Requires Improvement

Sheffield Health and Social Care NHS Foundation Trust

Community-based mental health services for adults of working age

Quality Report

Fulwood House
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South Yorkshire
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Date of inspection visit: 27- 31 October and 12 November 2014
Date of publication: 09/06/2015

Locations inspected

Name of CQC registered location	Location ID	Name of service (e.g. ward/ unit/team)	Postcode of service (ward/ unit/ team)
Fulwood House	TAHXK	North Locality Community Mental Health Team	S5 8BE
Fulwood House	TAHXK	South East Locality Community Mental Health Team	S12 4QN
Fulwood House	TAHXK	South West Locality Community Mental Health Team	S11 9AR
Fulwood House	TAHXK	West Locality Community Mental Health Team	S6 1LX

Summary of findings

Fulwood House	TAHXK	Sheffield Assertive Outreach Team (SORT)	S3 7EZ
Fulwood House	TAHXK	Liaison Psychiatry Service for Adults	S5 7AU
Fulwood House	TAHXK	Out of hours duty team	S3 7EZ

This report describes our judgement of the quality of care provided within this core service by Sheffield Health and Social Care 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 Sheffield Health and Social Care NHS Foundation Trust and these are brought together to inform our overall judgement of Sheffield Health and Social Care 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	Requires Improvement 
Are community-based mental health services for adults of working age safe?	**Requires Improvement** 
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?	**Requires Improvement** 
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

Community mental health teams had sufficient numbers of staff to provide the care that people needed during the daytime; with large multi-disciplinary community mental health teams and an effective assertive outreach team. However the resource of staffing at night time to manage the out of hours and crisis demands meant that out of hours provision was not fully safe or responsive to people's needs. There were no overall systems to record how the limitations on the out of hours service impacted on patient care to monitor its' responsiveness. There were a number of pressures within the community mental health teams. These included staff managing higher and complex caseloads in some cases, staff covering the caseloads of vacant posts and colleagues who were off sick, waiting times for access into community mental health services, staff morale, reported stress sickness and vacancies within certain CMHTs.

Teams worked within the principles of the recovery model to aid people's recovery from mental ill health or severe distress. Effective care plans were in place to support people. Staff were well supported with appropriate training and supervision. New staff were well supported in their induction. There was very good multi-disciplinary working with visible consultant psychiatrist and psychology input within the teams. The service adhered to the Mental Health Act Code of Practice in relation to community treatment orders in most cases. On occasions the conditions of the community treatment orders stated that the patient must accept treatment when community patients cannot be compelled to take treatment in the community. There were a small number of examples where there were delays in providing people on a CTO with their rights whilst subject to conditions in the community.

Staff were committed to providing a high quality service to people in the community. Positive comments were received from patients. There were innovative service user involvement initiatives to facilitate patients to comment on community mental health services. Complaints were responded to appropriately.

There was a commitment to provide high quality care in line with the trust's stated values and strategy. Morale in most teams was largely good despite the significant changes following integrated working and challenges of working within areas of significant need and deprivation.

In conclusion, community services for adults were effective, caring and well-led. We identified good practice in relation to service user involvement and effective multi-disciplinary working. However the trust needs to improve the overall safety and responsiveness of the community mental health services for adults.

Summary of findings

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

Are services safe?

Requires Improvement

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

Community mental health teams (which incorporated the crisis team function) had sufficient numbers of staff to provide the care that people needed during the daytime; with large multi-disciplinary community mental health teams and an effective assertive outreach team. The resource of staffing at night time to manage the out of hours demand including the crisis function consisted of no more than two workers which had temporarily increased to three workers across Sheffield city wide. This meant that that four community mental health teams (some with over 50 staff within them) handed over to a very small number of staff in the out of hours team which could not always meet the demands placed upon it. People in mental health crisis in Sheffield at night did not therefore have timely access to professional input by staff within the trust with the exception of those people assessed as requiring a Mental Health Act assessment.

There were a number of pressures within the community mental health teams. These included:

- some staff managing higher and complex caseloads with people being managed with significant acuity and co-morbidity issues,
- staff covering the caseloads of vacant posts and colleagues who were off sick,
- waiting times for access into community mental health services
- staff morale within certain CMHTs
- appropriately managing the reported levels of stress and sickness within certain CMHTs
- addressing vacancy rates.

Some teams were monitoring and managing these pressures better than others.

The offices within the community mental health teams provided an appropriate environment to base community mental health teams. Where teams were visiting people at home, teams were aware of the risks and adapted the way they worked. Patient's risk assessments were well completed and up-to-date. Where risks were identified, there were plans in place to reduce or manage the risk. This meant that staff within the community mental health teams did what they could to keep people safe. Staff within the assertive outreach team were managing a number of complex cases well; many of which had a significant forensic history.

Summary of findings

Staff were knowledgeable about their responsibilities regarding safeguarding and the process for reporting safeguarding concerns.

Staff had the opportunity to have debriefing following significant incidents with psychologists based within the teams to help ensure that incidents were understood and lessons learnt from them.

Are services effective?

Good

We rated community based mental health services for adults of working age as good because:

Teams worked within the principles of the recovery model to aid people's recovery from mental ill health or severe distress. Records showed that people had comprehensive assessments of patients' needs which included their social, occupational, cultural, physical and psychological needs and preferences. There were effective care plans in place to support people.

Staff were well supported with appropriate training and supervision. New staff were well supported in their induction.

There was very good multi-disciplinary working with visible consultant psychiatrist and psychology input within the teams. Teams worked using a fully integrated health and social care model within which for example, nurses were employed as Approved Mental Health Professionals. We found the service adhered to the Mental Health Act Code of Practice in relation to community treatment orders in most cases. On occasions the conditions of the community treatment orders stated that the patient must accept treatment when community patients cannot be compelled to take treatment in the community. There were a small number of examples where there were delays in providing people on a CTO with their rights whilst subject to conditions in the community.

People using the community mental health services had a high degree of autonomy and independence to determine aspects of their daily lives. Staff understood the process to follow should they have had to make a decision about or on behalf of a person lacking mental capacity to consent to proposed decisions, in accordance with the Mental Capacity Act (2005).

Are services caring?

Good

We rated community based mental health services for adults of working age as good because:

Staff were committed to providing a high quality service to people in the community. Positive comments were received from patients.

There were innovative service user involvement initiatives to facilitate patients to comment on community mental health

Summary of findings

services, including the employment of peer workers, service users involved in interviewing community staff and other initiatives that took into account the populations that the community mental health teams worked within.

Are services responsive to people's needs?

Requires Improvement

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

The trust did not have fully responsive out of hours crisis services. The resource of staffing at night-time to manage the out of hours and crisis demands meant that out of hours provision was not fully responsive to people's needs. There were no overall systems to record how the limitations on the out of hours service impacted on patient care to monitor its' responsiveness, for example, the delays in responding to telephone calls, the numbers of patients that had to be sent to accident and emergency and the occasions when the office was unstaffed due to out of hours staff having to attend a Mental Health Act assessment.

In some teams there were delays in people waiting to receive a proper service – for example some people were waiting many weeks before they received a routine assessment and started to receive a service once they had been accepted for a non-urgent assessment into the service.

All the community based teams now provided integrated services with community mental health teams (CMHT) covering a range of functions which included assessment into the CMHT, recovery based CMHT work, early intervention services (EIS) and crisis resolution and home treatment teams. This meant that people were managed within the same service and where possible by the same worker to ensure consistent and responsive care. Staff worked flexibly to meet needs which meant that people's needs were considered holistically. People received support to fully aid recovery. Staff within the services recognised that the early intervention service was not as well developed as it could be and were looking to introduce specialisms within some teams to address this.

Staff triaged referrals into the service using a traffic light system to manage and prioritise assessments.

We saw that complaints were well managed. One community mental health team had a higher number of complaints but when we looked at these there were no significant concerns about service quality overall. The complaints within each service were looked into and responded to. Where complaints were not upheld, frequently the complaint would still look at in order to establish what could be learned or improved.

Summary of findings

Are services well-led?

Good

We rated community based mental health services for adults of working age as good because:

There was a commitment to provide high quality care in line with the trust's stated values and strategy. Morale in most teams was good despite the significant changes following integrated working and challenges of working within areas of significant need and deprivation.

Staff in most teams were positive about their experience of working within the trust. Staff felt supported by their colleagues. Senior Practitioners worked within the team, as did managers. Staff in most team felt able to raise concerns to their management team and were confident they would be listened to.

Teams were committed to developing and improving the service provided. In some cases this could be improved further through ensuring that appropriate action was taken following local audits.

Summary of findings

Background to the service

Sheffield Health and Social Care NHS Foundation Trust provided a range of community based mental health services to adults of working age within Sheffield. The community mental health teams work with people with a wide range of mental health issues and supported people to cope with periods of mental ill health and severe distress. They offered support to people who required short term interventions alongside those requiring longer term care planning, supporting them to stay out of hospital wherever possible. The community mental health team service was available to people aged 18 or over and operated Monday to Friday between 8.00am-6.00pm, with the service between 6.00pm and 8.00pm provided through a duty rota amongst the CMHTs.

Since late 2011, the trust reviewed all of its community based teams as part of a reconfiguration of community mental health services. This meant that eight community mental health teams that worked in Sheffield became four separate teams in the south east, south west, north and west of the city. All the community based teams provided an integrated service with community mental health teams (CMHT) covering a range of functions which included:

- the core function of a CMHT supporting people with mental health issues to be treated in the community and to recover from their mental ill health
- early intervention services (EIS) for people under 25 with a diagnosis of severe and enduring mental health needs and
- crisis resolution and home treatment teams which provided short term work to help support people at home when in mental health crisis and support with earlier discharge from hospital. 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

The trust also operated an Assertive Outreach Team (AOT) – which is a recovery orientated service providing intensive and longer term support and tailored packages of care to patients who have struggled to engage with services. The service was available to people aged 18 or over and operated from 8.00am-8.00pm seven days a week.

There was also a Liaison Psychiatry Service for Adults. The team were based at the Northern General Hospital in Sheffield. Staff in this service provided advice, training and support to teams within the acute hospital in relation to patients they were caring for who may have had mental health problems. The team carried out assessments and evaluations of patients who may have had a mental illness. The service provided advice to staff about how best to meet the needs of patients during their stay in accident and emergency or on the wards of the general hospital and throughout the discharge planning process. The service operated between 9.00am-5.00pm five days a week on the wards and within the Accident and Emergency Department the team operated between 7.00am until 9.00pm on Monday to Friday and 9.00am to 5.00pm on Saturdays and Sundays.

During the night, community mental health services were provided by an out of hours team which provided a duty assessment service from Netherthorpe House.

Sheffield Health and Social Care NHS Foundation Trust have been inspected on a number of occasions since registration. However the community based mental health services for adults of working age have not previously been inspected by the Care Quality Commission. In November 2013, we carried a Mental Health Act monitoring visit to look at the arrangements the trust had for supporting community treatment orders (CTOs). Where we found issues, the trust provided an action statement explaining how they would improve adherence to the Mental Health Act (1983) (MHA) and MHA Code of Practice in relation to CTOs.

During this inspection, we visited a sample of these teams. The teams we visited were:

- Four Community Mental Health Teams (CMHTs)
- The Assertive Outreach Team
- Liaison Psychiatry Service for Adults
- Out of hours duty team

Summary of findings

Our inspection team

Our inspection team was led by:

Chair: Alison Rose-Quirie, Chief Executive Officer, Swanton Care.

Team Leader: Graham Hinchcliffe – Inspection Manager

Head of Inspection: Nicholas Smith, Head of Inspection – Hospitals Directorate (Mental Health), Care Quality Commission.

The team looking at the community mental health service for adults of working age included a CQC inspection manager, a Mental Health Act reviewer, specialist advisors which included a consultant psychiatrist, senior nurses, social workers and a psychologist.

Why we carried out this inspection

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

How we carried out this inspection

To get to the heart of people who use services' experience of care, 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 visiting, we reviewed a range of information we hold about community-based mental health services for adults of working age and asked other organisations to share what they knew, including speaking with local Healthwatch, Independent Mental Health Advocacy Services and other stakeholders. We reviewed comment cards left by patients. Four comments cards related to community mental health teams – two comment cards were positive commenting on the caring nature of staff, one comment card was overall neutral and one comment card was negative about the accessibility and responsiveness of the service.

We carried out an announced visit over three days between 27- 31 October 2014 and carried out an 'out of hours' visit to the out of hours duty team on 12 November 2014. During the visit we held focus groups with a range of staff who worked within the service, such as nurses, doctors, therapists and allied health professionals. We talked with people who used services who shared their views and experiences of the service. We observed how people were being cared for and talked with carers and/or family members. We reviewed care or treatment records of people who used services. We reviewed Mental Health Act documentation for patients subject to a Community Treatment Order (CTO). We spoke with senior managers.

We inspected a range of community mental health services in Sheffield including the Psychiatric Liaison Service. We spoke with five patients, spoke with 32 staff from a range of disciplines and looked at 19 sets of patient notes. We looked at the environment, the availability of equipment, cleanliness and information provided to patients.

Summary of findings

What people who use the provider's services say

We spoke with five patients during our inspection. Overall, people we spoke with told us that staff treated them with respect and dignity. People said they could approach staff with any issues they had and staff provided good quality care.

One person told us they were very happy with the service they were receiving and the support which was provided to them. Another person we spoke with was complementary about the care they received stating that the care co-ordinator they had was very caring and understanding.

A third person did comment about the unresponsiveness of the night duty team.

Good practice

We found the following areas of good practice:

- There were innovative service user involvement initiatives to facilitate patients to comment on community mental health services, including the employment of peer workers, service users involved in interviewing community staff and other initiatives
- There was integrated health and social care working within the community teams including nurses acting as Approved Mental Health Professionals and community psychiatric nurses providing social circumstance reports

Areas for improvement

Action the provider MUST or SHOULD take to improve

Action the provider SHOULD take to improve

- The trust should continue to monitor and manage the pressures within the community mental health teams, including:
- managing caseloads and caseload weightings of community mental health team staff
- waiting times for access into community mental health services
- staff morale within certain CMHTs
- appropriately managing the reported levels of stress and sickness within certain CMHTs
- addressing vacancy rates
- ensuring the early intervention service is fully functional.
- The trust should continue to work with commissioners of services and ensure resources are arranged to make sure appropriate crisis services are available to people 24 hours a day.
- The trust should ensure conditions of CTOs provide clarity about the lack of compulsion for treatment for mental disorder whilst people are in the community and community patients receive information on their rights in a timely manner.

Sheffield Health and Social Care NHS Foundation Trust

Community-based mental health services for adults of working age

Detailed findings

Locations inspected

Name of service (e.g. ward/unit/team)	Name of CQC registered location
North Locality Community Mental Health Team South East Locality Community Mental Health Team South West Locality Community Mental Health Team West Locality Community Mental Health Team Sheffield Assertive Outreach Team (SORT) Liaison Psychiatry Service for Adults Out of hours duty team	Fulwood House

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.

The community mental health teams had Approved Mental Health Professionals (AMHP) integrated within the teams, including the Assertive Outreach Team and the out of hours team. There was also a further AMHP employed on a 'twilight shift' to work between 4.00pm and 12 midnight. This meant that when a person required a Mental Health Act assessment, an AMHP was available to arrange the assessments within reasonable timescales. Many AMHPs we spoke with identified difficulties and delays in getting section 12 doctors to medically assess patients.

We reviewed a small sample of records relating to the care and treatment of patients subject to community treatment orders (CTOs) under the Mental Health Act. We found the service adhered to the Mental Health Act Code of Practice in relation to community treatment orders in most cases. We found that on occasions there were delays in providing

rights to CTO patients and the conditions of the community treatment order stated that the patient must accept treatment when community patients cannot be compelled to take treatment in the community.

Mental Capacity Act and Deprivation of Liberty Safeguards

Overall we found that services were compliant with the requirements of the Mental Capacity Act (MCA) 2005 and Deprivation of Liberty Safeguards (DoLS).

People using the community mental health services lived in the community and therefore had a high degree of autonomy and independence to determine aspects of their daily lives. Staff took practical steps to enable patients to make decisions about their care and treatment wherever possible. Staff understood the process to follow should they have had to make a decision about or on behalf of a person lacking mental capacity to consent to proposed decisions, in accordance with the MCA.

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

Summary of findings

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

Community mental health teams (which incorporated the crisis team function) had sufficient numbers of staff to provide the care that people needed during the daytime; with large multi-disciplinary community mental health teams and an effective assertive outreach team. The resource of staffing at night time to manage the out of hours demand including the crisis function consisted of no more than two workers which had temporarily increased to three workers across Sheffield city wide. This meant that that four community mental health teams (some with over 50 staff within them) handed over to a very small number of staff in the out of hours team which could not always meet the demands placed upon it. People in mental health crisis in Sheffield at night did not therefore have timely access to professional input by staff within the trust with the exception of those people assessed as requiring a Mental Health Act assessment.

There were a number of pressures within the community mental health teams. These included:

- some staff managing higher and complex caseloads with people being managed with significant acuity and co-morbidity issues,
- staff covering the caseloads of vacant posts and colleagues who were off sick,
- waiting times for access into community mental health services
- staff morale within certain CMHTs
- appropriately managing the reported levels of stress and sickness within certain CMHTs
- addressing vacancy rates.

Some teams were monitoring and managing these pressures better than others.

The offices within the community mental health teams provided an appropriate environment to base community mental health teams. Where teams were visiting people at home, teams were aware of the risks and adapted the way they worked. Patient's risk assessments were well completed and up-to-date. Where risks were identified, there were plans in place to reduce or manage the risk. This meant that staff within the community mental health teams did what they could to keep people safe. Staff within the assertive outreach team were managing a number of complex cases well; many of which had a significant forensic history.

Staff were knowledgeable about their responsibilities regarding safeguarding and the process for reporting safeguarding concerns.

Staff had the opportunity to have debriefing following significant incidents with psychologists based within the teams to help ensure that incidents were understood and lessons learnt from them.

Our findings

Safe and clean environment

The offices within the community mental health teams provided an appropriate environment to base community mental health teams. During the daytime access into the mental health centres for appointments and clinics was generally through a staffed reception with comfortable waiting areas. The out of hours services were based at Netherthorpe House and visits were not encouraged due to the limited staff on duty. The out of hours service operated mainly through a telephone service between 7.30pm and 8.00am. Where people required urgent assessment during these hours they were seen at the accident and emergency department or in their own homes. There was an intercom system at Netherthorpe House so that any visitors into the building could be screened.

We looked at a small sample of clinic rooms within the community mental health teams where medication such as depot medication was administered. We saw these were clean and well maintained with medication stocks kept in an orderly manner and fridge and room temperatures recorded and reviewed to ensure that medication was

Requires improvement

Are services safe?

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

stored safely. Staff had designated responsibility to ensure stocks of medication were maintained. Systems were in place to manage and monitor medication administered from the community mental health teams with paper based records kept and maintained.

We looked at a sample of interview rooms where people who used the service met with the staff for assessments. We found these to be clean, well maintained and safe environments which enabled staff to raise an alarm if they felt unsafe. This could be done either through an in-built alarm system in the room or an alarm device carried on their person.

Safe staffing

The trust reviewed all of its community based teams as part of a reconfiguration of community mental health services. This meant that eight community mental health teams were changed to four separate teams in localities across the city. All the community based teams now provided an integrated service with community mental health teams (CMHT) covering a range of functions which included supporting people with mental health issues to be treated in the community and to recover from their mental ill health, early intervention services (EIS) for people under 25 with a diagnosis of severe and enduring mental health needs and crisis resolution and home treatment function.

Community mental health teams had sufficient numbers of staff to provide the care that people needed during the daytime; with large multi-disciplinary community mental health teams and an effective assertive outreach team. The resource of staffing at night time to manage the out of hours demand consisted of up to four workers until midnight and no more than two workers after midnight supported by a senior house officer and a Specialist Registrar providing medical cover. This had increased to three workers on a temporary basis until March 2015. This meant that that four community mental health teams - some with large teams with well over 50 staff within them – handed over to a very small out of hours team.

There were a number of reported pressures within the community mental health teams. These included:

- some staff managing higher and complex caseloads with people being managed with significant acuity and co-morbid drug and alcohol or personality disorder issues,
- staff covering the caseloads of vacant posts and colleagues who were off sick,
- waiting times for access into some of the community mental health services,
- staff morale within certain CMHTs,
- appropriately managing the reported levels of stress and sickness within certain CMHTs,
- addressing vacancy rates.

Some teams were monitoring and managing these pressures better than others. Some staff in the West and South West locality CMHT reported that staff morale was low with staff holding complex cases, staff sickness and some staff leaving. The South West community mental health team had two band 5 nurse vacancies and a support time recovery worker vacancy but adverts were out to recruit to these posts

We found in the assertive outreach teams that caseloads were 'capped' to ensure they were manageable for staff. However, staff within the CMHT's told us that their case loads were up to 35 and higher in some cases as well as covering regularly for staff who were off sick in addition to other duties such as carrying out assessments and manning the duty phone. The Department of Health 'Policy Implementation Guide for CMHT's' (2002) recommends caseloads of no more than 35. Staff told us the increase in caseloads was largely due to sickness and some staff vacancies. Caseload pressures were exacerbated by the other duties of the teams including duty cover requirements.

Assessing and managing risk to patients and staff

The service had effective systems in place to assess and monitor risks to individual people. We reviewed the care records of 19 people using the service. Each person had an up to date risk assessment in their care records utilising a specific risk assessment tool called a detailed risk assessment and management plan (DRAM). DRAM records included ongoing and comprehensive risk assessments in relation to key risks including demographic risks, historical risk incidents, levels of vulnerability, safeguarding and risk to themselves and others to help predict future risks. Where a risk was identified, an ongoing care plan was in place to help manage the risk. This meant that staff within the community mental health teams did what they could to keep people safe. Teams included senior practitioners (who

Requires improvement

Are services safe?

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

were staff with significant professional experience) which meant that people with more complex needs were provided with consistent care which also helped to manage risks.

Each person had a risk assessment in place which identified possible alerts related to the person's home environment which could impact upon care delivery. Where a risk had been identified, there was a plan in place to manage this which staff told us occurred in practice. Where teams were based within geographical areas identified as posing higher risks such as higher reported crime rates, teams were aware of the risks and adapted the way they worked. For example where staff went to assess newly referred people or there were known risks in terms of the individual person or the area they lived then staff would visit in pairs to help manage risks. Where risks were deemed to be higher we saw that there were professionals meetings to discuss ways to manage risks and ensure appropriate multi-disciplinary plans were in place to manage the risks.

Staff within the assertive outreach team were managing a number of people with complex needs. People within the assertive outreach team were discussed on a daily basis to help ensure that all staff within the team knew people well. Many people receiving care from within the assertive outreach team had significant forensic histories and staff within these teams had a good understanding of managing people with forensic histories and effective working with police, criminal justice and probation services.

Staff were knowledgeable about their responsibilities regarding safeguarding and the process for reporting safeguarding concerns. Staff had received appropriate training in safeguarding and there was an identified safeguarding lead within the teams. Staff were clear about the procedure for identifying potential abuse, documenting and reporting this appropriately to their managers and to the local authority. We observed clear information about reporting safeguarding issues in the office areas where people visited and where staff were based. Safeguarding procedures were available on the trust intranet. Staff told us about the trust's lone working policy and gave practical examples of how they followed this to ensure staff safety.

Reporting incidents and learning from when things go wrong

There was an incident reporting system in place which was completed following any incidents. This allowed the managers and senior practitioners to review and grade the severity of incidents. Staff were aware of how to complete incident forms and their responsibilities in relation to reporting incidents. Staff told us that guidance on incident reporting was available on the intranet. Incidents were analysed by managers to identify any trends and appropriate action was taken in response to these. Regular feedback was provided to teams on serious incidents which occurred across the trust and the recommendations were discussed so that lessons were learnt.

Staff had the opportunity to have debriefing following significant incidents with psychologists based within the teams to help ensure that incidents were understood and lessons learnt from them.

We saw incidents and actions discussed at team meetings or sent to staff via communications. For example, we saw an incident investigation for the duty team which identified that staff should be more specific about timings of attempted telephone calls to people requiring checks or support over the phone. This was disseminated to the team. In addition a recently published external review of a serious incident commissioned by NHS England involving the South East CMHT identified that the trust's own recommendations had been implemented and measures taken to prevent a reoccurrence. The external independent team was satisfied that all of the main issues following the incident which occurred in 2011 had been addressed.

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

We rated community based mental health services for adults of working age as good because:

Teams worked within the principles of the recovery model to aid people's recovery from mental ill health or severe distress. Records showed that people had comprehensive assessments of patients' needs which included their social, occupational, cultural, physical and psychological needs and preferences. There were effective care plans in place to support people.

Staff were well supported with appropriate training and supervision. New staff were well supported in their induction.

There was very good multi-disciplinary working with visible consultant psychiatrist and psychology input within the teams. Teams worked using a fully integrated health and social care model within which for example, nurses were employed as Approved Mental Health Professionals. We found the service adhered to the Mental Health Act Code of Practice in relation to community treatment orders in most cases. On occasions the conditions of the community treatment orders stated that the patient must accept treatment when community patients cannot be compelled to take treatment in the community. There were a small number of examples where there were delays in providing people on a CTO with their rights whilst subject to conditions in the community.

People using the community mental health services had a high degree of autonomy and independence to determine aspects of their daily lives. Staff understood the process to follow should they have had to make a decision about or on behalf of a person lacking mental capacity to consent to proposed decisions, in accordance with the Mental Capacity Act (2005).

Our findings

Assessment of needs and planning of care

We looked at a number of care plans which were electronically stored. People had a comprehensive and holistic assessment completed as part of the assessment process. This included people's social, cultural, physical and psychological needs and preferences. This also included risk assessment from identified risks and a care plan was then developed with the person to meet their identified needs. The care plans we looked at were regularly reviewed, centred on the needs of the individual person and demonstrated knowledge of current, evidence-based practice.

Care plans were written and reviewed, where possible, with the involvement of the person, although it was not always recorded if the person had chosen not to be involved. The consent of the person had been sought in the care plans viewed. Family, friends and advocates were involved as appropriate and according to the person's wishes, although this was not always recorded when the person had chosen for others not to be involved.

Care plans were goal oriented and had clear pathways of referral to other services such as other community teams, inpatient admission or discharge.

Best practice in treatment and care

We found evidence which demonstrated the teams had implemented best practice guidance within their clinical practice. People using the service were offered cognitive behavioural and psychological therapies as guided as recommended by the National Institute of Clinical and Health Excellence (NICE) guidance for the psychological treatment of a range of mental illness conditions such as psychosis, depression, anxiety and bipolar disorder. There was achieved through good integration of psychologists and psychology input into the community mental health teams. This meant that people were offered treatments other than treatments based on medication in line with NICE guidance.

People's physical health needs were properly considered alongside their mental health needs including monitoring symptoms, alerting the general practitioner or encouraging or making referrals to the appropriate health care professionals.

The teams also provided a range of activities and therapeutic interventions to patients to

support their recovery. These included both group and individual interventions.

Skilled staff to deliver care

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.

A full range of mental health disciplines provided input to the team. There was evidence of effective multi-disciplinary team working within the service. The community mental health teams included; community mental health nurses, support workers, social workers and Approved Mental Health professionals (AMHPs), psychologists, occupational therapists, art therapists, administrative support, consultant psychiatrists and more junior doctors including speciality doctor and a higher trainee. Staff told us that they had close working relationships with pharmacy.

Staff we spoke with confirmed they had an annual appraisal and were aware of their own personal development goals. Staff told us they had access to training to support them in their roles. This included specialist training in addition to mandatory training provided by the trust. Staff told us that their manager supported them to access specific training to meet the needs of people who used the service. The training records that staff had access to a range of training relevant to their role, however from the data that we were provided with at trust level about training uptake there were a number of gaps in uptake of mandatory and specialist training.

Staff received regular clinical and managerial supervision as well as weekly peer group supervision facilitated by a psychologist who was external to the team. Staff told us that they found these sessions invaluable and that they discussed complex or challenging clinical issues within these sessions to explore ways to improve the service they provided to people.

Multi-disciplinary and inter-agency team work

There was very good multi-disciplinary working with visible and active consultant psychiatrist and psychology input within the teams. Teams worked using a fully integrated health and social care model. Within most teams for example, nurses were employed as approved mental health professionals and provided social circumstances reports to tribunals.

The team had regular MDT meetings to review people who used the service. Staff told us they had weekly input from psychologists who they could discuss complex cases with. Staff told us medical staff were supportive and responsive, going out at their request to undertake joint assessments when concerns had been raised.

The team had established positive working relationships with a range of other service providers such as the inpatient wards, general practitioners, and local independent services such as the Sheffield Crisis House provided by the charity Rethink. Sheffield Crisis House provided short-term accommodation for people experiencing a mental health crisis. People could access the service for a maximum of seven nights, with non-nursing staff providing 24 hour emotional and practical support to assist people to resolve their crisis.

The trust worked with South Yorkshire Police. A pilot scheme called the street triage team (STT) was based with the Netherthorpe House offices which ran daily with community mental health nurses working alongside the local police. The function of the scheme was to support the police to divert people who have had contact with the police to receive appropriate mental health services and reduce the need for people to be admitted under compulsory police powers (section 136) into the health based place of safety suite. Staff we spoke with told us they felt the service they provided had a direct impact on reducing admissions into the 136 suite

We observed a team handover on the morning of our inspection which was well attended by staff and included medical staff and the shift co-ordinator. We found this to be an effective system for communicating important information between staff such as risk, referrals and assessments.

Adherence to the MHA and the MHA Code of Practice

Staff we spoke with were aware of the statutory requirements of the Mental Health Act. The community mental health teams had Approved Mental Health Professionals integrated within the teams, including the Assertive Outreach Team and the out of hours team. This meant that when a person required a Mental Health Act assessment, it could usually be arranged within reasonable timescales.

In November 2013, we carried a Mental Health Act monitoring visit to look at the arrangements the trust had for supporting community treatment orders (CTOs). This showed that the arrangements were largely good. We found issues in relation to recording capacity to consent for patients on a CTO, patients not always being informed of their rights and an out of date policy. The trust sent us an updated policy on CTOs. The trust provided an action

Are services effective?

Good

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statement telling us how they would improve adherence to the MHA and MHA Code of Practice in relation to CTOs. We saw local guidance for staff in community teams on CTOs to ensure people were clear about their responsibilities.

We reviewed a small sample of records relating to the care and treatment of patients subject to community treatment orders (CTOs) under the Mental Health Act. We found the service adhered to the Mental Health Act Code of Practice in relation to community treatment orders in most cases. This included ensuring people were informed of their rights when on a CTO and systems to ensure that renewal of CTOs were considered at appropriate intervals. In many cases however there was a delay in community staff providing rights to CTO patients as required under the MHA. We found that on occasions the conditions of the community treatment order was worded to infer that the patient must comply or accept treatment when community patients cannot be compelled to take treatment in the community.

Good practice in applying the Mental Capacity Act (MCA)

Overall we found that services were compliant with the requirements of the Mental Capacity Act (MCA) 2005.

People using the community mental health services lived in the community and therefore had a high degree of autonomy and independence to determine aspects of their daily lives. Staff took practicable steps to enable patients to make decisions about their care and treatment wherever possible. For example, one person told us that they were given information on advance statements and as a result drew up their own statement to help inform how they would like to be cared for in particular circumstances.

Staff understood the process to follow should they have to make a decision about or on behalf of a person lacking mental capacity to consent to proposed decisions, in accordance with the MCA.

Good

Are services caring?

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

Summary of findings

We rated community based mental health services for adults of working age as good because:

Staff were committed to providing a high quality service to people in the community. Positive comments were received from patients.

There were innovative service user involvement initiatives to facilitate patients to comment on community mental health services, including the employment of peer workers, service users involved in interviewing community staff and other initiatives that took into account the populations that the community mental health teams worked within.

Our findings

Kindness, dignity, respect and support

We were unable to speak to many patients during our inspection. We observed positive interactions between community staff and people who used the service. One person told us they were very happy with the service they were receiving and the support which was provided to them. Another person we spoke with was complementary about the care they received stating that the care co-ordinator they had was very caring and understanding.

We observed a review of one person who was being cared for by the assertive outreach team who had recently been discharged from hospital. There was good rapport between the consultant psychiatrist, the nurse and the person receiving care.

Four comments cards we received related to community mental health teams – two comment cards were positive commenting on the caring and helpful nature of staff, one comment card was overall neutral and one comment card was negative about the accessibility and responsiveness of the service.

We saw in some teams a number of compliments made by patients into the standard of care people received. For example in the South West Community Mental Health team between April and June 2014, the team had 27 compliments about the team.

We carry out an annual survey of community mental health patients by sending a questionnaire to patients receiving community mental health services in the trust. There were no significant issues of concern from the last survey in 2013. The trusts scored better than expected in terms of people receiving information about the medication they were prescribed. The trust was performing about the same in all other major areas of questioning with the exception of questions around patients not having personal circumstances considered as part of care planning and family members not being involved in the care planning process. The survey and comments received were not specific to which community teams the information related to. However it was not reflected in the treatment of patients we observed during our visits.

The involvement of people in the care they receive

The service provided support to people who were experiencing an acute crisis and deterioration in their mental health to prevent the need for the person to be admitted into hospital. Staff provided a range of flexible support to people dependent upon their needs. This included telephone contact and face to face visits with people in their own homes or at the community mental health teams during the daytime.

People were fully involved in planning their care and had opportunities to discuss their health, beliefs, concerns and preferences to inform their individualised care. People were able to decide who to involve in their care and decisions about their care, and to what extent. Family, friends and advocates were involved as appropriate and according to the person's wishes. Records showed that people had received a review of their care on at least an annual basis under the care programme approach.

We observed a small number of clinical meetings between staff and people using the services of the community mental health teams. Consultations were carried out in a participative manner with people given time to reflect on their experiences, progress and recovery. Physical health issues were discussed and promoted within the meetings.

Staff we spoke with were able to describe specific interventions they used to assist people with managing people's mental health and distress such as anxiety management, alcohol withdrawal, psychological interventions and relapse prevention work.

Good

Are services caring?

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

People had access to information in different accessible formats, interpreting and advocacy services if necessary. We were given examples by staff where interpreters had been accessed to support people whose first language was not English to attend assessments.

There were innovative service user involvement initiatives to facilitate patients to comment on community mental health services, including the employment of peer workers, service users involved in interviewing community staff and other initiatives that took into account the populations that the community mental health teams worked within.

Requires Improvement

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

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

The trust did not have fully responsive out of hours crisis services. The resource of staffing at night-time to manage the out of hours and crisis demands meant that out of hours provision was not fully responsive to people's needs. There were no overall systems to record how the limitations on the out of hours service impacted on patient care to monitor its' responsiveness, for example, the delays in responding to telephone calls, the numbers of patients that had to be sent to accident and emergency and the occasions when the office was unstaffed due to out of hours staff having to attend a Mental Health Act assessment.

In some teams there were delays in people waiting to receive a proper service – for example some people were waiting many weeks before they received a routine assessment and started to receive a service once they had been accepted for a non-urgent assessment into the service.

All the community based teams now provided integrated services with community mental health teams (CMHT) covering a range of functions which included assessment into the CMHT, recovery based CMHT work, early intervention services (EIS) and crisis resolution and home treatment teams. This meant that people were managed within the same service and where possible by the same worker to ensure consistent and responsive care. Staff worked flexibly to meet needs which meant that people's needs were considered holistically. People received support to fully aid recovery. Staff within the services recognised that the early intervention service was not as well developed as it could be and were looking to introduce specialisms within some teams to address this.

Staff triaged referrals into the service using a traffic light system to manage and prioritise assessments.

We saw that complaints were well managed. One community mental health team had a higher number of complaints but when we looked at these there were no significant concerns about service quality overall. The complaints within each service were looked into and responded to. Where complaints were not upheld, frequently the complaint would still look at in order to establish what could be learned or improved.

Our findings

Access, discharge and bed management

The service had a system in place which ensured that all new referrals were made through the access and assessment teams within the CMHTs. The access team reviewed each new referral based upon the information they received and assessed and what further support and referral to other services was required.

The access team used a risk rating system to triage each referral made to the team. All urgent referrals (high risk) were usually seen within 24 hours. Non urgent referrals were contacted by telephone on the day of referral and then an appointment was offered as soon as possible. In some teams there were delays in people waiting to receive a proper service – for example some people were waiting many weeks before they received a routine assessment and started to receive a service once they had been accepted for a non-urgent assessment into the service. Figures from the trust showed that community mental health teams (CMHT) waiting times for routine assessment reduced from nearly 11 weeks in 2012/13 to 6 weeks 2013/4 and continued to be a priority for the trust. The Northlands team was holding a waiting list of approximately 50 cases with people were waiting up to 4 weeks for a routine assessment appointment to access the recovery team.

Most patients received a follow up within seven days of being discharged from psychiatric inpatient care with the latest data showing that the trust scored 96.5% which was very close to the national average at 97%.

The trust did not have fully responsive out of hours crisis services. The out of hours service was operated by two staff on a city wide between midnight and 7.30am; this had recently increased to three staff on a temporary pilot basis. If people were in crisis, they were triaged to see whether they required a Mental Health Act assessment. If a MHA assessment was indicated then the office would be left unstaffed whilst the workers attended to the assessment. If a MHA assessment was not indicated, the service spoke

Requires Improvement

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with people over the phone, encouraged people to contact their usual CMHT team in the morning, asked people to attend accident and emergency or contact the Rethink crisis services which included a telephone helpline and a crisis house which did not provide professional nursing care. The accident and emergency department at the Northern General Hospital did not have a psychiatric liaison service throughout the night. One patent we spoke with who stated that recently when they were acutely unwell they rang the duty office at 11.00pm one evening and were told that a member of the team could not come out. The patient went onto say; "they put me off until the next day and asked me to come to the office. I said I was too ill, then they said I was not co-operating".

We were unable to get a clear picture of the unmet need throughout the night because there were no robust or overall systems to record centrally how the limitations on the out of hours service impacted on patient care. For example, records were not kept on the delays in responding to telephone calls, the numbers of patients that reported that they were in crisis and requested a visit which could not be met, the numbers who were advised to attend accident and emergency due to staff availability rather than patient need and the occasions when the office was unstaffed due to out of hours staff having to attend to a Mental Health Act Assessment.

There was an open referral system in place meaning that any person could self-refer and any external organisations could refer on. Referral could be made by telephone, fax or online. The team accepted referrals from a range of sources including self-referrals from people or their carers, GPs, the inpatient wards and between the different functions of the CMHTs.

The team visited people in their own home or at the access and recovery team offices dependent upon their needs and level of risk. People were also supported by regular telephone calls or an agreed level of contact.

The access team were the gatekeepers for inpatient beds. The wards were operating at higher levels of occupancy in common with many inner city mental health inpatient wards. Staff told us they sometimes had problems accessing beds within the trust when an inpatient admission was needed. This meant that on occasions 'out of area' placements had to be arranged. This had been recognised by the trust and there was a specific referral protocol in place to ensure the welfare of the person being referred in the rare instance that this took place.

The wards were considering discharge more formally as soon as people were admitted to ensure people were only in hospital for the shortest possible time and ward staff were looking at defining an indicative discharge date which is kept under regular review. The community teams had regular, at least weekly, contact with the acute wards to identify people who may be appropriate for early discharge with support from the team. This included providing support to people during leave periods from the ward.

A service which optimises recovery, comfort and dignity

Staff were committed to providing care to people which promoted people's privacy and dignity.

Care focused on people's holistic needs and not just on treating their mental distress or illness. For example care plans recorded and reviews observed included discussions and promotions of vocational and educational opportunities.

As the trust is a combined health and social care trust, teams encouraged people with self-directed support which provided people greater autonomy to identify the care and support needs themselves and then commissioning their own care package. Staff commented on their perceptions of the bureaucracy to progress self-directed support through the local authority.

Policies and procedures which minimise restrictions

Community mental health 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 home treatment function of the community mental health 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

The trust hosted Sheffield Community Access and Interpreting Service (SCAIS) which provided face to face

Requires Improvement

Are services responsive to people's needs?

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and telephone interpreting services. This ensured that people had access to information in different accessible formats and interpreting services if necessary. We were given examples by staff where interpreters had been accessed to support people whose first language was not English to attend assessments. People's individual, cultural and religious beliefs were taken into account and respected as demonstrated by the content of the care plans and observation at clinical meetings.

Staff within many of the community mental health services recognised that the early intervention service was not as well developed as it could be. The lack of proper ring fenced resources of the early intervention function meant that people who required early intervention services were not receiving the more specialist and intensive support required and therefore did not receive a responsive service because of the competing needs of other aspects of the CMHT functions. This was articulated well by one member of staff who stated that the early intervention service would fail the friend and family test stating that: "I would not want my daughter to receive services here". Managers in some teams were looking to introduce improved early intervention specialisms to address this.

Learning from concerns and complaints

We saw that complaints were well managed. The teams were proactive in their approach to gaining feedback from people who used the service.

People knew how to raise concerns and were given written information about making complaints. One community mental health team had higher number of complaints. We looked at the complaints in this service and saw that these complaints did not raise significant concerns about the quality of the service overall. The complaints within each service were looked into and responded to. Where complaints were not upheld, managers would still look at what could be learned or improved. Some complaints related to responsiveness of the service and in particular the duty team which had been fully or partly upheld.

Complaints and concerns which people had raised were discussed at the service meetings. We found evidence to show that managers had taken timely action in response to complaints which they had received. The trust produced a complaints report which highlighted the complaint and response to complaints which was published on the intranet. This helped to ensure that the service was open and accountable. Complaints were therefore well managed.

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

We rated community based mental health services for adults of working age as good because:

There was a commitment to provide high quality care in line with the trust's stated values and strategy. Morale in most teams was good despite the significant changes following integrated working and challenges of working within areas of significant need and deprivation.

Staff in most teams were positive about their experience of working within the trust. Staff felt supported by their colleagues. Senior Practitioners worked within the team, as did managers. Staff in most team felt able to raise concerns to their management team and were confident they would be listened to.

Teams were committed to developing and improving the service provided. In some cases this could be improved further through ensuring that appropriate action was taken following local audits.

Our findings

Vision and values

The trust had a strategy with the overall vision of being a leading provider of high quality health and social care services and recognised as world class in terms of co-production, safety, improved outcomes, experience and social inclusion. The trust had a number of high level values which included respect, compassion, partnership, accountability, inclusion, fairness and ambition.

Staff within the community teams showed professional commitment to these values as evidenced throughout our interviews with many staff. People who used the service commented favourably that they had received high quality care which showed staff were working within the stated values of the trust.

Good governance

The teams were overseen by committed managers who oversaw the quality and clinical governance agenda. Managers had lead responsibilities for carrying out checks on various elements of clinical practice such as medicines management, records checks, environmental and security checks. Identified issues from these had been shared through team meetings or other forums.

The teams held regular staff meetings that had an agenda which was focused on governance issues. These meetings linked into the directorate governance meetings which provided assurance that issues could be escalated and shared across services.

Staff we spoke with were clear about their responsibilities in relation to escalating any issues which may impact on the quality of the service they provided to the manager. Staff told us they felt well supported in their roles, and felt able to raise concerns. They told us they felt would be listened to, and the information acted upon appropriately. However some staff stated in some community teams that reported issues about high caseloads had not been fully addressed.

Staff told us they received the information they needed from the trust through their manager or via the internal intranet so they were kept informed of developments which may impact on their work.

Staff we spoke with confirmed they had an annual appraisal and were aware of their own personal development goals. Staff told us they had access to training to support them in their roles. This included specialist training in addition to mandatory training provided by the trust. However the data provided at trust level about training uptake showed significant gaps in training. Managers told us that training uptake was monitored locally through the electronic training records and local email reminders, but when we asked for an up to date list of training uptake this could not be provided from some of the teams we visited.

Leadership, morale and staff engagement

The teams were well-led at local level in most teams. Staff and managers were motivated to continually improve and develop the service. All of the staff we spoke with told us that they felt proud working for the team. They felt supported by their manager and felt they could approach them if needed. Staff told us that their manager was very accessible and contactable. Staff told us they felt the team had a healthy culture where they felt comfortable discussing any issues they may have with colleagues within the team. Some staff in the West and South West locality

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.

CMHT reported that staff morale had been low with staff holding complex cases, staff sickness and some staff leaving. This resulted in staff having higher case loads and some staff feeling a sense of loss of recognition of their specialisms.

There was a whistleblowing procedure in place which staff were aware of and told us that they would raise any issues if they were unable to this this within the team.

Commitment to quality improvement and innovation

The teams had governance and leadership meetings which were minuted which showed that there was a commitment to quality improvement. The issues discussed included, medical care and cover, serious untoward incidents, administration support to the teams, supervision of staff, transfers, team risk register, infection control and the clinic room environment. This meant that managers were overseeing the service and ensuring that issues were addressed and improvements noted.

We saw examples of very good service improvement initiatives, for example the South West Community Mental Health Team had a service road map with key projects with involvement and workshops held within teams to identify issues and improvement measures. This had led to piloting a refined referral processes from GPs to improve the quality of the initial information received into the team about new patients. Additionally, more active case review processes were being implemented to ensure that those patients that had been stable over a continuous period were considered for discharge back to primary care. Staff reported that they felt involved in these initiatives, comparing their experience much more favourably with colleagues within in-patient services who felt that service change was imposed on them without much consultation.