA) regarding incident reporting by the trust between these dates assessed there was no evidence of risk in relation to reporting by the trust. This indicated there was no impact on risk in relation to patients being discharged early from hospital or provided with alternative services to admission.

One carer of a patient who received services from the AOT at York contacted us during our inspection to tell us "I have no doubt that the support that my brother receives from this team has enabled him to continue to live in his own home and that, were he to relocate, it would be unlikely that he would receive a better standard of service."

We found some good examples of how teams ensured that the physical health care needs' of patients were being met. For example, both of the AOT teams escorted patients to their general practitioner if required to ensure they received their annual health check. They had an effective system in place to ensure these appointments were not missed; and at Millfield House, the team had implemented a new nutritional tool to identify patients' needs as part of the assessment process.

The consultants from the CMHTs and AOTs retained responsibility for patients who were prescribed high doses of anti-psychotic medication in line with best practice rather than their care being transferred to the patients' GP.

Skilled staff to deliver care

The teams operated within a multi-disciplinary team (MDT) framework. There was good evidence of effective MDT team working within the service which included input from nurses, health care support workers, social workers, medical staff, occupational therapists and psychologists. Teams could also access a pharmacy when required. At Linden House, the team had access to nurse prescribers which reduced the time patients had to wait for their medication. The team had also established a specialist training link with Leeds bereavement forum specifically in relation to dementia.

One member of staff told us they had recently been employed by the trust and completed an induction. They described it as a "strong induction which covered what was expected and was linked to best practice."

Although we found that not all staff had attended the mandatory training required based upon the information the trust provided, staff did tell us that they were supported by their managers to access a range of training to meet the needs of patients. This included some staff accessing training in psycho-social interventions and dual diagnosis training at the University of York.

One consultant psychiatrist we spoke with told us that training for medical staff was supported and promoted by the trust. Other medical staff we spoke with confirmed this. This is reflected in the outcome of a survey conducted by the General Medical Council in 2014 which assessed the trust's performance against a range of quality measures regarding training medical staff received which showed no evidence of risk.

We did however find significant differences in the number of staff who had received a staff appraisal in the previous 12 months within the teams as per the trust's policy based on data which the trust provided. Figures showed that all the staff within the liaison psychiatry for older people's team had received an appraisal within the last 12 months. In York North East team and York assertive outreach team (AOT); over 75% of staff were in date with their appraisals. In the South intensive support team (IST) and Leeds AOT over 64% had received an appraisal. However, figures for the other teams with the exception of the East North East ICS; were between 53%-57%. We were concerned that the figure for the East North East ICS was 4%. The trust was aware that the figure for appraisals was lower than expected and this had been escalated to the trust's risk register. An action plan had been put in place to address this issue which was being monitored by the board on a monthly basis so we were assured that the trust was addressing this issue.

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Multi-disciplinary and inter-agency team work

We observed handovers, a clinical supervision session and MDT meetings in some of the teams. These were all well planned, structures and organised. Each patient currently receiving care was discussed, including any new referrals for follow up. We observed appropriate sharing of information to ensure continuity and safety of care.

The CMHTs held weekly formulation meetings to discuss cases in addition to weekly MDT meetings whereas the AOTs met daily. Some teams had recently had an increase in the psychological input they received from psychologist to assist with formulations. One health care support worker (HCSW) at Linden House told us, "The formulation meeting on a Wednesday is a real opportunity and everyone is heard including HCSW's."

We found some good examples of how the teams worked closely with other teams to support patients both within and outside of the trust. The teams worked closely with the wards to facilitate the discharge of patients and to support patients who were admitted from their caseload. At Linden House, we found examples of how the team had remained actively involved in supporting patients if they were admitted to the acute general hospital and throughout their discharge process.

The teams had developed effective relationships with the local police, substance misuse service and a range of third sector providers. We spoke with a St Anne's worker from the harm reduction service who stated they felt part of the AOT team.

We found evidence of some excellent close working and communication with GP's within the teams. This included informing GP's of outcome of reviews at Linden House memory service and changing the way the teams recorded discharge information for GP's. This change was made in response to the outcome of a survey which the team had sent to GP's from feedback about the service.

Adherence to the MHA and the MHA Code of Practice

All the teams visited provided care and treatment to patients which was underpinned by the principles of the recovery model. Teams were committed to adhering to the 'least restriction principle' in line with the MHA Code of Practice. In the care records we looked at, we found examples of risk assessments and care plans in relation to patients subject to community treatment orders (CTO) at Millfield House, Linden House CMHT and the Leeds AOT, which either did not indicate the patient was subject to a CTO or did not detail the conditions which were stipulated within the CTO. This is important as a breach in the conditions stipulated within a patient's CTO could mean that they are liable to be recalled back to hospital. It is therefore imperative that staff providing care and treatment to a patient subject to a CTO are aware of the conditions stipulated within the order as these may influence the care they should receive.

Patients on a CTO require a legal form completing to receive medication for a mental disorder. At Millfield House, we found two patients CTO records which were not in date with the medication these patients were prescribed. This meant that staff were administering medication to these patients without the authority to do so.

Good practice in applying the MCA

We found that most staff had not received training regarding the MCA and DoLS as this was not part of the compulsory training provided by the trust. The director of nursing told us that this had been discussed in the trust's Mental Health Act Committee and it had been agreed that this training would be incorporated within the mandatory training matrix. We found inconsistencies in staff understanding of the application of the MCA. In the care records we looked at, capacity was considered and recorded. Staff were aware that information was available on the trust website and how to access this.

One carer of a patient who received care from the AOT at York contacted us during the inspection to tell us they had concerns about their relatives' capacity to make competent financial decisions which resulted in the granting of a deputyship for the management of their finances. They told us that throughout this process, the issues were discussed with family members to endeavour to obtain the best result for their relative.

Good

Are services caring?

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

Summary of findings

We held a series of focus groups and listening events prior to and during our inspection to gain feedback from patients and carers about their experiences of using the services. During this inspection, we spoke with 25 patients, four carers and reviewed the comment cards we received back from patients and carers. We also observed two handovers, three CPA/MDT meetings and one initial assessment of a patient.

All the feedback we received was very positive. Patients and carers all reported they were happy with the service they received and that staff treated them with respect and kindness.

We found good evidence within all the teams we visited of how staff had pro-actively involved patients and family members in all aspects of their care.

From our observations, we saw that staff were sensitive and respectful of patient's wishes and were committed to providing personalised care based upon the needs of patients.

Our findings

Kindness, dignity, respect and support

Patients and carers told us they were happy and satisfied with the care they received.

At Millfield, one patient said "I can't speak highly enough about the team. I am a completely different person. I can tell them anything and not feel stupid; they have given me so much help." Patients' told us they received personalised care and were treated with respect and dignity by staff. We observed caring staff/patient interactions throughout our visits to all the teams. We saw that interactions with patients were focussed on patients' needs and not task orientated.

One patient receiving care from the AOT told us, "Staff are always polite and treat me with respect. They understand my needs." Another patient who was subject to CTO told us, "I don't really agree with the doctor but I accept we all have different ideas. If I was unhappy, I would tell staff to their face."

During our visit to the teams, we left comment cards for carers and patients to leave feedback. All the comments we received were positive. Comments made included:

"I have been treated with dignity and respect and care. I was given the right care and treatment."

"I cannot fault the service. It's really helps in maintaining a decent quality of life."

"Always feel listened to. Services are very good. People are kind and welcoming."

Comments patients who used the intensive support services included:

"It's the best thing since sliced bread. The service and staff are good".

"The service is very excellent and the staff are very helpful but are overworked"

"Very good all round".

"Staff could not be more helpful"

"Have not been here long but find it very relaxing and the staff all first class"

"Patients treated with Dignity & Respect".

The involvement of people in the care they receive

We reviewed information about the teams from the Care Quality Commission (CQC) Community Mental Health Patient Experience Survey 2013. 250 respondents had completed the survey. One result from the survey was that 50% of respondents stated that in the preceding 12 months; they had not had a care review meeting to discuss their care. This was against an expected rate of 38.3% and not in line with Department of Health Guidance 'Community Mental Health Teams' (2002). The trust had flagged this as a risk. The majority of patients we spoke with however, told us they had been involved in reviews about their care.

We found evidence the service proactively involved patients and their carers in the care they received. During our visit to Linden House, we observed an initial assessment of a patient who had been referred to the service. We saw the assessment was carried out in

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collaboration with the patient and included their physical, psychological, social and cultural needs. The assessor was sensitive and respectful of the patient's wishes throughout the assessment.

At Linden House; we found good evidence of how staff had involved patients and family members in their care. This included discussing the outcome of assessments with patients' and treatment options. In the York CMHT, the team has developed a carer lead for older people and one for adults to promote engagement with patient's families and carers. The team also explained how they were raising the profile of the trust' service user network in York to ensure patients' views were represented in York at this forum as it was predominately attended by patients from Leeds.

The liaison psychiatry for older people team had undertaken an audit to obtain feedback about the service from patients and their carers between 27th June and 24th July 2014. Respondents were asked to rank the service on a scale of 1 to 10 with 10 being the highest score. The mean score was 8.46 which indicated that patients' and their carers' had high satisfaction levels with the service and care provided. One carer had commented "It was such a useful meeting; it is nice to know what is going on with my mum. Staff are so friendly and supportive."

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

The trust had introduced a single point of access (SPA) into the service as part of the transformation of community services 12 months ago to improve response times to referrals. We found that services had good systems in place to triage patients' needs based upon their individual risks. This enabled the teams to prioritise response times based on patient's risks and needs. We found evidence which demonstrated the system was effective and responsive.

As part of the transformation of CMHTs; the trust had implemented an 'ageless' service which was based upon providing care to meet patients' needs rather than being based on the patients' age. The CMHTs had split the teams into each of these pathways to enable staff to develop specialist skills and knowledge relevant to the pathway they were working with.

The patients CPA care co-ordinator remained consistent throughout the patient's admission and discharge from hospital. This meant that the discharge process was seamless and patients received continuity of care.

We found some good examples of how teams had worked pro-actively in providing a flexible approach to meet individual needs and promote access to the services. One team for example, met patients at a community based dementia café' as a social event to enable patients to access a nurse in a more informal, less stressful environment.

The teams had access to translators through a service called Language Link. Staff told us they could access leaflets in different formats and languages through the trust's diversity team if required.

Overall, staff we spoke with were able to explain the complaints procedure and action they would take in line with trust policy if someone wished to make a complaint.

There was inequity between the services provided in Leeds and York. The York services did not provide intensive community support services or liaison psychiatry service for older people which could result in patient's staying in hospital longer than was necessary.

Our findings

Access, discharge and bed management

The trust introduced a, 'single point of access' (SPA) point for all new referrals into the service as part of the transformation process 12 months ago. The SPA team reviewed each new referral based upon the information they received and assessed which service was the most appropriate to meet the patients needs'. The SPA team used a red (emergency), amber (urgent) and green (routine) RAG matrix rating system to triage each referral made to the service. We found evidence which showed that patients referred to the CMHT, who had been triaged as needing to be seen in one to seven days, were seen within 48 hours. The CMHTs had allocated assessment slots for new referral assessments each week. In the York team, staff told us this had been increased to 19 per week due to an increase in demand. This demonstrates that staff were responsive to urgent calls and were able to prioritise their work accordingly. Less urgent referrals were seen within the 14 day timescale for assessment. The community mental health teams (CMHT) were set a target by Leeds commissioners in 2013/2014 and 2014/2015 for 60% of referrals to be seen in 14 days over a quarter. The teams were meeting this target with the last reported compliance for Q4 13/14 being 61.8%.

However; some patients and carers did express concerns about the reduction in community based locations which meant they had difficulty accessing services. For some patients, this meant they now had to use several buses to access their nearest CMHT.

All staff we spoke with told us that since the introduction of the SPA, response times to referrals had improved. Patients we spoke with told us they did not have any problems contacting the teams when they needed to. One patient who received services from AOT told us, "I know how to contact the team if I need to. There is usually always someone available."

In the liaison psychiatry team for older people; the number of referrals to the service had increased significantly from since 1999 when the team was established. In 1999, the team received 210 referrals and in 2012, this had increased to 1,600. 67% of referrals were seen by the team within one working day of referral. The majority of the rest of the

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referrals were seen within three working days. The team had expanded to provide a service from five days a week to seven days a week in 2011 in response to the increase in demand for the service.

It is a requirement that patients discharged from hospital who are subject to CPA should receive a follow up within 7 days of their discharge. The information the trust provided showed that 95% of patients discharged received a follow up within 7 days.

The trust had three bed managers who had responsibility for reducing the number of patients who were classed as 'delayed discharges' from the wards. All the teams we visited had developed strong links with the acute wards and bed managers which included weekly or daily bed review meetings to make sure that patients' were discharged from hospital as soon as they were assessed as clinically appropriate for discharge. Aftercare support for patients' was determined and agreed through the CPA process which included attendance from the patients' CPA care co-ordinator. The patients' CPA care co-ordinator remained consistent throughout the patient's admission and discharge from hospital. This meant that the discharge process was 'seamless' and patients' received continuity of care.

Policies and procedures minimise restrictions

All the teams had a philosophy which was based upon the principles of the recovery model. This meant that the teams focussed on assisting patients to remain within the community and avoid admission to hospital where possible. The ICS teams also facilitated the early discharge of some patients from hospital by offering them intensive support during the transition from hospital to the community to reduce the risk of them relapsing whilst promoting their recovery.

Meeting the needs of all people who use the service

Since the transformation of CMHTs which resulted in the teams providing an 'ageless' service, the teams had developed two distinct care pathways to meet the needs of all patients. One pathway was for patients' diagnosed with a common mental health or psychosis type illness whilst the other was for patients' with a cognitive and/or dementia related illness. The CMHTs had split the teams into each of these pathways to enable staff to develop specialist skills and knowledge relevant to the pathway they were working with.

Unlike Leeds, the York services did not have intensive community service's (ICS) or a liaison psychiatry service for older people. This meant that patients in York were unable to access ICS as an alternative to hospital admission or to facilitate their early discharge from hospital. This could result in patients' spending longer than was necessary in hospital.

Staff at York CMHT's hub told us the team base was not accessible for some patients with mobility needs due to the number of steps to access the base. They told us that the teams were flexible and offered appointments at home to any patients who could not attend the base to ensure their needs were being met.

The teams had access to translators through a service called Language Link. Staff told us they could access leaflets in different formats and languages through the trust's diversity team if required.

We were told by staff that the teams had developed good links with GP's in relation to supporting university students; many of whom were living away from home for the first time and were more likely therefore to have less direct support from their families.

At Linden House, staff told us they often arranged to meet patients at a local dementia café as a social event to enable patients to access a nurse in a more informal, less stressful environment. One carer we spoke with who accessed the café described it as, "A lifeline which provides support, social contact, a carer network and information sharing between carers." The team had also developed a range of leaflets for patients in addition to verbal information to overcome issues patients may have retaining information due to their cognitive impairment and memory loss.

We found good evidence that teams were flexible in meeting patients' needs. One patient told us the team at Linden House had agreed with their request to retain their care co-ordinator there even though their care had been transferred to a different CMHT.

Listening to and learning from concerns and complaints

The majority of patients we spoke with were aware of how to make a complaint and told us they would feel confident in doing so. Overall, staff we spoke with were able to explain the complaints procedure and action they would

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take in line with trust policy if someone wished to make a complaint. They told us that where possible, they would try to resolve the complaint locally but if this was not possible or appropriate; they would escalate it to their team manager.

All the teams we visited were aware of the patient advice and liaison service (PALS) and worked closely with the team. We saw that leaflets were available for patients regarding PALS, advocacy and how to make a complaint.

Staff told us that complaints were discussed at their team meetings so they could share learning locally within the team.

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

Despite some of the teams experiencing significant changes over the past year due to the transformation of community services which the trust had implemented, we found that morale among staff was high. Staff were positive about their experience of working within the teams and told us they felt supported by their colleagues and managers. All staff stated they felt able to raise concerns to their management team and were confident they would be listened to.

At a local level, we found staff were clear about the direction and vision of the team they worked in however; some teams felt a disconnect from the wider trust. The trust had implemented a range of initiatives to improve engagement with these teams to address this issue.

We found the teams were committed and motivated in improving their service through the process of clinical governance. The teams were at different stages of embedding this in clinical practice. The teams had established team meetings and supervision meetings in place to support them with this process. We found some good examples of how some teams had pro-actively sought feedback from patients, stakeholders and carers through the use of audit and used this information to improve services provided.

The teams were committed to developing and improving the service provided and we found some excellent examples of how they had achieved this through working with partnership organisations.

Our findings

Vision and values

All the teams we visited provided services based upon the principles of the recovery model which was in line with the trust vision and values. Staff we spoke with were clear about the vision and direction of the service they worked in at local level. However, we found there was a disconnect in most of the teams we visited in relation to how the trust visions and values linked into those at local level. This was particularly apparent within teams which were geographically isolated or 'stand-alone' services. Staff at these teams reported they felt the board was not visible. However at other teams, staff were able to give us examples of how the board including the chief executive officer (CEO) had visited their team as part of the trust's initiative 'Getting to know you'. This included members of the board informally meeting staff within their teams. One health care support worker told us they had recently sat with the CEO over a coffee and felt able to discuss openly issues they wished to raise. They told us they had felt listened to by the CEO.

Some staff told us they did not always feel involved in decisions which were made at strategic level. The trust staff survey results in May 2013 found that 50% of staff did not feel included in decisions. In response to this, the trust had launched the 'Your voice counts' initiative as a way of providing staff with an opportunity to feedback to the trust on issues they wished to comment on. Staff we spoke with were aware of this initiative and felt the trust were moving in the 'right direction' in relation to engaging and listening to staff.

The trust had provided staff coaching in September 2013 for staff involved in the York community mental health services re-design project. This involved holding engagement days and monthly coaching sessions to support staff. Staff we spoke with told us they had found this useful and supportive.

Good governance

Senior managers and clinical leads we spoke with during a focus group we held told us they had worked hard with the trust over the previous 12 months developing the new governance structure from their level to the trust board which included the appointment of key senior staff. Without exception, they all told us this structure was now embedded and they were now focussing on developing and improving the governance structures from their level to the teams.

This had involved team managers organising away days for teams to provide staff with an opportunity to discuss how they could develop their service and improve quality. These had open agendas so all staff could be involved and share their ideas.

At York CMHT, we attended the team's first governance team meeting. This was well organised and covered appropriate governance issues relevant to the service. The team had developed work streams when the teams had

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amalgamated to look at specific issues they had identified as in need of reviewing such as 'informed consent and choice' and 'health and safety'. However, we were informed that data from these works streams had not all been collected and analysed yet. This meant it was difficult to determine the effectiveness of the work streams or the impact these had on improving practice.

There were regular meetings for managers to consider issues of quality, safety and standards. This included oversight of risk areas in the service such as incidents. These were being monitored regularly by senior staff in the service. The teams received action plans in relation to lessons learnt regarding serious incidents and formal complaints which had occurred within the trust. However, most staff within the teams told us they did not have access to any aggregated information from incidents, complaints or safeguarding at team or directorate level. Staff in some teams also told us they did not always receive feedback from these incidents. This meant it was not possible for them to gain an overview of these for analysis to identify any trends. The trust was in the process of implementing a Datix electronic reporting system which will enable teams to access this information in real time. The trust was also introducing quality dashboards for teams which included information regarding other quality indicators such as staff sickness rates, mandatory training compliance and appraisals however, this had not been embedded in all the teams we visited.

Although all the teams held regular team meetings and supervision where governance issues were discussed there was not a strategic agenda for these meetings. This meant that there was no consistency across the service regarding the content of the meetings which could result in important information not been disseminated to all staff.

We found differences across the teams in relation to mandatory training staff had completed. Some teams had a system in place which flagged when mandatory training was due to expire however, this practice was not shared across all teams.

Leadership, morale and staff engagement

At a local level staff were positive about their experience of working within the teams and told us they felt supported by colleagues and their managers. All staff stated they felt able to raise concerns to their management team and were confident they would be listened to. Both the AOT teams described morale and leadership within their teams as being "Excellent."

At Linden House, one new member of staff described the team as "Up-beat and wanting to do their best."

Some staff in York CMHT reported that staff morale had been low due to the transformation which led to some staff leaving. This resulted in staff having higher case loads and some staff feeling a sense of loss of recognition of their specialisms. We were told this had improved over recent months with the recruitment of new staff and the implementation of the new care pathways.

Without exception, we found all staff we spoke with to be committed, highly motivated and proud of their work and the teams they worked within. All staff told us they felt confident raising any concerns they may have with their manager and were confident they would be listened to and acted upon appropriately.

Commitment to quality improvement and innovation

We found the teams were motivated in developing and improving their services and found some good examples of how they had achieved this. The Memory Services in Leeds had successfully completed the 'Memory Service National Accreditation Programme (MSNAP) which was valid until January 2016. The service had also met the Commissioning for Quality and Innovation (CQUIN) targets set by commissioners in 2013-2014.

In York, we found the teams had developed excellent partnership working with York St John University through the 'Converge' partnership. Converge provides support and access to courses specifically designed for people who use mental health services.

The team had also undertaken an audit in June 2014 which surveyed local GPs to gain their views on the quality of communication between the CMHT and GPs. The audit included whether GPs thought the quality of discharge summary information and frequency of communication was adequate. The results showed GPs were generally satisfied with the current standard and frequency of communication they had with the teams. However; they feedback that the patients medication and their monitoring responsibilities as GPs was not always recorded on the discharge summaries. Analysis by the team showed

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that where a doctor had not been involved in writing the discharge summary; it was more likely that these issues were not included. The team devised an action plan which included CMHT staff ensuring that a doctor was always involved in writing discharge summaries where patients were prescribed medication to improve this. The results of the audit and action plan were discussed with staff in their team meetings.

The liaison psychiatry for older people's team had undertaken a survey to gain feedback from patients' and their carers' in June to July 2014. Overall, feedback from the survey was positive however, the survey highlighted that patients' did not always receive written information regarding their condition. The team told us they were considering this feedback and action to improve the provision of information in response to this feedback.

These examples demonstrate the service pro-actively seeks information from patients', stakeholders' and carers' to continuously improve the services provided.

Compliance actions

Action we have told the provider to take

The table below shows the essential standards of quality and safety that were not being met. The provider must send CQC a report that says what action they are going to take to meet these essential standards.

Enforcement actions

Action we have told the provider to take

The table below shows the essential standards of quality and safety that were not being met. The provider must send CQC a report that says what action they are going to take to meet these essential standards.