Good

Sheffield Health and Social Care NHS Foundation Trust

Community-based mental health services for older people

Quality Report

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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)
Fulwood House	TAH	Functional Intensive Community Service	S2 4EA
		Dementia Rapid Response and Home Treatment Team	
		Older Adult Community Mental Health Teams	

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.

Summary of findings

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 older people	Good
Are community-based mental health services for older people safe?	Requires Improvement
Are community-based mental health services for older people effective?	Good
Are community-based mental health services for older people caring?	Good
Are community-based mental health services for older people responsive?	Good
Are community-based mental health services for older people 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

Contents

Summary of findings

Overall summary

Sheffield Health and Social Care NHS Foundation Trust provided good community services for older people with a functional mental illness, such as depression, and organic conditions, such as dementia.

Services for older people required improvement in medicine management. Staff understood and implemented safeguarding procedures. In addition, community caseloads were well managed, despite the demand on the service, which led to patients waiting up to four weeks for an assessment. There were good systems in place to manage risk on a day-to-day basis.

Patients' care and treatment was planned effectively, which helped to achieve good outcomes. Patients' needs were comprehensively assessed. Staff provided person-centred care and treatment that was in line with patients' individual care plans. We found the way in which the multidisciplinary teams worked together was excellent, and that information was shared appropriately. Staff were supported by managers and received appropriate training, supervision and professional development. This enabled staff to deliver safe and effective care.

Staff provided kind and compassionate care. Patients and their carers were treated with respect, and their dignity and privacy were maintained. Carers were involved in the planning and delivery of care. Information was recorded as to whether carers wanted a carer's assessment. Staff were committed to providing good quality care and treated patients as individuals.

Services were responsive to patients' and carers' needs. The teams understood patients' needs and wishes, and could respond to these. Services were planned and delivered in a way that met the different needs of the local communities. For example, we saw a patients had access to staff that provide advice which addressed the different cultural needs of patients by supporting the community service. In addition, the FICS and DRRHTT services provided an extended seven-day service in the community. This meant that they could respond more effectively to patients' needs. There also were good arrangements in place to support effective working with patients discharged from the older adult wards at Michael Carlisle Centre (Dovedale wards 1 and 2) and Grenoside Grange Hospital by preventing admission to hospital and supporting patients in crisis.

Services for older people were joined-up and well-led. Managers were visible and accessible to patients, carers and staff. The trust encouraged development of the service development and also involved patients and their carers. The trust's governance structure supported the delivery of the service.

Summary of findings

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

Are services safe?

Requires Improvement

The service requires improvement in medicine management. We found that community nursing staff routinely repackaged medicines into compliance aids where patients had been discharged to the community teams. Staff were repackaging medicines as part of monitoring patients' compliance with medication. Trust procedures were not followed and these compliance aids were not properly labelled with their contents and dose instructions.

The service had a good track record on safety and staff understood and implemented safeguarding procedures.

Community staff caseloads were also well managed. This helped staff to deliver safe and effective care and treatment. In addition, there were good systems in place to manage risk on a day-to-day basis and make sure that lessons were learnt from any incidents

There was no dedicated pharmacist input into community mental health services to support the safe and effective management of medicines.

Are services effective?

Good

Patient care and treatment was planned effectively, which helped to achieve good outcomes.

Patient needs were comprehensively assessed. Staff delivered care that was in line with patients care plans, and that reflected their individual needs. Staff received training, supervision, support and professional development that enabled them to deliver effective care.

We found the way in which the multidisciplinary team worked together was excellent, and information was shared appropriately.

Are services caring?

Good

Staff provided kind and compassionate care and support to patients and their carers.

Patient dignity and respect was seen to be paramount to staff. Staff provided person-centred care and there was clear evidence that carers were also involved. We found the services were focused on the patients they cared for as individuals, and staff were committed to providing good quality care.

Are services responsive to people's needs?

Good

Services for older people were responsive to patients needs.

Summary of findings

There were clear care pathways in place, and the teams understood patients' needs and wishes and could respond to these.

Services were also planned and delivered in a way that met the different needs of the local communities. In addition, there was an extended community service, which operated seven days week and ensured services were responsive.

Are services well-led?

Good

The trust's vision and direction was communicated effectively to staff.

The governance structure in place also supported the delivery of the service. Services for older people were joined-up and well-led.

Summary of findings

Background to the service

The community based mental health services for older people were all based and managed from 7 Edmund Road. The service was made up from three different teams.

Functional Intensive Care Service (FICS)

This service provided short term intensive home treatment to older adults (over the age of 65) who had functional mental health needs. The aim of the service was to prevent hospital admission by supporting patients to remain in their own homes by avoiding admissions and provide post discharge support. The average length of involvement by the service for the involvement of admission avoidance was five weeks; the average length of involvement of discharge support was six weeks. The length of involvement could be up to ten weeks dependent on the circumstances and needs of the individual. The service was open Monday to Friday 8am-6pm and at weekends and bank holidays 8am-4pm.

Dementia Rapid Response and Home Treatment Teams (DRRHTT)

This service provided assessment, care and treatment to patients with a working diagnosis of dementia and who were experiencing some degree of crisis or difficulty. There was no age limit. The team worked in a patients' own home (this may be a nursing or residential home), attempting to provide prompt interventions (treatments) aimed at resolving the individual's immediate difficulties and improving the situation. The service was open Monday to Sunday 8am to 8pm.

Older Adult Community Mental Health Teams

This service offered prompt assessment, treatment and ongoing support for patients over the age of 65 who had long term or severe and enduring mental health needs. The service offered four teams to cover the city of Sheffield. The service was open Monday to Friday 9am to 5pm. Referrals were accepted from GPs and specialist services within the Trust.

Our inspection team

Our inspection team was led by:

Chair: Dr Alison Rose-Quirie Chief Executive Officer, Swanton Care and Community Ltd

Team Leader: Graham Hinchcliffe, Care Quality Commission

Head of Inspection: Nicholas Smith, Care Quality Commission

The team included CQC inspectors and a variety of specialists: including a consultant psychiatrist, expert by experience, a mental health act reviewer, a psychologist, a social worker and registered nurses. The expert by experience was a person who had used a service or a carer of someone using a service.

Why we carried out this inspection

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

How we carried out this inspection

To get to the heart of the experience of people who use services, we always ask the following five questions of every service and provider:

- Is it safe?
- Is it effective?
- Is it caring?

Summary of findings

- Is it responsive to people's needs?
- Is it well-led?

Before this inspection, we reviewed a range of information we hold about the core service and asked other organisations to share what they knew.

We visited the functional intensive care service (FICS) and dementia rapid response and home treatment teams (DRRHTT) on 29 and 30 October and the four older adult community mental health teams (CMHT's) on 30 October 2014. We visited and spoke with six patients, as well as looking at the care records and pathway of seven patients. We attended three handovers and two multi-disciplinary team (MDT) meetings. We spoke with 33 staff including consultant psychiatrists, registrar, GP trainee, service manager, team managers, occupational therapist, registered nurses and support workers. This included interviewing staff in small focus groups on site.

What people who use the provider's services say

Patients, relatives and carers told us staff were responsive to their needs and treated them with dignity and respect. Staff were described as 'caring', 'friendly', 'polite' and most of all dedicated.

Good practice

Areas for improvement

Action the provider MUST or SHOULD take to improve

Action the provider MUST take to improve

- The provider must review the arrangements for the supply of medicines in compliance aids for patients being discharged.

Action the provider SHOULD take to improve

- The provider should review the provision of dedicated pharmacist input into all trust services.

Sheffield Health and Social Care NHS Foundation Trust

Community-based mental health services for older people

Detailed findings

Locations inspected

Name of service (e.g. ward/unit/team)	Name of CQC registered location
Functional Intensive Community Service Dementia Rapid Response and Home Treatment Team Older Adult Community Mental Health Teams	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.

There were no patients cared for by the team on community treatment orders. Teams contained or had access to approved mental health professionals (AMPH's) who could access inpatient beds if patients had been assessed under the Mental health Act 1983 and required detention.

Mental Capacity Act and Deprivation of Liberty Safeguards

Staff had undertaken training in the Mental Capacity Act (MCA) 2005 and Deprivation of Liberty Safeguards (DoLS), which was updated every two years. Staff we spoke with demonstrated good understanding of the MCA. They were aware of recent legal decisions in respect of the MCA and how this affected their practice.

Detailed findings

When reviewing patient's health care records we noted patients' capacity was recognised and records showed formal consent to care and treatment. Where patients' capacity to understand their care or treatment this was managed by use of 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

The service requires improvement in medicine management. We found that community nursing staff routinely repackaged medicines into compliance aids where patients had been discharged to the community teams. Staff were repackaging medicines as part of monitoring patients' compliance with medication. Trust procedures were not followed and these compliance aids were not properly labelled with their contents and dose instructions.

The service had a good track record on safety and staff understood and implemented safeguarding procedures.

Community staff caseloads were also well managed. This helped staff to deliver safe and effective care and treatment. In addition, there were good systems in place to manage risk on a day-to-day basis and make sure that lessons were learnt from any incidents

There was no dedicated pharmacist input into community mental health services to support the safe and effective management of medicines.

Our findings

Safe and clean ward environment

The functional intensive community service (FICS), dementia rapid response and home treatment team (DRRHTT) and four community mental health teams (CMHT's) shared a modern well equipped building at Edmund Road. All the teams had their own office space and senior managers were also located within the building. There were offices for consultant psychiatrists and rooms for members of the multi-disciplinary team to meet and interview patients in private. There was a large meeting room and clinic room for the storage of medicines. The building was clean and hygienic. The entrance to the building had disabled access. The entrance was controlled by a locked reception so no one could enter the building without signing in via reception. Staff had their own individual passes to enter the building beyond the reception area.

There was a lift to the first floor and access to disabled toilet facilities. The building had been redesigned with an occupational therapist so work spaces were appropriate for patients and staff. A further second floor had been created to allow for the teams occupying the building. The building had met all safety and disabled access and equipment standards before being occupied in April 2014.

We saw the results of the local infection control audit of Edmund Road for 2014 and the action plan for the manager to complete. The audit identified the service had passed the audit. It noted there was a large amount of full sharps bins found in clinic room, which were taken to a waste facility on the day. At the time of our visit, sharps bins were not full and closures of them were in place reducing the risk of needle stick injuries. We saw records where staff recorded when sharps bins were started and closed off when full. Some staff required mandatory refresher training, which was completed at the time of the audit and the remaining staff needed to attend mandatory training updates.

The Governance report for July 2014 reported staff were using protective aprons and gloves for face to face contact with patients and hand gel at Edmund Road and satellite bases. Staff confirmed in focus groups they had sufficient personal protective clothing available to them.

Safe staffing

Staffing in all the community teams was sufficient to meet the needs of patients. The community teams had effective systems in place to manage caseloads. Community staff told us that caseloads were generally between 20 and 25 patient although this differed between the four CMHT's, FICS and DRRHTT. Individual caseloads were based on patient's level of needs rather than being a prescribed number.

Team members were supportive of each other and shared new referrals to ensure that staff were able to manage their work load safely and effectively. Staff told us how allocations of patient using the service were sometimes changed depending upon the person's needs and who was best able to support them. Staff in the CMHT's normally assessed new patients in pairs to ensure staff safety. We were told of similar arrangements for FICS and DRRHT.

Requires improvement

Are services safe?

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

Staff also visited in pairs to consider emergency referrals or depending on information on the acuity of a patients' mental health. Staff told us senior nurses would accompany them on these types of visits.

Assessing and managing risk to patients and staff

Community team staff were confident in risk management and used positive risk management in the community in order to prevent unnecessary admissions to hospital and to support patient's wishes to be cared for and treated at home where this was possible and safe.

The teams used the detailed risk assessment and management plan (DRAM) which was completed when patients were referred and assessed. Following triage patients had a brief risk assessment and management plan (BRAM) completed before the more detailed DRAM assessment. We looked at seven patient's records across the six teams and saw the assessment required the staff to update the risk assessment and management plan if there had been an incident or the level of risk was raised. This meant reviews of risk enabled staff to accurately assess the risk to the patient themselves and others.

The trust information technology system supports access to information within primary care and the acute trust. The community mental health services therefore had access to all blood investigations, scans, outpatient letters and discharge summaries from the whole of Sheffield. The medication prescriptions were part of the IT system, which highlighted potential drug interactions.

We found that nursing staff routinely repackaged medicines ielectronnto compliance aids on behalf of patients in the process of being discharged. Trust procedures were not followed and these compliance aids were not properly labelled with their contents and dose instructions.

There was no dedicated pharmacist input into CMHT's to support the safe and effective management of medicines.

Community mental health team managers monitored the quality of risk assessments and addressed any shortfalls directly with individual staff. Community staff were aware of the risks entered on the risk register for their team. We observed three handovers and a review as well as a discussion of a risk that had been identified in the team. Safe systems were put in place to prevent a reoccurrence of the situation.

Staff were aware of the needs of patients and was able to explain to us how they were supporting them. We saw that individual risk assessments had been conducted in respect of patients. Staff told us that where particular risks were identified, measures were put in place to ensure the risk was managed. Individual risk assessments we reviewed took account of patient's previous history as well as their current mental state. Most risk assessments had been updated daily.

Staff had received training in safeguarding vulnerable adults. Staff we spoke with had good knowledge of safeguarding issues and knew how to recognise a safeguarding concern and the process for making a safeguarding alert. Safeguarding was discussed at team meetings and during individual supervision to ensure staff had sufficient awareness and understanding of safeguarding procedures.

Staff were aware of the trust's safeguarding policy. They provided examples of safeguarding referrals that had been made and said they received feedback on outcomes at team meetings. Staff were aware the trust was making more safeguarding training places available as it was behind on figures. Staff were consulted about the content of safeguarding training to ensure it was appropriate to their needs.

Case management discussions covered areas of risk such as child protection and adult safeguarding. Flow charts of safeguarding procedures were available to support staff and contained a list of important contacts in different local agencies. Policies and procedures were available on the trust intranet.

We case tracked the safe transfer of patient from two patents being discharged from the older people's acute functional and dementia care service to the CMHT and DRRHTT. We found there were collaborative working arrangements between the inpatients and community services to support the smooth discharge of patients into the community. This involved community staff being involved with patients following admission by pre-existing arrangements or allocation of a community worker. Community staff attended care programme approach (CPA) and multi-disciplinary team (MDT) meetings as well as supporting patients prior to discharge. This involved liaising with and including families and carers in the assessment of patients by community staff. This meant patients were discharged safely..

Requires improvement

Are services safe?

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

Staff were aware of the trust's whistleblowing policy and told us they felt able to raise any concerns they had about the care and treatment of patients with senior managers.

Systems were in place to maintain staff safety. The service had good lone working practices in the form of a buddy system. Staff informed another identified staff member of their whereabouts at all times and checked in with them at the end of the day. We observed good discussion and consideration of risk and safety in the day to day management of patient's care. In our small focus groups the various team members described how the duty system operated a follow up system if staff did not call in safely following a visit. If staff did not return at the expected time then staff at the team base made a call to check they were safe. Some teams used a code word to alert they were at risk. However some teams did not and staff said this would be a useful idea for discussion at their next team meeting. Staff were aware of the trust's lone working policy.

Reporting incidents and learning from when things go wrong

The community service for older people had a clear system in place for the reporting of incidents. Staff we spoke with clearly explained the process for reporting incidents. Staff were confident in being able to report incidents appropriately. Information on safety was collected from a range of sources to monitor performance, this included information on incidents and trends were identified. The service had a low rate of incident reporting. The overall reporting of incidents from April 2013 to March 2014, in the service for older patient as a whole, was low; only three incidents had been reported within the last 18 months. Staff could recall individual incidents within teams. For example when a patient had slapped staff. This was reported immediately and the risk assessment and management plan reviewed. Staff visited in pairs and a warning flag placed on the electronic records system.

Staff told us that reporting incidents was encouraged. Incidents were investigated and the outcome shared with staff and more widely at local governance meetings. Staff told us presentations of learning from serious incident investigations were used as training scenarios. For example an incident where a patient tried to get out of a moving car.

Incidents were discussed in team meetings and changes were made to the care of patients as a result of any learning identified. We found both learning within and across teams took place. Staff told us, and we observed safety and risk was always discussed in team meetings.

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

Patient care and treatment was planned effectively, which helped to achieve good outcomes.

Patient needs were comprehensively assessed. Staff delivered care that was in line with patients care plans, and that reflected their individual needs. Staff received training, supervision, support and professional development that enabled them to deliver effective care.

We found the way in which the multidisciplinary team worked together was excellent, and information was shared appropriately.

Our findings

Assessment of needs and planning of care

We saw that patients had an initial detailed risk assessment and management plan (DRAM) completed which highlighted their individual risks. We saw the DRAM was linked through the IT system to assessments for risk of self harm or harm to others, self neglect, vulnerability and relapse. We saw these assessments were completed in all the seven patient records we reviewed. The system included the most recent incidents and saw risk assessments and management plans were reviewed as a result. This meant that risk assessments were reviewed following incidents so staff had the most up to date information about patient risk indicators.

We saw that risk management and care plans were amended as a result of reviews so staff had up to date information on how to manage risks.

We noted during home visits that community mental health nurses routinely provided information to patients about their medicines and potential side-effects. For example information about mood stabilising medication and long term anti-psychotic intramuscular injections used.

The community teams used a duty system to ensure that calls to the teams could be responded to quickly. We noted that staff on duty were knowledgeable about individual patients being supported and cared for by the team and were able to respond effectively to enquiries from other agencies. Staff on duty knew about on-going risks and how they were being managed.

Patient's needs were assessed and care was delivered in line with their individual care plans.

When we reviewed patient's health care records we found detailed descriptions of patient's needs with clear management plans in place.

Comprehensive summaries of patient's care were available and we saw evidence to show that patient's physical health needs were assessed and responded to.

There were individual relapse/crisis plans in place to support patient using the service in case they were needed. This included information on relapse triggers and indicators and who patents should contact in case of crisis/ relapse.

The promotion of good physical and mental health was evident in case discussions we observed in a community mental health team meeting. Staff had good knowledge of the physical as well as mental health needs of older patient.

The consultant psychiatrist from the appropriate CMHT provided medical cover for patients under the FICS team. However, when a patient was on leave from an inpatient ward nominal responsibility remained with the appropriate ward consultant during their usual working hours.

Assessment requests to the FICS team following triage was normally completed within 2 hours of receipt of the referral. This was normally a senior nurse within the team or shift co-coordinator. The purpose of the triage was to establish the key facts about the crisis, the risk factors and the patients' support networks to decide if the referral was appropriate for FICS to accept the referral and assess how quickly a response was needed. The triage nurse considered the urgency of the referral and the required response including arranging the time and date of response.

The initial assessment, care and risk plan were developed using the DRAM and a patients was allocated a key worker for the duration of their involvement with the FICS team. The Key Worker was responsible for ensuring that the care plan was implemented, up to date and reviewed within the MDT.

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A professional advisor who was a consultant psychiatrist attended a consultant led multi-disciplinary team (MDT) meeting for the DRRHTT team. At the meeting the referral process was discussed. We were told routine referrals were initially seen by two triage nurses and then had to wait for the MDT meeting of up to a week before being allocated to a worker who then had one week to provide an assessment appointment. Similar arrangements were in place for a medical appointment for diagnosis and treatment.

Best practice in treatment and care

A range of tools and scales were used to make assessments of patient's mental health needs, such as health of the nation outcome scale, falls risk assessments, suicide screening tool. National institute for clinical and health excellence (NICHE) guidance on depression and dementia and relapse signatures and prevention plans recorded in care programme approach discharge plans. Occupational therapists used the assessment of motor and process skills (AMPS) standardised functional assessment.

Staff provided care to patients based on national guidance, such as National Institute for Clinical and Health Excellence (NICE) guidelines. Staff were aware of recent changes in guidance. For example, a staff member told us about the NICE guidelines for delirium and how these were reflected in their practice.

Record keeping audits and audits of care planning were carried out regularly. Performance targets included a target of 12 months for conducting care programme approach (CPA) reviews and follow-up within seven days of patient discharged from older patient's inpatient services. We saw the governance monitoring tool for monitoring how many patients did not have a care plan in place after 6 weeks. Team managers told us the seven-day follow-up target was routinely met and we saw carers were offered a carers' assessment as part of the patients' assessment process.

Senior staff told us assessment of patients covered medication reconciliation and followed NICE guidance on the prescribing and use of anti-psychotic medication. Monitoring of medicines was by the registered mental health nurses working in the community teams for two weeks while the medication was adjusted to meet the patients' needs. Patients were then monitored by the CMHT. The registered nurses in the CMHT for older people also took part in a study of the use of antipsychotic medication.

The DRRHTT team provided rapid intensive holistic assessment and intensive short term support/interventions for patients with dementia in crisis. This was in the patient's own home or residence. The team approach was to meet patients' unmet needs, optimise care interventions and avoid admission to hospital and care homes where appropriate. The team adopted the 'Newcastle challenging behaviour teams' evidence based model of dementia care. This approach was taken to optimise the overall quality and application of best practice needs to be implemented by all members of the team. A recent report identified the following team successes.:

- In 2012 the team had 350 referrals of which only 25 were admitted to hospital. As a result, the number of beds could be gradually reduced from 44 to 18 for a total population of 500.000. Even with this the trust still only average 75% occupancy on the assessment ward.
- Antipsychotic prescribing was reduced; of the patients on antipsychotics at the point of referral, 25% had it either stopped or reduced and only 4% had an anti-psychotic initiated (all for psychotic symptoms).
- All evidence demonstrated that the quality of care from dementia service was greatly enhanced; it was achieved thorough innovation, leadership and multidisciplinary teamwork, and it was all achieved within budget.

Skilled staff to deliver care

Community mental health teams (CMHT's) typically consist of a consultant psychiatrist, community psychiatric nurses, support workers, occupational therapists, social workers and psychologist. The older people's CMHT's do not have social workers embedded in them.

Our data pack did not identify any concerns from the community mental health survey relevant to the effective domain.

Staff received appropriate training, supervision and professional development. Staff told us they had undertaken training pertinent to their role and that the trust was very supportive in respect of staff training and development. Records showed that most staff was up to date with statutory and mandatory training requirements.

Staff were well supported to attend additional specialist training and development opportunities. For example, the recognising and assessing medical problems in psychiatric settings (RAMPPS) physical care training programme, which

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was open to all teams including medical staff, nurses and support workers. This was a web based interactive training programme (1 day with 30 visual screens). It provided the staff teams with immediate feedback. It had been used for two years. We received very good feedback received from staff about the training and suggested it is better than statutory and mandatory training they received from the trust. Staff also undertook training in cognitive behavioural therapy, an introduction to medication and side effects, Mental Capacity Act 2005, Mental Health Act and MHA Code of Practice and all staff had either attended or were booked on safeguarding adults training.

Staff supervision was ongoing and the staff nurses were supervised by the senior staff. Support workers were supervised by staff nurses monthly.

In a small focus group administration staff described a clear process of referral management and were able to access records and process reports and letters promptly as clinicians ensured these were complete without delay.

The specialist registrar we spoke with described good access to continuous professional development and good multi-disciplinary working and communication, which they believed was due to the teams and different disciplines being based at Edmund Road.

FICS

We spoke with staff of the FICS team in a focus group and observed a handover of the team. We saw staff were supported by the team manager or band 6 nurses. The band 6 nurse held the role of coordinator and was considered a senior practitioner. The role operated from 08:00 to 17:00 Monday to Friday. The coordinator was responsible for receipt and triage of referrals, screening for appropriateness, allocating appropriate staff to undertake initial visit and liaison with the referrer / patient. The coordinator managed and coordinated the day to day operation of the team.

Staff in the FICS told us there were regular team meetings and separate meetings for registered nurses. Staff said a 'supervision tree' was in place, which identified which staff member was responsible for supervising them. In addition there were weekly reviews of all patients undertaken and all staff on duty attended these. Staff told us this supported them to discuss complex patients and identify the management of risk.

Registered nurses told us they received supervision every six to eight weeks as well as peer group practice. Staff said they valued the reflective practice groups led by the psychologist where they could discuss complex patients and formulate plans of care and risk amazement. Staff told us the manager monitored training and development through supervision, which was an improvement as they could talk about their own individual training needs.

Staff said they were supported by their team and service managers and were encouraged to contribute toward the teams' development. One staff member told us, "I recently returned to work following long term sickness. It has been a pleasure to come back. I had an induction and the support has been great". Another staff member told us, "I see patients improve through good team work, we link to other disciplines and have a diverse team and MDT works really well". Staff told us the trust were looking at introducing 'Schwartz round'. Schwartz rounds were a monthly open meeting for a defined group with lunch. It is an open meeting to provide a space and a place to discuss the emotional impact of the work people do

We observed a staff handover of DRRHTT team members and saw this included good multidisciplinary information about patients. Staff said working extended hours 365 days per year and understanding their roles within the team and the time allowed to assess patients' benefitted patient care. In our small focus groups and interviews with staff DRRHTT members told us they only had small case loads, which varied dependent upon the level of experience and role of the team members. This was controlled through case management and the team did not have a waiting list as they only supported patients for time limited periods.

Multi-disciplinary and inter-agency team work

Assessments of patient were multidisciplinary in approach, with involvement from medical, nursing and occupational therapy. There was evidence of effective multidisciplinary team (MDT) working in patient's records. Patient had access to a range of professionals with specialist skills, such as cognitive behavioural therapists where needed. We saw that care plans included advice and input from different professionals involved in patient`s care. In all community teams we found staff valued the different disciplines in the team and worked well together.

Are services effective?

Good

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Information sharing between inpatient mental health wards and community services was effective and staff told us they worked well together. We saw two good examples of communication about the discharge of patients using the older peoples' service from acute hospital wards.

The community teams did not have social workers embedded within the team. This was a recent development. Concerns were expressed by the MDT about the difficulties they experienced in accessing social service staff for best interest meetings for vulnerable patients needing extra supervision. This problem had escalated over the last 6 months when social services staff had been moved from being located with the CMHT and other teams. Staff members said the impact of not having direct access to social worker staff was problematic in other areas, for example obtaining a social care assessment.". As a result we understand the service manager arranged a meeting with social care managers to try and resolve this.

The CMHT staff may undertake the assessment of the patient at home and make a decision to either admit the person to the ward or offer intensive treatment and interventions in the person's own home via the FICS team. The CMHT worker would advise FICS what service was required initially and the risks identified by the CMHT. The MDT agreed an appropriate care and risk management plan. The care plan review, risk review and intervention review was undertaken by FICS in liaison with the CMHT and the appropriate consultant in the CMHT where the patients lived. Ongoing assessment and monitoring of the patient's mental health based on the agreed plan of care was undertaken during their involvement with the FICS

Reviews were undertaken in the weekly MDT meeting, were discussed in handovers on a daily basis when contact made or any issues arose and an appropriate consultant may be requested to review a patient if needed. All reviews were recorded.

A professional advisor who was a consultant psychiatrist attended a consultant led multi-disciplinary team (MDT) meeting for the DRHTT team. We saw the process of the MDT meeting was efficiently led by the consultant and access to IT based case notes helped in this process.

Adherence to the MHA and the MHA Code of Practice

We have no comments to make as there were no patients cared for by the team on community treatment orders. Teams contained or had access to approved mental health professionals (AMPH's) who could access inpatient beds if patients had been assessed under the Mental health Act 1983 and required detention.

Good practice in applying the MCA

Staff had undertaken training in the Mental Capacity Act (MCA) 2005 and Deprivation of Liberty Safeguards (DoLS), which was updated every two years. Staff we spoke with demonstrated good understanding of the MCA. They were aware of recent legal decisions in respect of the MCA and how this affected their practice.

When reviewing patient's health care records we noted patients' capacity was recognised and records showed formal consent to care and treatment. Where patients' capacity to understand their care or treatment this was managed by use of 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

Staff provided kind and compassionate care and support to patients and their carers.

Patients dignity and respect was seen to be paramount to staff. Staff provided person-centred care and there was clear evidence that carers were also involved. We found he services were focused on the patients they cared for as individuals, and staff were committed to providing good quality care.

Our findings

Kindness, dignity, respect and support

We accompanied several community staff on visits to patients, with their permission. Patients and carers we spoke with were very positive about the older peoples' community service. For example, we accompanied an occupational therapist from the DRRHTT team to a patient with memory difficulties. The purpose of the visit was clearly explained to the patient and their family member. The visit was conducted with sensitivity and goals discussed with the patient about using information technology to help them to be safer in the community by using a portable satellite navigation/tracking system.

We visited another patient supported by the FICS team. This was a discharge meeting. The patient confirmed how the staff member had referred them to other services for their health problems. The staff member went through the discharge and left a discharge plan the patient had agreed to. The staff member confirmed they had referred the patient to a befriending service. The patient thanked the staff member for their kindness and patience.

A person we visited in the community told us they were very happy with the service they received from their community psychiatric nurse.

This was typical of feedback we received from patient using the service and carers. When we observed staff interactions with patient using the service, we saw they were kind, compassionate and respectful to patient. They demonstrated a caring and understanding attitude. When patients were discussed during referral and allocation meetings this was done respectfully and staff showed real empathy for the patient they spoke about and worked with. Staff demonstrated respect for patient's cultural beliefs.

Information provided to us by the trust as part of our data pack was from the community patients' survey. The number of responses had risen to 271 responses, which was up by 32%.Red risk areas identified patients not having personal circumstances considered as part of care planning and family members were not 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 patient in the care they receive

Patients were involved in their care. Patient's choices were respected and we saw examples of when care had been refused and this had been respected. When patient had asked for a change of consultant or allocated community mental health nurse, the request had been accommodated and a different nurse or consultant assigned. We found information in patient's care records about how patients were being involved in care planning.

Community staff told us that they involved patient and their carers in patient's care as much as possible. They supported carers directly and signposted them to other organisations for additional support. We saw carer assessments were offered to carers as part of the patient's assessment process and staff recorded the outcome of the offer on an assessment to carers.

We observed considerable emotional support provided to carers and patients by staff. Staff were committed to working towards patient's recovery. Written information about diagnoses and treatment was given to patients and carers to take away. Patients were given a patient information leaflet about the older peoples' community mental health teams. This included information about operating hours, medical and mental health nursing assessment, psychological assessment and intervention, occupational therapy assessment and intervention, medicine management, relapse privation and recovery support, health promotion and working with other teams.

Good

Are services caring?

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

For example referral to the Sheffield memory service or crisis team on discharge if necessary. The information leaflet also told patients about how they would be involved in planning their care and treatment.

The service was in the process of developing a feedback form based on the friends and families test. The service manager told us this was going to piloted once agreement had been sought through the clinical governance team. This will ask questions about team performance and allow patients to make comments about their care. Respondents can be anonymous as self-addressed envelopes will be provided to patients to send their comments back.

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

Services for older people were responsive to patients' needs.

There were clear care pathways in place, and the teams understood patients' needs and wishes and could respond to these. Services were also planned and delivered in a way that met the different needs of the local communities. In addition, there was an extended community service, which operated seven days week and ensured services were responsive.

Our findings

Access, discharge and bed management

Referrals to the older peoples' community mental health teams (CMHT's) were accepted from GPs and specialist services within the trust.

The service provided support for patients 65 years who had a functional mental health need and in line with the trust transition protocol of adults to older adult services. This also included a clear inclusion criteria for access into the teams that covered organic and functional mental disorders and was based on the needs, risks and Mental Health Act status of patients.

The community teams provided care and treatment to patient operating over five days.

We observed a referrals meeting taking place and noted that patient were allocated to staff according to their needs. Waiting times for services were monitored. The service manager told us the average time for waiting for an assessment following initial referral was between 22and 27 days for the four older person's CMHT's due to demand and patients were prioritised dependent upon risk. The IT system was able to monitor if patients were seen outside of the 28 day waiting time and flag this so patients were not lost in the system..

Community staff told us that if an inpatient bed was needed for a person using the service this was nearly always available. They told us that access to inpatient beds could be arranged for patient in advance where there were concerns that they may not be able to maintain their safety at home. Patients were well supported in the community which reduced the need for inpatient beds. Staff described several examples of good preventative work with patient that enabled them to remain at home and good contingency planning meant patient rarely needed to use crisis services, though access to the crisis house was an option to support patients. Staff also commented on the move to Edmund Road in how this had provided better acceptance of referrals. One staff member told us, "Since we moved here accepting referrals has improved 100% as we're all less than one roof. I can access the consultant more easily.

Staff were able to access patient's acute care electronic records in order to monitor test results. This helped in the prioritisation of assessments as the information indicated the person's level of medical fitness.

The community teams followed-up patient promptly after they were discharged from the in-patient mental health wards. They were good at meeting the target of follow-up within seven days.

Information provided by the trust as part of our data pack was the proportion of patients on the care programme approach (CPA) who were followed up within 7 days of discharge was similar to the national average. The most recent quarter, June 2014 shows a score of 96.5%, just below the England score of 97%.

Systems in place to ensure the effective transfer of patient from acute adult teams were good. Discussions took place between services to ensure the person was placed with the team that could best meet their needs. There was no strict age cut off for transition from one service to another. Decisions were based on the needs of the individual.

Delayed transfers of care were measured by both the number of days delayed and number of patients who experienced delays had been variable over the period September 2013 to August 2014. There had been a gradual reduction in the number of delayed days at the trust from a peak of 422 in November 2013 to 237 in August 2014. The number of patients with a delayed transfer of care has fluctuated between nine in September 2013 to a peak of 16 in May 2014 to eight in August 2014. From this information we conclude the trust was responding appropriately to ensure patients' transfer of care was not delayed.

When we observed a community team handover/ allocations meeting we noted that care was patient centred and responsive to patients' individual needs.

Good

Are services responsive to people's needs?

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

Referral to the service was through the community mental health teams (CMHT) then referred onto FICS. Referrals from the CMHT were accepted by FICS between 09.00 and 17.00, Monday – Friday. When required initial assessment were undertaken by the CMHT member who would make a decision to refer to the FICS. FICS did not accept referrals outside of normal hours. Referrals outside normal working hours were directed through GPs, GP collaborative and accident and emergency. The crisis assessment service was available to manage a crisis or a mental health act assessment.

Referral to the FICS from the mental health inpatient service was through multi-disciplinary team (MDT) meetings. Patients could be referred to the CMHT for further support following discharge from the FICS discharge service.

FICS also offered an admission avoidance and discharge support service. Referrals were accepted form the CMHT's, liaison psychiatry, GP via the CMHT as an emergency or when in crisis, a risk of self harm and harm to others, required intensive treatments or case management and assessment under the Mental Health Act.

Discharge support was for patients returning home where it had been assessed that additional discharge support was required. The service offered assessment of the patients' mental health to promote recovery and self management and support them in compliance with their agreed discharge treatment plan. This was short term service aimed at supporting patients to maintain their independence. FICS would do the seven day follow up following discharge if it was the most appropriate team to do this and agreed as patients were discharged.

We saw referrals to the DRRHTT were accepted from the older adult community mental health teams, specialist services within Sheffield Health & Social Care NHS Foundation Trust and GPs. Referral was accepted for patients with an established diagnosis of dementia or working diagnosis of dementia who were experiencing some degree of crisis that required rapid assessment and intensive short term interventions. This included helping manage discharge from the specialist older adult wards within the trust. Information provided by the trust was the 7 day follow up on discharge is not consistent fluctuating between 90 to 100%. The national average was 97%. This meant patients who presented a risk may not be followed up within seven days of discharge and the risk of relapse could increase.

The service optimises recovery, comfort and dignity

From our observations of staff engagement with patients, families and carers and comments we received about the service. We saw patients' needs were responded to promptly for example prior to one visit staff were informed of a change in the patient's health, so the staff member was able to prepare in advance to manage the visit.

Patients and their families told us the service was responsive and often staff would go the 'extra mile' or do 'a little bit extra'. One relative told us, "They even helped with his washing". During our visits we saw staff responded openly and honestly to questions from patients and carers and were able to provide them with information about the service, medicines they were prescribed and other services they could access.

Policies and procedures minimise restrictions

The service was able to support patients' discharge from hospital, access an inpatients be when needed and support patients through a crisis and receive treatment at home. We saw an example when a community mental health nurse responded to a relative's concern about their family member by telling them about the 'buddy', which a portable satellite tracking system was used to monitor where a person was, when they went out. We saw the patient was given an explanation of how this worked which meant the patient could go out and not be restricted to their home, as their relative would be able to know where they were. The team were not supporting patients on a community treatment order (CTO). However a CMHT service manager told us until recently the team had supported a patient on a CTO. The patient had relapsed and due to the team's good relationship with the patient, meant they were able to support the patient to return to hospital for treatment with dignity.

Meeting the needs of all people who use the service

We noted that access to psychology services was good across the community teams. The older peoples 'community mental health team dash board for October

Good

Are services responsive to people's needs?

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

recorded the psychologists were supporting 40 patients across the teams. The psychology service was limited to patients with more complex needs and could be accessed within four weeks of referral.

Clear care pathways were evident. The acute liaison team worked closely with staff in acute hospitals and intermediate care and responded quickly to referrals for the assessment of older patient. Community reams were described as responsive by patients' relatives. One relative commented, "Rapid response were excellent and came to my home to assist in care. They even helped with laundry".

Patient's diversity and human rights were respected. Staff had undertaken training in equality and diversity although this was in need of updating. Patients from black and ethnic minorities could be referred to a staff based in the CMHT recovery teams who had specialist knowledge and skills around providing cultural sensitive services. There was a transcultural team until July 2014, which took such referrals. Four of the team were redeployed to the CMHT recovery teams but were still accessible to offer support and advice to the older peoples' community mental health services.

Listening to and learning from concerns and complaints

There was a system in place to learn from complaints. We saw information on how to make a complaint was displayed in community team offices.

The trust received 147 written complaints in 2013/14, 4 more than the previous year. 18.4% of complaints received in 2013/14 were upheld, a decrease from the previous year. The older peoples community mental health team had received one written formal complaint as recorded in the governance report template for July 2014.

Information on the patient advice and liaison service (PALS) and independent mental health advocacy services were also available. Patients who were seen by community staff at home were provided with information on how to make a complaint or contact the patient advice and liaison service (PALS).

Staff told us they tried to address patients' and carers' concerns informally as they arose and provided examples of changes made to patient's care as a result. For example if a patient wanted to change their care worker. Most patient and carers we spoke with told us they felt they would be able to raise a concern should they have one, and believed they would be listened to by staff.

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

The trust's vision and direction was communicated effectively to staff.

The governance structure in place also supported the delivery of the service. Services for older people were joined-up and well-led.

Our findings

Vision and values

Staff told us they understood the vision and direction of the trust and most felt connected to senior management and the trust board. Trust messages were cascaded via a regular newsletter and in team meetings.

Good governance

There was a clear governance structure in place that supported the safe and effective delivery of the service. Lines of communication from the board and senior managers to the frontline services were mostly effective, and staff were aware of key messages, initiatives and the priorities of the trust. Staff understood the management structure and where to seek additional support.

For example the specialist directorate senior management team minutes from February to July 2014 reflected how the trust was developing the governance arrangements further. This included the introduction of the governance dashboard which had been piloted by the memory services and was being introduced into the community teams. Community teams were also piloting remote working and the use of tablets as part of information technology.

A review of the dementia rapid response and home treatment team (DRRHTT) team in 2013 highlighted that 64% of patients referred to the team continued to live in their own home. Patients gave a satisfaction rate of over 90% with the service for the patients and their family or carer being involved in their care planning, the care patients received, staff understanding patient's needs, being treated with dignity and level of communication from the team. Staff in the team gave a satisfaction rate of over 90% with the leadership of the team, understanding their roles, training, their input being valued and feeling they provided a quality service. The result of the review of the service concluded there is a demand for this team as there were fewer patients being admitted to hospital as a result and fewer patients needing 24 hour care. Patients, carer and staff feedback was excellent.

The DRRHTT used a patients and carer questionnaire to gain feedback about the assessment of patients, care provided and discharge form the service. In addition the service was using an evaluation of the service the patient received. This looked at the patients' diagnosis, referral information received, care arrangements at the point of referral and discharge, if medication was prescribed, other interventions such as a nursing plan or memory diary, length of stay with the team and if discharge was delayed.

Local governance arrangements were monitored through the older adult community services dashboard. This allowed the service manager to monitor access to services via the number of referrals, assessment within four weeks and crisis intervention if needed. Monitoring of team goals through performance indicators/activities were monitored for effectiveness of the service to ensure best use was made of the team resources. Data was monitored to ensure patients were seen by the appropriate clinician and that care was safe and coordinated. Data included information about team case loads and the numbers of referrals and discharges.

Staff told us they were also being offered coaching on the use of microsystems to support the development of individuals and teams to support the improvement of health care. For example improvement of the multi-disciplinary team meetings. Microsystems are made up of staff who work together on a regular basis to provide care to patients. This includes the clinical care of patients by developing good practice, sharing information and identifying outcome for both patients and the service.

We saw team governance templates setting out the teams objectives, how they would be measured, progress made and action plans for remedial measures identified to progress the plans forward. The trust team governance meeting minutes followed the five key questions we use at our inspections. We saw these focused on safety and risk, staffing, complaints as some examples.

Staff sickness rates at the trust have been consistently well above the England average for mental health and learning disability trusts over the two years between April 2012 and March 2014. The trust's average for the most recent quarter

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of data January to March 2014 was 1.3% higher than the average for Yorkshire and the Humber across all NHS organisations. In the older peoples mental health teams the average sickness rate reported was 5%.However at the time of our inspection there was no staff sickness. There were vacancy rates of 8% in the older peoples' community mental health team south east, but we did not receive any feedback form patients, relatives or staff that this was impacting upon the service provided.

Leadership, morale and staff engagement

Staff told us they were engaged with the executive team but this could be improved. A staff member said, "… (chief executive officer) spent the day with us three weeks ago. He's very visible and quite honest. We had a non-executive director (NED) visit about three months ago, but this was rescheduled after fifteen minutes. I would like to see more execs and NED's come and do a full day with us and sees the reality of how hard we work".

We found the community mental health teams for older patient were well-led and there was evidence of clear leadership at a local level. Team managers were accessible to staff. The culture of teams was open and staff were encouraged to bring forward ideas for improvements in care. Most staff told us they felt valued and empowered to develop and improve the service.

The service manager described a supportive culture within the service and local teams. They said the understanding of staff about the local and trust vision had changed and said senior managers were supportive and accessible. The community team as a whole was described as 'caring and dedicated'.

Staff told us about the local initiatives to include staff in the development of services. An example was the 'journal club'. A senior nurse explained they had taken the lead on this for their team and brought in relevant articles from health and social care journals to discuss with the staff team.

We spoke with staff at different levels in the community mental health teams for older people.

All staff reported feeling supported by their manager, and service manager with one manager being described as "quite inspirational, I feel valued and recognised". Staff were kept up-to-date about developments in the trust through regular newsletters and emails. The views of staff were collected through supervision sessions and at team meetings. Most staff told us they felt confident in being able to raise concerns.

At focus groups we organised, a number of community staff expressed feelings they said they had been consulted on changes taking place they felt that their views had been listened to and taken on board by senior management. A senior nurse in the team told us about an initiative they were piloting on behalf of the trust called, 'love and nuts'. They explained they had canvased all staff on information about what they 'love' about their work and what drove them 'nuts'. They said, "This is meant to reach the parts other teams don't. This is trust led and about what you can improve in the workplace. We had a meeting yesterday and everyone loves 'love and nuts'. The potential for change is good as we will have staff as team level representatives".

Commitment to quality improvement and innovation

Community staff told us they had access to ongoing leadership training and development which had been very beneficial in terms of increasing skills and confidence in managing teams and engaging with trust managers.

The service manager told us about work in progress within the teams, for example creating a direct referral process for hospice care and fast track access for patients discharged from the service who had been referred.

Staff told us about the pilot they were going to be involved in on the use of assistive technology to promote flexible remote working and arrangements for this were being finalised.

Data on performance was collected monthly. Performance measures included completion of staff training and appraisal and clinical measures such as the number of incidents and complaints reported. Performance against these targets was monitored by senior managers to ensure any shortfalls were addressed. Where performance did not meet the expected standard action plans were put in place and implemented to improve performance.

Requirement notices

Action we have told the provider to take

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

Regulated activity	Regulation
Treatment of disease, disorder or injury	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment **How the regulation was not being met:** We found that community nursing staff routinely repackaged medicines into compliance aids where patients had been discharged to the community teams. Staff were repackaging medicines as part of monitoring patients' compliance with medication. Trust procedures were not followed and these compliance aids were not properly labelled with their contents and dose instructions. **Regulation 12(f)** **The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014**