CareQuality Commission

Coventry and Warwickshire Partnership NHS Trust
Wayside House
Quality Report

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Date of publication: 17/04/2014
Date of inspection visit: 20-24 January 2014

This report describes our judgement of the quality of care at this location. It is based on a combination of what we found when we inspected, information from our 'Intelligent Monitoring' system, and information given to us from people who use services, the public and other organisations.

Summary of findings

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Summary of findings

Overall summary

Coventry and Warwickshire Partnership NHS Trust provides a range of community based mental health and community health services which mainly provide a service in a person's home.

These services are varied and are registered with CQC at the Trust's Headquarters address.

Due to the wide range of services provided in the community by this trust, we did not inspect all of them, instead we took a sample and looked at a smaller number more in-depth.

On this occasion we inspected community based health services and community mental health services. These services are provided across adult and children's services, meeting mental health and physical health needs.

Adult community based services

We found that the trust did not have suitable storage, recording and monitoring systems to ensure medicines were handled safely and appropriately.

There was an effective referral system in place and people received care quickly. Where there were waiting lists, people were assessed and knew when they would be seen.

There were consistent staffing levels and people knew who their care coordinators were. People were involved in the care planning process and reviews of their care. We heard positive reports on how staff had worked with people to help improve their mental health.

We saw there was good communication between community mental health teams in each area inspected and there was good collaborative working between social workers, community psychiatric nurses and occupational therapists. The effectiveness of communications with teams working in the acute admission wards varied and did not always facilitate people being discharged smoothly.

Staff across the teams we visited spoke about their concerns regarding the trust's reorganisation programme. Staff were unclear about how the new structure would look and were worried about the impact for staff jobs, roles and responsibilities and how this would affect people using the service. Some staff expressed concern that their views were not being listened to.

Child and adolescent mental health services

We talked to doctors, managers, nurses and other staff from the service who told us they were struggling to cope with an increasing workload with more priority cases and child protection work. They were concerned about having to deal with more young people that they felt to be at risk, and that this meant that others who had less urgent need had to wait a long time to get a service.

There were plans to reorganise the service to improve access and manage workloads, but it had not been made clear to staff how this would work and there was a lot of anxiety about how the service would cope in the future. We talked to young people and families who used the service and they felt that they got good support, but they had to wait a long time and sometimes there were too many changes in staff.

Community services for adults with long-term conditions

Across all three services, staff were well trained and training was appropriate to their role. The exception to this was the children's nursing within the Health Visiting service. Staff told us that their mandatory training was out of date and that staff did not always have the opportunity to attend specialised training specific to their job roles. For example, some nursery nurses found working part time hours reduced their time available for training because they prioritised client contact above their own training needs.

Across all three services, most people described their care as good to excellent and said that staff were caring, despite being busy.

Care plans within the district nursing services did not always reflect people's needs. However, most people felt that they were involved with their care and informed about their treatment.

Summary of findings

Staff were full of praise for their immediate line managers, who supported and listened to them. However, the trust's restructure programme made them feel unsettled. Communication between the senior management team and clinicians was good.

We looked at staffing levels and workloads across Willenhall and Tile Hill District nursing teams. Both teams organised their work in advance and several nurses told us they were able to incorporate additional calls during the day. Staffing levels were at a safe level at Willenhall and most people received care according to their needs.

However, we saw risk assessments and care plans were not always in place and updated at regular intervals. Vacancies at Tile Hill meant a high use of agency staff. District nurses told us that the agency nurses were unable to fulfill a number of the tasks undertaken by regular staff, for example referrals to other agencies or ordering equipment. Additionally they were not familiar with the workload and trust's policies and procedures, which meant that nurse's time was often spent explaining what the agency worker needed to do.

The Willenhall team had not implemented all the lessons learned from previous medication errors to improve standards and safety for people who used the service.

During home visits, we saw nurses responded well to people's needs. Nurses listened to people and answered questions relating to their care and treatment. Nurses also worked effectively with external agencies, making referrals for specialist assessments and equipment to improve people's care.

Community services for children and families
Health visitors and children's nursery nurses who provided support to the team told us that overall they felt they had enough staff to meet appointments. However, nursery nurses said that not all staff were able to attend mandatory and specialised training to support them in their roles, especially part-time workers, who found it difficult to attend training and manage their workload.

Mothers told us that health visitors and children's nurses provided sound advice and support during one-to-one consultations. However, contacting health visitors was problematic as they had busy workloads and clinics were often full.

School nursing services
Doctors, managers and nurses from the service told us they were struggling to cope with demands of general school nursing duties and managing additional child protection work. They provide health reports for all case conferences as well as attending these and doing the necessary work and liaison afterwards. The sharp increase in safeguarding and child protection work, which always takes priority, meant that they struggle to do other work, especially health promotion. School nurses told us they had good training programmes in place and were able to attend mandatory and specialised courses. School nurses told us they had very good appraisals and supervision systems in place.

We talked to school nurses who told us that due to increased child protection work placed upon them they were struggling to respond to the day-to-day school referrals. The increased time devoted to attending safeguarding meetings and case conferences had resulted in fewer school nurses being available to meet the students' needs.

Summary of findings

The five questions we ask and what we found

We always ask the following five questions of services.

Are services safe?

Adult community based services

Staff had been trained in safeguarding adults and, where appropriate, safeguarding children and there were policies, procedures and information available. However, safeguarding meetings were not always organised in a consistent manner.

Arrangements to store, manage and monitor medicines were not safe, and the systems for managing 'sharps' were not suitable in the places we visited.

The lone working policy was not consistently being used by staff across services.

There were standardised risk management systems; these involved people, promoted their self-awareness and encouraged them to take responsibility. Systems were in place to report incidents, and escalate concerns if caseloads exceeded acceptable and manageable limits.

Child and adolescent mental health services (CAMHS)

Children and young people were waiting a long time to receive a service. This was a particular concern for those who were in a crisis or who needed specialist inpatient care. The staff at CAMHS worked hard to provide a service and they prioritised urgent cases, but did not have the capacity to meet increasing demand.

Some children and young people were not getting the care that they needed because they were waiting long times on general hospital wards without getting specialist support. People aged over 16 did not always get the right service when they needed inpatient care.

Community services for adults with long-term conditions

We saw that people received care and treatment from district nurses in their homes which reflected their needs. Nurses were calm and unhurried with people and took time to answer their questions. Staff and people receiving a service told us there was sufficient staffing and time allocated for nurses to deliver care safely. Risk assessments were not always in place to identify people at risk, for example those at risk of falls or pressure ulcers.

Incidents were managed appropriately by the senior management team. However, lessons learned were not always shared with nurses delivering care.

Community services for children and families

Health visitors delivered advice and support to children and families at the right time, were up to date with mandatory training and were supported to attend specialist training.

Nursery nurses told us attending mandatory and specialist training was an issue, especially for part-time staff.

Incidents relating to health visitors were managed appropriately and lessons learned were shared among teams to improve practice.

School nurses provided excellent support and advice with child protection cases; however, there were inadequate staffing levels for nurses to meet routine and safeguarding workloads.

Are services effective?

Adult community based services

- People's social situation, physical health needs and personal circumstances were considered and people were supported if necessary to access healthcare services.

Summary of findings

- There were effective referral and assessment processes in place.
- When people were referred, their needs were considered by multi-disciplinary teams to ensure people were signposted to the right support.
- The Improving Access to Psychological Therapies service accepted self-referrals making it easily accessible to people.
- Some information was made available to people about the services, but in some areas only general information packs were available. Staff used a range of communication methods, as well as face-to-face contact, to engage with people
- There were not always systems in place to ensure people received their medicines at the time they were needed. This included injections given by nurses and medications to take on holidays.
- When being discharged, some people had access to a rapid re-entry system to enable them to get care and support quickly if their health deteriorated.
- We saw that staff from a range of disciplines and backgrounds worked well within teams to provide seamless care to people.
- Community mental health services were fully staffed. This ensured people received a prompt service and saw the same staff on a regular basis.
- Staff received regular mandatory training and also role specific training.

Child and adolescent mental health services (CAMHS)

When children and young people got a service from CAMHS, they told us that it had helped them and treatment was effective. However, some people had experienced a lot of changes in doctors, which they found difficult and meant that they did not get consistent care.

The quality of recording of notes varied, and the system for staff to access records at one team base needed to be improved. There was not enough management cover to ensure that the practice was monitored and improved or that staff had adequate supervision.

Community services for adults with long-term conditions

District nurses demonstrated robust partnership working with: community matrons, occupational therapists and physiotherapists, GPs, speech and language therapists (SALT), dieticians, tissue viability nurse specialists, palliative care nurse specialists and equipment loans services. District nurse 'Link nurse role' was introduced in specialist areas, such as palliative care, tissue viability and infection control, as a source of expertise to disseminate new information and promote evidence based practice among team. People told us they did not always know when the district nurse was going to turn up, as nurses did not provide time slots.

Feedback from people was gathered from the district nurse service every quarter to look at quality and standards of care delivered.

Staff attended mandatory and specialist training within district nurse teams to ensure care was safe and effective based on up to date evidence.

Community services for children and families

Health visitors and school nurses demonstrated good partnership working with GPs, midwives, police and social services. People told us that they considered health visitors to be knowledgeable and the advice they were given was supportive, practical and worked.

School nurses were suitably qualified and competent. Nurses were encouraged to attend specialist training to ensure safeguarding cases were assessed and managed with speed and sensitivity.

Routine referrals from schools were not always accessed in a timely fashion due to increased volume of child protection cases.

Summary of findings

Mothers told us breast care information at clinics was excellent.

Are services caring?
Adult community based services

- People were routinely involved in the care planning process and received copies of their care plans.
- Not all care plans we saw were kept up to date.
- Records indicated that people were supported towards achieving their goals.
- We saw that good contact notes were mostly kept each time the person saw their worker.
- We observed positive and respectful interactions between people and staff.
- People's views were taken into account and they were given the opportunity to ask questions.
- The majority of people were given information about their medicines and the potential known side effects.
- There was an emphasis on social inclusion and some groups were run to improve people's independence and confidence.
- There were some support systems in place for carers but these varied between teams.

Child and Adolescent Mental Health Services (CAMHS)

- CAMHS services were caring; the majority of people told us that they felt listened to and that treatment was person-centred.

Community services for adults with long-term conditions

- Treatment and care by district nurses was not always planned and delivered to ensure people received the support they needed in a timely way; for example care plans were not always in place and/or completed appropriately by district nurses to reflect potential or actual risks to people.
- We saw district nurses provide care to people in their homes in a dignified and respectful manner.
- We saw district nurses put people at their ease and completed their visits leaving patients looking and feeling better than when they arrived.
- People told us district nurses provided excellent care and described nurses as, "Angels", "Superb at their job" and "A God send".
- One person told us they are not given a choice of when the district nurse visits – there were no time slots or 2 hour windows to choose from.

Community services for children and families

- Health visitors were described by mothers as, "excellent source of expertise" and "provided sound advice which really worked".
- Mothers told us health visitors were not always easy to contact and needed to more accessible for more effective communication.
- Mothers told us health visitors were respectful and polite during clinics and consultations and took a genuine interest in the care and welfare of mother's children and families.
- School nurses told us they felt they had excellent communication between teams and line management and felt communication systems were effective and robust.
- Complex child protection cases were managed with care and compassion.
- Due to workload pressures of balancing routine school referrals and child protection cases, school nurses did not have the capacity to ensure children and families received care and support for less critical issues, as child protection cases came first.

Summary of findings

Are services responsive to people's needs?

Adult community based services

- There was not a systematic way for gathering people's views or feedback about individual teams' performance.
- Different recording systems for community and inpatient staff could increase risks to staff working with people.
- The rapid access system for some people being discharged was inventive and helped to reduce readmission rates.
- There was a crisis intervention team available and people we spoke with knew how to access this.
- We saw an effective system in place for learning from and responding to complaints and concerns.
- Staff tried to resolve any concerns at the earliest opportunity.
- There were systems in place to inform staff on how to respond where people did not attend planned appointments.
- Staff could access interpreters to communicate with people whose first language was not English.

Child and adolescent mental health services (CAMHS)

- Although CAMHS had a good system for dealing with referrals and ensuring that people got a prompt initial appointment, it was not responsive because people had to wait a long time to get a service after that.
- The increasing demand for services meant that staff had to focus on the most urgent cases and people with less urgent needs were waiting for longer and longer periods.
- People felt that appointments were not always at convenient times.

Community services for adults with long-term conditions

- District nurse teams managed complaints in an open and transparent way and resolved complaints at local level to the satisfaction of the person concerned.
- We saw from attending home visits that the majority of people had their individual needs met. However, there was a lack of attention to detail which delayed nurses responding to care needs efficiently.
- District nurses acted as a point of contact to take the lead with care from other healthcare professionals ensuring a seamless service pathway was followed.

Community services for children and families

- School nurses and managers told us time was spent assessing and managing referrals from diverse areas of Coventry where interpreters were required. This impacted on resources and meant response times from school nurses were slower.
- Staff told us that working with asylum seekers whose needs were often more complex and involved translators slowed down the assessment process and caused workload backlog.
- The trust had systems in place to seek feedback from people, information was reviewed and actions taken where necessary.
- Current problems with school nursing staffing levels were being discussed between the trust and commissioners.

Are services well-led?

Adult community based services

- We found that staff were dedicated and felt supported by their managers.
- Staff told us their morale was being affected by proposed changes to ways of working and downgrading of a number of staff.
- We found that audits on the quality of patient records within teams were not frequent enough.
- Teams worked well together and we saw many examples of effective collaborative working

Summary of findings

Child and Adolescent Mental Health Services (CAMHS)

- We found there were gaps in management posts which meant that the service was not getting the support it needed to make sure that it was operating effectively.
- Staff told us that the reorganisation was creating uncertainty and undermining their morale.
- Senior managers felt that they were providing good and supportive leadership but this was not consistent with the views and experience of staff.
- The service had more demand than staff could respond to and they were concerned about managing risk as staff numbers were being reduced.
- There was not enough quality assurance to support good analysis of the effectiveness of the service or to help staff improve practice.

Community services for adults with long-term conditions

- District nurses told us that they had direct contact with their managers and felt well supported and listened to.
- Recruitment to permanently vacant posts remained an issue, and prolonged use of agency staff meant care standards and quality were affected. Staff wanted management to be more creative to fill posts.
- We were told nurses were happy with their team structure but worried about the greater trust re-structure, as communication from the trust's board and visibility was not so apparent.
- Support from direct line managers and senior management team following serious incidents were rigorous and staff felt supported and nurtured.

Community services for children and families

- Health visitors told us clinical supervision and appraisals were managed effectively by line managers.
- Nursery nurses need to complete mandatory and specialist training supported by their line managers.
- Support from direct line managers and senior management team following serious incidents were rigorous for health visitors and staff felt supported and nurtured.
- School nurses told us line managers provided excellent support and leadership.
- School nurses felt listened to and told us their personal development was important to them and senior managers in providing safe and effective care.
- We were told lessons learned from serious case reviews were successfully communicated by managers and between teams.
- More work is required between the trust and commissioners to review staffing levels to ensure care is provided for routine and child protection cases.

Summary of findings

What we found about each of the main services at this location

Child and adolescent mental health services

We found that CAMHS were not safe because children and young people were waiting a long time to get a service. This was a particular concern for those who were in a crisis or who needed specialist inpatient care. The staff at CAMHS worked hard to provide a service and they prioritised urgent cases, but did not have the capacity to meet increasing demand and there were not enough services to meet needs. Children and young people were at risk of deteriorating while waiting for a service, and some were not getting the care that they needed because they were waiting long times on general hospital wards without getting specialist support. People aged over 16 did not always get the right service when they needed inpatient care.

When children and young people received a service from CAMHS, they told us that it had helped them and treatment was effective. Some people had experienced a lot of changes in doctors though, which they found difficult and meant that they did not get consistent care. The quality of recording of notes varied a lot, and the system for staff to access records at one team base needed to be improved. There was not enough management cover to ensure that practice was monitored and improved or that staff had adequate supervision.

CAMHS services were caring; the majority of people told us that they felt listened to and that treatment was person-centred.

Although CAMHS had a good system for dealing with referrals and ensuring that people received a prompt initial appointment, it is not responsive because people have to wait a long time to get a service after the initial assessment. The increasing demand meant that staff had to focus on the most urgent cases and people with less urgent needs are waiting for longer and longer periods. People felt that appointments were not always offered at convenient times.

We found that gaps in management posts meant that the service was not getting the support it needed to make sure that it was operating effectively. There was a reorganisation underway that was creating uncertainty for staff and undermining morale. Senior managers felt that they were providing good and supportive leadership but this was not consistent with the experience of staff. The service had more demand than staff could respond to and they were concerned about managing risk as staff numbers were being reduced. There was not enough quality assurance to support good analysis of the effectiveness of the service or to help staff improve practice.

Adult community-based services

Staff told us that teams were well managed and they felt supported in their role. Where teams were located in the same building there was particularly good collaborative working. There were stable staffing levels in community services and people usually saw the same staff member on each occasion. People knew who their care coordinator was and also knew how to access support in the absence of their main worker or out of hours when community teams were not available.

At trust level, staff across many services told us they were concerned about the reorganisation programme. Staff told us they were unclear about how the new structure would look and how this would impact on staff jobs, roles and responsibilities as well as how this would affect people using the service. Some staff expressed concern that their views were not being listened to.

We found that the trust did not have suitable storage, recording and monitoring systems in place to ensure medications were handled appropriately. There were not safe or consistent arrangements in place to ensure sharps were disposed of safely and quickly.

Summary of findings

We found that the majority of the feedback from people was positive. People told us they had good relationships with staff. People were involved in the care planning process and their views were taken into account. There was information provided to people on who they could contact in the absence of their care coordinator, or out of hours.

Quality assurance systems were not consistently used in all areas. While there were some checks on care records in place these were inconsistently used across the different teams and were not used to evaluate overall quality of the service provided.

Community services for children and families
Health visiting services

Health visitors and children's nursery nurses who provided support to the team told us that overall, they felt they had enough staff to meet appointments. However, nursery nurses said that not all staff were able to attend mandatory and specialised training to support them in their roles, especially part time workers, who found it difficult to attend training and manage their workload.

Mothers who told us health visitors and children's nurses provided sound advice and support during one-to-one consultations. However, accessing health visitors was problematic as they were difficult to contact due to having a busy workload and clinics were often full.

School nursing services

We talked to doctors, managers and nurses from the service who told us they were struggling to cope with demands of general school nursing duties and managing additional child protection work. They provide health reports for all case conferences as well as attending these and doing the necessary work and liaison afterwards. The sharp increase in safeguarding and child protection work, which always takes priority, meant that they struggle to do other work, especially health promotion. School nurses told us they had good training programmes in place and were able to attend mandatory and specialised courses. School nurses told us they had very good appraisals and supervision systems in place.

We talked to school nurses who told us that due to increased child protection work placed upon them they were struggling to respond to the day-to-day school referrals. The increased time taken devoted to attending safeguarding meetings and case conferences had resulted in fewer school nurses available to meet the needs of the school population.

Community services for adults with long-term conditions

Across all three services, staff were well trained and training was appropriate to their role.

Across all three services most people we spoke to described their care as good to excellent and said that staff were caring, despite being busy. This was confirmed by speaking to people during home visits and also at patient telephone feedback sessions carried out after the inspection. We saw that care plans within the district nursing services did not always reflect people's needs. However, most patients felt that they were involved with their care and informed about their treatment.

Staff we spoke with across all services were full of praise for their immediate line managers. They felt well supported by their managers and told us they felt they were listened to. Staff told us they were aware of the trust's restructure programme which made staff feel unsettled. However they told us communication between senior management team and clinicians was good.

District nursing services

We looked at staffing levels and workloads across Willenhall and Tile Hill District Nursing Teams. We saw both teams organised their work in advance and we were told by several nurses they were able to incorporate additional calls during the day. We saw staffing levels were at a safe level at Willenhall and most people received care according to their needs.

Summary of findings

However, we saw risk assessments and care plans were not always in place and updated at regular intervals. We saw vacancies at Tile Hill meant a high use of agency staff, which brought problems. We saw the Willenhall team had not implemented all lessons learned from previous incidents relating to medication errors to improve standards and safety for people who used the service.

During home visits, we saw nurses responding well to people's needs. Nurses listened to people and answered questions relating to the care and treatment. We saw nurses working effectively with external agencies making referrals for specialist assessments and equipment to improve people's care.

Summary of findings

What people who use the location say

Community Mental Health Patient Experience Survey 2013

This survey was conducted to find out about the experiences of people who receive care and treatment. Those who were eligible for the survey were receiving specialist care or treatment for a mental health condition aged 18 and above and had been seen by the trust between 1 July 2012 and 30 September 2012. The questionnaire was sent to 850 people, responses were received from 230 people.

Analysis of data from the Community Mental Health Patients Experience Survey showed that overall the trust was performing about the same as other trusts in all the nine areas assessed. The trust's performance had decreased on seven questions asked in comparison to 2011, in regard to people's experiences with their care coordinator, attending care reviews, involvement with care plans and support with day to day living. We found at the inspection, the trust had taken specific action to respond to the area which had significantly decreased and identified a risk, which was the answer to the question 'Do you know who your care co-ordinator is?'

Areas for improvement

Action the provider MUST take to improve

Adult community based services

- Ensure there are suitable systems in place to store, manage and monitor medicines.
- Implement effective sharp disposal systems.
- Ensure that the lone working policy is used consistently to adequately protect staff.

Child and adolescent mental health services (CAMHS)

- Ensure that there are robust systems for the recording, storage and retrieval of records.
- Ensure that there are adequate staffing levels to meet the needs of children and young people requiring mental health services and child protection workloads.

Community services for adults with long-term conditions

- Reduction of the use of agency and bank staff through continued recruitment of permanent staff.
- Documentation relating to patient care must be in place: specifically falls risk assessments, pressure ulcer risk assessments and care plans to reflect people's needs.
- Improve communication systems to inform people of their visit times/slots.

Community services for children and families

- Mandatory training and specialised training must be improved for children's nursery nurses.
- There were inadequate staffing levels to meet the needs of general school nursing practice and child protection workload.

Good practice

Our inspection team highlighted the following areas of good practice:

- The rapid re-entry policy in place allowed some patients to gain quick access to community services within 12 months of discharge if they considered they required community mental health support.

- The Perinatal service worked well with midwifes to offer screening to all pregnant women to establish if they required an assessment from the perinatal consultant or Community Psychiatric Nurses.

Summary of findings

- The introduction of the 'T card system' had streamlined workload delegation at Willenhall District Nurse Team. This is a system used to keep track of daily visits for each nurse and allows managers to have a quick overview of the visits that are required.
- Introduction of Link Nurses within both district nurse teams for specialist areas acting as a source of expertise within respective teams.

- We saw that Health Visiting Clinics contained excellent patient information about breast feeding.
- The School nursing service had a well organised and effective training, support and supervision programmes.

Wayside House

Detailed findings

Services we looked at: Adult community-based services, Child and adolescent mental health services, Community services for adults with long-term conditions, Community services for children and families

Our inspection team

Our inspection team was led by:

Chair: Professor Patrick Geoghegan OBE

Team Leader: Jackie Howe, Care Quality Commission

The team included Care Quality Commission (CQC) inspectors and analysts, consultants in psychiatry and learning disabilities, doctors, general and mental health nurses, student nurses, Experts by Experience, and senior NHS managers. Experts by Experience have personal experience of using, or caring for, someone who uses the type of service we were inspecting.

Background to Wayside House

The trust has a total of 21 active locations. There are three main hospital sites: Brooklands, St Michael's Hospital and Caludon Centre. 9 of these locations provide mental health services.

The trust provides a wide range of mental health and learning disability services for children, young adults, adults and older adults as well as providing a range of community services for people in Coventry.

Coventry and Warwickshire Partnership NHS Trust has been inspected 21 times since registration. Out of these, there have been 10 inspections covering five locations which are registered for mental health conditions.

The community services have not been previously inspected. Where specific locations are registered to provide regulated activities to people, separate reports are available for each inspected location.

Why we carried out this inspection

We inspected Coventry and Warwickshire Partnership NHS Trust during our Wave 1 pilot inspection. The trust was selected as one of a range of trusts to be inspected under CQC's revised inspection approach to mental health and community services.

The CQC community nursing inspection team focused the inspection process on District Nursing, Health Visiting and School Nursing services. Before the inspection, we looked at information we were sent by the trust about community services. We saw that 64% (Data Pack) of serious incidents occurred within people's own homes. We looked at pressure ulcer incidents and medication error data supplied by the trust across District Nursing services and saw incidents were at their greatest at Willenhall and Tile Hill.

Detailed findings

How we carried out this inspection

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

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

The inspection team inspected the following core services at this inspection:

- Adult community-based services: – Community mental health teams; assertive outreach; early intervention and community learning disability teams
- Child and adolescent mental health services (CAMHS)
- Community services for adults with long-term conditions:- District nurses and health visitors
- Community services for children and families:- Health visitors and school nurses

Before visiting, we reviewed a range of information we hold about the trust and asked other organisations to share what they knew about them.

Adult community based servicesAs part of our inspection we visited five Community Mental Health Teams, three Assertive Outreach Teams, two Early Intervention Teams and one Improved Access to Psychological therapies team. At each service we looked at a sample of people's care records. We sought views from people through a range of methods to assess people's experiences of receiving services. This included observation of outpatient's appointments, attending some group activities, visiting patients at home with their care co-ordinators and through telephone discussions with patients to find out about their experiences. We also spoke with some relatives and carers by telephone. At all our visits to services we spoke with a range of managers and staff, sometimes individually and also spoke with groups of staff.

Community services for adults with long-term conditions

We carried out unannounced visits at two locations - Willenhall and Tile Hill Primary Care Centre - to review district nursing.

At each site we talked to staff from different grades. We looked at patient records of personal care and treatment. We accompanied community nurses visiting four patients in their own homes observing how staff provided care. We talked to patients on the day of the inspection and conducted a telephone feedback survey one day after the inspection with 28 patients and relatives who received district nursing. The feedback from patients across all three services was very positive who felt that overall, care was responsive and provided in a sensitive and caring manner, despite staff being busy.

Community services for children and families

We reviewed Health Visiting Services and we visited the main School Nursing base at the Paybody Unit.

Child and adolescent mental health services (CAMHS)

Coventry and Warwickshire Partnership NHS Trust provides CAMHS services in the community from five bases across three localities in south Warwickshire, north Warwickshire and Coventry. Inspectors visited two of these community bases, one at the City of Coventry Health Centre, the other at Orchard House in Leamington Spa.

As part of our inspection an inspector visited two paediatric wards to review the arrangements for young people with mental health problems who were admitted to those wards, with a focus on young people detained under the Mental Health Act, and assess the interface with the CAMHS teams.

We carried out the announced visits to the services from 21 to 24 January 2014.

Child and adolescent mental health services

Information about the service

Coventry and Warwickshire Partnership NHS Trust provides CAMHS services in the community from five bases across three localities in south Warwickshire, north Warwickshire and Coventry. Referrals to CAMHS services can be made by any agency or professional, and these are channelled through a single point of entry (SPE). Assessment and follow-up services are provided by a range of staff based in multi-disciplinary teams at each locality. These include specialist child psychiatrists, nurses, clinical psychologists, psychotherapists, speech and language therapists and occupational therapists. This range of services is available to children and young people up to their 17th birthday. CAMHS provide advice, support and emergency responses via a duty system during weekday office hours. Out of hours, an on-call psychiatrist is available.

The trust does not have any inpatient beds (known as Tier 4 services) specifically for children and young people with mental health problems within its locality. Young people are admitted to paediatric inpatient services at University Hospital Coventry (ward 14) and Warwick hospital (MacGregor ward) through the Emergency Departments. These young people are assessed by CAMHS and may go on to access Tier 4 beds outside of the area from there.

Summary of findings

We found that in the CAMHS services children and young people were waiting a long time to get a service. This was a particular concern for those who were in a crisis or who needed specialist inpatient care. The staff at CAMHS worked hard to provide a service and they prioritised urgent cases, but did they did not have the capacity to meet increasing demand and there were not enough services to meet needs. Children and young people were at risk of deteriorating while waiting for a service, and some were not getting the care they needed because they were waiting for a long time on general hospital wards without getting specialist input. People aged over 16 did not always get the right service when they needed inpatient care.

When children and young people received a service from CAMHS, they told us that it had helped them and the treatment was effective. Some people had experienced a lot of changes in doctors which they found difficult and meant they did not receive consistent care. The quality of recording of notes varied a lot, and the system for staff to access records at one team base needed to be improved. There was not enough management cover to ensure that practice was monitored and improved or that staff had adequate supervision.

CAMHS services were caring; the majority of people told us that they felt listened to and that treatment was person-centred.

Although CAMHS had a good system for dealing with referrals and ensuring people got a prompt initial appointment, people had to wait a long time for a service after this. Increasing demand meant staff had to focus on the most urgent cases and people with less urgent needs were waiting for longer periods. People felt that appointments were not always at convenient times.

We found there were gaps in management posts which meant the service was not getting the support it needed to make sure it was operating effectively. There was a reorganisation underway that was creating uncertainty for staff and undermining morale. Senior managers felt they were providing good and supportive leadership but

Child and adolescent mental health services

this was not consistent with the experience of staff. The service had more demand than staff could respond to and they were concerned about managing risk as staff numbers were being reduced. There was not enough quality assurance to support good analysis of the effectiveness of the service or to help staff improve practice.

Are child and adolescent mental health services safe?

Child and Adolescent Mental Health Services (CAMHS)

Reviews of case files and discussion with CAMHS staff demonstrated that staff were good at recognising risks and concerns, relating to the safety and well-being of the young people using the service, in their day to day practice. Many examples were seen where staff had identified concerns, and had promptly sought advice from safeguarding leads within the trust. They had taken action such as making referrals to Children's Social Care services, and communicated appropriately with other agencies such as school nurses. Details of these actions were clearly documented on case files, but there was no clear system for 'flagging' files, that is, marking the file in some way so that all professionals who had contact with the young person would know that there was a child protection concern so that information was not lost. Risk assessment forms were available for staff to use, and these included sections on identifying risk to the young person or to others, but these were not being regularly completed which undermined their effectiveness in prompting staff to consider potential risks more proactively. CAMHS staff had undertaken the required level of safeguarding training for their role, but there was no process for them to have regular, dedicated safeguarding supervision. This was being addressed by group supervision sessions for safeguarding which were due to start the week after the inspection.

The CAMHS teams were struggling to meet the increasing demand for their service in a timely way. This situation was being compounded due to lack of resources and was leaving increasing numbers of young people at risk. While people received a prompt appointment for an initial assessment, the number of children and young people on the waiting list to receive a follow up service was rising rapidly. The teams were effectively prioritising urgent cases and ensuring they received a service, but this was becoming increasingly difficult. Young people's health was at risk of deteriorating health while waiting and there was no system for monitoring them to ensure that changes would be recognised. There was a newly developed pathway to ensure that young people who deliberately self-harmed were prioritised and seen as an urgent case,

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but there had been a huge increase in numbers in this group. There was not a crisis team or intensive support service to offer to these young people or others who had urgent mental health problems in the community. Parents told us "There wasn't any help in an emergency. I was given a number (adult mental health services) but no-one helped. They said call an ambulance" and "when things are really bad and you are desperate for help – emergencies are still a problem".

Young people up to the age of 17, that presented at the hospital Emergency service, would be offered admission to the paediatric wards, but due to a shortage of beds they could remain there for some time until they were offered a place in a specialist unit. We found recent cases where young people had had to stay on the paediatric ward for three or four weeks at a time. At one time, one paediatric ward had seven of its 12 beds occupied by young people with mental health problems. The CAMHS service lacked the capacity to undertake assessments and provide a service to this number of young people, leading to bed blocking and growing backlogs.

The paediatric ward staff worked hard to provide appropriate care, but were not trained or experienced in meeting the needs of this group of young people. Coventry and Warwickshire Partnership NHS Trust arranged for agency staff to be available on the ward.

One clinician said "The lack of mental health inpatient beds for young people is unacceptable. If they need to stay, this place is not safe as a speciality service. We are not trained to assess their mental state and keep them safe."

Agency staff provided by CAMHS to support ward staff were not always consistently attending or did not have the right training to meet the young person's specialist needs. There were no care plans on the ward to specifically address the young person's mental health support needs. Paediatric ward staff had not received training in the Mental Health Act 1983 and so were unclear about dealing with the legal requirements for documentation, permissions and allocation of a responsible clinician for people detained on the ward under that Act. This meant that it was unclear who was taking responsibility for medical decisions such as prescribing medication.

In addition, young people who were under 18 were being admitted to adult mental health services and guidance on these admissions that is set out in the Mental Health Act

Code of Practice was not being followed, which put vulnerable young people at risk. We found one example where a 16 year old person was admitted to an adult ward from the Emergency Department at Warwick hospital, which was not in line with the policy agreed between the two trusts. Action is needed for Coventry and Warwickshire Partnership NHS Trust to review pathways of care for young people in crisis to ensure they are kept safe and have access to timely and appropriate treatment.

Are child and adolescent mental health services effective?
(for example, treatment is effective)

We met several young people and their parents, most of who spoke positively about the service that they had received and how this had helped them. One young person said "It has given me an insight into what's wrong with me – now I know what I'm doing. I understand myself better". There was also evidence in the cases that we looked at of effective input and positive outcomes for young people. Where we did hear criticisms, these related to staff capacity and staff turnover – in particular, there had been a long-standing vacancy for a consultant psychiatric post, which was being covered by locum staff. One young person had seen seven different doctors in one year, which does not provide continuity of care and undermines the ability of the young person and their family to engage with services.

Case records across the CAMHS service were paper-based, with no electronic system, although it was planned for this to be introduced in the near future. Examples of impressive case recording reflecting the depth of work and positive clinical practice were found, particularly in the team base at Leamington Spa. In other cases, it was hard to track the 'journey' of the young person, because the case files had no chronologies, lacked clear care plans and did not have records of progress against identified actions or treatment programmes. In one care record we reviewed we found relevant historical information had not been followed up or used to inform more recent assessment and treatment. The system for storage and retrieval of medical records at the Coventry base was not working well enough to ensure that staff had access to records in a timely manner when needed. This was of particular concern as the practitioners making assessments at the Single Point of Entry (SPE) would not have access to historical information to inform

the initial screening of referrals. The management team were aware of the problems and an action plan had been developed, and the situation was expected to be much helped by the planned new IT system.

We were told that there was no dedicated budget for staff training. Workload related pressures and staff shortages meant that staff lacked capacity to attend routine training, although some had attended sessions in areas such as eating disorders where a need for specialist input was identified. We heard consistent messages that staff felt well supported by peers within the team, and that they had good access to advice from colleagues. This was felt to be a strength by those that we spoke to. Positively, staff prioritised attending reflective team meetings where people had family therapy, ensuring continuity in the therapeutic process. However, the lack of adequate management cover across teams had led to insufficient supervision arrangements and there were no formal arrangements for quality assurance of practice.

A recent audit had been done of all children, young people and parents attending CAMHS over one week in February 2013. This identified overwhelmingly positive accounts about the service from those that returned questionnaires (nearly 300 were returned). There were however some critical responses about access to the service, appointments, turnover of staff and communication. While a report had been produced, it lacked critical analysis or reflection of the lessons to be learned. We heard that although this piece of work had been nominated for a quality award, when it was taken to the trust's Safety and Quality Committee, it was noted an action plan had not been developed, and there was insufficient management capacity to address the areas identified as needing improvement.

Are child and adolescent mental health services caring?

Parents and young people that we spoke to were positive about the service, reporting it to be person-centred. They said they felt listened to; were given information, and were sign-posted to other sources of support. Three young people rated the service that they had had at CAMHS as "nine out of ten". However, there was evidence that a supportive approach was not embedded across the service. Some families felt that appointments were brief and did not routinely give information about medication or support services. Some young person indicated that they were used to frequent staff changes and one said that they "weren't bothered if they didn't see [the practitioner] again" meaning that it made no real difference. One young person gave the service six out of ten.

The verbal accounts that we heard closely reflected findings from the audit report of the service in March 2013. The majority of people in the audit indicated that staff were caring, supportive and positively engaged people in the treatment that they received, but a consistent low percentage expressed that this was not their experience.

Are child and adolescent mental health services responsive to people's needs? (for example, to feedback?)

Referrals into CAMHS were channelled through a single point of entry (SPE) that was established two years ago as a means to ensure that all new referrals are promptly screened and directed towards the most appropriate service. This system has benefited from input from agencies offering "Tier 2" services from the voluntary and independent sector (that is, services that offer support to people with less complex or urgent mental health problems) which means that people can be promptly offered a service from them if they do not meet the criteria for CAMHS. Those that were identified as needing it were sent an initial appointment for a more detailed assessment by a member of the CAMHS team within 16 weeks. Staff across all services we spoke with were positive about the SPE process and felt that it worked effectively. However, the number of new referrals was increasing, an average of 35 per day, and some people we spoke with had concerns about the capacity of services at Tier 2 to meet demand for that level. The system has been driven by and is dependent upon enthusiastic staff who were committed to maintaining daily reviews of all referrals, but was not underpinned by evidence-based assessment. There had been no formal quality assurance to determine the quality of decision making or monitor outcomes for people referred. Therefore senior managers could not be assured, that the quality of the service was optimised or that all relevant information was identified and risk assessments undertaken to inform the decisions made.

Child and adolescent mental health services

Due to increasing demand and resource pressures the time from initial appointment to first appointment for treatment was lengthy and growing. Waiting time for treatment was up to seven months. Families that we spoke with consistently reported that it "was a battle" to get to the point of receiving treatment. Some had persisted in contacting the service to try to get an earlier appointment, especially where they felt that the young person's health or situation was deteriorating, and generally the teams were responsive to recognising changing needs. However, the workload pressures to deal with urgent cases had an impact on waiting times for non-urgent cases, especially for young people with autistic spectrum disorder, as the waiting time for these appointments got pushed further back.

The area in the audit that identified the most dissatisfaction (11%), related to the convenience of appointments. While appointments for therapists could be set in advance to help families plan attendance, some had experienced more difficulty in getting appointments for consultant psychiatrists and identified this as an area for improvement.

There was apprehension across the service about the impact of a restructuring process that has been under discussion for many months. Some staff have known that their post is at risk for some time and have felt unable to start therapeutic intervention without knowing if they would be in post to complete it.

We heard that the service saw relatively few children from ethnic minority groups compared to the population. We saw no evidence of any recognition of this or planning to address it. Ethnic monitoring forms in the case notes were not completed and it was not clear whether accurate data was being obtained or analysed.

Are child and adolescent mental health services well-led?

Only one of three team leader posts was filled at the time of this inspection, having been vacant for over six months. While these posts had been recruited to and post-holders due to start imminently, the vacant service manager post (direct line management to the team leaders) remained unfilled. The team manager in post had been making huge efforts to cover the managerial role across the service, and had implemented some effective processes that are valued

by staff, for example a weekly Senior Leads meeting to review urgent case allocation and progress. Senior leads and team leader strived to offer staff support, to maintain a safe and effective service. They were highly regarded by clinicians. The senior leads were seen as crucial in supporting the continued daily operation of the service. However there was no capacity across these post holders to undertake day to day management tasks other than "fire-fighting" for a service that was under significant pressure due to increasing demand and waiting lists. The lack of management support undermined the effectiveness of the team. One person described the service as having been 'managing on a week to week basis', but said now it was 'day to day' and even this was becoming difficult to manage. Staff had concerns at the "high level of risk holding" that they were responsible for and while concerns were reported to senior managers, there was no clear action plan to address the situation and mitigate risk.

At the time of this inspection, a lengthy restructuring process was underway. Staff told us that posts including all senior clinical psychology posts, had been identified as being 'at risk' for a number of months, and there were plans in place to reduce clinical and administrative capacity. Clinicians told us they were not aware of an overarching vision for the service or the rationale for decision making around the restructuring. In particular, how this addressed shortages in resourcing that had previously been identified across the service. Anxieties about the impact of the restructuring on workloads and capacity were high. Uncertainty about job security and some negative experiences of the process used in the reorganisation had undermined morale, and some staff had experienced it as uncaring.

Senior managers we spoke with had a clear understanding of the issues facing the CAMHS service, and were aware of gaps in provision which were being reviewed with the relevant commissioners. Detailed consideration had been given to the redesign of the service to ensure that the needs of young people can be met within a manageable workload. An 'Away Day' had been scheduled to discuss an action plan that had been circulated to staff. There was disconnect between the perception of senior managers, who felt that they were providing clear management and leadership, and that of staff in services who felt unclear and unsupported. Action is needed to address this disparity

Child and adolescent mental health services

and establish better communication and stronger, more supportive leadership as the current situation is undermining the effectiveness of the team as well as morale.

Quality assurance has been established to monitor performance indicators (CQUINS) set by the clinical commissioning group around care pathways for clinical specialisms such as eating disorder and deliberate self-harm. However, the quality assurance framework was not embedded and was not focused on driving the quality of practice or determining outcomes for children and young people.

Adult community-based services

Information about the service

Coventry & Warwickshire Partnership NHS Trust also provides a range of community healthcare services for the people of Coventry and Warwickshire within their own homes. The adult community-based services provided include:

Community Mental Health Teams (CMHT's)

The trust operates seven Community Mental Health Teams (CMHT's). The teams provide services to adults between the ages of 18 – 65 who are experiencing mental health problems.

Assertive Outreach

The Trust operates four Assertive Outreach Services; these teams offer services to patients with psychosis and enduring mental illness. The teams offer support with benefits, housing, social inclusion and psychosocial interventions with patients who may not have engaged well with mental health services.

Early Intervention Team (EIT)

The trust operates four Early Intervention in Psychosis Teams (EIT). We visited two of the teams as part of our inspection. The service operated by the EIT's accepted referrals from people aged between 14 and 35 years of age who are considered to have experienced a first psychotic episode or people who may be considered to be at risk of experiencing a psychotic episode.

Community Learning Disability Teams (CLDT)

There are five community learning disability teams operating throughout Coventry and Warwickshire. The teams provide support for patients with learning disabilities who live in the community.

Summary of findings

Adult community based services

Staff told us that teams were well managed and they felt supported in their role. Where teams were located in the same building there was particularly good collaborative working. There were stable staffing levels in community services and patients usually saw the same staff member on each occasion. Patients knew who their care coordinator was and also knew how to access support in the absence of their main worker or out of hours when community teams were not available.

At trust level staff across many services told us they were concerned about the trust's reorganisation programme. Staff told us they were unclear about how the new structure would look and how this would impact on staff jobs, roles and responsibilities as well as how this would affect patients using the service. Some staff expressed concern that their views were not being listened to.

We found that the trust did not have suitable storage, recording and monitoring systems in place to ensure medications were handled appropriately. There were not safe or consistent arrangements in place to ensure sharps were disposed of safely and quickly.

We found that the majority of the feedback from people was positive. People told us they had good relationships with staff. People were involved in the care planning process and their views were taken into account. There was information provided to people on who they could contact in the absence of their care coordinator or at out of hours times.

Quality assurance systems were not consistently used in all areas. Whilst there were some checks on care records in place these were inconsistently used across the different teams and were not used to evaluate overall quality of the service provided.

Adult community-based services

Are adult community-based services safe?

Management of patient risk

There was a standardised risk assessment format which was used throughout the trust. The assessment of risk included consideration to risks to staff or risks to the person from other people. The risk assessment considers the risk of self-harm. There was a stepped process in place, which worked from an assessment by staff, to working positively with the person enabling them to recognise triggers and signs that would indicate they were at risk. We saw plans in place to describe what actions staff and the person could take if there were elevated risks. We saw that all risks were recorded and plans in place to minimise and manage risks.

We saw that all risks were recorded and a stepped process was in place. The risk assessments showed that staff worked with people to identify risks and enable them to develop coping strategies that would minimise any risks.

The patient assessment process included asking patients about their alcohol and drug use. This included illegal drugs, prescribed drugs or over the counter medicines. This ensured that this could be taken into consideration when deciding what care and treatment people needed.

Caseload Management

At all but one of the Community Mental Health Services we visited, staff told us there was not a waiting list meaning people received intervention and support when it was needed. At the IAPTs service we were told there was a waiting list however each person had been assessed to establish their needs.

Staff told us there were systems in place to monitor caseloads and escalate concerns to the trust board if caseloads exceeded acceptable numbers.

Learning from incidents

Staff we spoke with were familiar with the electronic reporting system to report incidents. Staff were able to describe to us occasions when they had used the system. Whilst in most services staff used the electronic reporting system we found that some staff used a paper based system which was put onto the electronic system at a later date. This meant there could be a delay in incidents being known about or analysed.

Most staff we spoke with told us that they received feedback on significant incidents at team meetings. Some staff told us there was good feedback given to them looking at lessons learned but this was not so good where the incidents related to staff themselves. For example where people were abusive to staff.

Safeguarding people

Staff we spoke with confirmed they had received training in safeguarding adults and, where it was appropriate to their role, safeguarding children. Staff knew where to find the safeguarding procedures. Staff described to us circumstances where they had made safeguarding referrals when they were concerned adults or children were potentially being abused. One staff member described an example where safeguarding procedures had been instigated to protect a person from financial abuse. We saw other examples where staff had reported child protection concerns and were involved in multi-agency case conferences. In many teams we saw information booklets relating to safeguarding which also provided information on capacity and consent.

We discussed with staff how safeguarding referrals were handled. There was a range of staff involved in safeguarding processes, some health and some social services staff. We found some inconsistencies throughout the teams we visited as to how meetings were organised, who chaired meetings and which agencies were involved in safeguarding meetings. We saw an example where one safeguarding meeting was chaired by the person's care coordinator. We also observed meetings where safeguarding concerns were discussed, but the meeting was not regarded by staff to be a safeguarding concerns meeting. Not all staff involved in chairing safeguarding meetings had received training for this role.

In summary whilst staff were receiving safeguarding training, and appropriately reporting concerns, the pathways to handle the concerns were not always consistent across teams.

Staff safety

There was a lone working policy and procedure in place; however this was not explicit in describing how staff whereabouts were monitored. The lone working policy was utilised but localised and differing mechanisms for its implementation were noted within individual teams. In all but one team we visited, staff were able to provide a clear outline of the method used. However these were not

consistent with the policy and procedure in place. This included using different monitoring systems to ensure other staff whereabouts was known and when they were expected to return. One staff member told us, "We all look out for each other in our team to make sure we remain safe." One team we visited were not adhering to the policy and discussion took place with the team manager who told us they intended to address this issue with the team as soon as was practicable.

There was a system in place to highlight where people presented identified risk to staff safety. We saw that the electronic care plan system indicated when staff should not undertake visits alone. The decision to include this information onto the electronic system was reached through discussions with managers ensuring a consistent approach was used. We also saw examples in care plans where it was recorded that staff should visit in pairs.

Clinical waste

In two Community Mental Health Teams we saw an excess quantity of sharps waste stored in treatment rooms. Sharps waste is the ampoules and syringes used where people are prescribed injectable medicines. One staff member we spoke with told us they had tried to get these collected and showed us emails to demonstrate their attempts. The staff member told us there was not a regular collection scheduled to collect sharps waste but there were systems to collect other types of waste.

The tracking labels on the containers were not being completed by staff. This meant that there would not be an audit trail possible should staff handling these incur any injuries. In one unlocked medicines case we saw part of a broken ampoule which presented a risk to staff using the case. We found there were no regular systems in place to ensure sharps waste was removed and disposed of suitably on a regular basis.

Management of medicines

There were inconsistent and unsafe management of medicines in community mental health services. In one service no nurses were available and each nurse had their own key so we were unable to assess medicines management. A second service used key-safes to store keys and only clinical staff knew the codes. At other services we saw that medicines keys were not securely kept and were stored in open key cupboards in administration offices. These were accessible to non-clinical staff. In one service a non-clinical staff member took the keys from an open key

cupboard and showed us the medicines, this included unlocking the medicine storage cupboards. The fridge was already open as it had not been suitably locked by the last staff member who accessed it.

Staff we spoke with confirmed there was no monitoring of room and fridge temperatures to ensure that medicines were being stored in suitable conditions. There were insufficient stock management systems in place and staff did not know what stock should be available. Receipt documents were available to record what had been received but staff did not sign to record what medicines they were using. It was therefore not possible to establish how much stock should be available. Staff told us there were no internal audits of medicines completed and no visits from the trust's pharmacists had taken place.

There were some medications in cupboards that belonged to people where they had obtained them from their local pharmacists. Staff told us these were usually removed by staff when medications changed and they were no longer needed by the person. There was no record to state what medications had been removed or were being stored. At one service we saw a medication returns bin containing items which had been removed from people's homes. There was no record of what was being disposed of. One staff member we spoke with was not clear what the waste bin was for and how it was to be used.

At one service we saw that a supply of prescription pads were stored in a lockable, but portable tin, in a medicines cupboard where all staff members potentially had access.

The lack of monitoring and recording of stock and people's medication meant it would not be possible to know if this was unlawfully removed from the cupboards.

Are adult community-based services effective?
(for example, treatment is effective)

Community treatment orders under the Mental Health Act 1983

Some patients were subject to Community Treatment Orders; this meant that lawful procedures had been used under sections of the Mental Health Act 1983 to require people to accept treatment whilst living in the community. We saw that where patients were required to accept

Adult community-based services

treatment this was included in their plan of care. We also saw that procedures were in place for patients to be made aware of their rights and appeal against the treatment order.

We did not assess the Mental Health Act 1983 legal documents relating to the Community Treatment Orders.

Information about services

Inconsistent information was made available to people. Some community mental health services had information leaflets available for people and for agencies that were likely to make referrals to the service. These described the criteria for referrals and informed people about the support available. However these were not available for all teams or services so people may not always be clear who to contact or what they expect from the service they were accessing.

A general information pack was available for people but this was not specific in giving contact details of the service they were accessing.

At the Early Intervention Team we saw a leaflet was available for potential referrers to inform them about the service and the referral criteria.

Referral and assessment processes

The trust operates a single point of access referral system for patients (known as SPA) for secondary mental health services. This meant that all referrals were managed through a single entry system. The benefit to people of the single entry system was that people were referred directly to the most appropriate service. Each referral was assessed by senior clinicians to establish what care and support the person may need. We observed a multi-disciplinary meeting where referrals were considered. These considered the person and their needs in a respectful and holistic manner. We saw that risks were considered and also if other agencies would be of benefit to the person. For example it was considered that one person's safety could be improved by seeking advice from the fire officer.

After the initial referral the same assessment format was used by all teams. This meant that a consistent approach was used and information could easily be understood and transferred between the types of service without the person having to tell their story again.

One Community Mental Health Team included two Community Psychiatric Nurses who delivered a dedicated perinatal service to pregnant and post natal women in the

Coventry area. There were systems in place to routinely offer pregnant women the opportunity to be screened by midwives to establish if they met the referral criteria and would benefit from being offered perinatal support. This early intervention ensured support was offered at the earliest opportunity.

We saw that the assessment format considered people's healthcare needs, social needs and personal circumstances as well as their mental health needs. This ensured staff would be aware of significant aspects that may be affecting the person's mental health. Staff we spoke with told us how they supported and encouraged people to access healthcare services if they were needed.

For the IAPT's service people could self-refer by telephone. There were leaflets available for people and GP's to inform them about the service and how people could access the support.

Engagement with people

We saw that staff utilised technology to engage with people. This included using telephone calls, texts and emails to support, encourage and communicate with people. This was in addition to, and not in place of, face to face contact.

The IAPT's service routinely offered telephone sessions as part of their working practice. These appointment times were flexible enabling people to continue working and were not disruptive to their lifestyles. If it was assessed that people required face to face contact, and for example they needed interpreters, these were offered.

Medication

We saw from medicines records that some people were not receiving their injections at the intervals prescribed. It was not possible to establish in all circumstances from the people's records why this had occurred.

There were not always suitable arrangements in place to ensure people had supplies of medicines when they went on holiday. We saw two examples where people's mental health had deteriorated whilst on holiday as they had no access to their medicines whilst they were away. This was particularly relevant as the local population included significant numbers of people who originated from different countries and sometimes they spent significant amounts of time visiting relatives. The increased support and care required on people's return impacted on the resources provided by the trust.

Adult community-based services

Rapid re-entry policy

When people were discharged there was a system in place where some people could quickly re-access the service if they needed to within a 12 month period. This was highlighted on the computerised records to ensure staff had access to this information. This system ensured people received support quickly if their mental health deteriorated.

Multi-agency working

We observed a range of multi-disciplinary meetings. We found that multidisciplinary teams communicated and worked well together to ensure coordinated care. All of the people we spoke with knew who their care co-coordinator was and also knew the names of other staff members they could contact if their named worker was not available.

Managers and staff told us that where teams were located in the same building, and particularly where they were managed by the same manager, this enhanced communication, collaborative working and cross service referrals.

We found inconsistencies in recording of care plans. Documentation following contacts with people did not always reflect what was contained in the care plans. We found care plans which included goals that had been achieved but the plan had not been updated. In most areas we saw that people were asked what they wanted to achieve and these had been incorporated in their care plan.

People told us they received support to access a variety of services to meet their needs. In care plans we were able to see how referrals to other organisations had been completed with the person to address a variety of social, financial and physical health needs.

We saw that some people had a care coordinator that they saw on a regular basis but they also saw staff from other disciplines such as occupational therapists and psychologists to provide support for specific interventions. The vast majority of people confirmed to us they had been involved in planning their care and they had received copies of their care plans.

We saw examples of medical care plans which consultant psychiatrists sent to GPs. We also attended an appointment with a person, their care coordinator and the person's GP to hand the care responsibility back to the GP.

Relevant written information was handed to the GP and there were open discussions with the person to ensure they were clear about how to re-access care and support if they needed it.

Staffing

There were no staff vacancies on any of the teams we visited. Staff told us that agency/bank staff were not widely or regularly used in the community mental health services. This ensured that people received a continuous service from staff they knew.

Suitably qualified and competent staff

Throughout the teams we visited staff told us they had access to regular training. Staff told us there was a range of mandatory training which was booked by their manager each year. Additionally staff told us they were able to access training which was specific to their role. People told us they had confidence that the staff who supported them were suitably knowledgeable and skilled.

Are adult community-based services caring?

The care people received

Everyone we spoke with told us they had been involved in the care planning process and had been given copies of their care plans. We saw some care plans that were clear, goal oriented and included the views of the person. Most people we spoke with had been given information about their medications and the potential side effects they could experience. In one service we saw people had been asked to complete an assessment tool to identify if they were experiencing any side effects. However these were not seen in all areas. Whilst most people's medications were reviewed on a six monthly basis we found that this was not always completed.

Some care plans we saw were not always updated as changes occurred. We saw from ongoing records that goals had been achieved but these people's care plans were not updated. This demonstrates positive goal setting but meant that the care plan may not always reflect the person's needs.

We saw reviews of care to be comprehensive with staff engaging positively with the person and their families to establish their goals and views. At the IAPTs and EIT we saw that people were asked to complete self-assessment tools

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on a regular basis. The results were put onto graphs or on spreadsheets where it was possible to gain an immediate overview of how the person was progressing. The scoring of the different sections enabled staff to target interventions where progress was not being achieved.

Consistently people knew where to contact staff if they needed urgent support. There were also arrangements in place to cover absences of the person's care coordinator. People told us they usually knew a few of the team members so if their coordinator was not available, there was someone to contact who they were familiar with.

We observed some outpatient appointments. We saw that people were regarded with respect and open discussions were held. At each appointment medications and side effects were discussed with the person. The doctors also conducted physical health checks including weight, height and blood pressure. These are important as some medications can have an impact on people's health. We spoke with one person who told us they had experienced significant weight gain on one medication. They told us the doctor had listened to their concerns and alternative medicines had been successfully prescribed.

Most people were positive about their experiences of receiving community mental health services, We had a range of descriptions about the staff saying they were 'brilliant 'and 'one of the good guys'. Another person told us 'they have been very helpful to me'. People received the support they needed at varying frequencies dependent on the stage of their recovery. We saw how appointment times were gradually increased as people approached discharge. People told us that they could request further appointments if they needed to. One person told us 'they always spend enough time with me I never feel rushed in my care'.

Our observations of staff's interactions with people were that they were respectful and gave people time to speak and share their views. There were open discussions and people were able to ask questions. Staff had regard for people's capacity to understand information and checked out with people that they had understood the information given to them.

Group activities

The teams we visited considered people's social needs as well as their mental health needs. The assertive outreach teams particularly told us they regarded social inclusion as key to people's recovery.

Some teams ran or promoted community groups to enable people to improve independence and social inclusion. We attended a pool group and found staff to be supportive enabling people to attend the group. We observed that this was enjoyed by everyone who attended. One person told us it was 'calming and fun'. The staff at the group demonstrated a good knowledge about people and their needs.

We spoke with one person who was concerned about the loss of a gardening group due to a lack of funding. They told us how peer support, as well as staff support, had been very important within the group.

Part of the service offered by the IAPT's team included a focussed six week stress management course. A leaflet was available to inform patients about what to expect. As part of our inspection we attended and observed a stress management group attended by 17 people. Staff reported to us that these were well attended.

Advocacy

One team told how they had a really positive relationship with the Independent Mental Health Advocate (IMHA). They told us that the IMHA was willing to provide advice and support to other staff even if they were not involved with the person.

Support for carers

At some teams there were staff from social services whose role it was to assess and provide support for carers. This was not available in all teams. At other teams we were told that carer's events were arranged but staff could not recall when the last event took place. We saw that where people gave permission for carers and relatives to be involved, they were asked their views and included in care plan reviews.

Adult community-based services

Seeking views from people and planning local services

The majority of the people we spoke with could not recall being asked to share their views of the service they experienced in a structured manner. Managers we spoke with told us that they were aware of events held that involved engaging people across the trust but they were not directly seeking feedback about their own team's performance from patients. In some teams we visited they periodically sought patient and carer feedback in relation to educational work or specific training sessions that staff had provided. The feedback was used to make improvements to any future sessions in regard to their delivery and content. This meant that feedback at a local level was not being sought to inform service planning specific to the local community. Generally there were inconsistencies amongst the teams we visited with regard to gaining people's views in a systematic and regulated manner.

Safe transfer between services

We found that inpatient services used a paper based recording system and did not input into the electronic care planning and recording system used by the community mental health services. This meant if a person went out on leave from hospital into community, or vice versa, staff would not have direct access to the most up to date information about the person's needs and risks. For people receiving a service this meant they may have to be reassessed and repeat their story to staff because there were no shared systems in place. One staff member gave us an example where a person had been discharged without any care programme approach paperwork. This meant community staff did not have sufficient information on the person.

Staff we spoke with told us that communication between community and inpatient staff was poor at times. They gave some examples of this. One was that a person was sent out on leave and their care co-ordinator was not informed. Other staff present confirmed they had experienced similar issues with one staff member saying discharge systems were 'muddled'. At other teams we were

also given examples by staff where due to the pressure of inpatient beds, people were sent on prolonged leave or discharged without community staff being informed. This meant people may not be monitored and supported appropriately when at home or in the community.

Where people had been detained under the Mental Health Act 1983, there must be clear discharge plans in place to support the person when they leave hospital. The discharge records we saw were variable in quality. We saw some person centred plans where there had been good input from community staff and the views of the person were included. We saw others with minimal information which was not detailed or specific to the person leaving hospital.

Preventing readmission

We saw that some people, who had been discharged in the past 12 months, had agreed plans in place where they quickly re-accessed community services. This system was called a rapid re-entry policy. This meant that if people required a service again they could bypass the usual referral routes and get access to mental health services through the rapid access system. People who were eligible for this level of access were identified by a marker on their computerised record so that staff could ensure a prompt response to any issues arising. This meant people presenting in crisis could access instant assessment to avoid any further deterioration in their mental state thus reducing readmission rates. People we spoke with were aware of, and had been involved in, the development of their 'crisis plan'. They had contact numbers for services provided outside of normal working hours.

Out of office hours support was provided to people through a crisis intervention team. Each person we spoke with knew how to contact this team.

We spoke with one person's family who told us about an emergency situation had occurred where the police had been involved. They told us that staff had been supportive and responsive to the person in difficult circumstances.

Missed appointments

We spoke with staff about what arrangements were in place if people did not attend appointments or were not at home for planned appointments. Staff told us there was a policy in place and we found that staff across all teams were following the same guidance. Staff told us that attempts would be made to telephone the person and

Adult community-based services

where permission had been granted, contact with a named relative or friend would be tried. Staff advised us that each person's risk profile and information would be assessed to establish if there were potential risks to the person's well-being. If there was significant risk evident staff told us they would involve other agencies such as the police.

Complaints and concerns

A clear system was in place in respect of the complaints process. Managers we spoke with were clear about their role, and that of their staff, in managing issues arising at the earliest opportunity before a formal complaint was made. Managers told us they would not directly investigate complaints that were linked to their team but would undertake investigations for other teams. We saw information displayed in the lobby areas of buildings, meeting rooms and other areas accessed by people that provided information on how to make a complaint. We did not see any information in alternative formats on display, although we were told other languages and formats could be accessed as required. Staff we spoke with said they would always encourage people to complain and supported them in this process where appropriate. One person we spoke with told, "I have never had to complain but would not hesitate to if I had a problem". This meant that the trust had an effective system in place to respond to complaints. A system for feedback to the relevant parties for learning or to bring about changes in practice, were shared at the conclusion of any investigation.

Most people we spoke with were satisfied with the care they received. One person told us 'I have no reason to complain but if I did, I would speak to the staff and I know they will help me'.

Some people told us they had raised complaints about other areas of the services offered by the trust but these did not relate to the community services they received. We also saw that some people had sent cards to thank staff. We undertook one discharge visit where the staff member was given a gift as a thank you for their support. The person told us how much the support had helped them to be more positive and recognise the changes that occurred when they became ill. They told us how much this had improved their independence and confidence.

Interpreters

The trust provided services to an area where there were many people for whom English was not their first language and interpreters were required. Staff we spoke with told us they had good access to interpreters and that written information was available in other languages on request. We spoke with one staff member who had a little knowledge of many languages. They told us they often worked with people whose English was not their first language however this was not ideal as their knowledge of each language was limited. Some staff told us that family members were sometimes used to communicate with people. This may not be an effective method of communicating with people as the staff member would not be able to verify the correct information was conveyed and that the views were truly those of the person receiving care.

Are adult community-based services well-led?

Change management

Most of the staff we spoke with, which included nurses, occupational therapists and social workers, told us they felt well supported by their managers. They all spoke positively about their role and demonstrated their dedication to providing quality patient care. However, as key stakeholders in the organisation, staff shared with us some concerns about forthcoming changes to how services are to be organised. They told us that senior managers and board members had engaged them in the change process, providing information and consulted with them in a variety of formats. A number of staff told us they felt some of the basic questions they had asked had not been responded to, to their satisfaction. They voiced concerns about the impact of the proposed changes on the people they currently cared for. Staff reported to us that morale in teams was low due to uncertainty about future changes. One member of staff told us they had received a wealth of information from the board, but that it had lacked details.

Engagement

Senior managers told us that a wide range of professionals from across all disciplines attended a meeting known as the Safety and Quality meeting. These meetings incorporated discussion around current trust policies and identified work groups to review or write new policies. This meant that the engagement in policy development was encouraged from all levels within the organisation.

Governance

We were told that regular random audits of the quality of Care Programme Approach (CPA) documentation was

undertaken by managers but no recording of any findings was available for us to see. Senior managers told us that feedback about any identified gaps in documentation, were discussed with the staff member through supervision. A more extensive overview of the quality of entries in patient records, for example the content of assessments or care plans, was undertaken once a year. However again we were unable to see records of these checks. In addition to these some themed auditing within the trust was undertaken periodically throughout the year. Despite some checks being undertaken there was no proactive, overarching assessment undertaken of how the service was functioning and results were not used to improve the quality of the service.

Leadership

Staff told us they felt coherent as a team and that all members were valued and respected regardless of discipline or level of seniority. We were able to observe teams working in collaboration and saw many examples of positive working relationships. Transfer of care between teams and shared care within teams was effectively managed overall. This enabled smooth transition between teams for the patient as part of their ongoing recovery. Staff we met with were clear about the lines of accountability and who to escalate any concerns to.

On a day-to-day basis staff reported good communication with regular handover/information sharing meetings being held. At team level we found that staff reported there was good morale and staff were supportive of each other. The staff we spoke with were passionate about their role and how people should always be at the heart of what they do.

Staff reported that caseload numbers were capped and waiting lists were effectively managed. Higher levels of caseload numbers were escalated to board level for a risk management discussion to take place and action plan development. Managers described how all people on the waiting list had been provided with an initial assessment of their needs and also had access to a duty worker within the team.

Case load supervision of staff by their line managers was regular and consistent in the teams we visited. Issues discussed in these sessions included any caseload issues, training or performance issues.

We saw there was inconsistency across teams with respect to clinical supervision. Specific professional supervision or staff trained in specific therapies for example, Behavioural Family Therapy or Non-Medical Prescribing (NMP) was not being routinely provided. Staff voiced their concerns regarding this and in most cases they had raised the issue with their line manager in the appropriate arena. This meant that staff utilising additional qualifications or skills to enhance the patient experience, were not being suitably supervised.

Community services for children and families

Information about the service

Health Visiting Service provides family centred support and care to families and children within Coventry from birth to five years. Health visiting teams were based in health centres around the city.

Each school in Coventry has a named school nurse. Providing health promotion, reduce inequalities, promote social inclusion and involvement of safeguarding children issues. School nursing teams were based at the Paybody Unit, City of Coventry Health Centre, and in health centres around the city.

Summary of findings

Staff were well trained and training was appropriate to their role, the exception to this was the children's nursing within the Health Visiting service. Staff told us their mandatory training was out of date and that staff did not always have the opportunity to attend specialised training specific to their job roles.

Health visiting services

We talked to health visitors and children's nursery nurses who provided support to the team. They told us that overall, they felt they had enough staff to meet appointments. However, nursery nurses stated that not all staff were able to attend mandatory and specialised training to support them in their roles, especially part time workers, who found it difficult to attend training and manage their workload.

We talked to mothers who told us health visitors and children's nurses provided sound advice and support during one to one consultations. However accessing health visitors was problematic as they were difficult to contact due to having a busy workload and clinics were often full.

School nursing services

We talked to doctors, managers and nurses from the service who told us they were struggling to cope with demands of general school nursing duties and managing additional child protection work. They provide health reports, attend all case conferences, and undertake any work and liaison afterwards. Safeguarding and child protection work, always takes priority, and this meant they struggled to do other work, especially health promotion. School nurses told us they had good a training programme in place and were able to attend mandatory and specialised courses. School nurses told us they had very good appraisals and supervision systems in place.

We talked to school nurses who told us that due to increased child protection work placed on them they were struggling to respond to the day-to-day school referrals. The increased time devoted to attending safeguarding meetings and case conferences had resulted in fewer school nurses available to meet the needs of the school population.

Community services for children and families

Are community services for children and families safe?
(for example, treatment is effective)

Health visiting service
We talked to four qualified health visitors and two nursery nurses who worked in the service. All staff told us the trust had recently recruited additional health visitors and therefore workloads were more manageable. Health visitors told us they were up to date with mandatory training and were supported to attend specialist training. Nursery nurses told us attending mandatory and specialist training was an issue, especially for part time staff, which impacted on their ability to provide a safe and effective service. We were told the health visiting team at Willenhall had recruited a new manager and staff were confident staff training would improve.

School nursing service
We spoke with nine school nurses who told us mandatory and specialised training was well attended and up to date. We were told staffing levels was an issue because nurses spent a large proportion of their daily work attending case conferences and children's safeguarding meetings. This meant less time was available to focus on general school nursing duties. Staff told us, they felt the trust had learned lessons from recent serious case reviews which meant 'at risk' children were being identified quickly and dealt with appropriately. However they felt that this was to the detriment of the rest of their workload. The senior management team told us commissioners expected staff to work more wisely, but considered that teams did not have the resources.

Are community services for children and families effective?

Health visiting service
Health visitors across Willenhall and Tile Hill teams told us they worked collaboratively with their midwifery and school nursing colleagues to achieve the best outcomes for their patients. We talked to nursery nurses from Willenhall who told us communication between staff in the team was robust. For instance if a nursery nurse had concerns about a mother or child following a meeting, information was communicated quickly to the health visitor and acted upon to ensure support was speedy and effective.

School nursing service
School nurses told us there was ample opportunity to work collaboratively across disciplines. Following investigation of serious case reviews staff were encouraged to improve communication and cross partnership working to ensure no children 'at risk' slipped through the net. Staff stated there was now much more robust and integrated provision in regards to safeguarding children. For instance, child sexual abuse cases have regular meetings, toolkits and work more closely with police and social services. The trust had introduced agile working, which meant staff were given laptops to improve efficiency. Nurses told us, the Trust is now looking at software packages to assist with letter and report writing in the community.

Are community services for children and families caring?

Health visiting service
We talked to health visitors and nursery nurses who told us they felt they delivered a caring and supportive service to mothers and families. We talked to mothers who told us, "The health visitors have been great. They must have read my notes as I had problems last time and they must have known because they have offered so much support to help me. They visited every week in the early days but then we tailed it off as I got more confident." Another mother told us, "They are brilliant they offer really good advice and support. They told me about the different services available".

School nursing services
We talked to nine nurses who told us they felt they provided excellent care and support to children and families. Each child referred to them received a holistic assessment, using a systematic approach and semi-structured interview protocol. However this took time which had a bearing on the amount of referrals they could accept and manage. Staff told us they have less time with health promotion activities at schools. Vaccinations are provided from a specialist service and there is increasing integration with school nursing.

Community services for children and families

Are community services for children and families responsive to people's needs? (for example, to feedback?)

Health visiting services
Staff told us that since the trust had recruited more health visitors they felt their workload was "more manageable". However one mother told us, "I struggle to get hold of a health visitor if I need advice it would help if we could email them."

School nursing services
Nurses and managers told us they spent significant time assessing and managing referrals from the more diverse areas of Coventry where interpreters were required. This meant response times from school nurses were adversely affected. For example a referral involving asylum seekers meant that getting in touch to arrange initial assessments, interviews, meetings and translating all information slowed the system down. This caused a workload backlog as staff resources were not sufficient to meet current needs.

Are community services for children and families well-led?

Health visiting services
Health visitors based at Willenhall told us the trust has just recruited a new line manager. They felt attendance at

mandatory training and specialised training had been a problem. However they were hopeful the new manager would improve this. Health visitors at Tile Hill team told us they felt very supported by their line manager and they had received clinical supervision and plenty of training particularly in child protection. Two health visitors told us they felt informed about the trust's restructure programme and communication up and down the line was very good.

School nursing services
Nine school nurses told us that immediate line managers provided excellent support and guidance. They were encouraged to study for specialist modules at the University of Coventry and stated their mandatory training was up to date. Nurses told us they attended team meetings to discuss child cases and also organisational structure and felt valued. Nurses told us they had regular one to one supervision with their line managers and felt their managers listened to them and were approachable. Staff told us staffing levels were a problem due to the complexities of their workload. However, they understood this as a commissioning of services issue rather than one of poor management.

Community services for adults with long-term conditions

Information about the service

District Nursing services provides care to people with chronic diseases and long-term conditions. District nursing teams were based at five locations within Coventry.

Summary of findings

Across all these services, staff were well trained and training was appropriate to their role.

Across all these services most people we spoke to described their care as good to excellent and said that staff were caring, despite being busy. This was corroborated when speaking to people during home visits and also at patient telephone feedback sessions carried out after the inspection. We saw care plans within the district nursing services did not always reflect people's needs. However, most patients felt that they were involved with their care and informed about their treatment.

Staff we spoke with across all services were full of praise for their immediate line managers. They felt well supported by their managers and told us they felt listened to. Staff told us they were aware of the trust's restructure programme which made staff feel unsettled. However they told us communication between senior management team and clinicians was good.

District nursing services

We looked at staffing levels and workloads across Willenhall and Tile Hill District nursing teams. We saw both teams organised their work in advance and we were told by several nurses they were able to incorporate additional calls during the day. We saw staffing levels were at a safe level at Willenhall and most people received care according to their needs.

However, we saw risk assessments and care plans were not always in place and updated at regular intervals. We saw vacancies at Tile Hill meant a high usage of agency staff, which brought inherent problems. We saw the Willenhall team had not implemented all lessons learned from a previous incident relating to medication errors, to improve standards and safety for people who used the service.

During home visits, we saw nurses responding well to people's needs. Nurses listened and answered questions relating to care and treatment. We saw nurses working effectively with external agencies making referrals for specialist assessments and equipment to improve people's care.

Community services for adults with long-term conditions

Are community services for adults with long-term conditions safe?

District nursing

We looked at daily work schedules for individual nurses and compared it with the length of time taken for each patient visit. One inspector accompanied a nurse to visit two people from each team. Generally, we saw people received care and treatment which reflected their needs. We saw nurses were calm and unhurried delivering care to people and took time to answer their questions.

However we saw not all people had been supported appropriately. For example, we saw one person who was at risk of falls had no falls risk assessment in place. We saw the person's nutritional risk assessment had not been updated appropriately. For example the person told us they had lost four stones in weight over a four month period and their appetite was poor. They had a sore mouth and gums which meant they could not chew food comfortably and ate soup twice a day instead.

We looked in the care records and saw the district nurses had been visiting the patient once a week and had not captured this information. We saw the person was at risk of pressure damage, due to their reduced mobility and significant weight loss. However, the district nursing team had not supplied appropriate pressure relieving equipment such as a pressure relieving cushion and overlay mattress to prevent the risk of skin breakdown. This meant due to lack of information, care and delay in treatment the person had been placed at risk.

We were told by the management team that Willenhall district nurse team had been involved in two medication errors involving syringe drivers. A syringe driver is a device used to administer continuous medication through the person's skin. We were told by the manager that both incidents had been reported and dealt with appropriately. We saw there had been an incident management report for each incident to support this. We were told by nurses and a manager that lessons had been learned and actions had been taken to reduce the risk of future incidents.

During the inspection we visited a person who had medication delivered via a syringe driver and was receiving palliative care daily by the district nurse. We looked at the care records and saw there was no palliative care plan to indicate the person had a syringe driver. There were no

operational guidance notes to advise staff how to operate the syringe driver or what to do in the event of device failure. On arrival to the person's home we saw the syringe driver alarm was sounding to indicate an error had occurred. We saw there was no patient information to advise the person or relatives what to do if the driver alarm sounded. The nurse informed us the driver had alarmed because the syringe containing the drugs had dislodged itself from the holder.

We saw that one person had three care plans in place for diabetes, chronic kidney failure and cardiovascular problems. However, none of the care plans had been completed, signed or dated. The person told the nurse they had abdominal pain; however there was no pain care plan to monitor and manage pain levels. We saw the nurse act promptly when the person told her their heels and bottom were sore. The nurse respected the person's dignity and closed the curtains, and inspected the areas of concern. We saw the nurse delivered care in a caring and unhurried way.

Are community services for adults with long-term conditions effective?
(for example, treatment is effective)

District nursing service

We talked to staff at Tile Hill District nursing team. Staff in general told us they had vacancies which had not been recruited to which had impacted with provision of effective patient care. Staff explained that although agency nurses had been brought in, they were often unfamiliar with patient's needs. They did not know how to order equipment or make referrals to outside agencies. This meant permanent staff had to spend time completing agency tasks and told us, "This compromised patient care".

District nurses told us they had strong relationships with GPs and specialist nurses such as dietician, tissue viability nurse, community matrons and therapists. We saw nurses refer people quickly and sometimes whilst still in the person's home. On the day of the inspection we saw one nurse preparing for a meeting with GPs and a palliative care specialist nurse to discuss care and treatment of people with life limiting diseases. This meant the district nurse team engaged in multi-professional partnership working to ensure people's needs were being effectively met.

Community services for adults with long-term conditions

Are community services for adults with long-term conditions caring?

District nursing service

We saw district nursing teams engage with people in a caring and compassionate way. We saw people asked questions and nurses took time to answer and also explain alternative options to people. We observed that staff treated people with respect and dignity when providing care. People's permission was sought when the nurse needed to sit down to write in the care records or close the curtains to maintain the person's dignity and privacy when providing treatment.

Are community services for adults with long-term conditions responsive to people's needs?
(for example, to feedback?)

District nursing services

We were told Willenhall district nurse team had received two complaints within the last 12 months. The manager explained both people had been visited and given the opportunity to discuss their concerns with the manager. We were told both complaints had been resolved. We talked to one patient from Tile Hill district nursing team who told they complained about a member of staff who was rude and abrupt. The patient explained the manager dealt with the problem swiftly and sensitively and the member of staff was removed from future visits.

We carried out a telephone feedback survey one day after the inspection involving 24 people. Each person we contacted spoke very highly of both district nursing teams. They told us staff listened to them. One person told us the district nurse was quick to respond when their condition changed and they developed a wound infection. Another person told us staff always contacted the GP quickly if their relative deteriorated. In general people were very happy with the quality and standard of care provide by both district nursing teams. However the telephone feedback survey showed that the majority of people did not always know in advance when staff would

visit. One person told us they had diabetes and staff visited to give them their insulin each morning. They told us, "Yesterday the nurse came around 9am but today she turned up at 10:45am, it would be nice to try and stick to a time so I know when to have my breakfast." Another person told us, The nurse just turned up to change X's catheter, it was a good job I decided to stay in or I would have missed them". Several people told us they usually had a morning call but sometimes if staff were busy they received an afternoon call. We talked to a nurse and the manager, who explained people were not routinely given a time slot, but that staff would try and visit at the same time morning or afternoon. The manager explained if staff were late they tried to ring the person in advance. This meant there was no set structure to people's visits and visit times were inconsistent.

Are community services for adults with long-term conditions well-led?

District nursing services

District nursing staff we spoke with were full of praise for their immediate line managers. They felt well supported by their managers and told us they felt they were listened to. Staff told us they were aware of the trust's restructure programme which made staff feel unsettled. Staff at Willenhall told us they had been without a line manager for over 18 months and one nurse told us the team was in a poor state without a leader and had lost direction, which affected people's care. Eight months ago a new manager was appointed and nurses told us new ways of working had been implemented and the team was now more organised and happy. However, on the day of the inspection we were told by senior managers the current manager was leaving. Staff told us they were sad and worried and did not want to end up without a manager again.

Tile Hill district nursing team told us they considered the team to be well led, except for staffing levels. Nurses told us they felt managers listened to them and were aware of the challenges of using agency staff, however recruitment was slow. Staff from both teams told us they were supported to attend mandatory and specialised training. Several nurses told us they loved their jobs and wouldn't want to do

Community services for adults with long-term conditions

any other. We saw staff had attended weekly team meetings and fortnightly or monthly meetings to discuss organisational restructure, governance issues and to disseminate trust information.

Compliance actions

Action we have told the provider to take

The table below shows the essential standards of quality and safety that were not being met. The provider must send CQC a report that says what action they are going to take to meet these essential standards.

Regulated activity	Regulation
Nursing care Treatment of disease, disorder or injury	How the regulation was not being met: The registered provider was failing to protect patients against the risks associated with the unsafe use and management of medicines. Regulation 13 HSCA 2008 (Regulated Activities) Regulations 2010