CareQuality Commission

Requires improvement 🟠

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

Locations inspected

Location ID	Name of CQC registered location	Name of service (e.g. ward/unit/team)	Postcode of service (ward/unit/team)
RYGCR	Trust headquarters	Swanswell Point, Coventry Community Mental Health Team, IPU 11-17, Recovery and Early Intervention.	CV1 4FH
RYGCR	Trust headquarters	Avenue House, Manor Site. Nuneaton Community Mental Health Team Recovery IPU 3-8 and Early Intervention	CV11 5HX
RYGCR	Trust headquarters	Warwick Mental Health Resource Centre. Warwick Community Mental Health Team. Recovery IPU 11-17	CV34 4GP

Summary of findings

RYGCR	Trust headquarters	Tile Hill, Coventry Community Mental Health Well-being Team, IPU 3-8.	CV9 9PN
RYGCR	Trust headquarters	St Marys Lodge, Leamington Spa Community Mental Health Team, IPU 3-8.	CV31 1JN

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

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

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

Summary of findings

Ratings

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

Overall rating for the service	Requires improvement 🟠
Are services safe?	**Requires improvement** 🟠
Are services effective?	**Requires improvement** 🟠
Are services caring?	**Good** 🟢
Are services responsive?	**Good** 🟢
Are services well-led?	**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 community-based mental health services for adults of working age as **requires improvement** because:

- Three patients with a criminal history, under supervision of the Ministry of Justice (MOJ), did not have their conditions included in their risk or care plans. The Ministry of Justice (MOJ) monitors and set conditions for the care, treatment, and whereabouts of mental health patients with a criminal history. Community Treatment Order (CTO) conditions were not included in the care plan for one patient. Two patients' MOJ records were not available at the MHA office at the Caludon centre. One patient's MOJ reports were kept on a clinician's own computer rather than on the electronic or paper records available for all staff to view. Mental Health Act (MHA) and Ministry of Justice (MOJ) records were not available in paper or electronic forms at Swanswell Point.

- Emergency equipment was not available on any site except at Avenue House day service. Some services administered depot medication on site. In case of an emergency, the services would be required to call emergency services. Clinic rooms were small and did not include a couch for physical examinations.

- Staff overall training rates for community teams were 85%, which did not meet the trusts 95% target for all mandatory training. Staff achieved 65% of training for mental Health Act and Mental Capacity Act training.

- We reviewed 42 patient care records and found that staff had not consistently completed care plans at Avenue House and Swanswell Point. Some care plans were not holistic and did not include the goals of patients.

- Some teams had a waiting list of up to six months for patients to access psychological therapies.

- Staff from a range of disciplines raised concerns about the integrated practice unit (IPU) model of patient care. The model uses a care clustering approach to determine which teams' patients are treated by. Clusters 3 to 8 are for patients with a non-

psychotic diagnosis and clusters 10 to 17 are for patients with a psychotic diagnosis. Staff spoke with us about their concerns for patients who do not fit in to this model. However, this did not impact on patient care.

- Managers at most of the services did not maintain a system to monitor the frequency of supervision and supervision target rates varied between sites. We therefore had to look through individual supervision notes to gauge how frequently supervision occurred. Supervision was mostly completed on a four to six weekly basis but there was a lack of consistency in recording supervision. IPU 3-8 at the Tile Hill centre had the lowest supervision rates of 68% which did not meet their target supervision rate of 83%. All other teams completed supervision exceeding their individual team target rates.

- Staff did not consistently monitor physical health across all teams. Patients at Avenue House and Swanswell Point were not consistently monitored for physical health or checks on an annual basis. However, for patients prescribed high dose anti psychotics or lithium there were systems in place.

- Teams across the trust used different recording systems. Staff at the community teams used the electronic system whereas doctors and inpatient ward staff used paper recording. This meant professionals between teams were unable to see entries from each other when patients moved between teams.

However:

- Staff used an approved risk assessment tool to assess and monitor risk.

- Patients had crisis and relapse plans in place.

- Patients waiting for care co-ordinator allocation were contacted regularly to give them an update. Care co-ordinator allocation took up to two weeks but there was scope for this to be done sooner if there was a risk or urgency.

- Staff were aware of and followed lone working policies.

Summary of findings

- Comprehensive assessments were completed in a timely manner.

- Staff followed National Institute for Health and Care Excellence (NICE) guidelines when prescribing antipsychotic medication.

- Staff explained patients their rights.

- Patients spoke positively about staff. They told us staff were kind, listened to them and supported them with their individual needs.

- Staff at two sites reviewed referrals and had set up a clinic to reduce waiting times for patients to have an assessment.

- We saw high levels of team working and positive interactions between staff members within all services visited.

Summary of findings

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

Are services safe?

We rated safe as **requires improvement** because:

- Three patients with a criminal history, under supervision of the Ministry of Justice (MOJ), did not have their conditions included in their risk or care plans. The Ministry of Justice (MOJ) monitors and set conditions for the care, treatment, and whereabouts of mental health patients with a criminal history.
- Community Treatment Order (CTO) conditions were not included in the care plan for one patient.
- No emergency equipment was available on any site.
- Clinic rooms were generally small and did not include a couch for physical examination.
- Staff struggled to access interview rooms to see patients for appointments at some sites.
- During our visit, many staff, specifically at the IPU at Swanswell Point, spoke with us about low staffing levels, the number of staff leavers, the effect on their workload and ability to deliver services safely. Staff also raised concerns about the number of and complexities of patients on some of their caseloads. However, this did not impact on patient care.
- Rapid access to a psychiatrist was not always available and some teams had to use the crisis team doctors.
- Staff training rates were 85%, which did not meet the trusts 95% compliance target for all mandatory training.

However:

- All areas were clean and well maintained.
- Caseloads were monitored and varied according to staff roles and level of experience.
- Staff used an approved risk assessment tool to assess and monitor risk.
- Patients had crisis and relapse plans in place.
- Patients waiting for care co-ordinator allocation were contacted regularly to give them an update.
- Staff were aware of and followed lone working policies.
- Robust medication management systems were in place.
- Staff said they were supported following incidents.

Requires improvement ●

Are services effective?

We rated effective as **requires Improvement** because:

Requires improvement ●

Summary of findings

- Patients care plans were not consistently completed across teams. Some were not holistic or did not include the goals of patients.
- No records of Mental Health Act (MHA) paperwork or Ministry of Justice (MOJ) warrants or orders were available in paper or electronic forms at IPU, Swanswell Point.
- Two patients MOJ records were not available at the MHA office at the Caludon centre.
- One patient's MOJ reports were kept on a clinician's own computer rather than on the electronic or paper records available for all staff to view.
- Teams across the trust used different recording systems. Staff at the community teams used the electronic system whereas doctors and inpatient ward staff used paper recording.
- Some teams had a waiting list of up to six months for patients to access psychological therapies.
- Patient's physical health checks were not consistently monitored across all teams.
- Staff did not consistently record supervision.
- Staff achieved a completion rate of 65% for MHA and Mental Capacity Act (MCA) training. This fell below the trust's target of 95%.

However:

- NICE guidelines were followed when prescribing antipsychotic medication.
- Staff were trained in a range of psychological interventions.
- The trust provided staff with an induction at the start of their employment.
- Staff meetings were held regularly.
- Staff had good working relationships within teams and links with external agencies.
- Staff explained patients their rights.

Are services caring?

We rated caring as **good** because:

- Patients spoke positively about staff. They told us staff were kind, listened to them and supported them with their individual needs.
- Staff attitudes and behaviours when interacting with patients were responsive and provided appropriate emotional and practical support.
- We observed four home assessments where we saw good relationships between staff and patients, including joint working and collaborative discussions.

Good ●

- Patients fed back positively about the care they received from staff. Patients told us that staff were willing to help and treated them with respect and dignity.
- We observed a care programme approach review meeting. The patient was encouraged to give their views on their strengths and needs and to participate in the review of their care plan

However:

- For all teams, staff did not always record in the care plan the fact that they had given the patient a copy of the care plan.

Are services responsive to people's needs?   **Good** ●

We rated responsive as **good** because:

- Data from the trust showed the longest waiting time for routine referrals was under five weeks and the shortest time was three days. Overall data provided showed the average waiting time for initial assessment was three weeks. From assessment to allocation, the waiting time was 15 weeks, which was within the trusts 18 week target.
- Staff used the Standard Operation Procedure (SOP) to keep in contact with patients on waiting lists for allocation to a care co-ordinator.
- Staff at IPU 10, Avenue House, were attending the central booking service to review referrals and speed up the referral to assessment process.
- Staff told us outpatient assessment appointments with doctors had the longest waiting times of up to 10 weeks. Staff at IPU 3-8, Tile Hill centre had set up a clinic to reduce waiting lists.
- Care co-ordinator allocation took up to two weeks but there was scope for this to be done sooner if there was a risk or urgency.
- Within each of the services we visited, we found that teams took active steps to engage with people who found it difficult, were reluctant to engage with mental health services, or did not attend appointment.
- The trust had an established personality disorder service that community teams could refer to if required.

However:

- Staff were not aware of key performance indicators concerning waiting lists for patients' assessments and there was variation in waiting list times at different services.

Are services well-led?   **Good** ●

We rated well-led as **good** because:

Summary of findings

- We saw high levels of team working and positive interactions between staff members within all services visited.
- Staff understood the need to be open and transparent and explain to patients when things went wrong.
- Staff told us their line managers were approachable and supportive and there was good team working.
- The trust kept Mental Health Act and Ministry of Justice records at the Caludon centre, rather than at the site the patient was seen.

However:

- The trust kept Mental Health Act and Ministry of Justice records at the Caludon centre, rather than at the site the patient was seen.

Summary of findings

Information about the service

There were 3 integrated practice units (IPUs) that were organised by super clusters from the Mental Health Care Clusters model.

These overall superclusters were separated into teams in each locality

IPU 3-8 (Non psychosis)

IPU 10 – Early Intervention (Psychosis)

IPU 11-17 – Recovery (psychosis)

They provided recovery-based interventions and support to people living with a mental health condition in their homes. Services provided were age independent and covered from 17 years onwards with no upper age limit.

Teams consist of administrative support staff, community psychiatric nurses, occupational therapists, psychiatrists, psychologists, social workers and support workers.

The teams were managed by Team Managers who were in turn managed by Locality Managers. The Head of Community IPU line manages the Locality Managers.

Teams work closely with other local mental health services, such as the crisis resolution team and inpatient wards. Staff provide support Monday to Friday from 9am to 5pm.

The last inspection of community based mental health services for adults was 21 to 24 January 2014. We inspected various services including community based mental health services.

At the previous inspection, we reported that the trust should ensure that lone working processes were in place and suitable storage, recording and monitoring systems were in place to ensure medications were handled safely and appropriately.

Our inspection team

The inspection team was led by:

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

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

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

The team that inspected this core service included two CQC inspectors, two specialist professional advisors and one expert by experience.

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

Why we carried out this inspection

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

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?

Summary of findings

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

During the inspection visit, the inspection team:

- visited a number of integrated practice unit (IPU) community mental health team offices and looked at the quality of the office environments

- spoke with 12 patients

- spoke with four carers

- observed six staff appointments with patients, including home visits

- observed a multi-disciplinary professionals meeting to review the care and treatment for patients

- spoke with 33 staff members

- spoke with eight managers

- reviewed 42 patient care and treatment records

- carried out a specific check of 16 patient medication charts

- reviewed 12 staff records

- carried out a specific check of the medication management of the services that held medication

- reviewed a range of policies, procedures and other documents relating to the running of the service

What people who use the provider's services say

Patients were very positive about the majority of staff across all of the teams. The positive comments included staff being kind, listening to them, and supporting them with their individual needs.

Carers told us their relative or friend was supported by the team and support was available to them as appropriate.

Patients told us they knew how to access the advocacy services.

Patients told us they knew how to make a complaint or compliment about the service.

One patient told us that staff were kind, compassionate, and caring.

One patient told us that the quality of care was brilliant.

During an initial assessment, one relative told us that they had to wait too long for an assessment. Staff supported the relative and informed them, with consent from the patient, of the care plan for their relative.

Areas for improvement

Action the provider MUST take to improve

- The provider must ensure emergency equipment is available on site.

- The provider must ensure that patients with CTO or MOJ the conditions are recorded on care and risk plans.

- The provider must ensure that MOJ and MHA records and reports are accessible to all staff.

Action the provider SHOULD take to improve

- The provider should ensure that staff receive mandatory training.

- The trust should ensure that care plans are holistic, recovery oriented and copies are given to patients.

- The provider should ensure physical health monitoring for all patients.

Care Quality Commission

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
Swanswell Point; Coventry Community Mental Health Team, IPU 11-17, Recovery and Early Intervention.	Trust Headquarters
Avenue House, Manor Site. Nuneaton Community Mental Health Team Recovery IPU 3-8 and Early Intervention	Trust Headquarters
Warwick Mental Health Resource Centre. Warwick Community Mental Health Team. Recovery IPU 11-17	Trust Headquarters
Tile Hill; Coventry Community Mental Health Well-being Team, IPU 3-8.	Trust Headquarters
St Marys Lodge; Leamington Spa Community Mental Health Team, IPU 3-8.	Trust Headquarters

Mental Health Act responsibilities

We do not rate responsibilities under the Mental Health Act 1983. We use our findings as a determiner in reaching an overall judgement about the Provider.

- Sixty five percent of staff had received training for the Mental Health Act, which fell below the trust's 95% target.

- Staff knew how to contact the Mental Health Act office for advice when needed.

Detailed findings

- Approved mental health practitioners (AMHP) were from multi-disciplinary backgrounds and most teams reported good access to coordinate Mental Health Act assessments.

- We saw evidence that staff explained patients' rights under the Act and community treatment orders at the start of treatment and routinely thereafter.

- Community treatment orders (CTO) and Ministry of Justice (MOJ) paperwork for restricted patients was not kept on site but was held at the Mental Health Act office at the Caludon centre.

- One patient's MOJ conditions included restrictions to where he lived and he had moved address. There was no record of the MOJ being informed of the change of address for this patient until several years after they had moved.

- MOJ paperwork was not held at the Mental Health Act office at the Caludon Centre for two patients.

Mental Capacity Act and Deprivation of Liberty Safeguards

- Staff compliance rates with Mental Capacity Act training was 65%, which fell below the trusts 95% target.

- Most patients' records we saw did not consistently identify if patients' mental capacity to make decisions had been assessed. Staff told us assessments were decision-specific and people were given every possible assistance to make a decision.

- We saw decision specific capacity assessments for consent to treatment and finances with best interest decisions recorded.

- Staff knew where to get advice on the MCA within the trust.

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 Integrated Practice Unit (IPU) teams had access to alarms when using interview rooms to see patients for appointments. Teams had systems for checking alarm equipment.

- All sites had a clinic room with locked key/keypad access by nurses to the medication cupboards. Staff regularly checked equipment for physical examination. However, most clinic rooms were small and did not include a couch for physical examinations.

- All medications were stored and monitored appropriately. All medications and disposable medical equipment were in date. There was easy access to sharps bins, alcohol gel and gloves showing that an infection control system was in place.Information was on display about infection control guidelines including hand washing.

- Staff checked and recorded fridge temperatures daily at locations where fridges were used.

- Staff had depot medication bags, which were regularly checked and replenished to ensure that appropriate equipment was available for staff to administer depot medication to patients.

- No emergency equipment was available on any site except at Avenue House day service. Some services administered depot medication on site. In case of an emergency, the services would be required to call emergency services.

Safe staffing

- Data from 1st December 2014 to 30 November 2015 showed that IPU 10-17 recovery team at Swanswell Point had 10% of staff leavers followed by 3% for the IPU 3-8 team at Tile Hill centre. The IPU, 10-17 early intervention team had staff vacancies at 10% followed by 8% for the IPU 3-8 team at Tile Hill centre.

- Several staff raised concerns about the number of doctor vacancies, specifically at Swanswell Point. Staff told us various locum doctors were being used which affected the consistency of patient care. However, this had now been rectified as there were regular locum doctors in post.

- The average caseloads for staff were 25 dependent on roles and level of experience.

- Staff told us that outpatient assessment appointments with doctors had the longest waiting time of up to 10 weeks.

- Data from 1 December 2014 to 30 November 2015 showed the overall community teams sickness rates were the lowest at 4% compared to other services. Within community services sickness rates were highest at IPU, 3-8 Tile Hill Centre at 8% and the lowest at 1% at IPU 10-17, Warwick Mental Health Centre.

- The service had bank and agency staff to cover some staff sickness, annual leave and vacant posts. Tile Hill used two long-term agency staff who knew the service well.

- Rapid access to a psychiatrist was possible except for services at the Tile Hill centre who used the crisis team doctors when required.

- Overall community mental health teams achieved 85% of mandatory training. With the exception of 100% for MAPA disengagement foundation refresher training, 100% for safeguarding children level 3, 97% for safeguarding children level 1 and 98% for safeguarding adults level 1 training, staff did not meet the trusts 95% target for mandatory training. Staff achieved 65% for Mental Health Act and Mental Capacity Act and Deprivation of Liberty training. Safeguarding adults level 3 training was for senior managers only and was at 17%. All other training was between 80-90%.

Assessing and managing risk to patients and staff

- Patients had individualised risk assessments. Staff used various clinical tools to assess and manage risk from initial triage to assessment.

- We reviewed three records of patients with a criminal history, under supervision of the Ministry of Justice (MOJ), who did not have their conditions included in

Are services safe?

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

their risk or care plans. The Ministry of Justice (MOJ) monitor and set conditions for the care, treatment and whereabouts of mental health patients with a criminal history.

- One patient receiving supervision in the community under a Community Treatment Order (CTO) had their leave restricted by the responsible clinician but this was not demonstrated in the care plan.

- We saw examples of staff completing crisis and relapse plans that identified triggers when a patient's mental health may be deteriorating.

- Priority referrals would usually be seen within three to seven days. Any urgent referrals would be passed immediately to the crisis team for assessment.

- Staff contacted patients on the waiting lists every two weeks in accordance with the trust's policy on waiting times for a care co-ordinator.

- Staff knew how to make a safeguarding alert and were aware of the trusts processes relating to safeguarding.

- Staff were fully aware of the lone working policy and lone working protocols were in place. Staff were able to explain the process and systems in place including updating their email diaries, calling in to the service, use of wording in an emergency and all staff had I-phones enabling them to access the trusts computer system wherever they were. Administrative staff ensured staff maintained contact with the service and managers followed this up if staff had not phoned in by 4.30pm.

- Teams had systems for medicines management, such as transport, storage and dispensing. We saw good management of stock medicines and medicines ordering for the clinics. We reviewed 16 medication charts, all medicines were clearly prescribed, allergies were recorded and there were no gaps in records.

Track record on safety

- Data from the trust for between 1 November 2014 and 31 October 2015 showed that there were 30 serious incidents for community services requiring investigation by community adult teams.

- The serious incidents included one accident, nine apparent or actual self-inflicted harm incidents, four unexpected deaths and two serious self-inflicted injuries.

- The majority of staff were aware of serious incidents and recognition of unexpected deaths. However, staff were unable to give us detailed examples of learning from these or changes in policy or practice as a result.

Reporting incidents and learning from when things go wrong

- There was an effective way to capture incidents, near misses and never events. Incidents were reported via an electronic incident reporting form. Staff knew how to report incidents and were encouraged to use the reporting system. Incidents were discussed at senior staff meetings or during team meetings.

- Staff received a group wide staff email of lessons learnt. One manager was able to tell us about the recommendations of a suicide that occurred within the team including completing storm suicide assessments for all patients. However, not all staff were able to give examples of improvements made in their team as a result of learning from investigations.

- Staff said that they were de-briefed and supported following an incident.

Are services effective?

Requires improvement 🟠

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

Our findings

Assessment of needs and planning of care

- Across each of the teams a comprehensive assessment was completed in a timely manner for newly referred patients.

- We reviewed 42 care records and found that care plans at Warwick Resource centre, Tile Hill and St Mary's Lodge were all completed, up to date, were holistic and included the person's goals. At Avenue House, care plans were not consistently holistic or included the goals of the patients. At Swanswell Point, we found eight completed and up to date care plans out of the 17 we viewed. These were not consistently detailed, holistic and did not include the goals of patients.

- We reviewed three records of patient's receiving Community Treatment Orders (CTO) under the Mental Health Act (MHA). This means these patients are under the supervision of mental health professionals with conditions attached to their care. We also reviewed three records of patients conditionally discharged under Ministry of Justice (MOJ) monitoring at IPU 11-17, Swanswell Point. No records of Mental Health Act paperwork or Ministry Of Justice warrants or orders were available in paper or electronic forms on site.

- When we visited the Mental Health Act office (MHA) at the Caludon centre, two patients' Ministry of Justice (MOJ) records were not available on file. Staff require access to MHA/MOJ records so that they can provide the appropriate care, treatment and monitoring of conditions attached to patient care.

- One patient's MOJ reports were kept on a clinician's own computer rather than on the electronic or paper records available for all staff to view.

- Teams across the trust used different recording systems. Staff at the community teams used the electronic system whereas doctors and inpatient ward staff used paper recording. This meant professionals between teams were unable to see entries from each other when patients moved between teams.

Best practice in treatment and care

- We saw evidence that National Institute for Health and Care Excellence (NICE) guidelines were being followed when prescribing medication. All patient records and prescription charts checked showed that medication was prescribed within the British National Formulary guidelines.

- Psychological therapies were offered by all teams. However, some patients had to wait for up to six months to access psychological therapies.

- Psychological interventions included cognitive behavioural therapy, counselling and dialectic behavioural therapy. Staff were trained in cognitive behavioural approaches and were supervised by psychologists with this. Psychologists at Swanswell point, IPU 11-17 worked with care co-ordinators to support patients. Family therapy was offered to patients and their family. Staff at Avenue House, early intervention service, IPU 3-8, received family therapy training with supervision from psychologists to support patients and their families.

- Patients at Warwick mental health centre, IPU10-17 received auricular acupuncture which is an alternative therapy focusing on points in the ear to help with mental health well-being.

- Patients at Avenue House and Swanswell Point were not consistently monitored for physical health or checks on an annual basis. However, for patients prescribed high dose anti psychotics or lithium there were systems in place.

- All community mental health services inspected used HoNOS (Health of the Nation Outcome Scales) as a clinical outcome measure.

Skilled staff to deliver care

- Each service had a range of skilled staff, which included consultant psychiatrists, specialist registrars and junior doctors, nurses, student nurses, social workers, psychologists, occupational therapists, medical students, team leaders and administrators.

- The trust provided staff with an induction when they commenced employment, this included an induction for students and bank or agency staff

- Team meeting minutes showed that meetings were held regularly and that a range of staff attended. Morning meetings were held at each site visited.

Are services effective?

Requires improvement 🟠

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

- Managers at most of the services did not maintain a system to monitor the frequency of supervision and supervision target rates varied between sites. We therefore had to look through individual supervision notes to gauge how frequently supervision occurred. Supervision was mostly completed on a four to six weekly basis but there was a lack of consistency in recording supervision. IPU 3-8 at the Tile Hill centre had the lowest supervision rates of 68% which did not meet their target supervision rate of 83%. All other teams completed supervision exceeding their individual team target rates.

- The data provided by the trust for appraisal rates showed that 74% of non-medical permanent staff working within the community adult mental health team has had an appraisal prior to November 2015. Data from teams showed that staff at IPU, 3-8 at Tile Hill Centre were the lowest at 63% and staff at IPU, 10-17 at Swanswell Point received the highest rate at 95%.

- Poor staff performance was being monitored through supervision. Supervised practise was available when needed

Multi-disciplinary and inter-agency team work

- Teams reported regular and effective multi-disciplinary meetings.

- Staff worked with external agencies, such as the police and the local authority. This included liaison with multi-agency public protection arrangements (MAPPA) where patients had committed a criminal offence.

- There were good working links including effective handovers with social services teams. Each team had local authority social workers within them.

- There were effective systems in place within each of the teams to share information when referring patients onto another service within the trust, except from and to inpatient areas due to the different recording systems. Staff managed this by visiting ward areas regularly.

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

- Staff achieved 65% of training for the Mental Health Act, which fell below the trusts 95% target.

- Staff knew how to contact the Mental Health Act office for advice when needed.

- Approved mental health practitioners (AMHP) were from a range of backgrounds and most teams reported good access to coordinate Mental Health Act assessments.

- We saw evidence in patients' case notes that staff explained to patients their rights under the Act and community treatment orders at the start of treatment and routinely thereafter.

- Community treatment orders (CTO) and Ministry of Justice (MOJ) paperwork for restricted patients were not kept on site but were held at the mental health act office at the Caludon centre with the exception of two patients MOJ records which were not held at the Caludon centre.

- One staff member told us that MOJ reports were saved on their own drive on their computer, which meant all staff could not access these reports for patients.

- Conditions of MOJ restricted patients were not recorded in patients risk and care plans.

- One patient's MOJ conditions included restrictions to where he lived which had changed. There was no record of the MOJ being informed of the change of address for this patient until several years after they had moved.

- MOJ paperwork was not held at the Mental Health Act office at the Caludon Centre for two patients.

Good practice in applying the MCA

- Staff compliance rates with Mental Capacity Act Training was 65%, which fell below the trust's 95% target.

- Mental capacity assessments were decision-specific and people were given every possible assistance to make a decision. We saw decision specific capacity assessments for consent to treatment and finances with best interest decisions recorded.

- Across the teams we visited, some staff were able to give us examples of patients where there had been concerns regarding capacity for specific decisions. They were able to talk us through the assessment process and tell us the outcome.

- Staff knew where to get advice on the MCA within the trust.

Are services caring?

Good ●

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

Our findings

Kindness, dignity, respect and support

- We observed and heard staff talk about patients with respect.

- Patients gave positive comments about a number of staff across all of the teams. They told us that staff were kind, listened to them and supported them with their individual needs.

- Staff attitudes and behaviours when interacting with patients were responsive and provided appropriate emotional and practical support.

- We observed four home assessments, where we saw good relationships between staff and patients, including joint working and collaborative discussions.

- Patients fed back positively about the care they received from staff. Patients told us that staff were willing to help and treated them with respect and dignity.

- Our discussions with staff evidenced that they understood the individual needs of patients.

- Staff were aware of the need to maintain patient confidentiality and were observed to do so.

The involvement of people in the care they receive

- For all teams, staff did not always record in the care plan the fact that they had given the patient a copy of the care plan.

- We spoke with 10 service users who were all positive about the service they had received.

- We attended four home visits and saw good involvement with care planning and two patients were given a copy of their care plans.

- We observed a care programme approach review meeting. The patient was encouraged to give their views on their strengths and needs and to participate in the review of their care plan.

- We observed two assessment interviews. Patients were able to give their views, were listened to and involved in decision making regarding options for care and treatment.

- We spoke with four relatives of patients using the mental health services. All said they were involved in the care their relative received and were supported by staff.

Are services responsive to people's needs?

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

Our findings

Access and discharge

- Referrals were received by the central booking system, which were cascaded to the relevant team for assessment and allocation if required.

- Data from the trust showed the longest waiting time for routine referrals was under five weeks and the shortest time was three days. Overall data provided showed the average waiting time for assessment appointments was three weeks. From triage to allocation, the waiting time was 15 weeks, which was within the trusts 18-week target.

- Staff were not aware of key performance indicators concerning waiting lists for patients waiting for an assessment and there was variation in the numbers of patients on waiting lists at different services. For example, staff we spoke with at Warwick Resource Centre and Avenue House said they did not have a waiting list, whereas, staff at all other teams had various times for patients waiting for an assessment.

- Staff used the standard operation procedure to keep in contact with patients on waiting lists for allocation to a care co-ordinator.

- Staff from a range of disciplines raised concerns about the integrated practice unit (IPU) model of patient care. Staff spoke with us about their concerns for patients who did not fit in to this model. For example, patients with a personality disorder and psychotic symptoms could fall within both IPUs. Staff also raised concerns about the difficulty and length of time it takes patients to move between IPUs due to changes in cluster ratings. However, this did not adversely impact on patient care.

- The average waiting time for an assessment was three weeks. However, IPUs 3-8 early intervention team at Avenue House had initiated a new approach where one staff member would attend the central booking service to screen all new referrals and arrange assessment appointments.

- Tile Hill, IPU 3-8 had set up a "cluster 3 clinic" to reduce their waiting lists. The clinic was run by a full time nurse who arranged assessments for all cluster 3 patients three times a week, and care co-ordinated these patients if required. The manager told us they had reduced their waiting list from 85 to 40 people since starting the clinic four months ago.

- Care co-ordinator allocation took up to two weeks but there was scope for this to be done sooner if a risk or urgency was identified.

- All teams had a duty worker rota in place to ensure referrals were seen within an acceptable time scale.

- Our discussions with patients and staff evidenced that all of the teams responded promptly and appropriately, when patients phoned in.

- Within each of the services we visited, we found that teams took active steps to engage with people who found it difficult or were reluctant to engage with mental health services.

- Staff took a proactive approach to engaging with patients who did not attend appointments, and would follow up patients who missed appointments to engage with these patients.

- Staff gave patients flexibility in appointment times where possible. Staff only cancelled appointments when absolutely necessary. Appointments were seen to run on time and people were kept informed when they did not.

The facilities promote recovery, comfort, dignity and confidentiality

- All rooms were sound proofed and spacious with appropriate furnishings.

- Reception areas had information on treatments, local services, patients' rights and how to complain. There were televisions with music or programmes for patients to watch or listen to whilst waiting.

- Staff struggled to access interview rooms to see patients for appointments due to limited availability. This included IPU 3-8 teams at Tile Hill and Avenue House. Staff said they used interview rooms at other sites on these occasions.

- The reception area at Tile Hill Centre did not have a clear sign to indicate where the mental health service

Are services responsive to people's needs?

Good ●

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

was located. On arrival, we could not find where the service was and had to ask two different reception areas until we were told where the mental health service was located.

- Teams had interview rooms to meet patients for appointments. The staff at Tile Hill and Avenue House told us it was difficult to book rooms due to limited room availability and the pressure of other staff from the same team using them.

Meeting the needs of all people who use the service

- Staff said they offered flexible patient appointments. Patients reported staff using information technology to keep in contact with them such as having direct access to staff via their mobile telephone.

- The trust had an established personality disorder service that community teams could refer to if required.

- All sites visited were accessible for people requiring disabled access, this included adapted toilets on site.

- There were no information leaflets in any language other than English available at any of the services visited, although they were available on request.

- Staff in all teams were aware of the arrangements to access interpreting and signing services and reported no issues with this.

Listening to and learning from concerns and complaints

- Trust data from the previous 12 months, showed IPU 3-8 teams with 22 complaints, four were fully upheld and nine were partially upheld. Data for IPU 10-17 teams showed three complaints, none was upheld. Issues related to cancelled or delays in appointment times, privacy and dignity, rights of patients, inadequate support, communication, attitude of medical staff and nursing care and treatment.

- Data from the previous 12 months showed that the service had 17 compliments, with the IPU 3-8 teams receiving the highest number of compliments.

- Patients knew how to complain and information about making a complaint was displayed in waiting areas. None of the patients we spoke with had made a complaint about the service and was, therefore, unable to tell us how staff handled complaints. Staff knew how to handle complaints appropriately.

- Some managers at the services we visited had been involved in investigating complaints. They were able to feedback to us the findings of recent complaints and actions taken as a result. Team managers gave appropriate feedback to staff regarding complaints.

- Managers and staff of the services we visited were aware of the duty of candour and considered this when responding to complaints. Managers and staff told us that the trust supported them to be candid with patients.

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 we interviewed were able to tell us what the organisational visions and values were.

- Staff knew who the senior managers were and these managers visited the team.

Good governance

- The trust had some governance processes in place to manage quality. Managers had access to dashboards, data and key performance indicators for their teams and could compare performance with others.

- Managers were using different systems to carry out supervision with staff. We saw both paper records and electronic records with different supervision objectives being used for staff members. Supervision was mostly completed on a four to six weekly basis but there was a lack of consistency in recording supervision.

- The trust generally kept Mental Health Act and Ministry Of Justice records at the Caludon centre rather than on the site where the patient was being seen.

- Staff followed safeguarding procedures. Staff raised safeguarding concerns to the team's social worker or service manager and they discussed whether they should raise an alert to the local authority.

- Staff were knowledgeable about the Mental Capacity Act and some teams had best interest assessors.

- The trust provided an organisational risk register as at November 2015, which detailed 42 risks, two of these related to community teams and concerned restructuring of services. There was no local risk register for community teams.

Leadership, morale and staff engagement

- We saw low morale at the Swanswell Point team where staff told us of their concerns around the lack of staff and how this had affected negatively on their caseloads and they felt unsafe. However, this did not adversely impact patient care.

- We saw high levels of team working and positive interactions between staff members within all services visited. Staff said they all worked well together as a team and there was mutual support for each other.

- Staff understood the need to be open and transparent and explain to patients when things went wrong.

- Staff told us their line managers were approachable and supportive and there was good team working.

- Staff were aware of external confidential support helplines and raising concerns processes. Managers identified support that had been given to staff, such as access to an occupational health service and employee assistance programme.

- Managers had leadership training and meetings to develop their skills and support teams.

- Forty nine percent of staff respondents in the Friends and Family Test data in 2015/16 would recommend the trust as a place to work, which is 13 percentage points below the England average of 62%.

- In the NHS Staff Survey 2015, the question relating to staff recommending the trust as a place to work or receive treatment scored below national average, compared to other mental health trusts.

Commitment to quality improvement and innovation

- Within the early intervention, IPU 10-17 team at Avenue House auditing had just started on the numbers of patients with an untreated psychosis for the last three months. The aim was to develop a greater understanding of patients' first episode of psychosis and to have monthly meetings to manage this. The services were not part of any national quality assurance programmes.

Requirement notices

Action we have told the provider to take

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

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment
Diagnostic and screening procedures	There was no emergency equipment on site for use in emergencies.
Treatment of disease, disorder or injury	Care and risk plans did not include Ministry of Justice and Community Treatment Order conditions.
	This was a breach of regulation 12(2)(a)(b)

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983	Regulation 17 HSCA (RA) Regulations 2014 Good governance
Diagnostic and screening procedures	Ministry of Justice (MOJ) and Mental Health Act (MHA) records and reports were not accessible to all staff.
Treatment of disease, disorder or injury	
	This was a breach of regulation 17(2)(b)(c)(f)