Cheshire and Wirral Partnership NHS Foundation Trust

Community-based mental health services of adults of working age

Trust Headquarters, Redesmere
The Countess of Chester Health Park, Liverpool Road
Chester
Cheshire
CH2 1BQ
Tel: 01244367397
www.cwp.nhs.uk

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Ratings

Overall rating for this service	Requires improvement
Are services safe?	**Requires improvement**
Are services responsive?	**Requires improvement**

Summary of findings

Community-based mental health services of adults of working age

Requires improvement

Summary of this service

Our overall rating of this service went down. We rated it as requires improvement because:

In January 2020, the CQC undertook an inspection of Cheshire and Wirral Partnership Foundation NHS Trust. The core service community-based services for adults of a working age was not scheduled to be inspected as part of this process. However, in information submitted by the trust prior to our inspection, attention deficit hyperactivity disorder services showed long waiting lists to access the service which we were concerned about. These services were included in a separate core service we inspected (community-based services for individuals with a learning disability) due to the trust's care group structure. It became clear whilst the inspection team were on site at the attention deficit hyperactivity disorder services that these services related to our judgements against the core service - community mental health services of adults of working age. Whilst on site we identified concerns with the attention deficit hyperactivity disorder services which we are required to report on. As a result, we completed a focused inspection on these services.

We last inspected the trust's community-based mental health services for adults of working age in October 2016 and rated them as good overall and across all key questions (safe, effective, caring, responsive and well-led).

During the inspection visit, the inspection team:

- spoke with two patients who were using the service;
- spoke with seven staff including managers, consultants, nurses, support workers and administrative staff;
- spoke with the senior leadership team of the clinical care group and the director of operations;
- attended and observed two patient appointments;
- looked at six care and treatment records of patients;
- looked at a range of policies, procedures and other documents relating to the running of the service.

Our overall rating of this service went down. We rated it as requires improvement because:

- There were long waiting lists for attention deficit hyperactivity services across all three geographical service areas.
- Staff did not fully monitor exisiting patients on the waiting list. This meant we could not be assured that staff were able to identify, respond and manage a deterioration in a patients' health or a change in their risk level.

Is the service safe?

Requires improvement

Our rating of safe went down. We rated it as requires improvement because:

- Patient risk was not monitored whilst patients were on the waiting list. This meant we could not be assured that staff were able to respond to a deterioration in a patients' health or a change in their risk level.

Summary of findings

Is the service responsive?

Requires improvement

Our rating of responsive went down. We rated it as requires improvement because:

- Patients were waiting for a prolonged period to access attention deficit hyperactivity services. There were 831 patients on the waiting list for Cheshire services with an average waiting time of 129 weeks. There were 1195 patients on the waiting list for Liverpool services with an average waiting time of 116 weeks. There were 1390 patients on the waiting list for Wirral services with an average waiting time of 76 weeks.

Detailed findings from this inspection

Is the service safe?

Assessing and managing risk to patients and staff

The service was not fully monitoring patients on the waiting list to detect and respond to changes in levels of risk. The service completed an annual administration review to advise patients that they remained on the waiting list. Patients were provided with an information leaflet explaining where they could access support if they experienced other mental health problems whilst on the waiting list. However, the service did not carry out active monitoring of patients on the waiting list to review and assess changes in the level or acuity of a patients' potential attention deficit hyperactivity disorder or any associated impact or risk.

The trust was aware of the long waiting list to access these services. The trust had a board assurance framework (dated October 2019) which captured high level risks within the organisation. This included a risk relating to waiting times to access the attention deficit hyperactivity disorder services, including 'risks to patient safety and experience'. We requested an updated board assurance framework following our inspection. The updated framework included a risk relating to waiting times to access the attention deficit hyperactivity disorder services. However, the risk description had changed and no longer made reference to patient safety. The risk description referred to risks around increasing 'waiting times and complaints from people who have not accessed services due to gaps in commissioning.

The service had recently introduced a single point of access process. This meant that patients not known to services completed an adult attention deficit hyperactivity disorder self-report scale and provided medication and risk history. The service had priority patient groups which were veterans, patients involved with multi-agency public protection agreements and patients transferring from child, young people and adolescent services to adult services. Each commissioning body also had funding pots to support priority treatment for specific cases.

However, risks relating to patients outside of priority groups and referred prior to the instigation of the single point of access triage process were not being monitored, managed or responded to. As a result staff would not be able to recognise or respond appropriately to patients risks or signs of deteriorating health.

Clinical commissioning groups, with the support of the trust had written to GPs regarding waiting times and service models. When a referral was received the service wrote to the patient and the referrer to explain the waiting list and the expected waiting time.

Is the service responsive?

Access and waiting times

The attention deficit hyperactivity disorder services had waiting lists in place. At the time of our inspection waiting lists and average waiting time (taken from minimum and maximum) in each area were:

Cheshire - 831 on the waiting list. Average waiting time 129 weeks.

Liverpool - 1195 on the waiting list. Average waiting time 116 weeks.

Wirral - 1390 on the waiting list. Average waiting time 76 weeks.

The trust informed us that waiting lists had developed due to commissioning levels and an inability to transfer patients into primary care services once they were stabilised. This was because GPs in each locality were not accepting discharged patients into their care and were not willing to prescribe medication for attention deficit hyperactivity disorder. This meant that patients on the waiting list had no access to medication to support their needs.

Detailed findings from this inspection

The service was taking steps to try and address these issues. There were ongoing discussions with commissioners in each locality. A new service model had been agreed with commissioners in Cheshire and the service was awaiting further discussion around funding levels. Work was also ongoing with commissioners in the Liverpool and Wirral localities. The service had also worked with GPs in the Wirral locality to develop a leading excellence with attention deficit hyperactivity disorder in primary care (LEAP) programme. This was a partnership with a group of GPs who received training and support to accept attention deficit hyperactivity disorder patients once they were stabilised. This had resulted in the discharge of approximately 200 patients in the first instance. The plan was to discharge a further 25 patients each month. However, the services had been launched in 2005 and the waiting lists had been in place for a considerable period of time. Current work with commissioners had begun in the summer of 2019.

Since February 2019 the service had received six complaints relating to waiting times in the attention deficit hyperactivity disorder service.

Areas for improvement

The trust must take the following action

- The trust must ensure that the waiting list for attention deficit hyperactivity disorder services is reviewed and that existing patient risk is identified and responded to. Regulation 12.
- The trust must ensure that risk on the attention deficit hyperactivity disorder service waiting list is monitored, managed and responded to on an ongoing basis. Regulation 9.
- The trust must continue to work with stakeholders to ensure that current waiting lists for attention deficit hyperactivity disorder services are reduced. Regulation 9.

Our inspection team

Our inspection team comprised of two CQC inspectors and two CQC specialist advisors. These were a nurse and a social worker.

This section is primarily information for the provider

Requirement notices

Action we have told the provider to take

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

Regulated activity	Regulation
Treatment of disease, disorder or injury	Regulation 9 HSCA (RA) Regulations 2014 Person-centred care

Regulated activity	Regulation
Treatment of disease, disorder or injury	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment