WM QRS

**West Midlands
Quality Review Service**

NHS

Reviews of Mental Health Services, Health Services for People with Learning Disabilities, Dementia Services and Care of Vulnerable Adults in Acute Hospitals

Coventry and Warwickshire Health Economy

Visit Dates: 14th, 15th, 16th, 17th, 20th, 21sth, 22nd & 24th June 2011   Report Date: September 2011

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Compliance tables for Appendix 2 can be found in a separate document.

INTRODUCTION

ABOUT WEST MIDLANDS QUALITY REVIEW SERVICE

West Midlands Quality Review Service (WMQRS) was set up as a collaborative venture by NHS organisations in the West Midlands to help improve the quality of health services by developing evidence-based Quality Standards, carrying out developmental and supportive quality reviews - often through peer review visits, producing comparative information on the quality of services and providing development and learning for all involved.

Expected outcomes are better quality, safety and clinical outcomes, better patient and carer experience, organisations with better information about the quality of clinical services, and organisations with more confidence and competence in reviewing the quality of clinical services. More detail about the work of WMQRS is available on http://www.wmqi.westmidlands.nhs.uk/wmqrs/.

This report presents the findings of the review of mental health services, health services for people with learning disabilities, dementia services and care of vulnerable adults in acute hospitals which took place on 14th, 15th, 16th, 17th, 20th, 21st, 22nd, and 24th June. The visit reviewed compliance with, and identified related issues, for the following WMQRS Quality Standards:

- Mental Health Services, Version 1, February 2011
- Health Services for People with Learning Disabilities, Version 1.1, December 2010
- Dementia Services, Version 1, February 2011
- Care of Vulnerable Adults in Acute Hospitals, Version 1.1, December 2010

These visits were organised by WMQRS on behalf of the following Care Pathway Groups: West Midlands Mental Health Care Pathway Group, West Midlands People with Learning Disabilities Care Pathway Group and West Midlands Dementia Care Pathway Group.

The report gives external assurance of the care within the Health Economy which can be used as part of organisations' Quality Accounts. For commissioners, the report gives assurance of the quality of services commissioned and identifies areas where developments may be needed.

The report reflects the situation at the time of the visit. The text of this report identifies the main issues raised during the course of the visit. Appendix 1 lists the visiting ream which reviewed the services at Coventry and Warwickshire health economy. Appendix 2 contains the details of compliance with each of the standards and the percentage of standards met.

ACKNOWLEDGMENTS

West Midlands Quality Review Service would like to thank the staff and service users and carers of Coventry and Warwickshire health economy for their hard work in preparing for the review and for their kindness and helpfulness during the course of the visit. Thanks are also due to the visiting team and their employing organisations for the time and expertise they contributed to this review.

KEY POINTS

1   This review visit covered Coventry and Warwickshire and, for health services for people with learning disabilities, Solihull. The visit identified several areas of excellent practice and some areas where further work was needed. Across the health economy there were good working relationships and good insight into the issues which needed to be addressed. Reviewers were concerned about differences in provision of services between the localities.

2   Mental health liaison services in acute Trusts were identified as a health economy-wide immediate risk. In South Warwickshire there was no acute liaison service and, in practice, across the health economy there was no out of hours service for people aged over 65 as crisis teams were only commissioned to provide care for adults of working age.

3   Reviewers were particularly impressed by the Coventry and Warwickshire Partnership NHS Trust approach to care planning, with a good policy, training and a pilot of hand-held electronic recording. A robust approach to medicines management was in place, especially on in-patient wards. Good use was made of quality dashboards and there was a monthly matron's quality report which was well-publicised in clinical areas. Very active use was being made of the 'productive series'.

4   Deprivation of Liberty Safeguards was covered briefly at staff induction but there was no policy within the Coventry and Warwickshire Partnership NHS Trust and no regular programme of awareness training. Reviewers were also concerned that there was no Trust policy on the use of Community Treatment Orders. Issues around admission of young people aged 16 to 18 to adult wards were identified in several services.

5   Reviewers suggested further work on points of access, further development and implementation of care clusters and clinical guidelines, and audit of implementation of guidelines.

6   IAPT services were available across Coventry and Warwickshire and reviewers were impressed by the range of initiatives targeted at different groups within the community and the group feedback at the end of each session. Concerns were raised about the low proportion of appropriate referrals, long waiting times and relatively low recovery rates.

7   Reviewers were impressed by many aspects of Early Intervention services across Coventry and Warwickshire and by the way in which these services were working together.

8   Crisis Resolution / Home Treatment teams for working age adults were aware of the challenges they faced and were working together to tackle these. Reviewers were concerned about the low number of medical staff within the service. A good range of alternatives to admission was available. The service was still working on staff training and clinical guidelines, including for medical review of patients,

9   In-patient services at the Caludon Centre, Coventry and St Michael's, Warwick were both welcoming and provided a good environment for in-patient care. Reviewers saw several examples of good practice, including the work of the discharge liaison nurses and the training programme for Health Care Assistants.

10   Assertive outreach services were working well and working hard to ensure that service users were not admitted to hospital unnecessarily. Services users were very positive about the care they received. Psychology input was low in the Coventry team.

11   Inconsistencies in the way community mental health teams worked across Coventry and Warwickshire were identified. There was a good 'PASS card' in Coventry which helped service users to access services. Carers workers specifically worked with carers to ensure their needs were addressed. Work was in progress on referral criteria, care clusters and clinical guidelines.

12   Coventry and Warwickshire Partnership NHS Trust provided a wide range of services for older people with mental health problems. Reviewers were impressed by several aspects of the services offered but were concerned about the lack of data collection. Further work was suggested on reducing fragmentation of the patient pathway, arrangements for CT scanning and reducing reliance on institution-based care.

13   Community teams for people with learning disabilities and the Gosford in-patient unit provided a generally high standard of care with several examples of good practice. Health facilitation and work with general practices were particularly strong. Community teams were in a process of transition. The four teams worked very differently and were moving towards a single point of entry in each locality. Work on care clusters and service re-design was also taking place.

14   The three acute hospital Trusts visited, George Eliot Hospital NHS Trust, University Hospitals Coventry and Warwickshire NHS Trust and South Warwickshire NHS Foundation Trust were providing generally good care for vulnerable adults. George Eliot Hospital had given particular attention to improving the quality and safety of care for this group of patients. Policies and training at all three hospitals showed some lack of understanding of the difference between the Mental Health Act, Mental Capacity Act and Deprivation of Liberty Safeguards.

HEALTH ECONOMY

General Comments and Achievements

The visit to Coventry and Warwickshire health economy identified several areas of excellent practice and some areas where further work was needed. Across the health economy there were good working relationships and good insight into the issues which needed to be addressed. Plans for the development of services were in place along with, in places, resistance to these changes. Reviewers encouraged the health economy to continue with the planned changes, and to strengthen their mechanisms for feedback from service users and general practitioners.

The review covered Coventry and Warwickshire and, for health services for people with learning disabilities, Solihull. Section 75 agreements were in place across Coventry and Warwickshire (but not funding agreements) and social workers were formally seconded to all mental health teams. The main provider organisations reviewed were Coventry and Warwickshire Partnership NHS Trust, George Eliot Hospital NHS Trust, University Hospitals Coventry and Warwickshire NHS Trust, and South Warwickshire NHS Foundation Trust. A range of third sector organisations also provided care and support to people with mental health problems, learning disabilities and dementia.

Immediate Risks:

1   **Mental health liaison services in acute Trusts**

    At the time of the visit there was no mental health liaison service within South Warwickshire NHS Foundation Trust and, in practice, no formal service for people with mental health problems aged 65 and over outside normal working hours across Coventry and Warwickshire. As a result, access to an urgent mental health assessment could be significantly delayed and patients were admitted to the acute Trusts while waiting an assessment. As well as the impact on these individuals and their families, this placed particular pressure on acute Trust staff and could affect other patients. Mental health liaison services were available during normal working hours at George Eliot Hospital NHS Trust and University Hospitals Coventry and Warwickshire NHS Trust. Crisis teams were available outside working hours but were not commissioned to care for people aged 65 and over. The 2011/12 service specification for Community Mental Health Teams for older people identified arrangements for urgent assessment but this was not yet reflected in practice. Reviewers were told that the crisis teams would sometimes see someone over 65 on a 'grace and favour' basis. This issue was identified as a concern in all 2010 Coventry and Warwickshire urgent care review visits. Since then the 'in hours' service at South Warwickshire NHS Foundation Trust has reduced and attempts to resolve the issue have not been successful.

Good Practice

1   There was a good policy on information sharing supported by service agreements and guidance for staff.

Concerns

1   DOLS - awareness & training

Issues around DOLS training and awareness are raised in the sections of this report relating to all provider organisations. Health economy-wide action to address this is therefore needed as people may not have access to a DOLS assessment when required. The level of referrals for DOLS assessment appeared low and, in practice, arrangements for access to a DoLS assessor were not robust.

2   Variation across services and localities

Availability of services, staffing levels and pathways varied across Coventry and Warwickshire. In some cases this was a result of specific commissioning decisions (for example, the Young Onset Dementia service was available for Coventry residents but not for Warwickshire), in others it was a response to a specific service change (for example, the establishment of the Community Assessment and Treatment Team in Rugby) but in others it appeared to be based on history or the interest of particular clinicians. Teams were often not aware of the referral and acceptance criteria laid down in service specifications and these criteria were not usually reflected in operational policies. Reviewers suggested that the health economy considers together the availability of services in each locality, and the differences between localities, to ensure that these give an appropriate response to local needs.

Further Consideration

1   Multiple Points of Entry

'Single point of entry' services had been established in three localities (Coventry, North Warwickshire and South Warwickshire) for adult mental health services and for older adult mental health services. For community learning disability services these were four 'single point of entry' services (ie. including Solihull as well). Direct referral to consultants and direct referral to individual teams were also in place. The 'single points of entry' services worked differently in different localities. Reviewers suggested that more work is needed with GPs, commissioners and Coventry and Warwickshire Partnership NHS Trust to ensure that points of entry to mental health, learning disability and dementia services are made simpler and more consistent. It may also be helpful to involve local authorities in this work to ensure that pathways to services such as social care and housing are also robust.

2   Transition to adult care

Reviewers were told that young people were transferred from CAMHs to adult care at age 17 but did not have access to crisis resolution / home treatment services until age 18, unless they were being cared for by Early Intervention Team. (See also the concern about admission of young people aged under 18 to in-patient care.) Commissioners and providers should ensure that young people aged 17 are able to access an appropriate range of services.

3   **Linking patients' care to locally authority funded personalised care**

Personalised care was being actively promoted by the Coventry 'POD' service. The promotion of personalised care for Warwickshire residents was less clear.

4   **Out of hours Mental Health Act assessments**

The process for accessing a Mental Health Act assessment was different for Coventry and Warwickshire. It may be helpful to review whether a common system could be introduced which would be simpler for staff to understand and follow.

MENTAL HEALTH SERVICES

TRUST-WIDE

COVENTRY & WARWICKSHIRE PARTNERSHIP NHS TRUST

General Comments and Achievements

Coventry and Warwickshire Partnership NHS Trust was formed in 2006. From April 2011 the Trust also provides community services for Coventry and, from 1st June 2011, learning disability services for Solihull. At the time of the visit the Trust employed 4300 staff. The values of the organisation are: Respect for everyone; Seeking Excellence; Giving Hope; and Breaking Down Barriers.

The Trust intranet provided a good range of information on support services for service users and carers who have internet access. The Trust had also worked with *Mental Health Matters* to set up a 24/7 helpline providing basic advice and support. Community-based service users were all provided with contact cards.

Reviewers were impressed with several aspects of the Trust's work, including clear accountability arrangements for professional leads, an estates strategy to bring teams who need to work together into the same buildings, and a good policy on meeting the needs of black and minority ethnic service users.

Safeguarding arrangements were good with a team-focussed robust procedure, induction and ongoing training.

Good Practice

1   **CPA Policy, My Care Plan and Training**

The Care Programme Approach system was very good. There was a clear policy supported by a training programme, an electronic system of recording data and a contact card for all service users. The use of hand-held devices to record relevant data was being piloted. (NB. This policy was not yet in use in learning disability services.)

2   **Medicines Management**

A robust approach to medicines management was in place, with dynamic leadership from the Chief Pharmacist. This included producing information for service users on medication, a monthly *Medicines Matter* newsletter, a drug error reporting group which ensured multi-disciplinary review of all drug errors, very good monitoring information (the 'medicines management dashboard') on drug errors with identified learning points, a self-assessment toolkit, a folder on antipsychotics and potential side-effects available on each ward for service users and staff, and a comprehensive programme of medicines audit.

3   **Trust IT system**

The Trust IT system provided good support for care planning.

4   **Quality Monitoring Dashboards and Reporting**

Good use was made of quality dashboards which covered all CQUINS, infection control, NICE implementation, safety metrics, medication errors, violence to patients and staff, and 'slips trips and falls'.

There was also a monthly matron's quality report which was well-publicised in clinical areas. Very active use was being made of the 'productive series'. The Trust had a large team of people trained to undertake Root Cause Analysis and a Trust Group reviewed these and identified lessons to be learnt. Incidents were also reported directly to managers' 'blackberries'. Quality monitoring was well-organised with three levels of reporting: Trust Board, senior management including the relevant Trust Committee, and the ward dashboard. Trust 'Best Practice Days' were held to publicise learning and service improvements.

5   **Carer Involvement**

Reviewers saw several examples of good involvement of carers, including carers workers within Community Mental Health Teams. *Rethink* provided a Warwickshire-wide information and support service targeting carers of people with mental ill health. Reviewers commented, however, that access to assessment of carers' needs could be more widely publicised.

6   A service user 'Q' award was in place, whereby users and carers could nominate a member of staff for a quality award.

Immediate Risks: None

Concerns

1   **DOLS Policy, awareness and training**

The Trust did not have a policy on Deprivation of Liberty Safeguards. (Reviewers were told that this was included in the Trust Safeguarding Policy but the Safeguarding Policy did not cover this area.) There was no ongoing programme of DOLS awareness-raising. DOLS was mentioned briefly in Trust induction but reviewers talked to several staff who said they had not received DOLS training. Reviewers were told that training was available through the Local Authority but staff were not aware that they could access this.

2   **Community Treatment Orders**

The Trust did not have a policy on the use of Community Treatment Orders. A draft policy written in 2008 was available.

3   **Older People's Services**

People aged over 65 did not have access to the same range of mental health services as working age adults. In particular, the crisis resolution / home treatment service was not available to adults aged over 65. (NB. This concern overlaps with the health economy immediate risk relating to mental health liaison services. It is included here as well because referrals will not all be through general acute hospital services.) The Trust was planning to move to age-independent services but timescales and commissioner support for this change were not clear.

Further Consideration

1   **Care clusters and guidelines**, **data collection and audit of implementation of guidelines**

Guidelines were available for pharmacological interventions but not for other therapeutic interventions or for the overall management of people needing a particular 'care cluster'. Activity data collection was in place but it was not clear that this would support a full programme of audit of implementation of guidelines. There was a Trust audit programme and individual teams also undertook audits of particular areas of interest. An annual prize day show-casing audit was also planned. These initiatives did not yet add up to a robust set of clinical guidelines for each care cluster, related data collection and audit of implementation. This issue is included in 'further consideration' at this stage but will be a 'concern' if reasonable progress is not made over the next few years.

2   **Quality monitoring and quality improvement**

Trust staff were clearly aware of the 'Best Practice' days. Arrangements for multi-disciplinary review and learning at an individual team level were less evident and the Trust should ensure that all teams have robust arrangements for this.

GPs involved with commissioning mental health services did not seem to be aware of the Trust quality monitoring data (see good practice). It may be helpful to share these data with GPs and discuss what other information about quality they would find helpful. Reviewers suggested including more patient experience and outcome data within the quality monitoring system.

Some staff within individual services did not seem to be aware of Trust plans for service redesign and it may be helpful to widen opportunities for involvement with this work.

3   **Workforce Planning and Development**

A programme of statutory and mandatory training was in place and work on skill mix and competences had started in some services. There was a nursing strategy (including a pocket size version) and a strategy for allied health professions. Reviewers did not find a robust programme for linking care clusters and expected activity levels to the competences and skill mix required for each service. Some teams had relatively little occupational therapy and psychology time available and may benefit from greater multi-disciplinary input.

4   **Medical staffing**

Medical staff were separately managed from other staff and reviewers saw examples where medical staff were not yet fully integrated into team-based multi-disciplinary workforce. The Trust was aware of this issue and had plans to bring together the medical and general management structures. Reviewers encouraged continuation of this work.

5   **Multi-professional supervision**

Staff in several of the services reviewed were not aware of the Trust policy on clinical supervision. The Trust policy covered only health staff and concentrated mainly on nursing staff. Review of this policy and reminding staff about it may be helpful.

6   **Pharmacy support for community teams**

The excellent pharmacy support available to in-patient services (see good practice) was not yet available to community services. Extension of this support should help to improve medicines management within community services.

7   **User Involvement**

A Trust strategy on user involvement was in place and several activities and links with service user groups were taking place at a Trust-wide level. Individual teams had variable awareness of this work and mechanisms for user feedback and involvement at an individual service level were less well developed. It may also be helpful to involve service users in training programmes to a greater extent.

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PRIMARY CARE

The primary care development programme in Coventry was facilitated by local GP leads and NHS Coventry's learning and development function. Training was undertaken both through protected training and learning sessions with good attendance from GPs and practice nurses and through specific workshops conducted by specialist teams. Coventry and Warwickshire Partnership NHS Trust also provided an e-learning package for GPs.

PRIMARY CARE-BASED PSYCHOLOGICAL THERAPIES

COVENTRY & WARWICKSHIRE IMPROVED ACCESS PSYCHOLOGICAL THERAPY

General Comments and Achievements

The IAPT service covered four localities, North Warwickshire, South Warwickshire, Rugby and Coventry. These localities were then divided into sectors in order to improve local access to services. Leadership and management of the service was strong and the locality teams worked well together. Good evidence of compliance with the Quality Standards was available and was clearly presented.

Good Practice

1   The IAPT service had undertaken a range of initiatives targeted at different groups within the community, including a 'FLASH' initiative at the local College, a peer support group for older people and an initiative targeted at black and minority ethnic communities.

2   A system of group feedback at the end of each session had been implemented. This reviewed the session and summarised the decisions and actions to be taken before the next session.

Immediate Risks: None

Concerns

1   The proportion of appropriate referrals was relatively low, although it had increased from 66% to 75%. It was not clear that all GPs were aware of the full range of services available from IAPT. Further work with GP referrers to enable appropriate detection of mental health problems and communication about IAPT is needed.

2   Membership of the IAPT Steering Group did not include GP or service user and carer representatives. These groups of (direct and indirect) service users are expected to be involved in decisions about the management of the service.

3   Waiting times were an average of six weeks (maximum six months) and so were not yet compliant with IAPT recommended standards. GPs who met the visiting team were concerned about long waits for access to the service.

4   Recovery rates were less than 50%. Employment data were shown as absolute numbers rather than as percentages and so could not be compared with other services.

Further Consideration

1   Staff within the localities had different terms and conditions of employment and different working patterns. This did not help the localities to work together to respond to capacity and demand pressures on the service.

2   The staffing structure within the service was relatively 'flat' with few opportunities for career progression for band 5 staff. The service may wish to consider developing a band 6 role to enable recruitment and retention of band 5 staff by offering career progression opportunities.

3   Action plans for planned service improvements may benefit from being more 'SMART' in order to increase the likelihood of them being fully implemented.

4   The PHQ score protocol incorrectly used < and > symbols which could result in service users receiving inappropriate interventions. Staff were, however, aware of the correct action to take.

SPECIALIST MENTAL HEALTH SERVICES

COVENTRY & WARWICKSHIRE SINGLE POINT OF ENTRY SERVICES

General Comments and Achievements

The Single Point of Entry services were operational during normal working hours for clients where there was no other direct route of access. (The services did not accept referrals of adults over 65 years of age, young children in education who required CAMHS, people with drug and alcohol problems, learning disability or eating disorders.) The services sought to ensure a smooth referral pathway and worked closely with other services to achieve this.

The aim of the services was the removal of unnecessary duplication and easy sign-posting to the most relevant service. This has the potential to streamline pathways and improve service users' experience of care.

Close links had been developed with the helplines and IAPT services so that clients could be diverted away from secondary mental health services. Helplines operated differently in different localities. Coventry had a 24/7 accredited helpline dedicated to people with mental health problems. Warwickshire operated a mainly weekend and evening service. Discussions about a more uniform approach were taking place.

The Single Point of Entry services believed that they were achieving a more consistent approach to triage, smoother pathways of care for service users and more effective service user and carer engagement. It was not clear to reviewers (see below) that the full potential of the services was being realised.

Good Practice:

1   CPA Policy, My Care Plan and Training**:** See Trust-wide section of this report.

2   IT System: See Trust-wide section of this report.

3   Information-sharing: See health economy section of this report.

Immediate Risks: None

Concerns

1   The expected speed of assessment was not clear in the operational policy and was not being monitored routinely. Reviewers were told that the speed of response varied both between and within the three localities. GPs also reported a variable response when they contacted the services which was undermining their confidence in them. This issue was of concern because the Single Point of Entry services were the route by which clients could access a range of other services.

2   Staffing levels were not yet based on a competence framework covering the skill mix, staffing levels and competences expected. Staff had previous experience in Crisis Resolution / Home Treatment or Community Mental Health Teams but it was not clear that competences for their work in the Single Point of Entry Services had been assessed and appropriate development plans agreed.

Further Consideration

1   Arrangements for clinical and managerial supervision did not appear to be robust. There was a Trust policy but staff were not aware of this and it did not appear to be being implemented in practice.

COVENTRY & WARWICKSHIRE EARLY INTERVENTION SERVICES

General Comments and Achievements

These services received very positive feedback from service users and carers. Several service users and carers met the visiting team and were extremely positive about their experiences. Staff were proactive and enthusiastic. The

services had a strong national reputation as a result of involvement in national research projects and local research involving service users and carers. There were several examples of good liaison with other services. The three services had a consistent approach to care, despite being based at three different locations.

Good Practice

1   CPA Policy, My Care Plan and Training**:**   See Trust-wide section of this report.

2   The services used mobile phones to communicate proactively with service users.

3   A "come dine with me" project was used to encourage service users to come together, cook together and provide mutual support.

4   A carer had been employed as part of the team in order better to understand the needs of carers and design service changes to meet these needs. This project had also audited that these changes were embedded.

5   Service user groups were run which actively engaged with service users.

6   Care pathways were clear and well-described.

7   Systematic planning of discharge from the Early Intervention Service started after 2.25 years involvement with service users so that they could be discharged before they had been with the service for three years.

Immediate Risks: None

Concerns

1   Reviewers were seriously concerned that the Early Intervention Service looked after young people from age 17 but local in-patient services admitted young people from age 18. Finding an appropriate bed for young people aged 17 who needed admission was often difficult and, as a result, young people aged less than 18 sometimes had to be admitted to an adult ward.

Further Consideration

1   Implementation of the Trust clinical supervision policy did not appear to be robust, including staff recording that clinical supervision had taken place.

2   Trust policies were clear in relation to the children of service users but had little detail on younger siblings. The needs of this group may benefit from review.

3   It may be helpful to review arrangements for liaison with schools to ensure service users are enabled to continue their education.

4   The service had collected a large amount of qualitative and quantitative data on its work. These data had not yet been analysed and reviewers encouraged continuation of this work.

COVENTRY & WARWICKSHIRE COMMUNITY MENTAL HEALTH SERVICES

Three Community Mental Health Teams were reviewed as examples of the Trust's nine teams. Some issues relating to the service at Railings were identified and reported to the Trust. Reviewers were impressed, however, by the way in which services at Railings were working together.

COVENTRY & WARWICKSHIRE COMMUNITY MENTAL HEALTH SERVICES - COVENTRY

General Comments and Achievements

This service was provided by an enthusiastic team who were working well together. Good relationships between disciplines could be used further to develop multi-disciplinary working. Service users were pleased with the service they received. Links with voluntary sector organisations and social care were good. A section 75 agreement was in place and social workers were seconded to work with Community Mental Health Teams. Lines of accountability and responsibilities were clearly identified. The work of the discharge liaison nurses enabled a smooth transition from in-patient care to the CMHT.

Good Practice

1   Service users were seen in a variety of settings. A 'POD', accessed by a personalised 'PASS' card, enabled quick access to services. A cafe provided 'step-down' to less intensive interventions. The PASS card meant that service users could rapidly re-access services if they needed to do so.

2   CPA Policy, My Care Plan and Training: See Trust-wide section of this report.

3   A Carer Worker was part of the CMHT, undertook carers' assessments and support, and worked closely with the care coordinator.

Immediate Risks: None

Concerns

1   DOLS training and awareness and CTO policy: See Trust-wide section of this report.

2   Staff were aware of the Trust 'Best Practice' days but arrangements for multi-disciplinary review and learning at CMHT team level were not evident.

Further Consideration

1   Referral, acceptance and discharge criteria were not clear.

2   Clinical guidelines for each care cluster offered by the teams had not yet been documented and robust audit of implementation of guidelines was therefore yet in place. This issue is included in 'further consideration' at this stage but will be a 'concern' if reasonable progress is not made over the next few years.

3   Psychology staff were accepting both primary and secondary care referrals and it was not clear that these were being directed to appropriate pathways of care.

4   The model of care was heavily dependent on nursing staff. It may be helpful to review the extent of multi-disciplinary input into care plans, including from staff within social care, occupational therapy and psychology competences. Reviewers suggested that if resources are not available to provide the expected input then this should be documented.

5   Staffing levels were not yet based on a competence framework covering the skill mix, staffing levels and competences expected.

6   Reviewers were told that CMHTs within the Trust did not work in a consistent way. This was also evident during reviews of Crisis Teams and in-patient services. Some staff were concerned about this. Reviewers also suggested that advantage may not be being taken of opportunities for avoiding duplication, shared learning, shared training, shared service improvement work and flexible use of staff to cover absences.

COVENTRY & WARWICKSHIRE COMMUNITY MENTAL HEALTH SERVICES – NORTH WARWICKSHIRE

General Comments and Achievements

Service users who met the visiting team were very positive about the services they received and the improvements that had been made over recent years. This team had an open, proactive attitude to improving the quality of services and staff worked together well. The team commented that they felt well supported by senior management within the Trust. Members of the CMHT worked well with discharge liaison nurses in order to smooth the discharge process.

Good Practice

1   CPA Policy, My Care Plan and Training**:** See Trust-wide section of this report.

2   Good 'Easy Read' information was available for service users with learning disabilities.

3   A Carer Worker was part of the CMHT, undertook carers' assessments and support, and worked closely with the care coordinator.

Immediate Risks: None

Concerns

1   DOLS training and awareness and CTO policy: See Trust-wide section of this report.

2   Staff were aware of the Trust 'Best Practice' days but arrangements for multi-disciplinary review and learning at CMHT team level were not evident.

Further Consideration

1   Although an assessment tool was in use, reviewers commented that this was not completed well in the notes which they saw. Additional staff training on using the prompts within the system may be helpful.

2   Referral, acceptance and discharge criteria were not clear.

3   Clinical guidelines for each care cluster offered by the teams had not yet been documented and robust audit of implementation of guidelines was therefore yet in place. This issue is included in 'further consideration' at this stage but will be a 'concern' if reasonable progress is not made over the next few years.

4   Links with voluntary sector agencies did not appear to be well established. Reviewers considered that this was particularly important as direct payments become more established.

5   Reviewers were told that CMHTs within the Trust did not work in a consistent way. This was also evident during reviews of Crisis Teams and in-patient services. Some staff were concerned about this. Reviewers also suggested that advantage may not be being taken of opportunities for avoiding duplication, shared learning, shared training, shared service improvement work and flexible use of staff to cover absences.

6   Reviewers did not find any evidence of service user and carer involvement in decisions about the organisation of the service.

COVENTRY & WARWICKSHIRE COMMUNITY MENTAL HEALTH SERVICES – SOUTH WARWICKSHIRE

General Comments and Achievements

Staff of the South Warwickshire CMHT were focussed on meeting the needs of service users and carers and were positive about improving the care offered. Users and carers were pleased with the service they received and had seen several improvements over the last 10 years. The team was aware of inconsistencies between the CMHTs within the Trust. The CMHT made good use of contact cards which service users found helpful. There were good arrangements for monitoring transition of patients to and from more specialised services.

Good Practice

1   A Carer Worker was part of the CMHT, undertook carers' assessments and support, and worked closely with the care coordinator.

2   CPA Policy and Training: See Trust-wide section of this report

Immediate Risks: None

Concerns

1   DOLS training and awareness and CTO policy: See Trust-wide section of this report.

2   Staff were aware of the Trust 'Best Practice' days but arrangements for multi-disciplinary review and learning at CMHT team level were not evident.

Further Consideration

1   Referral, acceptance and discharge criteria were not clear.

2   Clinical guidelines for each care cluster offered by the teams had not yet been documented and robust audit of implementation of guidelines was therefore yet in place. This issue is included in 'further consideration' at this stage but will be a 'concern' if reasonable progress is not made over the next few years.

3   Some teams had relatively little input from staff with occupational therapy competences.

4   It may be helpful to review arrangements for communication with other agencies to ensure that these are sufficient to meet the needs of service users.

5   Arrangements for learning from serious incidents and complaints may benefit from review.

6   Reviewers were told that CMHTs within the Trust did not work in a consistent way. This was also evident during reviews of Crisis Teams and in-patient services. Some staff were concerned about this. Reviewers also suggested that advantage may not be being taken of opportunities for avoiding duplication, shared learning, shared training, shared service improvement work and flexible use of staff to cover absences.

7   Reviewers did not find any evidence of service user and carer involvement in decisions about the organisation of the service.

COVENTRY & WARWICKSHIRE ACUTE CARE SERVICES – CRISIS RESOLUTION HOME TREATMENT

General Comments and Achievements

Five Crisis Resolution Home Treatment teams were reviewed based in Coventry, Nuneaton, Rugby, Leamington Spa and Stratford. These services provided care to people aged 18 to 65 years. Staff were enthusiastic with good insight and openness about the challenges that lay ahead. The teams had started working together to a greater extent, including through shared Development Days. Staff said they were empowered to take forward this work.

The Stratford CRHT team was piloting the use of a physical health screening tool which may be rolled out to other teams in the future.

Good Practice

1   A good range of alternatives to admission was available including a Crisis House and two day care places for urgent referrals.

2   CPA Policy, My Care Plan and Training**:** See Trust-wide section of this report.

3   IT System: See Trust-wide section of this report.

4   Information-sharing: See health economy section of this report.

Immediate Risks: None

Concerns

1   Staffing levels were not yet based on a competence framework covering the skill mix, staffing levels and competences expected. A skill mix review was planned which would look at the staffing levels and competences needed for the population served. It was also not clear which staff had undertaken which training. MCA and DOLS was covered at induction but there was no evidence of ongoing training.

2   Medical staffing varied between the five teams and was insufficient to ensure that a doctor of grade ST4 or above was available at all times, including for home visits. Medical staffing (of grade ST4 and above) was as follows: Coventry, 2 consultants + 0.5 staff grade; Nuneaton, 0.5 consultant + 0.5 staff grade; Rugby, 0.3 consultant + 0.5 staff grade; Leamington, 1 consultant; Stratford 0.4 consultant + 0.5 staff grade. A consultant was on call out of hours for the Crisis Team. The frequency of medical review varied between the teams. There were no guidelines covering the expected indications for, and frequency of, medical review and no audits had been undertaken on this.

3   DOLS training and awareness and CTO policy: See Trust-wide section of this report.

Further Consideration

1   Clinical guidelines for each care cluster offered by the teams had not yet been documented and robust audit of implementation of guidelines was therefore yet in place. This issue is included in 'further consideration' at this stage but will be a 'concern' if reasonable progress is not made over the next few years.

2   Reviewers were told that discharge of new patients to the care of Community Mental Health Teams was sometimes difficult and regular review by the Care Coordinator while clients were under the care of the Crisis Resolution / Home Treatment team did not always take place.

3   Arrangements for clinical and managerial supervision did not appear to be robust. There was a Trust policy but staff were not aware of this and it did not appear to be being implemented in practice.

4   Some of the expected Quality Standards were not yet met and it will be important to ensure that progress towards full implementation is achieved (see Appendix 2 for details of Quality Standards not met).

5   The teams were beginning to work together more closely to ensure that clients received the same quality of service wherever they lived. Reviewers suggested that opportunities for collaboration, for example, on training, service and cover for absences, should continue to be explored. Acute Care Forums were running on each in-patient site but links between these and Crisis Resolution / Home Treatment teams may also benefit from review.

COVENTRY & WARWICKSHIRE ACUTE CARE SERVICE – IN-PATIENT SERVICES – CALUDON CENTRE and ST MICHAEL'S WARWICK

General Comments and Achievements

Staff were enthusiastic and welcoming and had tried to make service users' experience of care consistent across both in-patient sites. A range of specialist services, for example, for people with eating disorders and those with challenging behaviour, were available and had been retained during changes to the configuration of in-patient services.

Reviewers were impressed by the environment in the wards at the Caludon Centre, Coventry. The Intensive Care Unit was busy but maintained high levels of observation and good outreach to in-patient wards because staffing levels were sufficient for this. The general wards were calm and the environment bright and cheerful. Some wards were large which made observation of patients more difficult. Visits to the wards took place at lunchtime and so relatively few activities were in progress. Reviewers were assured that activities did take place at other times. Reviewers were told that links with medical staff worked well on the wards where full 'functionalisation' had been implemented.

At St Michael's, Warwick staff were also friendly and helpful. Service users said that they were pleased with the care they received. Visits to the wards took place at lunchtime and so relatively few activities were in progress. Reviewers were assured that activities did take place at other times. Multi-disciplinary notes were in use as well as electronic records. Information about benefits advice was not easily available and this may benefit from review.

Good Practice

1   Information leaflets for service users and carers were very clear and easily available, especially at Coventry.

2   Service user and carer involvement was good. There was good evidence that issues identified by service users and carers were being addressed.

3   Five discharge liaison nurses supported clients during their transition out of hospital. This helped to reduce delayed discharges and ensured seven day follow-up. This service also meant that there were no delays in Community Mental Health Teams picking up clients. Discharge documentation was good with emphasis on early discharge planning.

4   The PICU outreach form was very clear and staff could easily complete relevant information.

5   A training programme was in place for health care assistants. This included a systematic approach to the competences expected and active training to achieve these competences. Training materials were good. Reviewers were particularly impressed with this because health care assistants are often the staff who spend most time with service users.

Immediate Risks: None

Concerns

1   Reviewers were seriously concerned that young people aged under 18 years had been admitted to wards for up to four months because no alternatives were available. The associated risks had been managed by provision of extra staff and the issue has been raised with West Midlands Specialised Commissioning Team. Clear guidelines covering arrangements for care of young people aged under 18 were not in place.

2   DOLS training and awareness and CTO policy: See Trust-wide section of this report.

Further Consideration

1   The in-patient wards were not using the same CPA documentation as community services. In-patient care plans seen by reviewers had been variably completed. Care plans were not always complete and some were not signed by the service user or nurse who had completed them. The care plans were not all clear about the therapeutic interventions which were expected. Some did not have risk management plans.

2   Only 1.1 wte occupational therapists were available within acute service, 1.1 wte psychologists, 1.2 wte cognitive therapists and 0.3 wte art therapist. Multi-disciplinary input to therapeutic interventions was therefore limited.

3   Some locum doctors had been in post for a long time and the Trust should ensure that permanent appointments are made as soon as possible.

4   Implementation of the Trust policy on clinical supervision was variable. Some staff received regular clinical supervision and others did not. A simple mechanism for staff to identify that they have not had clinical supervision or appraisal may be helpful.

5   A day hospital was available to support early discharge but links with social care, personalisation and community services were less clear. The day hospital may be an alternative to admission and support early discharge but it was not clear how 'moving on' to more appropriate services was being achieved.

6   The average length of stay was viewed as short by both reviewers and staff (reviewers were told that average length of stay was 22 days for in-patient wards and 18 days for PICU). This raised questions about the appropriateness of patients referred and, possibly, the number of readmissions. In particular, the PICU length of stay appeared very short compared with the minimum recommended stay of four weeks.

7   The number of visits made by Care Coordinators and CRHT staff varied between the different CMHTs and Crisis Teams.

8   Reviewers were told that the extent and style of input by medical staff was variable. Some wards had medical staff who worked in the community as well as in-patient services. Some medical staff had moved to a fully 'functionalised' model whereas others had only partially adopted this approach. Reviewers considered this issue was particularly important because some clients were admitted without having been seen by a Crisis Team before being medically reviewed, admission criteria were not clear and relatively few middle grade doctors were available.

9   Displays, especially in Coventry, were heavily dominated by productive ward activities. Relatively few other interesting displays were available. It may be helpful to review whether the productive ward displays are relevant to service users and whether more appropriate use could be made of display space.

COVENTRY & WARWICKSHIRE ASSERTIVE OUTREACH SERVICES

General Comments and Achievements

Assertive outreach services were provided by four teams serving North Warwickshire, South Warwickshire, Rugby and Coventry. Service users and linked services were very positive about the services provided. The South Warwickshire team had a full-time consultant. The North Warwickshire service was making good use of a graduate worker to ensure that service users received physical health checks. The teams were all working hard to ensure that service users were not admitted to hospital unnecessarily and, when in hospital, were able consistently to access benefits.

Good Practice

1   CPA Policy, My Care Plan and Training: See Trust-wide section of this report. Service users were positive about 'My Care Plan'.

Immediate Risks: None

Concerns

1   One of the Rugby team's psychiatrists did not regularly attend team meetings and other staff were concerned that this was adversely affecting communication about care for service users.

2   The Coventry team had no psychology input due a long-term psychologist vacancy. As a result, some service users were waiting several months for specific psychological interventions.

3   DOLS training and awareness and CTO policy: See Trust-wide section of this report.

Further Consideration

1   The four teams had different staffing structures and it was not clear that advantage was being taken of the potential for avoiding duplication, shared learning, shared training, shared service improvement work and flexible use of staff to cover absences.

2   The teams' policy on ensuring service users received regular reviews of their physical health was not clear. A graduate worker was specifically addressing this issue in North Warwickshire but medical staff were not sure that this was an appropriate model for the other teams.

3   The teams' acceptance criteria excluded people with dual diagnosis or personality disorder. It was not clear how the needs of these service users were being met.

4   Although good work with carers was taking place, it was not clear that all carers were aware that they could access an assessment of their own needs.

COMMISSIONING

NHS COVENTRY and NHS WARWICKSHIRE MENTAL HEALTH COMMISSIONING

General Comments and Achievements

Service specifications for mental health services were in place for NHS Coventry and CQUINS had been agreed. Active GP involvement and interest in the care of people with mental health problems was evident for both Coventry and Warwickshire. Regular clinical quality review meetings were in place in both areas.

Immediate Risks

1   **Mental health liaison services in acute Trusts:**   See health economy section of this report

Concerns

1   **DoLS awareness and training:**   See health economy section of this report

2   **Variation across services and localities:**   See health economy section of this report.

Further Consideration:

See health economy section of this report.

SERVICES FOR PEOPLE WITH DEMENTIA

NHS COVENTRY and NHS WARWICKSHIRE PRIMARY CARE FOR PEOPLE WITH DEMENTIA

A programme of awareness-raising and information for GP's on reducing the use of anti-psychotic medication had started. A Coventry and Warwickshire project was focusing upon raising awareness within specialist care homes and increasing information available to them.

MEMORY SERVICES

HEALTH SERVICES FOR OLDER PEOPLE, INCLUDING PEOPLE WITH DEMENTIA

General Comments and Achievements

Coventry and Warwickshire Partnership NHS Trust provided a wide range of services for older people with mental health problems, including three 'single point of entry' referral and triage services (covering North Warwickshire, South Warwickshire and Coventry), four day hospitals, four community mental health teams (CMHTs), a hospital liaison team at University Hospitals Coventry and Warwickshire, six in-patient wards, a specialist support team for older people placed in residential and nursing homes (Coventry and Warwickshire), a Young Onset Dementia team (Coventry only), Memory Assessment Service (Coventry and Warwickshire), Admiral Nurses (Warwickshire only), Community and Assessment Treatment Team (Rugby only) and an Intermediate Care Service. The Memory Assessment Service included clinics, Cognitive Assessment and Treatment Services and Memory Assessment Clinicians who, following multi-disciplinary discussion, were diagnosing dementia in non-complex situations.. The review concentrated on the Young Onset Dementia Team, CMHTs and Memory Assessment Services. The review did not visit all in-patient wards, or look in detail at the work of the day hospitals or intermediate care team.

Reviewers were impressed by several aspects of the services offered (see below). Staff were committed and working hard to improve the care they provided. There were ambitious plans for the further development of services, including significant reductions in time from referral to diagnosis. Good information for service users was available. There was good partnership working with advocacy services. Reviewers were told that there was a good working relationship with the Alzheimer's Society.

Good Practice

1   The Young Onset Dementia service for Coventry was well-organised with clear referral criteria and a good care pathway, short time to completion of assessment, and a primary care liaison worker. A Young Onset Dementia Focus Group had been established to enable user input to the work of the service.

2   CPA Policy, 'My Care Plan' and associated training: See Trust-wide section of this report.

3   The environment and facilities for services for the Older Adult Services in the Caludon Centre were welcoming, bright and well-equipped.

4   Reviewers saw patients on the in-patient wards being treated with dignity and respect, with many supervised activities in progress. Good work on falls prevention had taken place.

Immediate Risks: None

Concerns

1   Data were not being collected on key performance indicators, including time to diagnosis. (Historical data from 2003 and 2006 were available.) It was therefore not clear how the activity and effectiveness of the services were being monitored and how the service re-design plans would be evaluated.

2   DOLS training and awareness: see Trust-wide section of this report.

3   Variation across services and localities: See health economy section of this report.

4   **T**he commissioned diagnostic pathway for Warwickshire involved service users going back to their GP for the GP to request a CT scan. This introduced delays and complexity into the pathway and the potential that appropriate reporting of CT scans may not be requested. Reviewers suggested that the Trust should work with commissioners to ensure that CT scans (including appropriate reporting) can be requested by the memory assessment services.

Further Consideration

1   The memory assessment services for older adults appeared fragmented. Reviewers heard about the single point of access in each locality and saw operational policies for many of the services. The pathway for an older adult referred to the services and the relationship between clinics, the Cognitive Assessment and Treatment Services and the Memory Assessment Clinicians were not clear, including about medical input to the process of diagnosis. How these services then related to the work of community mental health teams for older adults was also not clear. There were plans to review the pathway and, in particular, to streamline assessment and diagnosis. Reviewers noted that there had been several previous attempts at service redesign and were not confident that the latest proposals would be followed through to full implementation.

2   The management structure for medical staff was separate from the operational structure and some medical staff did not appear to be involved in and committed to the proposed service changes.

3   Reviewers were told of 18 wte band 5 nurse vacancies on the in-patient wards. The mechanism for ensuring staffing levels were sufficient was not clear.

4   Links between older adult services and the Trust management and corporate functions did not appear to be as strong in services for older adults as in those for working age adults.

5   The service had six in-patient wards and four day services. This appeared high for the population served and the potential to reduce reliance on institution-based care should be explored with commissioners.

COMMISSIONING

NHS COVENTRY and NHS WARWICKSHIRE HEALTH FOR PEOPLE WITH DEMENTIA COMMISSIONING

General Comments and Achievements

Both NHS Coventry and NHS Warwickshire were actively working to improve the quality of dementia services for their populations. NHS Coventry had used CQuINS in 20009/10 and 2010/11 to remodel the patient pathway. NHS Warwickshire was a pilot site for the Skills for Care Carers and Dementia training. Training was delivered across wide range of agencies and co-facilitated by carers themselves. Good information, advice and support services were provided by Guideposts Trust in North Warwickshire and the Carers Support Service in South Warwickshire. These services offered support to carers of people with dementia. A training module on caring for people with dementia was also available.

Concerns

1   The commissioned diagnostic pathway for Warwickshire involved service users going back to their GP for the GP to request a CT scan. This introduced delays and complexity into the pathway and the potential that appropriate reporting of CT scans may not be requested. Reviewers suggested that commissioners should ensure that CT scans (including appropriate reporting) can be requested by the memory assessment services.

Further Consideration

1   The service had six in-patient wards and four day services. This appeared high for the population served and the potential to reduce reliance on institution-based care should be explored.

HEALTH SERVICES FOR PEOPLE WITH LEARNING DISABILITIES

Services reviewed included:

- Community teams for Solihull, North Warwickshire, South Warwickshire, Coventry and Rugby, which included a health facilitation team and staff working with general acute services

- The Gosford in-patient unit at the Caludon Centre, Coventry

The review did not cover:

- In-patient wards at on the Brooklands site as these had already been reviewed by the Royal College of Psychiatrists AIMS-LD review programme.

- Services for children and young people with learning disabilities

- Respite units at Solihull, Nuneaton and Rugby

- Domiciliary care service at Coventry

PRIMARY CARE

Findings relating to primary care services are given below in the Specialist Learning Disabilities Services section of this report.

SPECIALIST LEARNING DISABILITIES SERVICES

COVENTRY, WARWICKSHIRE and SOLIHULL – ALL SERVICES

General Comments and Achievements

Community teams within Coventry and Warwickshire were in a process of transition. The four teams worked very differently and were moving towards a single point of entry in each locality. Work on care clusters and service re-design was also taking place. The development of staff with special interests was being considered and a nurse specialising in epilepsy was already in place.

The Gosford Unit at the Caludon Centre was a calm and welcoming ward. En-suite facilities were available for all service users. Reviewers commented that, for an assessment and treatment service, the environment was relatively clinical and secure. The lead psychiatrist was actively involved with the running of the service. A garden was available, although redesign of some aspects was being considered.

Good staff training on MCA and DOLS was in place and there was a range of accessible information on these subjects.

Reviewers met only one service user and no carers. This section of the report may not therefore reflect the views of service users and carers to the same extent as other parts of the report.

Good Practice

1   A good discharge and transfer policy was in place. A relapse prevention policy was linked to the discharge and transfer policy.

2   Good links with acute hospital services were evident with good information for patients.

3   There was a good folder of information for GPs about community services for people with learning disabilities. This folder had been distributed to all GPs. It included details of a wide range of groups for people with learning disabilities that were available at a range of settings. Groups included, for example, bereavement and loss, men with learning disabilities, health and well-being, and a CHAT group for young people during their transition to adult services.

4   The Solihull service had lots of assistive technology available for supported living, including enuresis alarms, trips and falls monitors, electronic medication dispensers, door key safes and alarms, and smoke alarms. Lots of information was available in Easy-Read about the assistive technology.

5   In Solihull, health facilitation and information on physical health was excellent. There was very good data collection relating to primary care. The Coventry and Warwickshire Health Action Team also provided good support for physical health care and links with GPs.

6   A good 'leaving the unit' book was available in the Gosford Unit. This book approached leaving the unit from service user's perspective.

7   A CLIC communication media programme was available and was being further developed by speech therapists.

Immediate Risks: None

Concerns

1   The Medicines Management Policy provided to reviewers was dated 2007 and was due for review in 2008. The Medicines Management Policy did not cover rapid tranquilisation, immediate life support or resuscitation. A revised Trust policy had been agreed but staff in the learning disability services were not aware of this.

Further Consideration

1   **Care Planning**

Reviewers did not see evidence of active, consistent use of CPA or another structured process covering assessment, care planning and active review. Care plans were in place for individual issues but there did not appear to be a coordinated, holistic approach to care planning. It was not clear how the care plans were linked to the assessment process. There was evidence of some reviews but these were relatively sparse and those seen by the reviewers showed little progress. Arrangements for follow up within seven days of discharge from in-patient care did not appear to be robust. There was no evidence that the care plan was understood by the service user.

2   The criteria for acceptance by, and discharge from, the community teams were not clear. The therapeutic interventions being contributed by the community teams were also not clear. Reviewers were told that some clients were 'kept for ever' and some community team clients were not receiving active therapeutic interventions.

3   The separation between services for adults and those for children and young people was not clear. Some community teams said that they were working with children as well as adults with learning disabilities. One individual issue about separation of young people and adults was raised with the Trust during the review visit.

4   Pharmacy input to the multi-disciplinary care of people with learning disabilities was not apparent. Reviewers would have expected this to be in place, especially because of the level of risk associated with caring for some clients.

5   There was not a systematic, standardised approach to recording patient information. It appeared that each service had a different approach to recording patient information and approaches varied between different professional groups. This could make information difficult to find, may not help multi-disciplinary working, and may not make it easy for staff to move between services, for example, to cover absences or respond flexibly to changes in need for services.

6   NHS funded respite care was provided in three locations and it was not clear that these were meeting the expected Quality Standards for in-patient services for people with learning disabilities. A domiciliary care service was provided for Coventry. The therapeutic interventions contributed by these services were not clear and they appeared to reviewers to be providing primarily social care.

7   The Trust had plans for the future development of the Brooklands site. In taking these forward, the Trust will need to ensure that, wherever possible, clients continue to access community facilities.

8   Services in the different localities were different and it was difficult to assess whether all clients were having their needs met by the current arrangements. Links with Partnership Boards were in place although these worked in different ways. Some collaborative work between the Partnership Boards may be helpful so that the Trust is, wherever possible, providing services which are consistent and so that best use can be made of staff time and expertise.

9   A new advocacy group had been in place for less than 12 months. Mechanisms for service user and carer involvement, including feedback from services, may benefit from further consideration.

10   Changes to the management arrangements for primary care liaison and health facilitation were planned, with these teams becoming integrated with community services. It will be important to review and evaluate these changes and their impact on care for people with learning disabilities.

11   The development of specialist roles, such as in epilepsy, was being pursued and was supported by reviewers. Reviewers suggested that the model for these roles needed to ensure that a) all staff maintained their skills in these areas and b) cover was available for planned and unexpected absences of the specialist worker.

12   Team / service leaders within the learning disabilities service were not generally aware of Clinical Quality Review (CQR) meetings with commissioners and did not know who was responsible for commissioning their services. (CQR meetings did take place and involved the most senior staff from the learning disabilities service.) Enabling more contact between team / service leaders and commissioners may be helpful for all concerned.

COMMISSIONING

NHS COVENTRY AND WARWICKSHIRE- HEALTH SERVICES FOR PEOPLE WITH LEARNING DISABILITIES COMMISSIONING

Further Consideration:

1   Team / service leaders within the learning disabilities service were not generally aware of Clinical Quality Review (CQR) meetings with commissioners and did not know who was responsible for commissioning their services. (CQR meetings did take place and involved the most senior staff from the learning disabilities service.) Enabling more contact between team / service leaders and commissioners may be helpful for all concerned.

2   NHS funded respite care was provided in three locations and it was not clear that these were meeting the expected Quality Standards for in-patient services for people with learning disabilities. A domiciliary care service was provided for Coventry. The therapeutic interventions contributed by these services were not clear and they appeared to reviewers to be providing primarily social care.

3   Services in the different localities were different and it was difficult to assess whether all clients were having their needs met by the current arrangements. Links with Partnership Boards were in place although these worked in different ways. Some collaborative work between the Partnership Boards may be helpful so that the Trust is, wherever possible, providing services which are consistent and so that best use can be made of staff time and expertise.

CARE OF VULNERABLE ADULTS IN ACUTE HOSPITALS

ACUTE TRUST-WIDE & CLINICAL AREAS

GEORGE ELIOT HOSPITAL NHS TRUST

During this visit reviewers looked at Trust-wide guidelines and policies and tested their implementation in the following clinical areas: Emergency Department, Emergency Medical Unit, Acute Surgical Ward, Orthopaedic Ward and Lydgate Ward.

General Comments and Achievements

The care of vulnerable adults was given a high priority by the Trust. A clinical lead had recently been appointed and regular meetings with the lead Non-Executive Director were in place. PALS and the Patient Forum were involved in 'snap shot' surveys of care on in-patient wards. A lot of work had taken place on improving patient safety and the Trust Board was actively using patient stories to inform the Board on care received. A range of other mechanisms for patient feedback were also in use, including immediate 'smiley face' feedback, patient forums, use of volunteer in the 'snap shot' surveys, and regular consideration of findings by Trust governance meetings.

The Accident and Emergency Department had a good system of identifying people who were particularly vulnerable and 'flags' were carried throughout their stay in hospital. There was also a system of identifying repeat attendances of people who were particularly vulnerable. The Trust was piloting a new system for totalling fluid charts at lunchtime.

Good Practice

1   The Trust had implemented 'Back to Basics' Matrons. The Nurse Director, Matrons and Senior Sisters met once a week specifically to look at governance issues, in particular trends of serious incidents, root cause analysis and any 'lessons learnt' from incidents. This information was then cascaded to service areas.

2   The rapid tranquilisation protocol policy was good and had been developed with an acute trust focus. This policy included an aggression risk assessment tool (Walter Brennan tool) to assess potential violence and aggression. The implementation of the policy had been audited and reported to the Trust Board. The audit showed a low level of sedation episodes.

3   A wide range of information was available for patients with learning disabilities. The information in easy read was very good and explicit.

4   Specialist advice was readily accessible during normal working hours for queries about the care of people with dementia, learning disabilities and mental health problems. Staff were very positive about the support received. The staff who met the visiting team were clear about the roles of the specialist advisers and when to access them.

Immediate Risks: See health economy section of this report.

Concerns

1   **Mental Capacity Act (MCA) and Deprivation of Liberty Safeguards (DOLS) – Awareness**

Several staff who met the visiting team were unclear about MCA and DOLS and how to access assessments. Some staff were also unsure about the relationship with the Mental Health Act. Some training was available but this did not adequately explain these areas and the action staff should take if they had concerns.

Further Consideration

1   Work was taking place on the development of a consistent, concise system of handover at all levels (ISOBAR). Reviewers commended this work and encouraged evaluation and dissemination if the pilot achieved the aim of making ward handovers shorter and of better quality.

2   The Trust policy on missing patients may benefit from specific consideration of those people who lack mental capacity.

3   A review of care planning was taking place with the aim of making sure care plans were addressing patients' individual needs.

4   Information for staff and patients on raising concerns may benefit from review. It was not clear which information was intended for patients and carers and which for staff (or whether information was intended for both). Some posters had different information on who to contact out of hours. The NHS Warwickshire leaflet was very good but had an external telephone number.

5   A 'Safeguarding Care Bundle' was being introduced which included the introduction of sticky labels and duplicated form filling. Reviewers suggested that implementation should be carefully monitored to ensure that the care bundle is achieving the expected outcomes.

SOUTH WARWICKSHIRE NHS FOUNDATION TRUST

During this visit reviewers looked at Trust-wide guidelines and policies and tested their implementation in the following clinical areas: Acute Medical Admissions, Squire, Respiratory, Acute Medicine and Stroke Wards.

General Comments and Achievements

The Trust was aware of issues which needed to be addressed and had plans for further education and awareness of care of people with dementia and those with learning disabilities. Work undertaken to raise awareness of DOLS had led to an increase in the number and timeliness of referrals (17 in the last year). One nurse with both general and mental health training had made a good contribution to the training and awareness programme. The Trust had recently taken on the provision of community services for Warwickshire and several Trust-wide policies were, as a result, being revised.

Good Practice

1   The Observation Unit had one double bed space with facilities for relatives to stay during the initial phase of admission. Staff had a positive attitude to encouraging carers to stay to support people who were particularly vulnerable.

2   A visual, real time display board 'Heartbeat' showing triggers and markers of vulnerability was being rolled out across all departments. The information on the board stayed with the patient which helped transfers between different areas. Reviewers noted, however, this was completed better in some wards than others.

3   Patients were routinely part of staff education programmes which ensured that the patient perspective was given a high priority.

4   The discharge team was actively involved in clinical capacity management. The team visited wards daily and identified clinical issues which may be delaying the patient pathway as well as working with patients with more complex needs.

Immediate Risks: See health economy section of this report.

Concerns

1   No policy on restraint was available at the time of the review and implementation could not, therefore, be audited.

2   The Trust had no Mental Capacity Act policy. (There was a policy on DOLS but this did not cover MCA.)

Further Consideration

1   Reviewers observed an example on the respiratory ward where nursing staff did not respond appropriately to the needs of a distressed patient. This particular example was of concern. As this was the only example seen by reviewers this issue has not been included in the concerns section of this report. Reviewers recommended, however, that the Trust undertake further work to assure itself that these problems are not happening routinely.   On the same ward, bowel action charts had not been completed as expected.

2   Reviewers were told that PALS would investigate issues of concern rather than reporting these or referring for advice, and the level of investigation undertaken may not always be appropriate, especially for safeguarding issues.

3   Management arrangements for safeguarding and the care of vulnerable adults were under review following the integration with community services. Reviewers agreed that this review was needed and encouraged the Trust to ensure revised arrangements are clarified as soon as possible with consideration of a defined role for a safeguarding lead.

4   A competence framework for MCA, DOLS and safeguarding training had not yet been developed. Staff received 45 minutes training covering all three areas as part of mandatory training. Consideration should be given to some more in depth training, especially for some staff with 'front line' responsibility.

5   Several staff who met the visiting team were not aware of the missing patient flow chart. The flow chart covered patients who had been identified as vulnerable or where there were concerns about mental capacity. Appropriate action to find patients not previously identified as vulnerable was not clear in the flow chart.

6   Information for patients and carers on raising concerns about safeguarding was not easily visible. (An NMC poster targeted at staff was available.)

7   The future role of nursing staff with both general and mental health training may benefit from review to ensure best use is being made of these skills.

UNIVERSITY HOSPITALS COVENTRY & WARWICKSHIRE NHS TRUST

During this visit reviewers looked at Trust-wide guidelines and policies and tested their implementation in the following clinical areas: Trauma and Orthopaedic Ward, Stroke Ward, Clinical Decisions Unit, Elderly Care Ward and Short Stay Medical Ward.

General Comments and Achievements

Patient feedback gathered during visit was positive about the attitude and care given by staff. A good working relationship with partner agencies was evident, in particular, a proactive Partnership Board for the Coventry area.

Good Practice

1   A Dementia Lead in the acute Trust was working to increase the profile of care of people with dementia as well as providing good support and training and development for front line staff. Staff who met the visiting team clearly valued this role. Link workers for wards had also been trained.

2   The PALS service was developing innovative ways of gathering information on patients' experiences, especially those of different cultural groups. In particular, volunteers supported the in-patient surveys and there was an on-line feedback system. There was evidence that the Trust had made changes as a result of patient feedback, for example, wheelchair parks and improvements to the physical environment.

Immediate Risks: None

Concerns: None

Further Consideration

1   In addition to the patient feedback mechanisms already developed, it may be helpful to consider other specialised mechanisms to gather views from 'difficult to reach' groups (for example, frail elderly people and victims of domestic violence).

2   Staff were not always clear about out of hours arrangements for access to specialist advice on the care of people with dementia or learning disabilities. The crisis team was contacted for advice on the care of

people with mental health problems. A list summarising the link workers/ champions within the Trust and out of hours arrangements may help to address this.

3   Several policies and procedures were either not in place or in draft form and, if implemented, would have been of concern:

   a.   The restraint policy included a mental health section which only covered mental capacity. Reviewers suggested that the information in the draft policy could be misleading. The number of DOLS referrals in the last year appeared low (8).

   b.   The missing patients flow chart was insufficient as a standalone policy.

   c.   There were no guidelines on the care of people with challenging behaviour.

4   Support for feeding was triggered by verbal communication between staff. Reviewers suggested that consideration should be given to a systematic process (for example, red trays or marking on whiteboards or the bed head) to ensure that feeding support was consistently provided when needed.

5   The training strategy was in draft form and did not cover care of people with challenging behaviour. However some areas of practice were utilising the 'abc' system as advised by the Dementia Lead.

6   The bedside folder may benefit from being updated to include information on staff and information on reporting safeguarding concerns.

7   Representation on the Adult Safeguarding Board may benefit from review to ensure consistent, appropriate representation from the Trust. The named Director did not attend and the lead Consultant had not yet been included.

COMMISSIONING

NHS COVENTRY and NHS WARWICKSHIRE VULNERABLE ADULTS IN ACUTE HOSPITALS COMMISSIONING

Immediate Risk: See health economy section of this report.

No other specific commissioning issues were identified.

APPENDIX 1 MEMBERSHIP OF VISITING TEAM

Dr Doug Wulff (Executive Lead)	Medical Director	NHS Birmingham East and North
Colin Burbridge	Service User	
Julie Battersby	Modern Matron, Mental Health Adult Services	Wolverhampton City PCT
Dr Sarmishtha Bhattacharyya	Consultant in Old Age Psychiatry	Wolverhampton City PCT
Karen Bowley	Matron for Care of the Elderly /Stroke / Trauma & Orthopaedics	Royal Wolverhampton Hospital NHS Trust
Rosemary Brown	Senior Nurse / Modern Matron	North Staffordshire Combined Healthcare NHS Trust
Simon Cadman	Locality Manager	North Staffordshire Combined Healthcare NHS Trust
Dr Bhavana Chawda	General Adult Consultant Psychiatrist	Dudley and Walsall Mental Health Partnership NHS Trust
Frances Clarke	Associate Director of Nursing	Birmingham Community Healthcare NHS Trust
Felix Davies	Director of Psychological Services	South Staffordshire & Shropshire Healthcare NHS Foundation Trust
Lucy Dunstan	Support Worker	
Mary Elliffe	Service Manager	Birmingham & Solihull Mental Health NHS Foundation Trust
Dr Alan Farmer	Consultant Psychiatrist/Lead Consultant Community Business Unit	Worcestershire Health and Care NHS Trust
Robin Felton	Team Manager	Birmingham & Solihull Mental Health NHS Foundation Trust
Alison Geeson	Head of Nursing	Dudley and Walsall Mental Health Partnership NHS Trust
Elaine Giles	Lead Nurse / Midwife for Safeguarding Children / Vulnerable Adults	Birmingham Women's NHS Foundation Trust
Dr Isabel Gillis	Consultant in Public Health Medicine	NHS Walsall
Sandra Gough	Clinical Practice Advisor / Mental Health Lead	NHS South Birmingham
Paul Harper	Assertive Outreach Team Leader	North Staffordshire Combined Healthcare NHS Trust

Nigel Haydon	Carer	Carers in Partnership
Peter Hayward	Head Occupational Therapist, Consultant OT	Dudley & Walsall Mental Health Partnership NHS Trust
Mark Hemming	Directorate Manager, Mental Health	NHS Herefordshire
Linda Izquierdo	Senior Commissioning Manager – Acute Services & Quality	NHS Shropshire
Rachel Johnson	Occupational Therapy Clinical Specialist	North Staffordshire Combined Healthcare NHS Trust
Dr Shrikaanth Krishnamurthy	Associate Specialist Psychiatrist	Dudley & Walsall Mental Health Partnership NHS Trust
Emma Langford	Clinical Coordinator	Worcestershire Health and Care NHS Trust
Dr Christine Leaman	Clinical Director, Adult Division	NHS North Staffordshire
Carol Molloy	Service Lead for Assertive Outreach	South Staffordshire & Shropshire Healthcare NHS Foundation Trust
Hassan Omar	Head of Social Care	Dudley & Walsall Mental Health Partnership NHS Trust
Dr Darren Perry	Consultant Clinical Neuropsychologist	North Staffordshire Combined Healthcare NHS Trust
Diane Rhoden	Adult Safeguarding Lead Nurse	Sandwell & West Birmingham Hospitals NHS Trust
Sven Rouse	Inpatient Ward Manager	Worcestershire Health and Care NHS Trust
Sally Simmonds	Deputy Directorate Manager for Mental Health	NHS Herefordshire
Graeme Smith	Self Advocate	Mencap
Liz Staples	Head of Learning Disabilities Nursing / Clinical Service Manager	Black Country Partnership Foundation Trust
Sarah Taylor	Practice Educator - Service User and Carer Promotion	Worcestershire Health and Care NHS Trust
Don Walsh	AHP Lead (Combined Healthcare)	North Staffordshire Combined Healthcare NHS Trust
Melanie Watson	Operational Manager	South Staffordshire & Shropshire Healthcare NHS Foundation Trust
Emma Webber	Inpatient Ward Manager	Worcestershire Health and Care NHS Trust
Natalie Willetts	Nurse Consultant in Acute Services	Birmingham & Solihull Mental Health NHS Foundation Trust

WMQRS Members

Jane Eminson	Acting Director	West Midlands Quality Review Service
Sarah Broomhead	Quality Manager	West Midlands Quality Review Service
Elaine Woodward	Mental Health, Dementia & Learning Disabilities Lead	West Midlands Quality Review Service
John Levy	Mental Health, Dementia & Learning Disabilities Lead	West Midlands Quality Review Service

COVENTRY AND WARWICKSHIRE HEALTH ECONOMY

APPENDIX 2 COMPLIANCE WITH THE QUALITY STANDARDS

Analyses of percentage compliance with the Quality Standards should be viewed with caution as they give the same weight to each of the Quality Standards. Also, the number of Quality Standards applicable to each service varied depending on the nature of the service provided. Percentage compliance also takes no account of 'working towards' a particular Quality Standard. Reviewers often comment that it is better to have a 'No but', where there is real commitment to achieving a particular standard, than a 'Yes but' – where a 'box has been ticked' but the commitment to implementation is lacking. With these caveats, table 1 summarises the percentage compliance for each of the services reviewed.

Table 1 - Percentage of Quality Standards met

Service	No. Applicable QS	No. QS Met	% met	No. services / clinical areas
Mental Health Services				
Coventry Primary Care	10	9	90	-
Warwickshire Primary Care	10	9	90	-
Coventry and Warwickshire Partnership NHS Trust (Trust-wide)	11	7	64	-
Coventry & Warwickshire Improving Access to Psychological Therapies	30	19	63	4
Coventry & Warwickshire Single Point of Entry Services	46	32	70	3
Coventry & Warwickshire Early Intervention Services	52	44	85	3
Coventry Community Mental Health Teams	52	33	63	3 of 9
N. Warwickshire Community Mental Health Teams	52	29	56	
S. Warwickshire Community Mental Health Teams	52	28	54	
Coventry & Warwickshire Acute Care Services (Crisis Resolution Home Treatment Teams)	56	34	61	5
Coventry & Warwickshire Acute Care Services (In-patient Services)	52	30	58	2 hospitals
Coventry & Warwickshire Assertive Outreach Services	55	38	69	4
Commissioning - NHS Coventry	14	8	57	-
Commissioning - NHS Warwickshire	14	6	43	-
Health Economy	**506**	**326**	**64**	**-**
Health Services for People with Learning Disabilities				
Coventry & Warwickshire Primary Care General Practice	9	9	100	-
Solihull Primary Care General Practice	9	8	89	-
Specialist Learning Disabilities Service (Coventry and Warwickshire Partnership NHS Trust) - In-patients	46	23	50	1
Specialist Learning Disabilities Service (Coventry and Warwickshire Partnership NHS Trust) - Coventry & Warwickshire Community	45	27	60	4
Specialist Learning Disabilities Service (Coventry and Warwickshire Partnership NHS Trust) - Solihull Community	45	32	71	1

Service	No. Applicable QS	No. QS Met	% met	No. services / clinical areas
Commissioning - NHS Coventry	17	15	88	-
Commissioning - NHS Warwickshire	17	9	53	-
Commissioning - NHS Solihull	**	**		-
Health Economy	**188**	**123**	**65**	-
Dementia Services				
Coventry & Warwickshire Primary Care	10	4	40	-
Memory Services (Coventry and Warwickshire Partnership NHS Trust) *	56	28	50	*
Commissioning – NHS Coventry	17	13	76	-
Commissioning – NHS Warwickshire	17	7	41	-
Health Economy	**100**	**52**	**52**	-
Care of Vulnerable Adults in Acute Hospitals				
George Eliot Hospital NHS Trust - Trust-wide	24	19	79	-
George Eliot Hospital NHS Trust - Clinical areas	17	10	59	5
University Hospitals Coventry & Warwickshire NHS Trust - Trust-wide	24	16	67	-
University Hospitals Coventry & Warwickshire NHS Trust - Clinical areas	17	9	53	5
South Warwickshire NHS Foundation Trust - Trust-wide	24	14	58	-
South Warwickshire NHS Foundation Trust - Clinical areas	17	11	65	5
Commissioning - NHS Coventry	3	2	67	-
Commissioning – NHS Warwickshire	3	2	67	-
Health Economy	**129**	**83**	**64**	-
Totals				
Coventry & Warwickshire Partnership NHS Trust	**650**	**404**	**62**	-
George Eliot Hospital NHS Trust	**41**	**29**	**71**	5
University Hospitals Coventry & Warwickshire NHS Trust	**41**	**25**	**61**	5
South Warwickshire NHS Foundation Trust	**41**	**25**	**61**	5
NHS Coventry & NHS Warwickshire	**141**	**93**	**66**	-
NHS Solihull	**	**		
Health Economy	**914**	**576**	**63**	-
* Compliance is the combined view of in-patient services, memory services, community mental health teams for older adults and the Young Onset Dementia Service. Compliance within the Young Onset Dementia Service was higher than in the other services reviewed. ** Not reviewed				

Details of compliance with individual Quality Standards are in a separate document.

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