

# Coventry and Warwickshire Partnership NHS Trust

# Community-based mental health services for adults of working age

## Quality Report

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Date of inspection visit: 26-30 June 2017  
Date of publication: 08/11/2017

## 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	Coventry community mental health and wellbeing team (3-8 non-psychotic disorders)	CV4 9PN
RYGCR	Wayside House	North Warwickshire community mental and wellbeing team (3-8 non-psychotic disorders)	CV21 2AW
RYGCR	Wayside House	South Warwickshire community mental health and wellbeing team (3-8 non-psychotic disorders)	CV37 6NQ
RYGCR	Wayside House	North Warwickshire early intervention team (10)	CV11 5HX

# Summary of findings

RYGCR	Wayside House	South Warwickshire early intervention team (10)	CV34 4GP
RYGCR	Wayside House	Coventry recovery team (11-17)	CV1 4FH
RYGCR	Wayside House	North Warwickshire recovery team (11-17)	CV11 5HX
RYGCR	Wayside House	South Warwickshire recovery team (11-17)	CV37 6NQ

This report describes our judgement of the quality of care provided within this core service by Coventry and Warwickshire NHS Partnership 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 NHS Partnership Trust and these are brought together to inform our overall judgement of Coventry and Warwickshire NHS Partnership 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

Good 

Are services safe?

Good 

Are services effective?

Good 

Are services caring?

Good 

Are services responsive?

Good 

Are services well-led?

Good 

### **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 the community-based mental health services for adults of working age as good because:**

- During the most recent inspection, we found that the service had addressed the issues that led us to rate community-based mental health services for adults of working age as requires improvement following the April 2016 inspection.
- At our last inspection, we had found that clinical areas did not contain emergency equipment. The trust confirmed that its emergency response for community mental health teams was limited to the administration of basic life support, the use of automated external defibrillators, and a call to emergency services. Each community mental health team base had adrenaline pens, automated emergency defibrillators and additional safety equipment such as spill kits and resuscitation masks to support the administration of basic life support.
- At our last inspection, we were unable to locate legal documents associated with Ministry of Justice orders and community treatment orders. We also found that staff had not incorporated the conditions into risk assessments and care plans. At this inspection, we found that staff stored scanned copies of legal documentation in patients' electronic records, and that they incorporated the conditions into risk assessments and care plans.
- Since our last inspection, we found that staff received and were up-to-date with mandatory training that included safeguarding, infection prevention, personal safety, and basic life support. Care plans were holistic, person-centred and recovery-oriented. Records showed that staff offered patients copies of their care plans. Staff in all teams considered patients' physical healthcare needs and offered them support.
- At this inspection, we found that teams had sufficient staffing levels to cover shifts, and good duty arrangements to respond promptly to patients when they contacted by telephone.
- Staff received regular supervision and had access to weekly team meetings, monthly business meetings, peer group meetings and reflective practice sessions.

- Staff had good, collaborative working relationships with their patients. They showed dignity and respect towards patients and their carers/relatives in their interactions with them.
- All community teams took active steps to prevent non-attendance at appointments and work with patients who found it difficult to engage with services.
- Staff showed compassion and respect, and demonstrated genuine commitment to working together and achieving excellence.
- Staff morale was high across all teams we inspected. Staff experienced a strong sense of job satisfaction and empowerment in their roles, and benefited from good team working and mutual support.
- Community teams participated in a range of quality improvement and research projects.

However:

- The wellbeing teams had waiting times of between four to 12 weeks for a team assessment and long waiting lists for allocation of a care coordinator. Most teams had waiting times of up to five months for psychology services.
- Coventry wellbeing team staff found it difficult to access their team's psychiatrists urgently, and at times had to request medical support from crisis services.
- Clinic room temperatures at the Nuneaton base used by the North Warwickshire teams exceeded the maximum level on 11 occasions in the month to 28 June 2017.
- Some teams did not have enough suitable, lockable bags for the safe and secure transport of medicines.
- Four medication charts at the Coventry wellbeing team did not have consent to treatment forms attached to them.
- Staff had not yet migrated all patients' records onto the trust's new electronic care records system. Not all information was stored consistently on the new system.
- Not all staff had received their annual appraisals.
- Staff in the Coventry wellbeing team found it difficult to find available interview rooms onsite or in other premises, which meant that occasionally, they changed face-to-face appointments to telephone calls.

# Summary of findings

- Staff did not always inform the trust's complaints departments of the complaints they had dealt with, for the trust's records.
- Few staff knew about the duty of candour and the trust's policy.
- Some teams did not have administrative support in their teams and the trust's administrative hub did not meet their teams' needs effectively.

# Summary of findings

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

### Are services safe?

#### We rated safe as good because:

- Most teams had access to well-equipped clinic and physical examination rooms onsite or in other venues throughout the region.
- Teams had sufficient staffing levels to cover shifts, and good duty arrangements to cover sickness, leave and vacancies.
- Staff received and were up-to-date with mandatory training that included safeguarding, infection prevention, personal safety, and basic life support.
- Staff completed detailed risk assessments for their patients using a recognised standard framework (Steve Morgan Working with Risk), and completed additional assessments for specific issues such as suicide and self-harm risks, if required.
- Staff completed medication charts fully and accurately, and recorded patients' allergies.
- Staff knew how to report safeguarding concerns and incidents. Staff received feedback and lessons learnt from the findings of investigations. Staff received debriefs and support following serious incidents.
- The trust developed a transition policy following learning from a serious incident in which a patient was left without services as one team transferred the patient to another team.
- Staff used personal alarms when seeing patients in interview rooms that did not have alarms fitted and fully adhered to the trust's lone working practices when seeing patients in their homes.

However:

- North Warwickshire wellbeing team, North Warwickshire recovery team and Coventry recovery team had high rates of staff turnover.
- The wellbeing teams had long waiting lists for allocation of a care coordinator.
- Coventry wellbeing team staff found it difficult to access their team's psychiatrists urgently, and at times had to request medical support from crisis services.
- Clinic room temperatures at the Nuneaton base used by the North Warwickshire teams exceeded the maximum level on 11 occasions in the month to 28 June 2017.
- Some teams did not have enough suitable bags for the safe and secure transport of medicines.
- Few staff knew about the duty of candour and the trust's policy.

Good



# Summary of findings

## Are services effective?

### We rated effective as good because:

- Staff completed comprehensive assessments of patients' needs that included mental health, physical health and social circumstances.
- Staff developed care plans that addressed the full range of patients' needs.
- Staff offered patients a wide range of treatments and interventions based on best practice recommended by the National Institute of Health and Care Excellence and other relevant professional bodies.
- Staff used a wide range of recovery-based outcome measures such as recovery star, health of the nation outcome scales and the questionnaire about the process of recovery to assess and monitor their patients' progress.
- All teams offered patients some support with their physical health, including access to physical wellbeing clinics and annual health checks. Patients prescribed antipsychotic drugs such as clozapine and lithium had access to clinics that monitored their physical health and any side effects of medication.
- Community mental health teams comprised the full range of mental health disciplines (psychiatrists, social workers, community psychiatric nurses, support workers, occupational therapists and psychologists) and worked to a multidisciplinary approach.
- Staff were suitably qualified and experienced for their roles, and had access to a wide range of specialist training and development opportunities to enhance their skills.
- Staff received regular supervision and had access to weekly team meetings, monthly business meetings, peer group meetings and reflective practice sessions.
- Teams had good working relationships and links with other teams within the trust and external agencies such as social services, primary care and the voluntary sector.

However:

- Staff had not yet migrated all patients' records onto the trust's new electronic care records system. Not all information was stored consistently on the new system.
- Not all staff had received their annual appraisals.
- Psychiatrists attached to the Coventry wellbeing team were not fully integrated into the team.
- Four medication charts at the Coventry wellbeing team did not have consent to treatment forms attached to them.

Good



# Summary of findings

## Are services caring?

### We rated caring as good because:

- Staff had good, collaborative working relationships with their patients.
- Staff showed dignity and respect towards patients and their carers/relatives in their interactions with them.
- Patients and their carers/relatives gave positive feedback about staff and community mental health services.
- Staff knew their patients well. They adopted a person-centred approach to patient care and ensured patients received support tailored to their individual needs.
- Staff involved patients in assessment and care planning, and encouraged patients to identify their goals and objectives.
- Staff encouraged patients' involvement in service evaluation and development and actively sought feedback through a range of methods.

Good



## Are services responsive to people's needs?

### We rated responsive as good because:

- Staff actively managed their waiting lists. They kept in touch with patients to update them and check on their wellbeing, and referred them to other services where appropriate.
- Teams had duty systems or other arrangements that helped them respond promptly to patients when they contacted by telephone.
- All community teams took active steps to prevent non-attendance at appointments and work with patients who found it difficult to engage with services.
- Staff rarely cancelled appointments, they offered patients a choice of appointment times and venues, and patients reported that appointments ran on time.
- Staff supported a diverse range of people from their local community and made appropriate adjustments to meet their specific needs.

Good



However:

- Staff in the Coventry wellbeing team found it difficult to find available interview rooms onsite or in other premises, which meant that occasionally, they changed face-to-face appointments to telephone calls.
- Staff did not always inform the trust's complaints departments of the complaints they had dealt with, for the trust's records.
- The wellbeing teams had waiting times of between four to 12 weeks and most teams had waiting times of up to five months for psychology services.

# Summary of findings

## Are services well-led?

### We rated well led as good because:

- Staff knew and lived the trust's values. Staff showed compassion and respect, and demonstrated genuine commitment to working together and achieving excellence.
- Community mental health teams had effective systems and processes to help ensure effective local governance.
- Staff knew who the most senior managers in the trust were and most community mental health teams had received visits from the chief executive.
- Community teams enjoyed the autonomy the trust gave them to develop their staff and services to respond to local needs and demands.
- Staff morale was high across all teams we inspected. Staff experienced a strong sense of job satisfaction and empowerment in their roles, and benefited from good team working and mutual support.
- Community teams used a range of performance indicators to assess their performance. Teams shared changes and improvements with other team in their integrated practice unit.
- Community teams showed a strong commitment to quality improvement and innovation. A number of teams participated in research or service developments.

However:

- Some teams did not have administrative support in their teams and the trust's administrative hub did not meet their teams' needs effectively.

Good



# Summary of findings

## Information about the service

Coventry and Warwickshire Partnership NHS Trust provides a range of community-based mental health services for adults of working age.

Community-based mental health teams are organised into three integrated practice units (IPU) that are based on a mental health care cluster model:

- IPU clusters 3-8 provide services to people suffering from severe and/or complex anxiety, as well as mood and personality disorders (non-psychotic conditions). These teams are known as wellbeing teams.
- IPU cluster 10 provide early intervention to people with symptoms of psychosis. These teams are known as early intervention teams.

- IPU clusters 11-17 provide services to people suffering from major affective and psychotic disorders. These teams are known as recovery teams.

Each IPU cluster team (wellbeing, early intervention and recovery) has a team covering and based in the following areas:

- Coventry
- North Warwickshire (Nuneaton and Rugby), and
- South Warwickshire (Leamington Spa, Warwick and Stratford).

## Our inspection team

The Coventry and Warwickshire Partnership NHS Trust comprehensive inspection was led by:

Head of Inspection: James Mullins, Head of Hospitals (Mental Health), CQC

Team Leader: Paul Bingham, Inspection Manager (Mental Health), CQC

The team that inspected the community-based mental health services for adults of working age comprised two CQC inspectors, a consultant psychiatrist, three mental health nurses and an expert by experience. An expert by experience is a person who has personal experience of using, or supporting someone using, mental health services.

## Why we carried out this inspection

We undertook this inspection to find out whether Coventry and Warwickshire Partnership NHS Trust had made improvements to its community-based mental health services for adults of working age since our last comprehensive inspection of the trust in April 2016.

When we last inspected, we rated community-based mental health services for adults of working age as requires improvement overall. We rated the core service as requires improvement for Safe, requires improvement for Effective, good for Caring, good for Responsive and good for Well Led.

Following the inspection in April 2016, we told the trust that it must:

- ensure emergency equipment is available on site.

- ensure that conditions for patients with community treatment orders or Ministry of Justice orders are recorded on care and risk plans.
- ensure that Ministry of Justice and Mental Health Act records and reports are accessible to all staff.

We also told the trust that it should:

- ensure that staff receive mandatory training.
- ensure that care plans are holistic and recovery-oriented and that copies are given to patients.
- ensure that all patients receive monitoring of their physical health.

We issued the trust with two requirement notices associated with the community-based mental health services for adults of working age. These related to:

# Summary of findings

• Regulation 12 HSCA (RA) Regulations 2014. Safe care and treatment

• Regulation 17 HSCA (RA) Regulations 2014 Good governance.

## How we carried out this inspection

To fully understand the experience of people 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 people's needs?
- Is it well led?

Before the inspection visit, we reviewed information that we held about these services and asked a range of other organisations for information.

During the inspection visit, the inspection team:

- visited eight community mental health teams and observed how staff were caring for patients
- spoke with 25 patients and four relatives of patients who were using the service

- spoke with the managers for each of the teams
- spoke with 44 other staff members including doctors, nurses, social workers, psychologists, support workers and occupational therapists
- attended and observed two multidisciplinary meetings, four home visits and three therapeutic activity sessions
- collected feedback from four patients using comment cards
- looked at care records of 41 patients
- looked at the prescription charts of patients in each team inspected
- carried out a specific check of the medication management in each team
- 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 25 patients, four relatives and carers, and we reviewed comments cards from four patients.

Patients spoke highly about the staff in all the teams we inspected. Patients said staff were friendly and respectful, kind and caring, and treated them with dignity and respect. Patients described staff as professional, non-judgemental and responsive. Patients said they received excellent care and appointments ran on time.

Patients said they felt understood by staff and trusted them. They spoke of good working relationships that helped their recovery. Patients felt involved in their care and received a lot of information about services and their conditions. Two patients from the North Warwickshire Recovery team said they had attended courses about their specific mental illnesses.

Patients said that staff supported them with a whole range of issues that affected their health and wellbeing, and their everyday lives, for example, physical health conditions, employment, housing and finances. One

patient mentioned the coordinated, multi-agency support she had received to help her deal with domestic violence, and another patient said a staff member had accompanied her to court.

The relatives and carers we spoke with praised staff and services. They described good working relationships, communication and information sharing between staff and families. They said staff were accessible and responsive to their families' needs. Relatives and carers said that staff involved them in assessment, care planning and decision-making. Carers said staff kept them updated on their relative's care and progress.

Patients who received support from the Coventry wellbeing team expressed concern about the delays and difficulties in obtaining appointments with psychiatrists. Four patients said they experienced long waits for appointments; two of these patients reported frequent cancellations of appointments; two patients said they had waited over a year for an appointment.

# Summary of findings

## Good practice

Community mental health teams adopted a psychosocial approach to assessment and treatment that recognised the range of factors that affected a patient's mental health. Staff offered patients a wide range of appropriate evidence-based therapies and interventions that helped patients recover and/or maintain independence. They used a range of assessment tools and outcome measures to support their interventions.

Community teams actively participated in innovative practice and research, for example, North Warwickshire early intervention team had researchers of cognitive remedial therapy based in their team. Stratford wellbeing team worked jointly with the local MIND and Improving Access to Psychological Therapies (known as IAPT) services to develop and offer group-based therapies. The team planned to publish a paper on this approach. Trust psychiatrists had contributed to the published paper and

research on the flexible assertive community treatment (FACT) model, which the community teams had adopted. The early intervention teams offered a 10-week 'psychoeducative' course to carers that covered a range of topics including wellbeing and resilience. Coventry wellbeing team supported led the Thinking Ahead scheme, which was a fast-track social work training programme.

Community teams had developed a 'recovery college' with MIND that offered a range of groups and interventions, for example, mindfulness, assertiveness, and anxiety management. The recovery college ran services on eight sites throughout the trust's region, and these were open to patients and members of the public. The model encouraged self-help, prevention and an alternative to a medical-based approach to mental health.

## Areas for improvement

### Action the provider SHOULD take to improve

- The trust should ensure that staff adopt a consistent approach to record-keeping on the on the trust's new electronic system.
- The trust should ensure adequate signage to support visitors to the Coventry wellbeing team.
- The trust should ensure that there are sufficient and appropriate facilities for staff to meet patients face-to-face.
- The trust should ensure that staff receive their annual appraisals.
- The trust should ensure safe and effective contingency plans are in place to respond to high clinic room temperatures that affect medicines.
- The trust should ensure safe and secure transport of medicines with sufficient equipment (bags and locks) that is fit for purpose.
- The trust should ensure effective and responsive medical support to the Coventry wellbeing team and its patients.
- The trust should ensure that staff inform the complaints departments of all the complaints received and resolved locally for the trust's records.
- The trust should ensure that all staff know about the duty of candour and the trust's policy.

# Coventry and Warwickshire Partnership NHS Trust

## Community-based mental health services for adults of working age

### Detailed findings

#### Locations inspected

Name of service (e.g. ward/unit/team)	Name of CQC registered location
Coventry community mental health and wellbeing team	Wayside House
North Warwickshire community mental health and wellbeing team	Wayside House
South Warwickshire community mental health and wellbeing team	Wayside House
North Warwickshire early intervention team	Wayside House
South Warwickshire early intervention team	Wayside House
Coventry recovery team	Wayside House
North Warwickshire recovery team	Wayside House
South Warwickshire recovery team	Wayside House

#### Mental Health Act responsibilities

We do not rate responsibilities under the Mental Health Act 1983. We use our findings to help us reach an overall judgement about the provider.

The core service had patients subject to community treatment orders and Ministry of Justice restriction orders. At the last inspection, we were unable to locate the legal documents that showed the conditions attached to the orders. We also found that staff had not incorporated the

# Detailed findings

conditions into risk assessments and care plans. At this inspection, we checked the records of nine patients. We found scanned copies of the original documentation in the patient's electronic care records. The system clearly identified patients subject to restrictions, the conditions attached to the orders were set out clearly in the records, and incorporated into risk assessments and care plans.

Staff received Mental Health Act training, however, the trust did not monitor compliance centrally. Staff who needed to refresh their training found it difficult to access places on

the trust's MHA training course. Staff showed good knowledge of the Mental Health Act especially about community treatment orders. Staff informed patients subject to community treatment orders of their rights at the start of their order and at review points.

We found appropriate consent to treatment certificates attached to patients' medication charts in most cases. However, at the Coventry wellbeing team, we found four current medication charts that did not have the appropriate forms attached.

## Mental Capacity Act and Deprivation of Liberty Safeguards

As of 31 January 2017, 96% of staff in the core service had received training in the Mental Capacity Act. Staff had a good understanding of the Mental Capacity Act and the principles that underpinned it.

Staff assumed their patients had capacity and considered capacity to consent on a decision-specific basis. In cases of

uncertainty, staff sought advice and used the best interests framework, if necessary. Staff referred patients with capacity issues to independent mental capacity advocacy services.

Staff knew where to get advice on capacity-related issues. Most staff asked social workers for advice in the first instance. Staff had access to the trust's Mental Capacity Act lead who offered advice and monitored adherence to the Act.

# 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

- All community mental health team staff met patients on the trust's premises as well as in patients' homes. The interview rooms at the teams' bases did not have alarms fitted. However, staff signed out personal alarms when they used an interview room to meet a patient. This helped ensure their safety and call for help, if needed. In locations where there were ligature risks such as in the public areas of Coventry wellbeing team's base at Tile Hill Health Centre, the team had completed a ligature risk assessment, identified the areas of risk, and developed risk management plans. These included specific training for staff, easy access to ligature cutters, patients not left alone in interview rooms, and close observations of areas where risks were high, for example, toilets in the reception area and stairwells.
- There were well-equipped clinic and physical examination rooms in premises where staff saw patients. Physical examination rooms contained examination couches and a range of equipment such as electrocardiogram (known as ECG) machines, blood pressure machines and weighing scales that staff checked regularly to ensure they were in working order. The clinic rooms held adrenalin pens although staff did not always know exactly where they were stored. At our last inspection, we had found that clinical areas did not contain emergency equipment. The trust confirmed that its emergency response for community mental health teams was limited to the administration of basic life support, the use of automated external defibrillators, and a call to emergency services. The trust had ordered automated emergency defibrillators and additional safety equipment such as spill kits and resuscitation masks for each community mental health team base. All teams received these in the week following our onsite inspection.
- All the premises we visited had visibly clean and well-maintained patient and staff areas. Up-to-date cleaning charts showed that clinic rooms were cleaned regularly. We saw evidence of good infection control practice in clinic rooms such as handwashing gels, locked sharps bins and clean equipment. In some staff offices, teams

had hot desk working arrangements. In these offices, we saw cleaning wipes for use on desks, phones and keyboards to help maintain hygiene and infection control. However, staff told us that the busy nature of their work meant they often neglected regular cleaning of their desks and phones.

### Safe staffing

- Community-based mental health teams in Coventry and Warwickshire were known as integrated practice units. A partnership agreement between the trust and local authority under section 75 of the NHS Act 2006 meant that health and social care staff worked together in integrated, multidisciplinary teams. Some of the larger teams we inspected had two managers that reflected the main professional disciplines in the teams. For example, teams with two managers typically had a manager from a health background (nursing, occupational therapy) and one from a social work background. Each team had staffing levels estimated by the trust when it set up the integrated practice units three years earlier. Team managers had since modified their team structures and compositions to address the needs presented by their respective patient groups.
- The trust had three types of integrated practice units (IPU) based on the mental health care cluster model. The wellbeing teams supported patients who fell into mental health clusters 3 to 8 (non-psychotic disorders). Coventry wellbeing team was a large team led by two managers. The team had the following approximate whole time equivalent (WTE) staffing levels:
  - 21 community psychiatric nurses
  - 7 social workers
  - 3 occupational therapists
  - 5 trust support workers
  - 1 social care support worker
  - 5 psychologists
  - 3 cognitive behavioural therapists
  - 2.5 consultant psychiatrists
  - two staff grade doctors.

At the time of our inspection, managers had appointed to all vacancies in the team although the staff had not yet commenced employment.

# Are services safe?

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

- North Warwickshire wellbeing team covered the Nuneaton and Rugby areas and was led by one team manager. The team had approximately 12 WTE community psychiatric nurses and five support workers as well as psychologists, psychiatrists, social workers and occupational therapists. At the time of our inspection, the team had two vacancies for nurses and one vacancy for a social worker.
- Stratford-upon-Avon wellbeing team was one of two locality teams that formed the South Warwickshire wellbeing team. The team was led by one manager and had the following approximate WTE staffing levels:
  - 5 community psychiatric nurses
  - 4 support workers
  - 1 occupational therapist
  - 1 psychiatrist
  - 1 psychologist (shared across the South Warwickshire region).

At the time of our inspection, the team had a vacancy for an occupational therapist.

- The early intervention teams were set up to support patients who fell into mental health care cluster 10, specifically for those who presented with a first episode of psychosis for patients aged 14 -65 years old. The North Warwickshire early intervention team was based in Nuneaton and covered the Nuneaton and Rugby areas. The team was led by one team manager and the team had the following approximate WTE staffing levels:
  - 6 community psychiatric nurses
  - 2 occupational therapists
  - 2 support workers
  - 1 social worker
  - 1 psychologist
  - 2 psychiatrists.

The team had no vacancies at the time of our inspection.

- South Warwickshire early intervention team was based in Warwick and was led by one team manager. The team had the following approximate WTE staffing levels:
  - 5 community psychiatric nurses
  - 1 trust support worker
  - 1 social care support worker
  - 0.5 occupational therapist
  - 1 social worker
  - 0.7 psychologist
  - 0.5 consultant psychiatrist (plus 0.5 junior doctor and 0.5 staff grade doctor).

- The recovery teams supported patients who fell into mental health care clusters 11 to 17 and suffered from major mental illnesses. Coventry recovery team was a large team led by two managers. The team had the following approximate WTE staffing levels:
  - 18-20 community psychiatric nurses
  - 11 social workers
  - 5 occupational therapists
  - 9 trust support workers
  - 1 social care support worker
  - 2 psychologists
  - 1 third sector navigator (one year pilot)
  - 1.5 consultant psychiatrists (plus one additional medical session and access to three junior doctors).

At the time of our inspection, the team had two vacancies for qualified nurses that the managers had appointed to, and two vacancies for social workers. Agency staff covered the vacancies.

- North Warwickshire recovery team covered the Nuneaton and Rugby area and was led by two managers. The team had the following approximate WTE staffing levels:
  - 11 community psychiatric nurses
  - 7 trust support workers
  - 7 social workers
  - 1 psychologist
  - 1 psychiatrist
  - 1 occupational therapist.
- Stratford-upon-Avon recovery team was one of three locality teams that formed South Warwickshire recovery team. The team was led by one manager and had the following approximate whole time (WTE) staffing levels:
  - 6 community psychiatric nurses
  - 4 support workers
  - 3 social workers
  - 1 occupational therapist
  - 1 psychologist (shared across the South Warwickshire region)
  - 1 consultant psychiatrist (plus support from three junior doctors).

At the time of our inspection, the team had no vacancies for nurses or support workers and one staff member had left in the last 12 months.

- The trust has set a target sickness rate of 4.65%. As of 31 January 2017, the average sickness rate across this core service was 5.26%. Sickness rates were relatively high in

## Are services safe?

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

the Coventry (11%) and North Warwickshire wellbeing teams (13%). As of 31 January 2017, the staff turnover rate for the core service was 11%. The highest turnover rate was for healthcare assistants (32%) and nurses (22%) in the North Warwickshire wellbeing team. North Warwickshire and Coventry recovery teams had turnover rates of 21% for nurses. North Warwickshire recovery team had a turnover rate of 16% for healthcare assistants.

- The teams relied on bank and agency staff to ensure there was enough staffing cover for shifts. Wherever possible, team managers booked temporary staff for long periods to help ensure continuity of care for patients. Between 1 February 2016 and 31 January 2017, there were a total of 2090 staff shifts across the community teams. Of these, 255 shifts were filled by bank staff, 1282 shifts were filled by agency staff, and 114 shifts were left unfilled. Coventry wellbeing team, Coventry recovery team and South Warwickshire wellbeing teams used temporary staff most often to help ensure sufficient staffing levels.
- The community mental health teams had average caseloads of 21 patients per care coordinator. Staff with additional responsibilities such as approved mental health (AMHP) duties or supervisory responsibilities had reduced caseloads. However, AMHPs were required to allocate a greater proportion of their time than estimated to the approved mental health rota, which reduced the capacity in their respective teams. Team managers and supervisors reviewed caseloads with staff formally at regular one-to-one sessions, and informally on a weekly basis when they allocated new cases. In all teams, staff raised any concerns they had about their workload and requested help if needed.
- Early intervention team staff had caseloads of around 22, which was above the recommended caseload of 15 for effective early intervention practice. As such, staff expressed concerns about their caseloads and the impact on effective early intervention. For example, even though both North Warwickshire and South Warwickshire early intervention teams had staff trained in family therapy, they did not offer it because of their caseloads. The occupational therapist in the North Warwickshire early intervention team had a caseload of 20 when the recommended level for effective early intervention practice was 15. The South Warwickshire early intervention team manager informed us that the team had a total caseload of 134 patients although it was commissioned for 75 patients.
- Waiting lists for access to a care coordinator varied between the teams. As of 11 July 2017, Coventry wellbeing team had 25 patients and North Warwickshire wellbeing team had waiting 50 patients on their respective waiting lists. The early intervention teams that we inspected did not have waiting lists. Coventry recovery team had three patients waiting for allocation of a care coordinator although the wait was about one to two weeks. All teams tried to proactively reduce their waiting lists and offer a service as soon as practicable. For example, Coventry wellbeing team reviewed unallocated cases, identified any common themes, and set up intervention groups, if appropriate.
- All community mental health teams had good arrangements to ensure cover for sickness, vacancies or leave to ensure patient safety. All teams except the small South Warwickshire early intervention team had a duty system of two shifts (morning and afternoon) throughout the day. In some larger or busier teams, the duty system comprised two staff. In South Warwickshire early intervention team, administrative staff answered telephone calls and redirected them to staff on site.
- All community mental health teams arrangements for rapid access to psychiatrists. All teams had permanent psychiatrists allocated to them who staff contacted in the first instance. In addition, the trust employed temporary medical staff on a long-term basis to cover vacancies and help ensure continuity of care for patients. There were good cross-cover arrangements between teams, integrated practice units and other teams within the trust, for example, crisis resolution and home treatment teams, which helped ensure safe and adequate medical cover out of hours and during absences. However, while all other teams we inspected reported good and timely access to psychiatrists, we found that staff and patients of the Coventry wellbeing team found it difficult to access a psychiatrist for urgent or routine appointments. For example, one staff member described a situation in which she had struggled to make contact with a psychiatrist for a patient open to the team and in need of medical input. In the end, the psychiatrist's medical secretary offered a routine appointment in an outpatient clinic in October

# Are services safe?

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

2017. Patients told us they experienced long waits for appointments and frequent cancellations. Two patients said they had waited over a year for a medical appointment.

- The trust provided mandatory training to staff that included training on safeguarding adults, safeguarding children, infection prevention, fire safety, equality and diversity, Mental Capacity Act, resuscitation, basic life support, information governance, health and safety, personal safety, and manual handling. The average training compliance rate for the core service was 89%. As of 31 January 2017, all teams had achieved average training compliance rates of between 81% and 93% although this was below the trust's target rate of 95%. For safeguarding level 2 training, the compliance rate for medical staff who supported the recovery teams was 69% and the training rates for healthcare assistants in North Warwickshire recovery team was 71%.

## Assessing and managing risk to patients and staff

- We reviewed the care records of 41 patients across this core service. Staff undertook initial risk assessments of every patient assessed by their teams. Staff then completed detailed risk assessments of patients allocated to their teams. The core service used the Steve Morgan Working with Risk (WWR) assessment framework. The assessment had four components that covered specific areas of risk: WWR1 covered current risk, WWR2 covered historical risks, WWR3 looked at managing risk, and WWR4 looked at patient safety planning. In addition, staff used specific approaches and tools, where appropriate. For example, all staff completed Skills-based Training on Risk Management (STORM) to help prevent suicide and reduce self-harm risks. Staff used STORM assessments and risk management plans for patients who expressed suicidal thoughts or self-harmed. Staff updated risk assessments following any incidents or changes, and routinely on a six-monthly basis. All teams adopted a traffic light system (red, amber, green) for profiling patients' risks. This helped teams understand their patient profile, share information and monitor high-risk patients.
- Staff discussed and drew up crisis plans with their patients, where needed. Staff used the WWR4 assessment and patient safety plan to capture crisis plans and patients' wishes for treatment in case of a crisis (known as advance decisions). Staff completed WWR4 patient safety plans for all patients of the early intervention and recovery teams. Staff in the wellbeing teams completed patient safety plans if patients' needs and risks indicated the need for them.
- All teams responded appropriately to sudden deterioration in their patients' mental health. All teams had a duty system or other arrangements to respond quickly to urgent need. All teams had systems and processes for closely monitoring patients with complex needs, unstable conditions and high risks, such as a traffic light systems or 'shared care' lists. Staff implemented patients' safety plans and used other services if needed to support their patients, for example, the crisis resolution and home treatment teams. Teams with waiting lists for allocation of a care coordinator contacted patients to check on their wellbeing and re-prioritise them, if needed. However, Coventry wellbeing team struggled to access their psychiatrists promptly, and often had to refer patients to other services for urgent medical support, for example, the crisis resolution and home treatment team and the accident and emergency liaison team.
- Staff received training in safeguarding. As of 31 January 2017, the core service had an average training rate of 96% for safeguarding adults and children levels 1 or 2, as appropriate, and all managers had completed safeguarding level 3 training. However, for safeguarding level 2 training, the compliance rate for medical staff who supported the recovery teams (11-17) was 69%. The training rate for healthcare assistants was 71% for North Warwickshire recovery team (11-17) and 50% for Coventry early intervention team.
- Staff in all teams had good knowledge of safeguarding and knew how to make safeguarding referrals. All staff took responsibility for safeguarding issues but senior social workers undertook statutory investigations. Some staff we spoke with gave examples of safeguarding concerns they had dealt with that included child protection, domestic violence, and fraud. Staff knew where to seek advice; each team had a safeguarding lead or champion, and the trust had a designated safeguarding lead.
- All the teams we inspected had good lone working practices, in line with the trust's policy. Some teams such as the Coventry wellbeing team had additional lone working protocols that reflected local conditions. Staff arranged joint home visits in cases of unknown or high risks. Staff recorded in 'red books' or on white

# Are services safe?

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boards where they were going and when they were due back. Administrative staff or team members checked the whereabouts of staff twice a day. All staff had to declare they were safe at the end of each day. Staff had code words they used on the phone if they felt unsafe. At the end of the day, if any of the staff who were out of the office had not called to say they were safe, administrative staff informed duty officers. There was further escalation to managers, if needed. Where staff worked out of hours, there were alternative contact arrangements.

- We inspected the medicines management practices on all the sites we visited. Staff practised safe storage of medicines in locked cupboards. Staff kept the keys to the medicines cupboards in a locked key safe that only qualified staff accessed. Staff checked and recorded fridge temperatures daily, and monitoring charts showed they were within safe ranges. However, clinic room temperature monitoring charts at Avenue House, Nuneaton (shared by the North Warwickshire teams) showed that the clinic room temperature exceeded 25 degrees on 11 occasions between 26 May and 28 June 2017. Staff took action to address this issue by opening windows and closing blinds.
- We reviewed 15 medication charts for patients of North Warwickshire recovery team and all the medication charts present in clinic rooms for patients of Coventry recovery team, North Warwickshire early intervention team and South Warwickshire early intervention team. Staff completed medication charts fully and accurately, and recorded patients' allergies.
- We reviewed the prescribing practice in the Coventry recovery team and found that it was safe. Doctors prescribed long-acting injections for a two or three week period to ensure medical reviews. Staff ordered the injections only when required. Handover of prescribing to GPs occurred with a transition period for some medications in line with good practice and agreed protocols.
- Staff often carried medicines to patients' homes or other venues for administration. Staff in all teams had access to bags and cases for carrying medicines. However, we found that in some teams, there were no locks on these bags to help ensure safe and secure transport of prescribed medicines. We informed the team managers who immediately purchased locks.

Some teams did not have enough bags to meet the team's needs so staff supplied their own bags. Some bags we saw were not suitable for the purposes of safe storage and transport of medicines.

## Track record on safety

- Between 1 February 2016 and 31 January 2017, the community mental health teams reported 23 serious incidents. Of these, 16 involved the unexpected death of a patient. The other seven incidents involved self-harm including attempted suicide. Eleven deaths were of patients known to the Coventry-based teams (wellbeing, early Intervention and recovery). Three deaths were of patients known to Stratford wellbeing team. North Warwickshire early Intervention and wellbeing teams each had a death of a patient known to them.
- The trust developed a transition policy following learning from a serious incident in which a patient was left without services as one team transferred the patient to another team. The trust's policy promoted a robust and safe handover between services.
- In the last 12 months, the trust identified issues associated with the management of physical health, care records, and risk assessments including the suicide prevention and self-harm mitigation (STORM) tool. This resulted in actions required from relevant services across the trust. The trust monitored the outcomes through a range of mechanisms, for example, themed review reports, performance data, audits and feedback from staff.

## Reporting incidents and learning from when things go wrong

- Staff knew how to report incidents using the trust's online system. Staff used a decision-making tree if they were unsure about what to report or the seriousness of the incident.
- Staff gave examples of incidents they had reported, for example, medication errors. Staff knew the process for managing incidents after they reported them, for example, for serious incidents, immediate management reviews took place within 48 hours. The psychiatrists we spoke knew the process well as they had undertaken immediate management reviews.
- Staff's values and behaviours indicated an open and transparent approach to patient care and service delivery. Staff understood the general concept of

## Are services safe?

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openness and transparency, and gave examples of occasions when they acknowledged mistakes and apologised to patients. However, most staff we spoke with did not know about the duty of candour or if the trust had a policy. The trust had a policy named 'Being Open', which incorporated the duty of candour but it was not clear how it communicated the policy to staff.

- Staff received feedback from investigation of incidents through email alerts, safety bulletins and newsletters (for example, medicines management), at one-to-one supervision sessions and team meetings. Staff discussed incidents at existing meetings such as one-to-one sessions, team meetings, business meetings, reflective practice sessions, and training sessions. If deemed appropriate, psychologists arranged adhoc sessions for staff to discuss specific incidents.

- All teams confirmed that that the trust shared lessons learnt and any changes with staff. The trust sent learning alerts internally and shared national publications and learning from other sources such as the national mental health network.
- Staff received debriefs and support after serious incidents. All the staff we spoke with who had experienced serious incidents said they had received debriefs and support from their managers and colleagues. Team managers discussed staff's support needs with them immediately after an incident. Psychologists arranged a debrief for the team or the integrated practice unit after a serious incident.

# Are services effective?

Good 

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

- We reviewed care records for 41 patients. Staff completed comprehensive assessments of patients in a timely manner. Most staff used the provider's standard 'trusted assessment' tool. The assessment included questions about mental health, physical health and social circumstances. The early intervention teams had their own detailed assessment tool that included trauma and physical health screening and assessment of social functioning. This was in line with the early intervention model of care.
- We reviewed care plans in each team we inspected. Staff completed care plans that were holistic and person-centred. Staff worked with patients to develop a recovery-oriented care plan that identified the patient's goals and objectives. Staff ensured that care plans included any conditions associated with Ministry of Justice restriction orders and community treatment orders.
- The trust had introduced a new electronic records system that enabled easy information sharing across the trust's services. All community mental health teams used the new secure electronic care records system although some psychiatrists in the Coventry and Stratford wellbeing teams used only paper files. At the time of our inspection, staff had transferred most patients' records from the old to the new system but not all. Staff did not always store information in the same places on the new system and acknowledged they needed to become more familiar with the system to ensure consistency. In the meantime, staff had access to both systems and knew where to find their patients' records.
- As well as the trust's records system, social workers had secure access to the local authority's systems for logging safeguarding issues, making requests for social care funding, and completing best interest assessments.
- Some teams held old paper files for reference, for example, tribunal reports, court reports. They stored this information securely in offices. However, at the Stratford wellbeing team, we found unlocked filing cabinets containing patients' files in a group therapy room used by staff and patients. We informed the team manager who ensured the records were moved to a secure location immediately.

### Best practice in treatment and care

- Staff followed the National Institute for Health and Care Excellence (NICE) guidance when prescribing medication. We reviewed prescribing practice in the Coventry Recovery team for clozapine and long-acting injections, and found it was in line with good practice guidance. Patients prescribed clozapine had access to a dedicated clozapine clinic that monitored their physical health. Staff used the Liverpool university neuroleptic side effect rating scale (LUNBERS) with patients to monitor any side effects of medication.
- The community mental health teams offered patients a wide range of therapies and interventions recommended by NICE and other relevant professional bodies associated with psychology, psychiatry, occupational therapy, nursing and social work. For example, the wellbeing teams offered individual or group interventions for conditions such as agoraphobia, obsessive-compulsive disorders, and anxiety and depression. North Warwickshire wellbeing team ran a managing emotions skills (MES) group that patients spoke highly of. Most teams offered dialectic behaviour therapy (DBT), cognitive behavioural therapy (CBT), and eye movement desensitization and reprocessing (EMDR) for trauma. The early intervention teams offered behavioural family therapy (BFT), when resources allowed and the recovery teams ran 'hearing voices' groups.
- Where appropriate, staff referred patients to other services for interventions, for example, counselling services (IAPT), the trust's dedicated therapy-based personality disorder service (Olive Tree), and the recovery and wellbeing college. The recovery college was a joint initiative between the community teams and MIND that offered patients and the public a range of interventions for non-psychotic conditions such as anxiety and depression. These included confidence and assertiveness courses and anxiety management. The model encouraged self-help, prevention and an alternative to a medical-based approach to mental health.
- All teams adopted a psychosocial approach that recognised the range of social, psychological and medical factors that affected a person's mental health.

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Staff helped patients with employment, housing and financial issues. Staff also offered a range of social activities and groups, for example, swimming, knitting and pool.

- Staff in all teams considered patients' physical healthcare needs. Community teams offered patients some physical healthcare support although the level of support varied between teams and patients. For example, Coventry wellbeing team held physical wellbeing clinics for some patient groups although care coordinators could refer other patients to them. Otherwise, staff referred patients to their GP for physical health matters and encouraged them to ask for annual health checks. Staff in the early intervention and recovery teams offered all patients annual physical health checks and supported them with any physical healthcare needs. The teams ran physical health clinics once or twice a week. The early intervention and recovery teams followed the NICE guidelines on monitoring physical health in patients with serious mental illness. Staff used early warning scores to recognise and respond to physical deterioration in patients. Patients prescribed medicines such as lithium, clozapine, or sodium valproate received appropriate monitoring at dedicated clinics.
- Community mental health teams used a wide range of approaches, interventions, tools and outcome measures appropriate to their service to assess and monitor their patients' needs and recovery. Recovery-based outcome measures included the health of the nation outcome scale (HoNOS), recovery star and the questionnaire about the process of recovery (QPR). Screening tools included the comprehensive assessment of at risk mental states (CAARMS), the positive and negative syndrome scale (PANSS), the Calgary depression scale for psychosis, the generalised anxiety disorder assessment (GAD 7), and the dissociative experiences scale (DES). Staff used recognised outcome measures associated with specific interventions such as cognitive behavioural approach and early intervention in psychosis. Staff encouraged self-reported outcomes from patients, where appropriate. For example, patients attending the managing emotions skills group completed self-reported outcomes (the difficulty in emotional regulation scale) at the start and end of therapy.
- Occupational therapists used a range of tools and outcome measures to support their work such as the

model of human occupation screening tool (MOHOST), the occupation self-assessment (OSA), the work environment impact scale (WEIS), the worker role interview (WRI, the social and occupational functioning assessment scale (SOFAS) and the occupational case analysis and interview rating scale (OCAIRS).

- Staff participated in a range of audits within their teams or for the trust. We found examples of audits the trust had completed that were relevant to community mental health teams. For example, in January 2017, the trust completed an audit on to check 'did not attend' (DNA) practices in the wellbeing teams. In the same month, the trust completed an audit on active case management in community settings. The audit looked at the quality of care plans and found gaps or inconsistencies in them. In March 2017, the trust completed an audit of the 'trusted assessment' tool and found inconsistencies in their completion across teams. Individual teams completed audits to assess the quality of their services. For example, the early intervention teams had completed an audit on prescribing and Coventry recovery team had completed an audit on physical health notes.

## Skilled staff to deliver care

- Community mental health teams included or had to access to a wide range of mental health disciplines including psychiatrists, social workers, community psychiatric nurses, support workers, occupational therapists and psychologists. However, the strong focus on appropriate therapies and interventions towards recovery across all teams (recovery, early intervention and wellbeing) created huge demands on psychology staff. Although there were psychologists in every team, the demand outweighed capacity in most teams.
- Staff received an appropriate induction when they started work for the trust. This included statutory, mandatory and role-specific training for their roles and in line with national standards. The trust ensured that new substantive staff received the training even if they had worked as agency or bank staff beforehand.
- Community mental health team staff were suitably qualified and experienced for their roles in their specific teams. Nursing and medical staff were up-to-date with their professional revalidation and registration requirements. Team managers recognised skills gaps in

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their teams and tried to address them. For example, in Coventry wellbeing team, the managers had revised their staff mix in favour of more experienced staff to meet the complex needs of their patient group.

- Staff received the necessary specialist training for their roles. As well as statutory, mandatory and role-specific training, staff had access to specialist training that enhanced their skills and their team's effectiveness. For example, most teams had trained some or all of their staff in cognitive behavioural approaches. A number of staff had trained as cognitive behavioural therapists. Some staff in the early intervention teams had trained as behavioural family therapists. Some teams had nurses trained as prescribers. Community team staff had access to training on breakaway techniques, suicide prevention and self-harm mitigation (STORM), and dual diagnosis. In addition to formal training, staff provided training within teams to upskill staff, for example, psychologists in the Stratford wellbeing team provided training on personality disorders, and a deputy manager in the Coventry wellbeing team provided training on ligature awareness. Team managers encouraged staff to develop their skills by pursuing their interests. For example, support workers in Coventry wellbeing team had developed an obsessive-compulsive disorder group, and had started planning an autism group. Support workers in Coventry recovery team suggested and developed a group for people who struggled to go outdoors.
- Experienced social workers had access to approved mental health practitioner (AMHP) training. Several social workers were also best interest assessors for the local authority. The trust had adopted the Thinking Ahead fast track social work programme to train new social workers, and had four trainee social workers attached to the Coventry wellbeing team.
- Our interviews with staff and review of records showed that all staff received regular supervision every four-to-six weeks. Staff discussed caseloads, training, sickness and leave at supervision sessions and had the opportunity to raise any issues and concerns. Staff also received informal supervision and attended weekly team meetings, monthly business meetings, peer group meetings and reflective practice sessions. The average staff supervision rates were:
  - Coventry wellbeing team, 77%
  - North Warwickshire wellbeing team, 97%
  - Stratford wellbeing team, 100%

- North Warwickshire early intervention team, 100%
- South Warwickshire early intervention team, 76%
- Coventry recovery team, 88%
- North Warwickshire recovery team, 95%
- Stratford recovery team, 100%.

Some teams ran group supervision sessions for staff trained in cognitive behavioural approaches (CBA) and cognitive behavioural therapy. Social workers, psychologists, occupational therapists and psychiatrists had access to individual and peer group supervision from professional leads for their respective disciplines.

- Not all staff had received their annual appraisals. Nearly all community teams had appraisal rates below the trust's target of 95%. Appraisal rates were lowest for Stratford recovery team at 69%, and North Warwickshire recovery team at 36%. Managers of the recovery teams had a low appraisal rate of 56%.
- The core service addressed poor staff performance promptly in line with the trust's policies. This involved monitoring staff performance through one-to-one supervision sessions and annual appraisals. Team managers consulted the trust's Human Resources teams for advice on how to handle serious performance or misconduct issues.

## Multi-disciplinary and inter-agency team work

- The trust's integrated practice approach had helped promote multidisciplinary team working. The multidisciplinary teams comprised psychiatrists, social workers, community psychiatric nurses, support workers, occupational therapists and psychologists. Staff spoke positively about the genuine multidisciplinary approach in their teams that actively encouraged views from different perspectives and disciplines. However, we found that psychiatrists were not fully integrated into the Coventry wellbeing team. Staff described the traditional way in which the psychiatrists worked, which was not in line with the trust's integrated practice approach. Staff struggled to access psychiatrists and appointments promptly for their patients. All teams held multidisciplinary team meetings weekly, and had a process for prioritising patients for discussion. Coventry wellbeing team alternated their weekly multidisciplinary team meetings with formulation meetings led by psychologists.
- All teams had effective methods for sharing information within their teams. For example, recovery teams held

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brief handover meetings every morning where staff shared information about patients at risk. Coventry recovery team had a 'shared care board' that held the names and details of patients with high risk or complex needs. This summarised the patients' needs and issues. All teams used a traffic light system that highlighted patients at risk and helped ensure staff monitored them closely.

- Community mental health teams worked closely with other teams within the trust to help ensure effective joint working or safe handover. Staff from some wellbeing and recovery teams attended weekly meetings with crisis teams to discuss referrals. The early intervention teams had joint working arrangements with child and adolescent mental health services (CAMHS) for patients aged 14 to 17. All teams maintained regular contact with their local inpatients wards; the early intervention teams continued psychological interventions with patients admitted to hospital, where appropriate. Teams from different integrated practice units discussed patients who did not meet their access criteria. For example, the early intervention teams received a number of inappropriate referrals since the trust adopted an ageless model of service provision. North Warwickshire early intervention team manager had successfully negotiated local arrangements with other cluster teams to accept patients who would not benefit from an early intervention programme.
- The trust had a transition policy that supported the safe transfer of patients between services and teams. This required the transferring team to provide a service to the patient for a period of time before transferring them to another team. This approach resulted from lessons learnt from a serious incident.
- All teams had good working links with primary care, in particular, GPs and mental health services such as IAPTs (Improving Access to Psychological Therapies). The teams had strong links to social services supported by a partnership agreement between the trust and local authority under section 75 of the NHS Act 2006. The teams worked closely with a number of agencies in the voluntary sector that supported them with advice, advocacy, welfare rights, housing, employment and voluntary work. Coventry wellbeing team described good working relationships with the mental health workers at the local universities. Coventry recovery team had a 'third sector navigator' worker in their team who built connections with the third sector.

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

- Some teams had patients subject to Ministry of Justice restriction orders or community treatment orders. For example, Coventry recovery team had 26 patients subject to community treatment orders and 15 patients subject to Ministry of Justice orders; North Warwickshire early intervention team and Coventry wellbeing team each had three patients subject to community treatment orders. At our last inspection, we were unable to locate the legal documents that showed the conditions attached to the orders. We also found that staff had not incorporated the conditions into risk assessments and care plans. At this inspection, we found that legal documentation was easily accessible. Staff had uploaded scanned copies of original orders onto the electronic care record system. Patients' records showed an alert if they were subject to a specific order. The conditions attached to the orders were set out clearly in the records, and incorporated into risk assessments and care plans.
- The trust had a central Mental Health Act administration office and Mental Health Act lead who ensured that staff completed Mental Health Act records accurately and promptly, and completed audits on Mental Health Act documentation. Staff knew who the Mental Health Act administrators were for the trust, and contacted them for advice on Mental Health Act issues, when needed. Staff also sought advice from the approved mental health practitioners in their team.
- At the time of our inspection, the trust was unable to provide up-to-date and accurate data on staff compliance with Mental Health Act (MHA) training. However, all the staff we spoke with said they had received Mental Health Act training or were booked onto it. Some staff had struggled to access places on refresher training. Staff showed good knowledge of the Mental Health Act especially about community treatment orders. Staff informed patients subject to community treatment orders of their rights at the start of their order and at review points.
- Staff adhered to the consent to treatment and capacity requirements for patients subject to community treatment orders. Patients received assessments of their capacity to consent to or refuse treatment. In most cases, the appropriate consent to treatment forms were attached to patients' medication charts. However, at

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Coventry wellbeing team, we looked at four medication charts, and found that none of them had consent to treatment forms attached or located nearby for ease of reference.

- Patients had access to independent mental health advocates, as appropriate. Approved mental health practitioners routinely referred patients subject to Mental Health Act orders to advocacy services.

## Good practice in applying the Mental Capacity Act

- As of 31 January 2017, 96% of staff in the core service had received training in the Mental Capacity Act. Staff had a good understanding of the Mental Capacity Act and the principles that underpinned it.
- The trust had a Mental Capacity Act policy that was available on the trust's intranet.
- Staff assumed their patients had capacity and considered capacity to consent on a decision-specific basis. Staff explained information in different ways to help patients understand before they questioned their capacity. Some staff we spoke with described situations

in which they had questioned a patient's capacity, for example, the ability to manage finances, making unsafe decisions. In such cases, staff sought advice and used the best interests framework, if necessary. Some teams had social workers who were best interest assessors. Staff referred patients with capacity issues to independent mental capacity advocacy services. Staff noted any concerns around a patient's capacity and the actions they took in the patient's care notes.

- Staff knew where to get advice on capacity-related issues. Most staff asked social workers for advice in the first instance. Staff had access to the trust's Mental Capacity Act lead who offered advice and monitored adherence to the Act.
- Community teams supported adults aged 17 or over. However, the early intervention teams accepted referrals for 14 to 17 year olds known to the child and adolescent mental health services (CAMHS). The teams worked jointly with CAMHS until the young person reached 17 and transferred fully to the early intervention team.

# 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

- We spoke with 25 patients and four relatives. We also attended and observed home visits, outpatient appointments, activity groups and a multidisciplinary meeting. We observed kind and caring interactions between staff and patients. Staff spoke about patients respectfully. We observed good rapport and collaborative working relationships. Staff showed respectful and non-judgemental behaviours towards patients. Staff showed strong commitments to patients and their recovery, and went out of their way to help patients access activities, for example, in South Warwickshire early intervention team, staff collected patients from home and took them to an allotment group. We saw excellent engagement between staff and patients.
- The patients we spoke highly of the staff teams and said the staff treated them well. They described staff as caring and compassionate and found them understanding and responsive to their needs. Patients from all the teams we inspected gave positive feedback about the staff. Patients of the North Warwickshire recovery team expressed a high level of trust in staff, and one patient said, “staff are brilliant.” A patient from the Coventry wellbeing team said staff, “go above and beyond,” and another patient said, “they go out of their way to help me.” The relatives we spoke with also spoke highly of staff. One relative described the staff team at North Warwickshire early intervention team as “beyond amazing.”
- Staff had a good understanding of their patients’ needs. Staff adopted a person-centred approach that helped ensure that patients received care tailored to their individual needs. Patients felt that staff carefully considered and planned appropriate interventions that helped them with their specific issues. For example, patients spoke highly of the managing emotions skills group run by the North Warwickshire wellbeing team, and one patient commented, “this group has saved my life.” Patients from the South Warwickshire recovery team said staff considered people’s different needs and preferences.

- Staff maintained confidentiality in their day-to-day work. Staff kept confidential information in secure staff-only offices. Staff visited patients at home or met them in interview rooms that could not be overheard.

### The involvement of people in the care that they receive

- Staff involved patients in assessment and care planning. Patients’ records showed that they had contributed to risk and care plans, in particular, the goals and outcomes they wished to achieve. We observed a home visit at which the staff member fully involved the patient in their assessment and discussion about next steps. Patients, and their relatives, where appropriate, attended care and treatment reviews. The patients we spoke with said staff involved them fully in their care with the aim of aiding their recovery and maintaining their independence. One patient talked about her experience of domestic violence and described how staff supported her to make positive changes to her life. Records showed that staff routinely offered patients copies of their care plans. However, most of the patients we spoke with said they did not have copies of their care plans.
- The carers we spoke with said they were happy with the service they received and felt actively involved in their relative’s care. They described good working relationships and communication with staff. Staff offered carers’ assessments to all carers, and referred them to the appropriate services. The teams we visited ran carers’ groups but with mixed success. The carers’ groups run by the early intervention teams had good attendance. The early intervention teams also offered carers a 10-week ‘psychoeducative’ course that covered a range of topics including wellbeing and resilience. Carers gave positive feedback about the course. However, the carers’ groups run by the recovery teams had poor attendance. As such, the recovery teams had started to consider other ways of engaging with carers.
- All the teams we inspected used advocacy services based in their local community. Staff also regularly used the local citizens’ advice bureaux and law centres to help patients with specific issues. We saw posters and leaflets about advocacy services displayed in reception areas of teams’ offices. Staff told patients about advocacy services during initial assessments and then again, when required, for example, when a specific issue arose. Staff gave examples of situations in which they

## Are services caring?

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had referred patients to advocacy services, for example, to obtain support and representation for patients with capacity issues around finances. Approved mental health practitioners routinely referred patients subject to community treatment orders to independent mental health advocacy service. However, many of the patients we spoke with said they did not know about advocacy services.

- Staff encouraged patients' involvement in service evaluation and development. Staff used a range of evaluation and self-reporting forms to gather

information from patients about specific therapies and interventions. Staff also invited patients to give general feedback about the service they received and give suggestions for improvements. The teams used a number of methods to encourage comments from patients and relatives such as anonymous comments cards that patients dropped in a comments box at the receptions of teams' offices, and a friends and family application. All the teams we inspected held patients' groups at which patients discussed a range of topics and had the opportunity to raise any issues.

# 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

- Community teams had a range of national and local targets associated assessment and treatment. The trust used the 18-week referral to treatment pathway to monitor the wellbeing, early intervention and recovery teams. Indicators included the waiting time to a first appointment with the team (assessment), and the waiting time for a follow-up appointment (treatment). The early intervention teams had an additional target associated with the early intervention model. This required that 50% of patients received treatment within two weeks of referral to the trust. This target presented a challenge to the early intervention teams because of issues associated with the trust's single point of entry system. They reported issues with delays in receiving referrals of up to five days, and time taken dealing with inappropriate referrals to their service. North Warwickshire early intervention team had placed workers in the single point of entry service that had helped improve screening and access times.
- Trust data for the year to 30 April 2017 showed that all teams (wellbeing, early intervention and recovery) offered assessment and treatment well within 18 weeks. However, the early intervention teams' compliance with the two-week referral to treatment target of 50% varied from 38% to 88%. The service exceeded the target of 50% for nine months but achieved 38% to 41% during the other three months.
- North Warwickshire wellbeing team had a waiting time of 12 weeks to access a team assessment or a medical assessment, and six weeks for allocation to a care coordinator. Stratford wellbeing team had a waiting time of four weeks for an urgent team assessment appointment, and 12 weeks for a non-urgent team assessment. The team had a 16-week waiting time for a medical appointment. Following team assessment, the team had a four-week waiting time to access team treatment and/or allocation of a care coordinator. The Coventry wellbeing team had an estimated waiting time of four-to-five weeks for a team assessment and three-to-four months for a care coordinator. North Warwickshire and Stratford recovery teams had low waiting times of one week to access treatment (and/or allocation to a care coordinator).
- All teams reviewed their waiting lists regularly and prioritised patients, if necessary. Staff contacted patients on waiting lists to update them and check on their wellbeing. Staff considered referring patients to other appropriate services, for example, crisis teams, primary care counselling services.
- Most teams had internal waiting lists for access to their psychology services. At the time of our inspection, South Warwickshire early intervention team had a waiting time of four-to-five months (five patients), Stratford wellbeing team had six patients waiting for cognitive behavioural therapy. Coventry recovery team had a waiting time of five months (18 patients) and Coventry wellbeing team had 28 patients waiting for psychology services. Team managers and psychologists considered different ways of manage their waiting lists, for example, starting new groups. Psychologists also offered staff consultation sessions to help them support patients while they waited for psychology services. Coventry early intervention team had offered Coventry recovery team access to cognitive behavioural therapy to help with their waiting list.
- The teams responded promptly to patients when they contacted by telephone. Teams had duty systems or other arrangements that covered the whole day. Duty workers handled calls from patients on waiting lists, and patients allocated to workers who were not in the office. The patients we spoke described the services they received as responsive. Patients found it easy to contact their care coordinator and the team.
- All teams had specific access criteria determined by the mental health care cluster model. The wellbeing teams catered for patients with non-psychotic conditions whose initial assessments placed them in care clusters 3 to 8. The early intervention teams catered for people in care cluster 10 but predominantly those who met the early intervention criteria. The recovery teams worked with patients in care clusters 11 to 17 that covered severe and enduring mental illness. The trust operated ageless services for adults so the teams accepted referrals for patients 17 years old and over. However, the specialist early intervention teams operated a specific model aimed at people with their first presentation of psychosis between the age of 14 and 35 years old. Since the move to ageless services, the early intervention teams had received patients over the age of 35, some over the age of 50. This had an impact on the teams' workloads and their ability to offer an early intervention

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model effectively. The model assesses the duration of untreated psychosis and recommends intervention at the earliest possible opportunity for effective outcomes. Furthermore, the teams had patients who would not be able to benefit from the early intervention model and needed a more appropriate service.

- Where the service did not think it could meet the needs of a patient, staff liaised with the appropriate service to arrange a transfer, or signposted patients to other services. Each integrated practice unit (recovery, wellbeing and early Intervention) had developed links and working arrangements with the teams that they referred to the most. For example, North Warwickshire early intervention team had agreed with the local wellbeing and recovery teams that the evidence base for success of the early intervention model applied to patients aged 14 to 35. As such, the teams had agreed to take patients who did not meet the early intervention criteria. However, the South Warwickshire early intervention team was unable to reach such an agreement with its local wellbeing and recovery teams because the teams were too busy.
- All community teams took active steps to work with patients who found it difficult to engage with services. As well as maintaining contact, staff used skills and techniques associated with the model of flexible assertive community treatment (FACT). Staff tried to build trust with patients, based on openness and honesty. Staff encouraged patients to determine their own goals and objectives, and plan towards them, which helped patients take some control in their care. Some teams provided physical health services to patients who found it difficult to visit their GP, which helped engage them with services they needed.
- Community mental health teams tried to prevent non-attendance at appointments through a number of methods. Staff contacted patients by phone to offer them an appointment at a suitable time and venue, including home visits. They gave information about the team and explained what would happen during the appointment to reduce patients' anxieties. Some teams used appointment letters that promoted their service instead of the trust's generic letters.
- Staff across all teams rarely cancelled appointments but when this was necessary, staff explained the reasons to patients and offered an alternative appointment. In cases of staff absences, team or duty staff covered their colleagues' appointments, where appropriate. The

'shared care' arrangements for some patients in the recovery teams meant that patients saw other staff in their care team in cases of staff absence. However, the main reason for changed appointments was the lack of available interview rooms especially for Coventry wellbeing team and the North Warwickshire teams based in Nuneaton. Coventry wellbeing team regularly experienced challenges obtaining interview rooms onsite and at other venues, which resulted in them changing a face-to-face appointment to a telephone call or re-arranging the appointment. Staff contacted patients about any changes or delays to their appointments. The patients we spoke with said that they chose appointment times that suited them, and reported that appointments ran on time.

- Care records showed patients' status such as whether they were under the care programme approach (CPA), received section 117 aftercare, or met Care Act criteria (statement of care). Patients' records showed the patients' history that included their hospital admissions that staff reviewed in cases of uncertainty. In any event, health and social care staff in the community teams provided day-to-day services to patients based on their individual needs.

## **The facilities promote recovery, comfort, dignity and confidentiality**

- The community mental health teams we inspected had access to a range of soundproof interview rooms and facilities to support care and treatment. The teams were based at various locations and sites throughout Coventry and Warwickshire. Most teams had facilities on site at their team bases but staff also used other trust facilities throughout the region.
- The Coventry recovery team was located in a modern, well-furnished building with a range of facilities and meeting rooms. The office was large and open-plan, and shared with two other teams. The teams operated a hot desking system. Several staff we spoke with complained about the hot desking system, in particular, difficulties finding a free desk in the mornings; hygiene and cleanliness of desks and phones; and the need to adjust chairs and equipment. Team managers of sites that had hot desking arrangements assured us that staff with disabilities, reasonable adjustments or adaptations had permanent desks allocated to them. Staff complained about noise levels as a large number of them worked in

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the open-plan office. However, the office had a number of small offices and consulting rooms to the side of the open-plan office that staff used occasionally when they were empty.

- The Coventry wellbeing team was located on the second floor of a health centre in the centre of a residential estate nearby other facilities such as a shopping centre and a community centre. There was little or no signage to indicate that there was a mental health team located at the health centre. The team manager had placed an order for new signs with the trust several months earlier. In the meantime, staff had placed temporary signs (typed on A4 paper and laminated) in the reception area and near the lift to help orient patients. The team had access to interview rooms on the first floor that they shared with other community services such as podiatry and district nursing. Staff could also use interview rooms in other local trust premises. Staff expressed concern about the lack of availability of interview rooms onsite or on other premises, which meant patients' appointments had to be re-arranged or changed to telephone calls. Sometimes, staff used the podiatry clinic rooms, which were inappropriate for mental health appointments. Some staff complained about the hot desking system and the poor state of office equipment they had.
- The North Warwickshire teams were based in Avenue House on an old hospital site. The North Warwickshire early intervention team was based on the first floor of Avenue House and had sufficient space and facilities for its team. The North Warwickshire recovery team was based on the ground floor of Avenue House but did not have sufficient space and facilities for staff and patients. However, the whole unit was due for imminent refurbishment to create a fit-for-purpose base for a number of mental health teams with facilities for staff and patients.
- South Warwickshire early intervention team was based in a converted house in the centre of Warwick. The base had staff offices only. Patients reported to the reception in the adjoining building and staff used its interview rooms. Staff could also use trust facilities in Leamington Spa and Stratford, which helped them access patients in those areas.
- All community mental health teams held a range of information on treatments, local services, patients' rights and making complaints. The teams displayed these in reception and waiting areas. Staff took some

leaflets with them when they did initial assessments in patients' homes, for example, on complaints. The early intervention teams had produced a welcome pack that introduced their service and provided key information such as telephone numbers, emergency contacts and other support services. However, the teams had experienced delays to its publication at trust level.

## Meeting the needs of all people who use the service

- The core service made appropriate adjustments to work effectively with a range of people with specific needs. For example, most of the team sites had disabled access such as ramps and lifts. Where these were not available, staff used alternative facilities nearby or visited patients in their homes.
- Staff from all community mental health teams gave examples of the diverse range of patients they worked with, for example, people from different ethnic backgrounds, students, people with physical or sensory disabilities, transgender people, and military veterans. Staff helped address the specific needs of the local populations they served. Coventry and some parts of North Warwickshire had high levels of social deprivation. Staff supported patients with specific issues such as housing, welfare benefits, employment, and domestic violence. Coventry and Warwickshire had a large student population. Teams had developed links with the mental health services within the local universities. Stratford wellbeing team developed a veterans' pathway and ran a veterans' project. The team also had a clinician who was a veteran who acted as a champion for the veteran service.
- Staff used the language service commissioned by the trust to meet patients' language needs. Staff ordered leaflets in other languages and requested translation of information, as needed. The trust had some leaflets in other languages such as Punjabi available online. Staff used the trust's language service to request interpreters when needed. Some teams had staff who spoke other languages such as Punjabi, Italian and Spanish. Staff gave examples of using face-to-face interpreters to communicate with patients who did not speak English, signers for patients with deafness, and translators for producing written information in another language. Staff found it easy to access interpreters and translators although one team had experienced a number of cancellations that had created delays for a patient.

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## Listening to and learning from concerns and complaints

- The core service received 26 complaints and 34 compliments between 1 February 2016 and 31 January 2017. Of these, the trust upheld five complaints and partially upheld 12 complaints. The complaints received covered a range of issues including disputes with medical staff about diagnoses and treatment, the attitude of medical staff and disagreements about the level of support offered.
- Most patients we spoke with said they knew how to complain. They said they would raise any issues or concerns with their care coordinator or the team manager. However, few of the patients we spoke with knew about the trust's complaints system (PALS). Several patients we spoke with described how staff had satisfactorily dealt with the issues they had raised. Patients said they had received a response and feedback but not always in writing.
- Staff took patients complaints seriously and handled them appropriately. Staff dealt with formal complaints received through PALS in line with the trust's policy. Staff

gave an example of a complaint they received from PALS about their service and described how they dealt with it. PALS passed the complaint to the appropriate team manager for investigation. The investigating officer investigated and compiled a report that they returned to PALS. This resulted in an outcome that the trust relayed to the complainant in writing. However, staff did not always follow the trust's complaints policy for complaints received and resolved locally. In three complaints that patients told us about, we found that staff did not inform PALS for recording on the trust's system.

- Teams discussed complaints and compliments at their team meetings. Team managers fed back local and trust-wide lessons learnt and changes. However, some staff said they did not always receive feedback on complaints they or their patients made about other services. Team acted on the findings of complaints, where appropriate, for example, Stratford wellbeing team developed their veterans' project following a complaint about a lack of access to appropriate services for veterans.

# Are services well-led?

Good 

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 knew and agreed with the trust's vision and values. All community teams included the trust's values in their team's objectives, and staff demonstrated the values in their conduct and behaviours. The teams we inspected and the staff we spoke with showed compassion and respect, and genuine commitment to working together and achieving excellence.
- Staff knew who the most senior managers in the trust were and most community mental health teams had received visits from the chief executive. However, staff described a distance between them and the trust, which had benefits and disadvantages. Community teams enjoyed their autonomy, in particular, the opportunity to develop their teams in response to local needs and demands. However, the teams experienced delays to tasks that relied on other trust services, for example, estates and facilities matters, new signage or safety equipment, training places, and publication of new materials.

### Good governance

- Overall, community mental health teams had effective systems and processes to help ensure effective local governance. Staff received mandatory and role-specific training although some staff struggled to access places on Mental Health Act training. Staff received supervision and appraisals although there were gaps, some of which were associated with poor recording practices. Staff spent most of their time on direct care activities with patients. However, since the implementation of a new electronic care records system, staff struggled to allocate time to migrate all patients' records onto the system.
- Staff participated in a range of audits within their teams or for the trust. Staff recognised and reported incidents and safeguarding concerns. Staff received debriefs, lessons learnt and changes to practice, as appropriate. Staff followed Mental Health Act and Mental Capacity Act procedures, and had good access to expertise locally and through the trust.
- Community mental health teams had a range of performance measures appropriate to their teams that helped them monitor their own performance. We saw copies of performance data displayed in offices. The

- teams reviewed their performance and took action to address any areas of concern. The teams also used findings from audits to improve practices. Teams shared performance issues and actions with the other teams in their integrated practice unit, which promoted consistent service improvements across the service.
- Team managers had sufficient authority to lead and develop their teams. The team managers we spoke with showed good knowledge and experience of their team's specialism. This helped teams develop their staff and service and focus on clinical improvements. Most teams had access to some administrative support. Teams and managers with onsite administrative valued this highly. However, the teams based in Nuneaton and Stratford that had only remote access to the trust's administrative hub found the service ineffective for their needs.
  - Staff raised issues and concerns with their team managers who submitted appropriate items to the trust's risk register, using internal governance mechanisms.

### Leadership, morale and staff engagement

- The community mental health teams had sickness rates above the trust's average. Coventry and North Warwickshire wellbeing teams had the highest rates of sickness in the core service.
- Staff knew how to use the whistle-blowing process and raised concerns within their teams and the trust without the fear of victimisation.
- Staff morale was high in the teams we inspected. The staff we spoke with described good team working and mutual support. Staff showed dedication and commitment to their teams and to their patients. Staff experienced a strong sense of job satisfaction and empowerment in their roles. Staff spoke highly of their team managers, the support they received from them and their focus on staff wellbeing and patient care.
- The trust ran reward and recognition programmes for staff to recognise good practice and dedication. South Warwickshire early intervention had a staff member who had received the employee of the month award. North Warwickshire wellbeing team ran a managing emotions skills group that was nominated for the trust's 'working together' award. North Warwickshire early intervention team had won the trust's 'Q' award for their contribution to research project on cognitive remedial therapy (CRT).
- Staff had access to a range of training and development opportunities related to their roles. As well as offering

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formal training courses, team managers encouraged staff to develop their skills. For example, a support worker in North Warwickshire Early Intervention team took a lead role in developing the recovery college. A support worker in Coventry wellbeing team ran physical health clinics alongside a qualified nurse.

- Few staff knew about the duty of candour and the trust's policy. However, staff understood the general concept of openness and transparency, and gave examples of occasions when they acknowledged mistakes and apologised to patients.
- Staff had a range of forums such as team meetings and business meetings through which they gave feedback about services and input into service development. For example, the occupational therapist in the North Warwickshire early intervention team had devised an electronic care plan specifically for occupational therapy interventions. Team managers actively encouraged staff to share innovative ideas and develop new services.

## Commitment to quality improvement and innovation

- We found a number of examples of innovative practice and research in this core service. Stratford wellbeing team worked jointly with the local MIND and IAPT services to develop and offer group-based therapies. The team planned to publish a paper on this approach. Trust psychiatrists had contributed to the published paper and research on the flexible assertive community treatment (FACT) model, which the community teams had adopted. North Warwickshire early intervention team hosted research assistants who were researching cognitive remedial therapy (CRT). The team had won the trust's 'Q' award for their active participation in the project.
- The trust ran 'Thinking Ahead', a fast-track one-year programme for training new social workers. Coventry wellbeing team had four students placed in their team during 2016-17, and a new cohort of four students had been selected to start in September 2017.
- North Warwickshire early intervention team worked with the trust's IT department to pilot a new secure, live care planning tool that supported agile workers.