Review of Community Mental Health Services

Coventry and Warwickshire Health Economy

Visit Date: 19th May 2015   Report Date (V2): January 2016

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Version	Date	Change from previous version
V1	17.09.15	-
V2	05.01.16	Minor changes to wording on pages 3, 6, 7 and 25 requested by Coventry and Rugby CCG.

INTRODUCTION

This report presents the findings of the review of community mental health services that took place on 19th May 2015. The purpose of the visit was to review compliance with the following West Midlands Quality Review Service (WMQRS) Quality Standards:

- Mental Health Services, Version 1, February 2011

The aim of the standards and the review programme is to help providers and commissioners of services to improve clinical outcomes and service users' and carers' experiences by improving the quality of services. The report also gives external assurance of the care 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 team that reviewed the services in Coventry and Warwickshire health economy. Appendix 2 contains the details of compliance with each of the standards and the percentage of standards met.

The community mental health services provided by Coventry and Warwickshire Partnership NHS Trust were commissioned by NHS Coventry and Rugby Clinical Commissioning Group, NHS Warwickshire North Clinical Commissioning Group and NHS South Warwickshire Clinical Commissioning Group. Lead arrangements for the contract were held by NHS Coventry and Rugby Clinical Commissioning Group.

Most of the issues identified by quality reviews can be resolved by providers' and commissioners' own governance arrangements. Many can be tackled by the use of appropriate service improvement approaches; some require commissioner input. Individual organisations are responsible for taking action and monitoring this through their usual governance mechanisms. The lead commissioner for the service concerned is responsible for ensuring action plans are in place and monitoring their implementation liaising, as appropriate, with other commissioners, including commissioners of primary care and social care. The lead commissioner in relation to this report is NHS Coventry and Rugby Clinical Commissioning Group.

ABOUT WEST MIDLANDS QUALITY REVIEW SERVICE

WMQRS is 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 www.wmqrs.nhs.uk

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.

COMMUNITY MENTAL HEALTH SERVICES

SPECIALIST MENTAL HEALTH SERVICES

COVENTRY & WARWICKSHIRE PARTNERSHIP NHS TRUST

General Comments and Achievements

Community mental health services provided by Coventry and Warwickshire Partnership NHS Trust had been re-configured in June 2014 from a Community Mental Health Team model into Integrated Practice Units (IPUs) which worked around three 'super-cluster' groups:

Clusters 3 – 8   Non-psychosis

Clusters 10 – 17   Psychosis

Clusters 18 – 21   Dementia

The philosophy behind this change was to ensure that service users received the appropriate specialist interventions and that clinical staff in the teams had the appropriate skills and expertise to deliver these interventions. Care clusters were based on the needs of service users from age 18 onwards. Service users were actively involved in re-designing the services, including the development of information for service users and carers.

Reviewers supported the re-design that had taken place and commented particularly that the new teams were recovery-focussed. Initial feedback on the new services from users and carers was positive. The teams were cohesive, working together well and committed to improving the quality of service provided. Links with the Early Intervention Service were good. Reviewers were aware that implementation of the new model was still being embedded.

Reviewers were impressed by work taking place on the pathway of care for people with neuro-developmental disorders, including transition to adult services. Assessments for people with these conditions had been introduced and the provision of therapeutic interventions was being planned. Reviewers also noted that maternal mental health was specifically identified in 'friends and family' monitoring arrangements.

Good Practice

1   Statutory and mandatory training was well-organised with a wide range of training taking place on a single day. Arrangements for monitoring uptake of this training were also clear.

2   The Warwickshire Carers' Team was a joint team with the Deprivation of Liberty Safeguards Team. Senior practitioners in the Team could carry out 'best interest' assessments.

3   Documentation on ligature point assessment was very clear, including good use of pictures.

4   Approved Mental Health Practitioners were easily available, including in the crisis team.

Immediate Risks: No immediate risks were identified.

Concerns

1   **Response to Safeguarding Concerns**

Reviewers were seriously concerned that the Dementia Team in Coventry was having difficulty in managing its response to safeguarding concerns. Reviewers had only verbal information on this issue and were not able to investigate in detail, but raised it with Trust managers during the course of the review. Reviewers were assured that recruitment of a second Team Manager, in order to increase the service's capacity was in progress. Reviewers were also assured that all outstanding safeguarding concerns had been reviewed as a matter of urgency.

2   **Single Point of Entry / Central Booking Service Processes**

Reviewers were seriously concerned about the Single Point of Entry (SPE) / Central Booking Service (CBS) arrangements for a combination of reasons:

   a.   The service provided triage for referrals with a wide range of presenting problems. It was not clear that staff within the service had appropriate competences and experience for triage of this range of problems. The triage tool in use at the time of the review was not considered to be 'fit for purpose' and implementation of a revised triage tool was being considered.

   b.   Reviewers were told that only about 50% of people booked for an assessment by the 3-8 IPUs actually attended their appointment. Staff who met the reviewing team considered that approximately 90% of clients who attended were then discharged back to primary care and only approximately 10% were 'taken on' by the teams. This situation may be related to individuals' needs changing over time or to problems with the triage and booking process but represented poor use of clinical time for staff in the 3-8 IPUs.

3   **Capacity within the Cluster 3-8 IPUs**

Staffing levels within the IPUs were variable and a clear process for relating capacity to demand was not evident. Waiting times for assessment were eight to 12 weeks and some teams had waiting lists. Reviewers considered that the expected caseload of 30 for a band 6 practitioner was reasonable but the intensity of work with this group of users may be challenging for some practitioners, especially because of changes in clients' needs over time. Reviewers also considered that the time spent assessing clients who were then not 'taken on' by the team may not represent the best use of the teams' clinical time.

4   **Care of People with Dementia**

Reviewers were told that the number of referrals to the 18-21 IPUs were 50% greater than the capacity available. Waiting times for an assessment exceeded 12 weeks. Multi-disciplinary working arrangements were not well developed. In particular, the arrangements for social worker involvement in these IPUs appeared variable and it was not clear that medical staff were appropriately involved in the assessment process. Staff reported that clinical and managerial supervision was not embedded in these IPUs.

5   **Document Control**

Many of the Trust policies and procedures had exceeded their review date, including the Adult Safeguarding Policy. Several policies and procedures were in the process of being updated and were awaiting 'sign off'. Staff had been briefed on the revisions and on the new procedures.

Further Consideration

1   Reviewers were told that referrals to the Crisis Team came through the Single Point of Entry and, if appropriate, were then passed directly to the Crisis Team. The Crisis Team contacted the service user within four hours of referral. This was usually a telephone call rather than a face to face contact and the timescales for a face to face assessment were not clearly defined. The criteria for prioritising face to face contact by the crisis service were also not clearly defined. Reviewers were concerned about this issue but, as part of this review, did not meet the Crisis Team and so suggested that further work in this area may be helpful.

2   Information for service users and carers was available but those who met the visiting team said that they had not been offered this information and they were unsure how to contact services and raise issues. Reviewers were shown several examples of confusing information for service users and carers. Wider dissemination of the available information to existing service users and carers may be helpful.

3   Medical staff were part of the IPU teams. Medical involvement and engagement as part of the teams appeared variable, however. Some consultants were actively involved in multi-disciplinary discussions but others did not attend these meetings for their team. Care Programme Approach (CPA) reviews were

undertaken by the care coordinators and the Trust policy was that all staff involved in the client's care should contribute to the review. Reviewers saw examples where consultant psychiatrists had not contributed to the CPA review even though they were involved in the client's care. Further work to ensure full involvement of medical staff in all IPUs may be helpful.

4   Re-configuration of the services had inevitably disrupted some links with general practitioners (GPs). GP satisfaction with the services was reported to be low. Reviewers suggested further work to build links between IPUs and their local GPs may be helpful.

5   Care Cluster 18-21 IPUs were reviewed using the Quality Standards for Community Mental Health Services. It may be more appropriate for these IPUs to meet the WMQRS Standards for Dementia Services V1.1.

6   The Trust Mental Capacity Act policy did not specify timeframes for assessing capacity within each service. The Medicines Management Policy did not include anything about the management of prescribing using FP10 prescription forms. Reviewers suggested that it may be helpful to include these points in the policies.

7   Clinical and managerial supervision was well organised and highly appreciated in some IPUs but implementation of the Trust policy on supervision appeared less robust in others. In particular, IPUs with multiple staff bases appeared to have more difficulty in this area. Ensuring full implementation of the Trust policy on supervision may help further to embed the new ways of working within IPUs.

8   Telephone lines were reported as always busy in some of the larger and busier team bases, resulting in difficulty in contacting staff.

9   Some staff commented that they were no longer using skills which they had previously acquired. Introducing some rotation of staff between IPUs in future may help staff to maintain skills.

10 Reviewers commented on the general use of two names for the Single Point of Entry / Central Booking Service. It may be helpful to decide on a single name for this service.

COMMISSIONING

NHS COVENTRY AND RUGBY CLINICAL COMMISSIONING GROUP

NHS WARWICKSHIRE NORTH CLINICAL COMMISSIONING GROUP

NHS SOUTH WARWICKSHIRE CLINICAL COMMISSIONING GROUP

Concerns

1   **Commissioning of community mental health services**

Reviewers were concerned about the commissioning of community mental health services for a combination of reasons:

a. Joint Strategic Needs Assessments had been produced but action plans to address the needs identified were not yet in place.

b. Service specifications in place at the time of the review were out of date and did not reflect the service being provided. Work to revise the specifications to reflect the new service model was in progress.

c. Key performance indicators were in the evidence provided to reviewers by the Trust but were not provided by commissioners. Commissioner reports on activity and achievement of key performance indicators were not available at the time of the review.

d. Terms of reference and membership of the Partnership Group were being revised with the aim of improving effectiveness and ensuring alignment with the work of the Mental Health

Contracting Group. At the time of the review the meetings which were taking place did not appear to have clearly identified actions and timescales.

2   The concerns identified in the Trust section of this report may require commissioner support and monitoring to ensure they are addressed, in particular:

    a.   Response to Safeguarding Concerns
    b.   Single Point of Entry / Central Booking Service Processes
    c.   Capacity within the Cluster 3-8 IPUs
    d.   Care of People with Dementia
    e.   Document Control

Further Consideration

1   Reviewers queried why care clusters 3 and 4 were being commissioned from specialist mental health services rather than from Improving Access to Psychological Therapies (IAPT) services. A more appropriate response to clients' needs and better value for money may be gained from commissioning these care clusters from IAPT services. This may also help to address some of the issues facing Cluster 3-8 IPUs.

2   The service specification did not mention Independent Mental Health Advocates or how mental health services should link with independent advocacy services. It may be helpful to include this in the updated service specification.

Appendix 1 Membership of Visiting Team

Visiting Team

Dr Shrikaanth Krishnamurthy	Specialist Registrar	Manchester Mental Health and Social Care Trust
Marcus Law	Joint Senior Commissioning and Development Manager – Mental Health	NHS Walsall CCG
Marisa Manning	PICU Ward Manager	Worcestershire Health and Care NHS Trust
Joanne Roberts	Acting Inpatient Lead Nurse	Worcestershire Health and Care NHS Trust
Sally Simmonds	Community Services Manager (Countywide)	2gether NHS Foundation Trust
Diane Topham	Operational, Business and Performance Manager	2gether NHS Foundation Trust

WMQRS Team

Jane Eminson	Acting Director	West Midlands Quality Review Service
Sue McIldowie	Quality Manager	West Midlands Quality Review Service

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 varies 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	Number of Applicable QS	Number of QS Met	% met
Community Mental Health Services			
Mental Health Trust-wide	11	8	73
Specialist Mental Health Services	54	30	56
Commissioning	13	5	38
Health Economy	**78**	**43**	**55**

MENTAL HEALTH TRUST-WIDE

Ref	Quality Standard	Met? Y/N	Reviewer Comments
GD-101	**General Support for Service Users and Carers** Service users and their carers should have easy access to the following services. Information about these services should be easily available: a. Interpreter services, including access to British Sign Language b. Independent advocacy services c. PALS d. Social workers e. Benefits advice f. Spiritual support g. Relevant support groups h. *HealthWatch* or equivalent organisation i. Where to go for further information	N	Information about independent advocacy services was not available in the evidence folder or in any of the locations visited.
GD-199	**Involving Users and Carers** The Trust should have: a. Mechanisms for receiving feedback from service users and carers about the treatment and care they received b. A rolling programme of audit of a random sample of service users' experiences of their treatment and care c. Mechanisms for involving service users and, where appropriate, their carers in decisions about individual treatment and care d. Mechanisms for involving service users and carers in decisions about the organisation of services.	Y	Mechanisms were in place for service users to give feedback. Carers who met reviewers were not clear about ways of raising concerns.
GD-298	**Clinical and Managerial Supervision** The Trust should have a policy on clinical and managerial supervision for clinical staff.	Y	
GD-510	**Care Coordination Policy** The Trust should have a policy on Care Coordination (including the Care Programme Approach).	Y	A policy was in place but it was not clear that it was fully implemented (see main report – 'further consideration' section).
GD-511	**Community Treatment Orders** The Trust should have a policy on the use of Community Treatment Orders.	Y	A good policy was in place which included a monitoring process. The policy did not include information about independent mental health advocacy.
GD-594	**Mental Capacity Act and Deprivation of Liberty Safeguards** The Trust should have a policy on adherence to the Mental Capacity Act and Deprivation of Liberty Safeguards.	N	The Mental Capacity Act Policy incorporating Deprivation Of Liberty Safeguards (DOLS) was in draft form. The DOLS standard operating procedure was in the process of being drafted at the time of the review.

Ref	Quality Standard	Met? Y/N	Reviewer Comments
GD-595	**General Policies** The Trust should have policies on: a. Lone Working b. Medicines Management c. Health and Safety d. Risk assessment and management	Y	All policies were in place. 'b': The Medicines Management policy did not include anything about the management of prescribing using FP10 prescription forms. 'c': The ligature point assessment documentation was very good. 'd': The risk assessment and management policy was large and complex and may be difficult for staff to understand and use.
GD-596	**Safeguarding Policy** A Safeguarding Policy should be in use. This should cover at least: a. Arrangements for investigation and, if necessary, referral of complaints and incidents relating to the care of vulnerable adults b. Expected staff training c. Who staff should contact if they have concerns about safeguarding issues d. Action to take when safeguarding-related allegations are made against a member of staff (or link to relevant HR policy).	N	The Adult Safeguarding Policy was due for review in August 2014 and did not cover 'Prevent' and other more recent guidance. Staff had, however, been briefed on the new policy. The Multi Agency Public Protection Agency (MAPPA) policy was due for review April 2015. The Child Safeguarding Policy was up to date.
GD-597	**Information Sharing** Local guidelines on sharing information about vulnerable groups of the population who are likely to attend other health and social care services regularly or who are approaching the end of life should be in use.	Y	Three policies for information sharing were in place: A good multi-agency policy was in use but out of date (due for review January 2015). The internal Trust information sharing and information governance policies were up to date.
GD-601	**Service Coordination and Liaison** The Trust should have appropriate arrangements for ensuring effective communication and liaison between services including: a. An Acute Care Forum b. A mechanism covering community-based non-acute services with links to primary care, social care and voluntary sector organisations.	Y	
GD-602	**Partnership Board Attendance** The Trust should participate in the local Partnership Board (or equivalent) with responsibility for improving services for people with mental health problems (QS GZ-701).	Y	See main report (commissioning – 'further consideration' section).

SPECIALIST MENTAL HEALTH SERVICES

Ref	Quality Standard	Met? Y/N	Reviewer Comments

GN-101	**General Support for Service Users and Carers**
	
	Service users and their carers should have easy access to the following services. Information about these services should be easily available:
	  a. Interpreter services, including access to British Sign Language
	  b. Independent advocacy services
	  c. PALS
	  d. Social workers
	  e. Benefits advice
	  f. Spiritual support
	  g. Relevant support groups
	  h. *HealthWatch* or equivalent organisation
	  i. Where to go for further information
		N	See Quality Standard GD-101.

GN-102	**Information about the Service**
	
	Service users and, where appropriate, their carers should be offered information about the service covering, at least:
	  a. Brief description of the service
	  b. How to contact the service for help and advice, including out of hours
	  c. Staff of the service
	  d. Belongings, visiting times and daily routine (in-patient services only)
	  e. How to give feedback on the service, including how to make a complaint and how to report adult safeguarding concerns
	  f. How to get involved in improving services (QS GN-199)
		N	Information about the services was available but service users who met the reviewers had not received the information and were unclear about how to access services and how to raise any issues of concern.

GN-103	**Care Plan**
	
	Each service user and, where appropriate, their carer should agree their Care Plan and Care Cluster. Service users and, where appropriate, their carers should be offered a copy of their Care Plan covering at least:
	  a. Overall aim and Care Cluster
	  b. Care coordinator
	  c. Arrangements for allocation / liaison with Care Coordinator
	  d. Therapeutic interventions and medication
	  e. Expected outcomes of the therapeutic interventions
	  f. Early warning signs of problems and what to do if these occur
	  g. Risk management plan
	  h. Planned review date and how to access a review more quickly, if necessary.
		N	A good care plan / initial assessment template was available, which included service user and carer involvement in the care planning process. Most of the Coventry service users who met reviewers did not have a care plan and those who did had not had it reviewed. Staff who met reviewers were clear about the care planning process and this appeared to be embedded in the Rugby team. Reviewers did not see case notes and so were not able to establish whether care plans were in place in all teams reviewed.

Ref	Quality Standard	Met? Y/N	Reviewer Comments
GN-198	**Carer Assessment** Each carer should be offered an assessment of their own needs and information and advice on services available to provide support.	Y	A Carers' Team had been established in Warwickshire since February 2015. The referral process to this team was clear. Coventry had a Carers' Centre and a carers' assessment pathway.
GN-199	**Involving Users and Carers** The service should have: a. Mechanisms for receiving feedback from service users and carers b. A rolling programme of audit of service users' and carers' experience c. Mechanisms for involving service users and, where appropriate, their carers in decisions about the organisation of the service.	Y	The Trust used the Friends and Family feedback format. Service users and carers had also been involved in the development of the IPU leaflets. Carers who met reviewers were not clear about ways of raising concerns.
GN-201	**Lead Practitioner and Manager** The service should have a nominated lead practitioner and lead manager.	Y	
GN-202	**Staffing Levels** The service should have sufficient staff with appropriate competences to deliver: a. the assessments and Care Clusters activities for the usual number of service users on each Care Cluster and the usual level of need / complexity of care required; b. the service's role in the identification and management of service users' physical health needs (QS GN-504). Staffing levels should be based on a competence framework covering skill mix, staffing levels and competences expected. The relationship between the competence framework and the usual number of service users, their needs / complexity and Care Cluster activities should be clearly identified. For Acute Care Services this applies only to the acute care aspects of each Care Cluster which should be able to be delivered in either a community or in-patient setting.	N	See main report.
GN-203	**Competence Framework and Training Plan** A competence framework should cover expected competences for roles within the service, including in Safeguarding, Mental Capacity Act and Deprivation of Liberty Safeguards. A training and development programme should ensure that all staff have, and are maintaining, these competences (QS GN-202).	Y	A good training needs analysis was in place. Statutory and mandatory training was well organised.

Ref	Quality Standard	Met? Y/N	Reviewer Comments
GN-204	**Case Management Competences** All staff involved in case management should have up to date competences in: a. Individualised recovery planning with goals and milestones b. Discharge/transition planning c. Coordinating service users' care d. Discharge planning e. Working with primary care and other services to ensure continuity of care across multiple agencies f. Working with people who have mental illness and substance use problems g. *Mental Health Act* (2007) and the *Mental Capacity Act* (2005) and the interaction between them.	N	Some training had taken place and further training was planned for 2015/16. At the time of the review training had not yet been completed for all staff and some staff were still in a process of transition to the new working arrangements. This was, however, being addressed systematically.
GN-205	**Approved Mental Health Act Practitioner** An Approved Mental Health Practitioner should be available at all times, either as a member of the team or through access to another service.	Y	All teams had an Approved Mental Health Act Practitioner. In Warwickshire an Approved Mental Health Act Practitioner was part of the crisis team in Warwickshire.
GN-206	**Lead Consultant Psychiatrist** The service should have a lead consultant psychiatrist responsible for coordinating medical input to the service.	Y	
GN-207	**CRHT Registered Practitioner** Acute Care Services (CRHT) only: At least one registered practitioner should be on duty at all times.	N/A	
GN-208	**CRHT Doctor Available** Acute Care Services (CRHT) only: A doctor of grade ST4 or above (or equivalent non-training grade doctor) should be available to the Acute Care Service, and able to do home visits, at all times.	N/A	
GN-209	**Nominated Links – Specialist Services** The service should have a nominated lead practitioner for liaison with each of the following services: a. Peri-natal mental health services b. Eating disorder services c. Intensive care and secure services d. Forensic services e. Neuro-psychiatry services. The nominated leads should take a lead role in relation to liaison with the specialist service, guidelines and staff development.	N	Links with specialist services were in place but lead practitioners for liaison with specialist services had not been identified.

Ref	Quality Standard	Met? Y/N	Reviewer Comments

GN-210	**Nominated Links – Local Services**
	
	The service should have a nominated lead practitioner for the care of service users with:
	  a. dual diagnoses
	  b. substance misuse problems
	  c. complex needs, including personality disorders
	  d. learning disabilities and /or other neuro-developmental disorders including Asperger's Syndrome, Autistic Spectrum Condition and ADHD
	  e. age 16 to 18, including those who have not previously been in contact with mental health services
	  f. dementia
	The nominated leads should take a lead role in relation to liaison with specialist services, guidelines and staff development.
		N	Lead practitioners were in place for 'a', 'c', 'e' and 'f'. Lead practitioners were not yet identified for 'b' and 'd'. These services were not provided by the Trust but leads for liaison with specialist services are expected by the Quality Standard.
			.

GN-297	**General Competences**
	
	All staff should have up to date training appropriate to their role in:
	  a. equal opportunities
	  b. racial awareness
	  c. gender awareness
	  d. disability awareness
	  e. religious awareness
	  f. sexual safety awareness
	  g. safeguarding children and young people
	  h. safeguarding vulnerable adults
	  i. Involving service users and carers in the planning, delivery and review of services.
		N	Statutory and mandatory training covered all except 'i'. A good system for monitoring the uptake of training was in place. Of the 12 categories of training, however, only two were at green (at or above the target percentage), nine at amber and one at red.

GN-298	**Clinical and Managerial Supervision** All practitioners should receive regular clinical and managerial supervision appropriate to their role.	Y	See main report ('further consideration' section).
GN-299	**Administrative and Clerical Support** Administrative and clerical support should be available.	N	The services had insufficient administrative support. The dementia IPU had no administrative support. In one of the 10-17 IPUs clinical staff were also covering the reception.
GN-302	**Pharmacy** Pharmacy advice and pharmacological supplies should be available at all times the service is operational. In normal working hours pharmacy advice with mental health specific expertise should be available.	Y	Good pharmacy support was available.

Ref	Quality Standard	Met? Y/N	Reviewer Comments
GN-303	**Residential and Day Opportunities** Acute Care Services and Assertive Outreach Services only: The service should have access to a range of residential and day opportunities as alternatives to admission to in-patient care.	Y	The services had access to Oakwood and Fennel Day Hospitals.
GN-304	**Access to Venepuncture and ECG** The service should have timely access to venepuncture and ECG services, including interpretation of ECGs.	N	Physical health and well-being clinics were being established which included access to venepuncture and electrocardiogram (ECG). Five analytical ECG machines had been purchased and further machines were on order. At the time of the review, clinics had not yet been set up in South Warwickshire.
GN-401	**Facilities for Seeing Service Users** All community-based services: Access to facilities for seeing service users away from their own home should be available at all times the service is operational.	Y	
GN-402	**Team Accommodation** community-based services: Accommodation for the service should be sufficient for the whole team, including space for team meetings.	Y	Team accommodation was satisfactory. Reviewers were told that telephone contact with some of the larger and busier teams could be difficult because phone lines were frequently engaged.
GN-403	**Mobile Phones and Cars** All community-based services: All clinical staff should have access to a mobile phone and a car.	Y	

GN-404	**Storage of Drugs**
	
	All community-based services :
	Appropriate storage for drugs should be available including:
	  a. Secure storage within the team's base including provision of cold storage (where applicable)
	  b. Cases for transporting drugs
	  c. Disposal facilities.
	Pharmacy approval of storage facilities should have been given.
		Y	

GN-405	**Storage of Case Notes** All community-based services : A facility for secure storage of case notes and access to service users' historic notes should be available at all times.	Y	Community staff had access to the EPEX system although this did not always have a full clinical history because the system was not yet used by in-patient services.

Ref	Quality Standard	Met? Y/N	Reviewer Comments
GN-406	**IT System** An IT system capable of care plan and care pathway monitoring should be available. This system should be capable of electronic communication with the service user's GP and with Local Authority IT systems, in order to facilitate comprehensive assessments.	Y	
GN-407	**In-patient Facilities** Acute Care Service (IP) only: In-patient services should comply with relevant guidance on facilities and equipment for in-patient mental health services.	N/A	
GN-501	**Assessment Tool** An assessment tool which ensures involvement of service users and, where appropriate, their carers should be in use. The outcome of the assessment should be communicated to the service user, their carer (where appropriate) and general practitioner and should be recorded in their case notes. (Appendix 6 summarises the areas which should be covered by the assessment tool.)	Y	A generic assessment tool was available. It may be helpful to tailor this for the different care clusters.
GN-502	**Clinical Guidelines** Clinical guidelines should be in use for each Care Cluster offered by the service. These guidelines should cover therapeutic activities, medication and prescribing for each Care Cluster, and the expected frequency of review.	Y	
GN-503	**Clinical Guidelines – Detail** Clinical guidelines (QS GN-502) should be explicit about alterations to the Care Cluster expected for service users with: a. a risk of harm to themselves or others (including consideration of safeguarding children and vulnerable adults) b. dual diagnoses c. substance misuse problems d. complex needs, including personality disorders e. learning disabilities and /or other neuro-developmental disorders including Asperger's Syndrome, Autistic Spectrum Condition and ADHD f. dementia. Clinical guidelines should also be explicit about i. Criteria for admission to in-patient care and for access to alternatives to admission (QS GN-303) ii. Care and management of pregnant and lactating women iii. Service users with young children.	N	Clinical staff who met the visiting team were not clear whether they could change the clinical guidelines for service users with differing needs. .

Ref	Quality Standard	Met? Y/N	Reviewer Comments

GN-504	**Physical Health Care**
	
	Guidelines should be in use covering the identification and management of service users' physical health needs, including:
	  a. Prevention programmes
	  b. Access to national screening programmes and
	  c. Management of commonly occurring long-term conditions.
	  d. Ensuring a physical health check was carried out in the last year.
	Where care is shared with the service user's general practitioner, guidelines should be clear about responsibilities, including responsibility for prescribing.
		N	Guidelines were in place but did not cover 'a' and 'c'.
			
			Physical health practitioners working across IPUs in Coventry had identified problems with some patients attending GP appointments.

GN-505	**Referral Guidelines – Local Services**
	
	Guidelines should be in use covering the indications and arrangements for seeking advice from, and referral to, other local services should be easily available. These should cover at least:
	  a. Primary care –based psychological therapy services
	  b. Early intervention services
	  c. Community mental health services
	  d. Acute care services (CRHT and in-patient)
	  e. Assertive outreach services
	  f. Substance misuse services
	  g. Memory services
	  h. Services for people with learning disabilities
	  i. Child and adolescent mental health services
	
	The referral criteria for CRHT should include:
	  i. all clients where hospital admission is being considered
	  ii. all *Mental Health Act* Assessments
	People with dementia should not be excluded from CRHT referrals.
		N	The Standard Operating Procedure for internal transfers was still in draft form. Guidelines on referral to 'f' and 'h' were not in place. (These services were not provided by the Trust but referral guidelines should be in place.)

GN-506	**Discharge to Services Providing Less Intensive Interventions** Early Intervention, Acute Care and Assertive Outreach Services only: Guidelines on referral or discharge to services providing less intensive interventions should be in use.	Y	

Ref	Quality Standard	Met? Y/N	Reviewer Comments

GN-507	**Referral Guidelines – Specialist Services**
	
	Guidelines should be in use covering the indications and arrangements for seeking advice from, and referral to, the following specialist services:
	  a. Peri-natal mental health services
	  b. Eating disorder services
	  c. Intensive care and secure services
	  d. Forensic services
	  e. Neuro-psychiatry services
		N	Arrangements for advice and referral were contained in the Standard Operating Procedure for Internal Transfers document which was still in draft format. A directory of services was available.

GN-508	**Transition to Adult Care**
	
	Guidelines should be in use covering transition from CAMHS to adult care which should include:
	  a. Age guidelines for the timing of the transfer
	  b. Involvement of the young person and, where appropriate, their carer in the decision about transfer
	  c. Involvement of the young person's general practitioner in planning the transfer
	  d. Joint CAMHS / adult service meeting/s in order to plan transfer to adult care
	  e. Allocation of a named coordinator for the transfer of care
	  f. A preparation period and education programme prior to transfer to adult care
	  g. Arrangements for monitoring during the time immediately after transfer to adult care.
	These guidelines should have been agreed with the CAMH service/s from which service users are usually transferred.
		N	Guidelines were in place but did not cover ensuring involvement of the GP ('c'), allocation of the named coordinator ('e') or monitoring arrangements ('g').

GN-509	**Transition to Memory Services**
	
	Guidelines should be in use covering transition to the care of the local Memory Service/s which should include:
	  a. Involvement of the service user and, where appropriate, their carer in the decision about transfer
	  b. Involvement of the service user's general practitioner in planning the transfer
	  c. Joint meeting with the Memory Service in order to plan transfer
	  d. Allocation of a named coordinator for the transfer of care
	  e. A preparation period prior to transfer
	  f. Arrangements for monitoring during the time immediately after transfer.
	These guidelines should have been agreed with the Memory Service to which service users are usually transferred.
		N	Guidelines did not cover 'a' or 'b' and monitoring arrangements ('f') were not clear.

Ref	Quality Standard	Met? Y/N	Reviewer Comments
GN-510	**Care Coordination** The Trust Policy on Care Coordination (including the Care Programme Approach) should be in use.	N	See main report ('further consideration' section).
GN-511	**Community Treatment Orders** A policy on the use of Community Treatment Orders should be in use. This policy should be clear about the service's role in decisions on the use of Community Treatment Orders.	Y	
GN-593	**Discharge Planning** A discharge planning policy should be in use which ensures that a discharge plan is agreed with the service user and, if appropriate, their carer. The discharge plan should be communicated to the service user, their general practitioner and, if appropriate, their carer and should be recorded in their case notes.	Y	
GN-594	**Mental Capacity Act and Deprivation of Liberty Safeguards** A Trust policy on adherence to the Mental Capacity Act and Deprivation of Liberty Safeguards should be in use.	Y	

GN-595	**General Policies**
	
	The following Trust Policies should be in use:
	  a. Lone Working
	  b. Medicines Management
	  c. Health and Safety
	  d. Risk assessment and management
		Y	Implementation of the lone working policy outside of 9am to 5pm was well understood by staff. Staff appeared less clear about implementation of this policy during normal working hours.

GN-596	**Safeguarding Policy** The Trust Safeguarding Policy should be in use.	Y	
GN-597	**Information Sharing** Local guidelines on sharing information about vulnerable groups of the population who are likely to attend other health and social care services regularly or who are approaching the end of life should be in use.	Y	

GN-601	**Operational Policy**
	
	An operational policy should be in use which ensures:
	  a. Each stage of the service user 'journey' takes place within expected time scales.
	  b. Each service user agrees a care plan.
	  c. The care plan and any revisions following review is documented and communicated to the service user, their carer (where appropriate) and general practitioner and is recorded in their case notes.
	  d. Each service user and, where appropriate, their carer is offered information about their Care Plan and Care Cluster.
		Y	

Ref	Quality Standard	Met? Y/N	Reviewer Comments
GN-602	**Liaison with Other Mental Health Services** The service should link effectively with the Trust-wide and Partnership Board (or equivalent) mechanisms for coordination and liaison between services through attendance at meetings or through arrangements for influencing and getting feedback on its work.	Y	See main report (commissioning – 'further consideration' section).

GN-603	**Liaison with Other Services**
	
	Arrangements for liaison with the following services should be in place:
	  a. Housing
	  b. Benefits advice
	  c. Employment support
	  d. Education
	  e. Probation and police
	  f. Relevant voluntary organisations
	  g. Youth offending teams
	  h. Children's services (Early Intervention Services and Acute Care Services)
	  i. Local authorities
		Y	

GN-604	**Review Meetings – Specialist Services**
	
	At least one representative of the service should meet at least annually with each service to which clients are referred in order to review links between services and identify shared learning:
	  a. Peri-natal mental health services
	  b. Eating disorder services
	  c. Intensive care and secure services
	  d. Forensic services
	  e. Neuro-psychiatry services
		N	Annual review meetings were not yet in place.

GN-605	**Mental Health Promotion Programme** The service should contribute to the local programme on mental health promotion and reducing stigma (QS GZ-102).	N	No information was available about the contribution of the services to local health promotion programmes.
GN-606	**Primary Care Liaison** The service should have arrangements for liaison with primary care services including the service user's general practitioner. The arrangements should cover operational issues, advice and feedback.	N	See main report ('further consideration' section). GPs could ring consultant psychiatrists.
GN-607	**Acute Hospital Liaison** The service should have arrangements for liaison with the link professional for people with mental health problems in the local general acute hospitals and should contribute to acute hospital training and development programmes	N	Acute hospital liaison was provided by the Arden Mental Health Assessment Teams (AMHAT) but it was not clear how the IPU's linked with AMHAT.

Ref	Quality Standard	Met? Y/N	Reviewer Comments
GN-699	**Primary Care Training and Development** The service should contribute to primary care training and development programmes (QS GZ-299).	N	It was not clear if the services contributed to primary care training and development programmes.
GN-701	**Data Collection** There should be regular collection of data and monitoring of: a. Referrals, including source of referral b. Individuals not considered appropriate for the service, including reason why not considered appropriate and onward referral destination / 'sign-posting' c. Individuals not accepted by the service for some other reason d. Key indicators of user journey (Appendix 7) e. Discharges, including expected care after discharge f. Minimum data set, including Health of the Nation Outcome Scores at assessment and discharge.	N	Some data were collected (Health of the Nation Outcome Scores at assessment and discharge, 'e' and 'f'). Other data were not yet routinely collected although the required data set was being redesigned.
GN-702	**Audit** The service should have a rolling programme of audit of compliance with the clinical guidelines for each Care Cluster offered by the service (QS GN-502).	Y	A comprehensive audit programme was in place.
GN-703	**Monitoring of Staff Retention and Turnover** The service should monitor and regularly review staff retention and turnover.	Y	Data were recorded on the services dashboard.
GN-798	**Review and Learning** The service should have appropriate arrangements for review of, and implementing learning from, positive feedback, complaints, outcomes, incidents and 'near misses'.	Y	Information was discussed at the Community Safety and Quality Group. Services were represented on the Serious Incident Group. Feedback to staff was good and staff who met reviewers were clear about incident reporting and serious reviews processes.
GN-799	**Document Control** All policies, procedures and guidelines should comply with Trust document control procedures.	N	Many polices had review dates that had expired. Some policies that had been updated were awaiting ratification.

COMMISSIONING

Ref	Quality Standard	Met? Y?N	Comments
GZ-101	**Advocacy Services** Advocacy services to support people with dementia in their contacts with services should be commissioned. Commissioners should ensure information about these services is available in primary care.	N	No information was available.
GZ-102	**Mental Health Promotion Programme** Commissioners should ensure a programme of mental health promotion and reducing stigma is run. This programme should include input from service users and carers.	N	No information as available.
GZ-299	**Primary Care Development Programme** Commissioners should ensure that a programme of training and development of primary care staff in the prevention, recognition, screening, early intervention, user and carer experience and ongoing care of people with mental health problems is available (QS GA-299).	N	A plan had been put in place to deliver training between June 2013 and January 2014 but it was not clear if this had been delivered.
GZ-597	**Information Sharing Agreement** Commissioners should ensure inter-agency guidelines on sharing information about vulnerable groups of the population who are likely to attend health and social care services regularly or who are approaching the end of life have been agreed.	Y	A multi-agency policy was in place but was out of date.

Ref	Quality Standard	Met? Y?N	Comments
GZ-601	**Commissioning: Mental Health Services** An appropriate range of the following services for the local population should be commissioned: a. Primary care-based psychological therapies b. Early Intervention Service c. Community Mental Health Service d. Acute Care Service (Crisis Resolution Home Treatment) e. Acute Care Service (In-patient) f. Assertive Outreach Service g. Mental Health Liaison Service. For each service commissioners should identify the Care Clusters which the service should offer. For each service commissioners should define whether they are expected to care for service users who also have: i. substance misuse problems ii. complex needs, including personality disorders iii. learning disabilities and /or other neuro-developmental disorders including Asperger's Syndrome, Autistic Spectrum Condition and ADHD iv. other dual diagnoses v. age 16 to 18 who have previously been in contact with child and adolescent mental health services vi. age 16 to 18 who have not previously been in contact with mental health services.	N	Service specifications were out of date (dated 2011 and due for review in March 2013). The service specifications shown to reviewers were not for IPU services.
GZ-602	**Commissioning: Mental Health Services - Detail** Commissioners should have agreed the indications and arrangements for referral to each service (QS GZ-601). The criteria for acceptance by each service should be explicit about the groups of service users listed in QS GZ-601 (i to vi). The referral criteria for CRHT should include: a. all clients where hospital admission is being considered b. all *Mental Health Act* Assessments People with dementia should not be excluded from CRHT referrals.	N	As Quality Standard GZ-601.
GZ-603	**Information for Primary Care** The indications and arrangements for referring clients to each service should be circulated regularly to GPs, other mental health services, police, social services and Emergency Departments within the catchment area of the service.	N	GPs had been informed about the criteria for referrals, based on the out of date service specifications. Information for other services identified in the Quality Standard was not available.

Ref	Quality Standard	Met? Y?N	Comments
GZ-604	**Residential and Day Opportunities** Commissioners should ensure a range of residential and day opportunities are available as alternatives to admission to in-patient care	Y	
GZ-605	**Criminal Justice Liaison** Arrangements for criminal justice liaison which take account of the needs of people with mental health problems should have been agreed.	Y	Arrangements for criminal justice liaison were discussed through the Mental Health Crisis Concordat and recorded in an action plan. A good street triage service was in place.
GZ-701	**Partnership Board (or equivalent)** Arrangements for coordinating mental health strategy and ensuring effective inter-agency cooperation should be in place. These arrangements should involve users and carers, local providers, social services, voluntary organisations and other relevant organisations.	Y	The Partnership Board met on a monthly basis (see main report: commissioning – 'further consideration' section).
GZ-702	**Needs Assessment** An assessment of the need for mental health services should have been undertaken which includes consideration of the needs of people with mental health problems who also have: a. substance misuse problems b. complex needs, including personality disorders c. learning disabilities and /or other neuro-developmental disorders including Asperger's Syndrome, Autistic Spectrum Condition and ADHD d. other dual diagnoses e. age 16 to 18 who have previously been in contact with child and adolescent mental health services f. age 16 to 18 who have not previously been in contact with mental health services.	Y	Joint Strategic Needs Assessments (JSNAs) were in place for both Coventry and Warwickshire for 2014 to 2015. Action plans to address the needs identified were not yet developed.
GZ-703	**Strategy** A strategy for meeting the needs of people with mental health problems and their carers should have been agreed. This strategy should ensure a holistic pathway of care for people with mental health problems and their carers with an integrated approach across health and social care and the voluntary sector. It should address the specific needs of the groups identified in QS GZ-702.	N	An overall Mental Health Strategy for Coventry was not yet in place. A strategy was in place for Warwickshire which included reference to a dementia strategy. This was due to be refreshed in January 2015.

Ref	Quality Standard	Met? Y?N	Comments
GZ-704	**Quality Monitoring – Primary Care** Commissioners should ensure that all general practice are: a. Offering a comprehensive, annual health check to all people with serious mental illness registered with their practice (QS GA-103) b. Collecting data on people with serious mental illness registered with their practice (QS GA-701).	N/A	This Quality Standard was not applicable to local commissioners at the time of the review as quality monitoring was carried out by NHS England. If primary care commissioning is delegated to Clinical Commissioning Groups then this Quality Standard should be met.
GZ-705	**Prisoner Primary Care** Commissioners responsible for prison health services should ensure that QS GZ-704 is met by these services	N/A	Primary care for prisoners was commissioned by NHS England.
GZ-706	**Quality Monitoring – Mental Health Services** For each mental health service commissioned (QS GZ-601), arrangements for regular review of the quality of services should be in place, including regular review of: a. number of clients not considered appropriate or not accepted for some other reason, b. key user journey indicators c. compliance with the Quality Standards.	N	Commissioner monitoring of service quality was not evident. Clinical Quality Review Meetings were in place but reviewers did not see evidence of monitoring as expected by the Quality Standard.