

Requires improvement

Coventry and Warwickshire Partnership NHS Trust

Community mental health services for people with learning disabilities or autism

Quality Report

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Date of inspection visit: 11 - 15 April 2016
Date of publication: 12/07/2016

Locations inspected

Location ID	Name of CQC registered location	Name of service (e.g. ward/unit/team)	Postcode of service (ward/unit/team)
RYGCR	Wayside House	The Loft, Bedworth - Community learning disability mental health team	CV12 8EA
RYGCR	Wayside House	The Railings, Rugby - Community learning disability mental health team	CV21 2AW
RYGCR	Wayside House	Oliver House, Solihull - Community learning disability mental health team	B37 7HJ

Summary of findings

RYGCR

Wayside House

Lower StudioCivic Centre 2 Little
Park Street Coventry
- Community learning disability
mental health team

CV1 5RS

This report describes our judgement of the quality of care provided within this core service by Coventry and Warwickshire Partnership NHS Trust. Where relevant we provide detail of each location or area of service visited.

Our judgement is based on a combination of what we found when we inspected, information from our 'Intelligent Monitoring' system, and information given to us from people who use services, the public and other organisations.

Where applicable, we have reported on each core service provided by Coventry and Warwickshire Partnership NHS Trust and these are brought together to inform our overall judgement of Coventry and Warwickshire Partnership NHS Trust.

Summary of findings

Ratings

We are introducing ratings as an important element of our new approach to inspection and regulation. Our ratings will always be based on a combination of what we find at inspection, what people tell us, our Intelligent Monitoring data and local information from the provider and other organisations. We will award them on a four-point scale: outstanding; good; requires improvement; or inadequate.

Overall rating for the service

Requires improvement



Are services safe?

Requires improvement



Are services effective?

Requires improvement



Are services caring?

Good



Are services responsive?

Good



Are services well-led?

Requires improvement



Mental Health Act responsibilities and Mental Capacity Act / Deprivation of Liberty Safeguards

We include our assessment of the provider's compliance with the Mental Health Act and Mental Capacity Act in our overall inspection of the core service.

We do not give a rating for Mental Health Act or Mental Capacity Act; however we do use our findings to determine the overall rating for the service.

Further information about findings in relation to the Mental Health Act and Mental Capacity Act can be found later in this report.

Summary of findings

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Summary of findings

Overall summary

We rated community mental health services for people with learning disabilities as requires improvement because:

- We reviewed 24 care records and found that staff were not updating these on a regular basis. We found 13 care records that did not have a risk assessment. We also found 10 that staff had not completed records or there was information missing.
- Of the care records we reviewed, four did not have an initial assessment in place identifying patients' initial needs. Care records were not accessible to other team members because individual staff kept their own word files. This meant that if a named worker was not available during a patient crisis, staff covering might not have the appropriate information to manage the patient's needs safely. Staff were not completing crisis plans with patients.
- Staff were non-compliant with mandatory training and managers did not audit training compliance. This meant that staff might not have the knowledge needed care for patients in line with the trust's policies and procedures and best practice guidelines. Staff had not received supervision in line with the trust's guidelines of six weekly for the first six months and then every two months.
- Staff had a poor understanding of capacity, best interests and Deprivation of Liberty Safeguards. Patients consent to care and treatment was not recorded and decisions about mental capacity were not always assessed and recorded in accordance with the Mental Capacity Act (2005). Training compliance was below the trust's target.

- Interview rooms did not have alarms fitted and if a risk of aggression was identified a second member of staff would either accompany the assessing staff, or wait outside the room. Staff told us they struggled to find appropriate rooms for assessing patients. They told us that there were not enough spaces and it took considerable time to organise.
- Community teams did not have effective governance systems in place to assess, monitor, and improve service performance. Managers did not undertake clinical audits that would have identified service short falls. Such as care plans and risk assessment's being incomplete.

However

- The service had robust systems in place for triaging referrals. Patients waiting for psychology support would be allocated a care coordinator in the interim, without delay.
- The acute liaison team supported individualised care for patients in general hospitals and prevented lengthy admissions.
- Patients and relatives told us that staff were kind and caring.
- Staff treated patients with respect and dignity. They always contacted patients if they were running late for appointments.
- The trust shared lessons learnt with staff in a variety of formats.
- Staff had access to development and professional training to enhance their roles.

Summary of findings

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

Are services safe?

We rated safe as requires improvement because:

- Individual risk assessments were not always complete. Staff did not always review risk assessments. Four patient files of 24 reviewed did not have an initial assessment of patient needs and risk plans had not been completed.
- Staff did not complete crisis plans with patients. We could not find evidence in the care records that staff discussed with patients how they prefer to be cared for when they present in crisis.
- 73% of staff had received updates in safeguarding vulnerable adults and children, compared with the trusts target of 95%.
- Interview rooms did not have alarms fitted. If a risk of aggression was identified a second member of staff would either accompany the assessing staff, or wait outside the room, this was in efficient use of staff time.

However

- The service had an acute liaison team that worked with acute hospitals to support patients with learning disabilities in the discharge process and signpost services that might be required following discharge.
- There was a robust lone working policy in place to protect staff and patients.
- The trust informed all staff of lessons learned from incidents through a variety of formats. Including email, and paper newsletters.
- There had been no serious incidents for the service in the last 12 months.

Requires improvement



Are services effective?

We rated effective as requires improvement because:

- Patient progress notes and care plans were stored in care coordinators' own work computer files. They also kept written records. These were not updated at the same time. Consequently, information was not always accessible or up to date. Particularly if patients presented in crisis and the care coordinator was not available.
- Patients consent to care and treatment was not being recorded and decisions about mental capacity were not always assessed and recorded in accordance with the Mental Capacity Act (2005).

Requires improvement



Summary of findings

- Staff had poor understanding of Deprivation of Liberties Safeguards and best interest assessments. 68% of staff had received training in MCA and DOLs which was below the trust's 95% target.
- Initially assessments did not include a space for recording individual's historic and present risk and mental capacity.
- Each professional involved in patients care wrote separate care plans. This did not always feed into other care plans for patients receiving a service.
- Staff did not monitor patients progress through HoNOS (Health of the Nation Outcome Scales), as was trust policy. Staff did complete the initial assessment but did not review it.
- Staff did not receive regular supervision to monitor performance and provide managerial support, in line with the trust's supervision policy.

However

- Information between professionals was shared at weekly multi-disciplinary meetings.
- There was a consistent service approach to processing new referrals and assigning them to teams and individuals appropriately.
- Staff could request specialist training to improve their awareness and knowledge of certain health conditions. They disseminated new knowledge to their colleagues.
- The acute liaison team provided an effective service in supporting acute hospitals and proactive discharge to the community.

Are services caring?

We rated caring as good because:

- Patients and carers told us that staff spoke with them with compassion and understanding.
- The access team created hospital passports for people with learning disabilities admitted to hospital. These easy read passports supported hospital staff to understand patient's needs, likes and dislikes.
- We saw kind and caring, positive interactions between staff and patients.
- Patients told us that staff were nice. Relatives told us that staff were caring and had patients' best interests at heart.
- Community staff knew how to access advocacy services for patients who might need this support.
- Patients and relatives, (if patients consented) were invited to care reviews.

Good



Summary of findings

- Staff showed respect for patients and notified them if they were running late for an appointment.

However

- Nursing care plans were not always completed, complete, or reviewed.

Are services responsive to people's needs?

Good



We rated responsive as good because:

- There was a short waiting list for psychology services and patients would be allocated a care coordinator to monitor patients whilst waiting for psychology input.
- Patients said staff responded quickly to their changing needs.
- The service investigated complaints thoroughly and staff knew how to support patients to access the patient advice liaison service.
- Staff received information from the trust about lessons learnt from incidents and discussed these within their teams.

However

- Staff did not have ready access to treatment rooms for assessments and meetings.
- Patients told us they didn't know how to make a formal complaint, although they felt they could approach staff.

Are services well-led?

Requires improvement



We rated as well-led as requires improvement because:

- Managers in the teams did not have governance systems in place to monitor the effectiveness of the service. Staff did not take part in clinical audits to identify if care plans and risk assessments had been updated or completed, or whether they had met targets from referral to treatment.
- Staff had not received supervision in line with the trust guidelines of six weekly for the first six months and then every two months.
- Mental Health Act and Mental Capacity Act training was below the trust target at 68%. This was below the trusts target of 95%. Some staff we spoke with did not have a good understanding of capacity and consent. The service did not have a plan in place to address this.
- Each community team was made up of a variety of different professionals, who each had their own individual manager. There was a lack of strong leadership.

Summary of findings

However

- The staff knew the trust's visions and values which were displayed on the wards and discussed these during yearly appraisals.
- The trust shared information about lessons learnt from incidents to staff. These were fed back to staff through a shared trust network and trust wide newsletter.
- Staff had opportunities for professional development. Community managers could undertake leadership training and unqualified staff could be seconded to achieve a national vocational qualification, foundation degree and following on from this a nursing degree.

Summary of findings

Information about the service

Community services for patients with a learning disability are provided in five locations across the trust. There is a total of 41 staff providing the service across all localities. The trust engages with three safeguarding boards in three different local authorities – Coventry, Warwickshire, and Solihull.

The service supports approximately 21,500 people across Coventry, Warwickshire and Solihull.

Multi-disciplinary teams (MDT) provide community learning disability services. This includes psychiatrists, psychologists, community nurses, speech and language therapists, occupational therapists, physiotherapists and healthcare support workers.

Patients requiring support from the community learning disability team are referred via a central booking service where a triage process takes place. The MDT at weekly meetings prioritises requests for services.

The community teams assess and support patients with continuing healthcare needs and provide specialist advice for patients who have behaviour challenges and complex health needs. Such as those patients with epilepsy. Physiotherapists provide support to patients with posture, mobility, and neurological conditions. Community staff are able to support patients with dementia, autism and mental health problems once assessment had taken place.

An acute liaison and health facilitation service are also available within the community team. The acute liaison service provides links between acute hospitals, Heartlands Hospitals, Good Hope, and community services. Liaison nursing staff work with the local University Hospitals of Coventry and Warwickshire, the George Eliot Hospital and Warwick General Hospital. The five locality teams include South Warwickshire, North Warwickshire, Rugby, Coventry and Solihull.

Our inspection team

Our inspection team was led by:

Chair: Paul Jenkins, Chief Executive, Tavistock and Portman NHS Foundation Trust

Team Leader: Julie Meikle, Head of Hospital Inspection, (mental health) CQC

Inspection Manager: Margaret Henderson, Inspection Manager, mental health hospitals CQC

The team that inspected the Community mental health services for people with learning disabilities learning disabilities services consisted of two inspectors, four specialist advisors and an expert by experience.

The team would like to thank all those who met and spoke with the team during the inspection and were open and balanced with the sharing of their experiences and their perceptions of the quality of care and treatment at the trust.

Why we carried out this inspection

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

Summary of findings

How we carried out this inspection

We spoke with patients who used the service and carers, observed care being provided, spoke with staff and reviewed records. We reviewed information provided about the service before our inspection. We visited four community teams and accompanied staff on visits.

To fully understand the experience of patients who use services, 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 patient's needs?
- Is it well-led?

During the inspection visit, the inspection team:

- visited four community localities where staff were based and patients attended clinics for treatment and advice
- spoke with five patients who were using the service
- spoke with six carers or relatives
- spoke with managers who managed the community nursing teams
- spoke with 14 other staff members; including doctors, nurses, psychologists, healthcare assistants, acute liaison staff
- accompanied staff on visits to three patients
- attended and observed two clinics
- looked at 24 treatment records of patients
- looked at a range of policies, procedures and other documents relating to the running of the service.

What people who use the provider's services say

We spoke with five patients and six carers:

- Patients who used the community learn disability service and carers and loved ones, told us the support they received was excellent. Staff were described as caring and considerate and accessible.
- Patients told us that they had not seen copies of their care plans.

- Carers told us that they felt supported by staff. They told us that staff discussed the patients' needs with them regularly.
- None of the relatives or carers we spoke with had been involved in care planning. However, they did feel that they were involved in review meetings and were involved in decisions regarding patients care.

Areas for improvement

Action the provider **MUST** take to improve

- The trust must ensure staff receive mandatory training, including safeguarding vulnerable adults and children training and training in the Mental Health Act, Mental Capacity Act and Deprivation of Liberty Safeguards.
- The trust must ensure that staff received regular supervision and appraisal.
- The trust must ensure there is an effective clinical governance system in place to monitor patients care, risk assessments, care plans, and adherence to the Mental Capacity Act.

Coventry and Warwickshire Partnership NHS Trust

Community mental health services for people with learning disabilities or autism

Detailed findings

Locations inspected

Name of service (e.g. ward/unit/team)	Name of CQC registered location
The Loft, Bedworth	Wayside House
The Railings, Rugby	Wayside House
Oliver House, Solihull	Wayside House
Lower Studio Civic Centre 2 Little Park Street Coventry	Wayside House

Mental Health Act responsibilities

We do not rate responsibilities under the Mental Health Act 1983. We use our findings as a determiner in reaching an overall rating for the trust.

At the time of inspection, the community teams were supporting patients who were subject to a section of the Mental Health Act 1983. Staff were supporting patients that were subject to Section 117 of the MHA which entitles patients to free aftercare following discharge from hospital. Staff had in the past provided care for patients on community treatments orders (CTO). A CTO is a legal order

made by the mental health review tribunal or by a magistrate. It sets out the terms under which a person must accept medication and therapy, counselling, management, rehabilitation and other services while living in the community.

Staff told us they would access advice and support from the trusts Mental Health Act administrator if they had any questions and queries about responsibilities for caring for someone under a CTO.

Detailed findings

Staff received mandatory training which combined Mental Health Act 1983, Mental Capacity Act 2005 and Deprivation of Liberty Safeguards. However, compliance with the training was low at 68%, compared to the trust mandatory training target of 95%.

Mental Capacity Act and Deprivation of Liberty Safeguards

Staff did not have an understanding of the Mental Capacity Act and capacity responsibilities.

Some staff did not understand the purpose of Deprivation of Liberty Safeguards. When decisions around capacity and

consent had been decided, there was no evidence about how staff had arrived at decisions. For example, they had not carried out capacity assessments which would include the patients, relatives and advocates.

Are services safe?

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

* People are protected from physical, sexual, mental or psychological, financial, neglect, institutional or discriminatory abuse

Our findings

Safe and clean environment

- The buildings that had interview rooms on site did not always have alarms. This meant that staff would not be able to summon assistance if they felt at risk. Staff told us that they assess risk prior to seeing patients. If a patient presented as agitated, or had a history of violence, they would see them with another member of staff present. If it could potentially increase the risk having another staff member present in the room then staff would wait outside to monitor any potential increase in risk.
- The community team's offices were all clean, tidy and well maintained. Cleaning staff completed cleaning rotas and filled them in regularly. There were no gaps identified.

Safe staffing

- The service had a whole time equivalent (WTE) establishment of 41 staff. This included 26 qualified and eight unqualified nursing staff. Teams also included occupational therapists, psychologists, and consultant psychiatrists. The teams had access to a speech and language therapist who worked countywide. The trust told us each team had a speech and language therapist as well as access to a single Specialist Dysphagia SALT that works countywide. The service had a 15 to 20% turnover rate across all locations. The services had vacancy rates that varied between 11% and 17%.
- Staff sickness rates were below that expected by the trust between 1 and 3% in a 12 month period between December 2014, and December, 2015. The trust's target was 4.5%.
- The average caseloads for care coordinators were between 25 and 30. Staff felt that their caseloads were manageable. They felt that they were able to offer sufficient time to their patients and would be able to respond to a patient in crisis in a timely manner.
- Staff managed their caseloads effectively. Staff discussed their caseloads during multi-disciplinary team meetings as well as in supervision. Staff felt able to

decline to take on cases should they feel it would be unsafe for them to take on more. The community teams did not have waiting lists for care coordinators at the time of inspection.

- The community teams all had short waiting lists for psychology support. The average length of wait for treatment was four weeks. However, the psychology service had longer waiting times in some areas. Staff told us that patients were allocated to a care coordinator whilst waiting for psychological support.
- Community staff were not up to date with their mandatory training. The compliance rate for mandatory training was 82%. Only 74% of staff had received safeguarding vulnerable children level two training.
- We spoke with the managers of community nursing teams who told us four staff had been seconded to the enhanced care team to support patients moving into the community as part of the transforming care project. This was a project aimed at reducing hospital admissions. This had resulted in additional work being allocated to other members of the teams.

Assessing and managing risk to patients and staff

- We reviewed 24 care records. Staff had not completed and updated risk assessments adequately. The trust used a nationally recognised risk assessment tool. This was a practical tool for guiding and documenting the integrated assessment and management of clinical risks in mental health services. Staff undertook risk assessments as part of the initial assessment. However, we found that staff were not updating these on a regular basis. We found 13 care records that did not have a risk assessment. We also found 10 that staff had not completed fully and had records had information missing. Some risk assessments dated back to 2014 with no evidence that staff had reviewed.
- Staff were able to place risk warnings on the electronic records. This meant that when staff reviewed patients records on the electronic system they would receive alert warning them of potential risks, such as aggressive behaviour. Staff showed us two examples of this but only one had a risk assessment for the warnings.
- Staff knew how to make safeguarding referrals by telephone or completing the referral form online. However, we attended team meetings in which staff

Are services safe?

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

discussed safeguarding concerns. We observed staff discussing a case where a patient was potential at risk of harm. However, they did not consider a safeguarding referral. We brought this to staff's attention so they could make the appropriate referral.

- The services had effective lone working procedures in place. Staff kept electronic diaries in which they recorded all their appointments, which line managers could access. Staff also had to sign in and out using a board displayed in the office area. The team administrator monitored this. They would alert management should staff not return within half an hour of their specified time.
- Staff did not keep medication on the premises. Staff would collect medication from a local pharmacist and take it straight to the patient.

Track record on safety

- The trust reported there had been no serious incidents requiring investigation in the past 12 months involving community learning disability services.

Reporting incidents and learning from when things go wrong

- Staff knew how to report incidents. The service used an online recording system for incident reporting. Staff told us they recorded incidents of aggressive behaviour, any abuse, medication errors, slips trips and fall, personal

safety incidents and near misses. Staff told us they would always inform the patient when things went wrong such as medication errors. The trust data did not show any incidents reported by the community learning disability service.

- The trust informed staff of lessons learned following incidents. Senior management sent out a lessons learnt bulletin from incidents. Staff then displayed these in the office areas. Managers shared information locally through multidisciplinary team (MDT) meetings and during staff supervision. We attended some MDT meetings and reviewed minutes from previous meetings. We looked at supervision records. We did not find any evidence of discussions of lessons learnt. Staff had told us that this was because there had not been any incidents reported in the past year. However, staff were able to tell us about incidents and lessons learnt. This included a patient who kept going missing. They were given a call assistance device, which allowed them to call for help if they became lost, or anxious. This supported the patient to retain their independence and remain living in the community.
- Staff were offered a debrief after incidents. Staff told us this could be done individually or in a group depending on the incident. Staff told us they offered patients debrief following incidents. None of the patients we spoke with had been involved in an incident.

Are services effective?

Requires improvement 

By effective, we mean that people's care, treatment and support achieves good outcomes, promotes a good quality of life and is based on the best available evidence.

Our findings

Assessment of needs and planning of care

- There was a consistent approach to assessing referrals for care. Each team had a member of staff allocated to triage referrals on a daily basis, who reviewed each referral and if the need was urgent they would arrange for an assessment within 48 hours. If the need was routine it would be discussed in the weekly multidisciplinary team meetings and allocated to an appropriate member of staff for assessment. Staff told us this would take place within four weeks, although they did not collate evidence that they had met this target.
- Staff assessed patients' needs using the trust assessment documentation. However the assessment did not cover all relevant information needed. For example, the form referred to capacity in places, but there was nowhere for staff to document if they had assessed the patients capacity. Staff could not document risks identified on the form, as there was not a section on the form for risks. Out of the 24 records checked, four did not have an initial assessment following referral.
- Patients who were receiving support from nursing staff did not all have nursing care plans in place. However, other health professionals wrote individual care plans for the patients they supported. We checked 24 care records both on paper and on the electronic system for patients receiving nursing care for physical health. We found that 10 of these patients did not have nursing care plans. We found one care plan dated 2013. This was of poor quality and only covered monitoring of physical health and annual reviews of needs.
- Completed care plans across the disciplines showed that patient involvement had not always taken place. Patients had not signed care plans to demonstrate consent and involvement. Nursing staff told us they kept their own individual records of care plans and progress notes on personal work drives on their computer. However, when we checked these we could not find any care plans. Staff could not account for this. We did find some personalised, holistic, and recovery orientated care plans completed by other staff disciplines, such as speech and language therapy and psychology. This meant that we could not be sure all information regarding a patient's care was available should the patient present in crisis as staff were not documenting patient care needs in care plans. Staff were not completing crisis plans with patients.
- We found records that patients had been included in consultations with medical staff and psychologists. However, information from the consultations was not used to develop multi-disciplinary care plans. Instead, the medical staff and psychologists would send patients a summary of the meeting which was used as a care plan. This was in letter format and not easy read which some patients might find difficult to understand. Staff recorded information about the patient's needs and the care provided in progress notes. It was not clear who was co-ordinating individual patient care or who was responsible for reviewing the patient's care. The paper records contained assessments and reports going back many years. There were sections in some patients' records where initial assessments and risk assessments were blank, which meant we could not be sure they had taken place.
- Staff did not keep patient information in an accessible format. Each profession within the team were keeping their own records of patient care interventions. They stored this on personal computer drives in their own individual folders. This information was not always available to other staff. Staff did not transfer this information into the patients care records; therefore this information was not freely available to all staff should they need it if a patient presented in crisis. The trusts care records management policy states that 'staff are responsible for the creation, maintenance and management of records' and that 'information in different formats should be recorded in paper records'. This meant that staff were not managing care records in line with trust policy. One staff member told us "record keeping here is a disaster". When we asked managers about record keeping they acknowledged there were problems with the current system but the trust was introducing a new electronic system. They said that this should improve record keeping. However, this was not being introduced until later this year.

Best practice in treatment and care

- Staff told us they were using guidance from the National Institute of Clinical Health Excellence (NICE) and the Department of Health. For example, patients were able to access a range of services in the community team

Are services effective?

Requires improvement 

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including speech and language therapists, physiotherapists, occupational therapists, and psychology. This included having access to a behavioural psychologist who does functional assessments. These assessments assess behaviour that challenges, including functional analyses and other methods of assessing behavioural functions. Staff told us that other treatments and therapies they provided included positive behaviour support plans and narrative therapy. Narrative therapy is a method of therapy that separates the person from the problem and encourages patients to rely on their own skill sets to minimise the problems that exist in their everyday lives. However, we did not find evidence in the care records that staff had developed and used positive behaviour support plans for patients.

- Staff did not always document patients physical health needs. Staff told us the GP's did a lot of the physical health monitoring. However, there was not always evidence that the GP had shared this information with the team and staff did not chase up information even when physical health issues had been identified. Staff in Coventry told us they used to offer a health facilitation service but the GP services now do this. The GPs then provide the information to the consultant. We could not find evidence that staff had recorded this information in the care records. Staff told us they had access to physical health monitoring equipment and could monitor patient's health if they needed too, but were unable to show us evidence that this took place.
- Staff were not using outcome scales to monitor patient's progress adequately. We found staff had been completing Health of the Nation Outcome Scales (HoNOS) for learning disabilities following initial assessments. Staff were unable to demonstrate that they had reviewed these or that they had used the information to monitor progress. The Royal College of Psychiatrists developed HoNOS as a means of assessing the progress of patients with learning disabilities who have a mental health condition.

Skilled staff to deliver care

- The service consisted of a full range of disciplines required to care for patients. This included input from nurses, occupational therapists, physiotherapists, social workers, psychologists and a psychiatrist. Staff had a wide range of experience and the psychologists were trained in different therapies.

- Staff were not supervised in line with trust policy. We looked at 12 supervision records and found that staff were not being supervised on a two monthly basis. Some staff had not received supervision for five months. During supervision staff discussed their caseload and any issues they were having. When supervisions did occur we saw that supervisors were not responding to issues raised. Some staff had referred to suffering from work related stress but there was no discussion about referring to occupational health, or support to reduce stress.
- Staff were not always receiving annual appraisals in line with trust policy. The average rate for the community services was 85%. This was below the trust target of 95%. The south Warwickshire team appraisal rate was 65% whereas the Solihull team had a rate of 100%. This meant that we could not be sure that managers were monitoring staff performance and competency adequately.
- Staff could carry out specialist training for their roles. We spoke with a range of staff who told us they had completed specialist training such as narrative therapy training and autism training. We spoke with one member of staff who had a specialist interest in epilepsy and provided the team with advice and information. They said the trust supported them to develop guidelines the team used for supporting patients with epilepsy. The community teams had protected learning time monthly. Staff chose the topics they discussed such as how to support patients with attention deficit hyperactivity disorder, the mental capacity act and deprivation of liberty authorisation process. They had arranged for a specialist in continuing healthcare funding to explain the process for applying for funding.

Multi-disciplinary and inter-agency team work

- The learning disability liaison team was part of the community learning disability team. They supported patients with a learning disability who were receiving treatment at the acute trust. They had an honorary contract with the acute hospital. The liaison nurse's role was to ensure the patient's needs were fully understood by hospital staff, and to support the patient when they returned home and liaise with the patient's GP and community services.
- The trust was developing a maternity pathway to support women with a learning disability through their

Are services effective?

Requires improvement 

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pregnancy and delivery. The liaison nurse provided community teams with information about patients who were in hospital and about their needs when they were discharged.

- Staff discussed recent assessments in the weekly multi-disciplinary team meetings. Staff discussed the needs of the patient and which of the staff disciplines would best meet the patient's needs.
- Staff worked closely with community providers to support patients in residential accommodation. Staff spoke of good working relationships with the local authority and the care commissioning groups when trying to arrange packages of care. This helped to speed up the process which meant that patients received the care and support they needed in a timely manner.
- Community acute liaison nursing staff worked with providers to ensure patients had hospital passports. These are documents which described, in words and pictures, what was important to the patient to help hospital staff understand how to care for them. This worked particularly well if the patient had difficulty with verbal communication. The community nursing team provided end of life care alongside district nurses and GPs to help meet the patient's needs, and supporting patients to remain at home for as long as possible, in line with their wishes.

Adherence to the Mental Health Act and the Mental Health Act Code of Practice

- Not all staff had been trained in the Mental Health Act, 1983 (MHA). 68% of staff had done the trust's mandatory MHA training, against the trusts target of 95%. Staff told us that they rarely supported someone on a Community Treatment Order. A Community Treatment Order (CTO) is a legal order made by the Mental Health Review Tribunal or by a Magistrate. It sets out the terms under which a person must accept medication and therapy, counselling, management, rehabilitation and other services while living in the community. The service was not supporting any patients subject to the MHA within the service when we inspected.
- Staff told us they had access to Independent Mental Health advocates if they had patients subject to the MHA. The trust used a local advocacy services that provided this service.

Good practice in applying the Mental Capacity Act

- Staff told us that as part of their protected learning time in team meetings they had received a talk on the Mental Capacity Act (MCA), 68% of community staff had received the trust's mandatory training on the Mental Capacity Act (2005). This was below the trust target of 95%.
- Some staff had poor knowledge and understanding of the Mental Capacity Act (2005). They had some knowledge about the MCA, but when asked, several were unable to show us examples of correctly completed capacity assessments. Staff did not understand the relevant consent requirements of the legislation. Only six of 24 records checked had evidence of consent to treatment documented.
- We found an example of a Deprivation of Liberty Safeguards (DoLS) assessment which staff had completed which stated staff could lock away a patient's medicines and knives as they had a history of self-harm and overdose. Staff documented that the patient agreed to this intervention. However, this was an inappropriate use of Deprivation of Liberty Safeguards assessment and staff should have covered this by doing a mental capacity assessment. This demonstrated a lack of understanding of how to implement MCA and DoLS.
- Staff had poor knowledge of best interest decision-making requirements of MCA. One patient's records contained a reference that they required an assessment by an occupational therapist. The records stated the patient did not have capacity to consent to the assessment and staff at the service could provide verbal consent in the person's best interests. There was no documentation of multi-disciplinary team best interest meetings, which involved relatives and patients in planning care interventions.
- We saw another example of a consent form, which a care home manager had signed on behalf of the patient. Staff had not completed capacity assessments and there had been no best interest decision meeting.
- Inspectors were shown a capacity assessment and the best interest meeting minutes for one patient. These had been completed with the inclusion of relatives and an advocate and were signed by all attendees. However, we did not see this in other patient records viewed.

Are services caring?

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

Our findings

Kindness, dignity, respect and support

- Staff treated patients with kindness, dignity, and respect. We visited three patients with staff and attended two clinic appointments. Before one visit staff explained that the parent likes people to take their shoes off in the house. This demonstrated the staff's understanding and respect for patients and carers wishes. When interacting with patient's staff spoke without using jargon and in a way that was appropriate to the individual patient. Staff allowed patients time to respond to questions and did not try to hurry them. We spoke with five patients who all told us that the staff were very kind and looked after them well.
- Staff maintained confidential records of patients care which were kept securely at the team office in locked filing cabinets within a locked room. Staff also used the trust's electronic records system.

The involvement of people in the care that they receive

- Patients were not always involved in the planning of their care. We spoke with five patients and only one had been involved in the development of a care plan. None

of the patients we spoke with had been asked to sign a copy of their care plan or been given a copy. All of the patients said they attended regular reviews with the doctors but did not know if they had care reviews. . We could not find evidence in the care records that staff discussed with patients how they prefer to be cared for when they present in crisis or that they were involved in planning their care.

- We spoke with six relatives or carers. They told us that they felt supported by staff. They told us that staff discussed the patients' needs with them regularly. None of the relatives or carers we spoke with had been involved in care planning. However, they did feel that they were involved in review meetings and were involved in decisions regarding patients care.
- Patients told us they were able to give verbal feedback about the support they received. However, they could not remember if they had received feedback from the service following this.
- Patients told us they could discuss things with their care coordinator. The trust did not offer any patient or carer forums where they could give feedback about services.
- Patients had access to advocacy and translations services if required. The trust used a local advocacy service and staff had information leaflets available in easy read formats to give to patients.

Are services responsive to people's needs?

Good 

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

Our findings

Access and discharge

- The service had a 28-day target for initial assessment. However, managers did not monitor if they had achieved this target. The service had a central booking service for receiving new referrals. Referrals were sent to the appropriate team for triage, and staff allocated to triage would review and prioritise the referral for assessment in the next available time. Routine referrals were discussed at the next multidisciplinary team (MDT) meeting. During these meetings staff would read through the referral and decide which team member would be best to assess the patient, depending on the needs highlighted in the referral. The trusts crisis team would assess anyone in crisis outside of office hours. From 24 records reviewed, staff were assessing patients within two weeks of the initial referral.
- The service had a 28-day target from assessing patients to treatment start dates. Most staff disciplines were meeting this target; however, the psychology service in some areas had a short waiting list. Staff we spoke with said that the team discuss any waiting lists in MDT meetings and if needs changed they prioritised for allocation. We observed staff discussing waiting lists for psychology in team meetings. Care coordinators would highlight if patients needed to be seen sooner due to increasing risks.
- Most patients we spoke with told us that staff responded to them quickly if they phoned for additional support. They told us that if staff were unavailable they would call back within a reasonable time. We spoke with carers and other services and they all stated that staff responded well when they contact the service.
- Patients told us that staff were very flexible in times of appointments. They always gave patients choice over when and where they were seen. If either staff or patients cancelled appointments staff rearranged these quickly and in a timely manner. Patients told us that if staff were running late they contacted to let them know when they are likely to arrive.

The facilities promote recovery, comfort, dignity and confidentiality

- Some team bases did not have access to adequate rooms and equipment. Staff would have to book rooms at other locations and staff told us that this was

sometimes difficult as other services also used the rooms. Clinic rooms were available at these locations should staff need them that had all necessary equipment for physical health examinations.

- Patients had access to a range of information on treatments, local services, patients' rights and how to complain. This information was available in a variety of formats including easy read formats. Staff showed us some information leaflets they had made in easy read format to tell patients about the community service. We also saw information staff gave patients on advocacy and how to complain.
- In Rugby the disabled access was via a lift which came out in the office area. This could potentially cause an issue with confidentiality as personal information such as who staff were visiting was display on staff communication boards. Staff told us that as patients have to use the intercom to gain access to the building, staff were aware of who is coming up and would take steps to prevent any data protection issues. For example, turning off computer screens.

Meeting the needs of all people who use the service

- The two teams that had rooms for seeing patients had disabled access. In Rugby the interview rooms were all upstairs and there was lift access. However staff told us that they mostly used rooms in another building on site to see patients. This building had ramps and disabled friendly access. We did not see the inside of this building. Staff from the teams that did not have access to rooms on site, told us that they can book rooms that have disabled access.
- Staff had access to interpreter services. Translators could support staff with contact at patients' homes and support patients in care reviews and doctor's appointments. This included access to signers to support patients who used sign language. Staff we spoke with knew how to access this service should they need too. Staff also told us they could get information in different languages but we did not see any examples of this. Staff told us they would have to request this when needed and it would be sent to them.
- The trust had an acute liaison service that worked within the local hospitals. They would assess patients who were admitted either via A&E in crisis or into the

Are services responsive to people's needs?

Good 

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

wards due to a deterioration in their physical health. They would support the hospital staff in managing their care and signposting to appropriate support networks upon discharge.

- Staff said when they visited patients at home they identified when care packages did not meet the patient's needs. Staff would raise their concerns with social services or the local clinical commissioning group.

Listening to and learning from concerns and complaints

- The service had received one complaint in the past year. This was with regards to sharing of information with another service. This complaint was investigated and was partially upheld. The trust dealt with complaints via their patient advice and liaison service. This service offered confidential advice, support, and information on health related matters. They provided a point of contact for patients, their families, and their carers.
- Three patients we spoke with said they did not know how to complain. However they said if they were not happy with anything then they would feel comfortable speaking to staff to raise any concerns. If they could not speak to their care coordinator they said they would phone the office to speak with another member of staff. One patient told us he did not have contact details of the team so would not be able to call them.
- Staff knew how to manage complaints in line with trust policy. Staff we spoke with told us how they would manage complaints and whom they would go to should a patient wish to make a complaint. Staff showed us a copy of the complaints form that they would complete. Staff had access to information regarding the patient advice and liaison service that they could give to patients.
- Staff received feedback from complaints. The trust sent out information on lessons learnt via email to all staff. Staff also discussed these in team meeting and how they would implement any recommended changes.

Are services well-led?

Requires improvement 

By well-led, we mean that the leadership, management and governance of the organisation assure the delivery of high-quality person-centred care, supports learning and innovation, and promotes an open and fair culture.

Our findings

Vision and values

- Staff were aware of the trust's visions and values. These were displayed around office areas on posters. Staff were able to refer to these when necessary.
- Staff knew who most of the senior managers were in the trust. Staff said that the senior managers occasionally visited the teams but not often.

Good governance

- The governance arrangements were unclear and ineffective. The services mandatory training, supervision, and appraisal rates were below the trust target of 95%. Managers we spoke with told us that they did not audit compliance with mandatory training but discussed this in staff's supervision and during annual appraisals. However, we saw that managers were not supervising or appraising staff in line with trust policy. This meant that the service was not monitoring mandatory training compliance regularly.
- Staff maximised shift time on direct patient care activities. Written progress notes were kept up to date. However, staff were not completing and updating risk assessments and care plans. Managers were not monitoring staff performance, as they were not completing clinical audits. Individual managers told us that they used performance indicators to monitor the effectiveness of the service. However, they could not demonstrate that the performance of the team was being monitored. Managers did not audit records and so could not tell if patients had received the capacity assessments. This also meant that they would be unable to identify individual learning needs of staff. For example, if staff had received mental capacity training and whether they embedded this knowledge in to practice.
- Managers told us they held quality and safety meetings to review the quality of services. During these meetings, the trust board discussed safety issues relating to reported incidents and complaints. We saw evidence of safety and quality committee meetings minutes. The trust fed back action plans to managers via the safety and quality operational group.

- Staff would receive information about investigation outcomes through team meetings and supervisions. Staff also received a trust wide lessons learnt update in the form of a newsletter.
- There was a management structure. Someone more senior from the same professional group managed each professional staff group. Staff told us communication between staff groups was good and there were regular heads of service meetings. However, it was not clear how staff made decisions if professional groups disagreed about an issue or who would take responsibility in a crisis.
- Staff told us that they would inform managers if they had any risk concerns that needed to be updated on the trusts internal risk register. Managers would then update the register accordingly. We asked staff about identifying and managing risk. We asked the trust about the process for managing risk and they told us any risks identified fed into the integrated community services (ICS) local risk register. Staff told us there were no local risks for integrated community services at the time of inspection.

Leadership, morale and staff engagement

- There was no manager overseeing individual community team, although the managers of each professional group within the teams did have administration support. Leadership was not evident at a senior level. Staff told us that communications within the service was good. They received regular bulletins via email, which contained information on new or updated policies and guidelines. Staff worked collaboratively and communicated well amongst the team. They had meetings each week and staff we spoke with said they felt very happy in their roles. They felt supported within their own management structure. Teams had arranged 'away days' for team development which staff felt helped morale and team building.
- At the time of inspection the trust did not provide information on staff surveys. However, staff we spoke with told us that morale was good amongst the team.
- Staff sickness rates were below the trust target at between 1% and 2% and the national average of 4%.
- The service had no ongoing bullying and harassment cases. Staff told us that they knew how to raise a whistleblowing concern. However, other staff told us

Are services well-led?

Requires improvement 

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that they would be fearful of making official complaints, feeling that they may experience repercussions.

Although at the time of inspection staff did not report any serious concerns about the service.

- Staff told us about the big conversation where staff were able to raise issues with senior managers. They welcomed this development as a helpful means of staff engagement.
- Staff were given opportunities to expand their knowledge and develop their roles. For example community managers could access a week's leadership and management course. Unqualified staff were supported to undertake national vocational qualifications, which could lead to a secondment to complete a foundation degree, followed by undertaking a nursing degree.
- The incident reporting system was effective.
- Staff were able to feedback into service development. For example, one member of staff who had an active interest in supporting patients with epilepsy had been involved in developing guideline for supporting this patient group.
- The chief executive had visited community services on a number of occasions to discuss the 'Transforming Care' programme. Staff felt senior managers were taking an interest in the programme and listened to the concerns they had.

Commitment to quality improvement and innovation

- The service was involved in the transforming care project. This is a programme set up by NHS England. It aims to improve services for patients with learning disabilities and/or autism, who display challenging behaviour. This includes those with a mental health condition. This aimed to drive system-wide change and enable more patients to live in the community, with the right support, and close to home. We asked to see the trust's strategy and project plans for the transforming care project. We saw this contained a number of work streams supporting the transformation programme. Staff were encouraged to be involved in these work streams and in the decision making process.
- The trust's quality strategy highlighted issues relating to the use of different systems across the trust preventing information being shared, and had plans to implement a new single patient database. Staff told us that they had attended demonstrations of the new system and clinical staff had been asked to contribute to the process of choosing the system they felt met the service's needs. The new system would allow staff to share information and keep multi-disciplinary care plans. However, staff told us the trust had delayed the introduction of this until 2017.

This section is primarily information for the provider

Requirement notices

Action we have told the provider to take

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

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Diagnostic and screening procedures Treatment of disease, disorder or injury	<p>Regulation 11 HSCA (RA) Regulations 2014 Need for consent</p> <p>How the regulation was not being met:</p> <ul style="list-style-type: none">Staff within the community team did not have a thorough understanding of capacity and consent. Training across the community teams was poor, only 68% of staff within the teams had received appropriate training in the Mental Health Act and Mental Capacity Act. Staff working with patients who may be lacking in mental capacity were not familiar with the principles associated with the Mental Capacity Act 2005. Care plans were not shared with or signed by patients using the service to indicate consent. <p>This was a breach of Regulation 11 (1) (2) (a)</p>
Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Diagnostic and screening procedures Treatment of disease, disorder or injury	<p>Regulation 17 HSCA (RA) Regulations 2014 Good governance</p> <p>How this regulation was not being met:</p> <ul style="list-style-type: none">Community teams did not have effective governance systems in place to assess, monitor, and improve service performance. Managers did not undertake clinical audits that would have identified service short falls. Such as care plans and risk assessment's being incomplete.Initial assessments following referral, care plans and risk assessments were not always completed or updated according to changing needs and risks.Crisis

This section is primarily information for the provider

Requirement notices

plans were not completed and some information held by individual care coordinators was stored in electronic word format that other staff would be unable to access if the care coordinator was not available.

This was a breach in regulation 17(1)(2)(a)(c)

Regulated activity

Assessment or medical treatment for persons detained under the Mental Health Act 1983

Diagnostic and screening procedures

Treatment of disease, disorder or injury

Regulation

Regulation 18 HSCA (RA) Regulations 2014 Staffing

How this regulation was not being met:

- Staff did not receive regular supervision and appraisal to monitor their performance. Mandatory training compliance was low, 82% of staff were up to date with mandatory training, when the trust target was 95%. Only 73% of staff were up to date with safeguarding vulnerable adults and children level 2 training, and only 68% of staff were trained in the mental health act / Mental Capacity Act and Deprivation of Liberty Safeguards.

This was a breach in regulation 18 (2) (a)