WM QRS West Midlands Quality Review Service

NHS

Reviews of Mental Health Services, Health Services for People with Learning Disabilities, Dementia Services and Care of Vulnerable Adults in Acute Hospitals

North Staffordshire Health Economy

Visit Date: 18th, 19th & 20th October 2011 Report Date: January 2012

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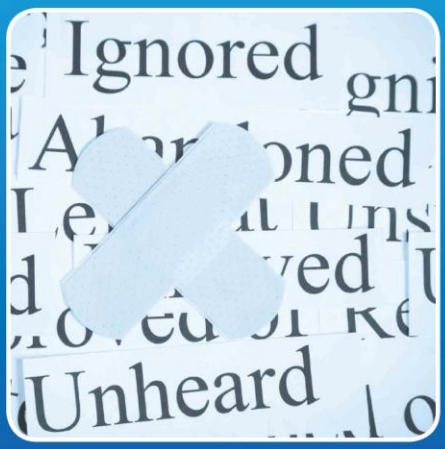

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INTRODUCTION

ABOUT WEST MIDLANDS QUALITY REVIEW SERVICE

West Midlands Quality Review Service (WMQRS) was set up as a collaborative venture by NHS organisations in the West Midlands to help improve the quality of health services by developing evidence-based Quality Standards, carrying out developmental and supportive quality reviews - often through peer review visits, producing comparative information on the quality of services and providing development and learning for all involved.

Expected outcomes are better quality, safety and clinical outcomes, better patient and carer experience, organisations with better information about the quality of clinical services, and organisations with more confidence and competence in reviewing the quality of clinical services. More detail about the work of WMQRS is available on http://www.wmqi.westmidlands.nhs.uk/wmqrs/.

This report presents the findings of the review of mental health services, health services for people with learning disabilities, dementia services and care of vulnerable adults in acute hospitals which took place on 18th, 19th & 20th October 2011. The purpose of the visit was to review compliance with WMQRS Quality Standards for:

- Mental Health Services, Version 1, February 2011
- Health Services for People with Learning Disabilities, Version 1.1, December 2010
- Dementia Services, Version 1, February 2011
- Care of Vulnerable Adults in Acute Hospitals, Version 1.1, December 2010

These visits were organised by WMQRS on behalf of the following Care Pathway Groups: West Midlands Mental Health Care Pathway Group, West Midlands People with Learning Disabilities Care Pathway Group and West Midlands Dementia Care Pathway Group.

The purpose of these standards and the review programme is to help providers and commissioners of services to improve clinical outcomes and service users' and carers' experiences by improving the quality of services. The report also gives external assurance of the care within the Health Economy which can be used as part of organisations' Quality Accounts. For commissioners, the report gives assurance of the quality of services commissioned and identifies areas where changes may be needed.

The report reflects the situation at the time of the visit. The text of this report identifies the main issues raised during the course of the visit. Appendix 1 lists the visiting ream which reviewed the services at North Staffordshire health economy. Appendix 2 contains the details of compliance with each of the standards and the percentage of standards met.

ACKNOWLEDGMENTS

West Midlands Quality Review Service would like to thank the staff and service users and carers of North Staffordshire health economy for their hard work in preparing for the review and for their kindness and helpfulness during the course of the visit. Thanks are also due to the visiting team and their employing organisations for the time and expertise they contributed to this review.

KEY POINTS

1 The review of North Staffordshire health economy found good integration of health and social care throughout commissioning and provider organisations. Good service user and carer engagement was evident throughout the review with particularly good input from the North Staffs User Group. Phase 1 of a service modernisation strategy had been agreed and was being implemented. Reviewers considered that phase 2 of this strategy was needed as a matter of urgency. They also commented on the importance of challenging service user, carer and staff expectations in order to ensure that future services had an appropriate focus on recovery.

2 North Staffordshire Combined Healthcare NHS Trust was engaged in a substantial programme of change. As well as preparing for Foundation Status and re-configuring in-patient beds, the Trust was facing a significant cost improvement programme. Reviewers were seriously concerned about IT systems and care records within the Trust. Concerns were also raised in several services about the lack of operational policies and clinical guidelines, and resulting dependence on informal processes and personal relationships.

3 Two primary care-based psychological therapy services provided good services, although reviewers suggested that relationships between them could be improved. Other mental health services had some examples of good practice as well as the Trust-wide concerns described above. The Early Intervention Service was well-organised with several examples of good practice. Reviewers were seriously concerned about the crisis intervention / home treatment team, for a combination of reasons which are described in main body of this report.

4 Commissioner input to the redesign of specialist mental health services, at a strategic level, will be important. Reviewers commented on the complexity of the commissioning arrangements and suggested that it may be helpful to identify a lead commissioner for mental health services who would be the focus for the development and implementation of the phase 2 strategy.

5 Health services for people with learning disabilities were working well together. Significant changes had already been made to specialist learning disability services and there was a shared understanding that further changes were needed, including for people who had been in-patients for over three years. There was good service user involvement in 'People's Parliaments' and Partnership Boards for people with learning disabilities.

6 Memory services provided by North Staffordshire Combined Healthcare NHS Trust were excellent with a clear, audited pathway which provided good support for service users and carers.

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HEALTH ECONOMY OVERVIEW

The review of North Staffordshire health economy found good integration of health and social care throughout commissioning and provider organisations. Section 75 agreements were in place and issues of transfer of social care staff to health organisations had been well worked through. Staff in all organisations were committed to reducing stigma and a greater focus on recovery. Relationships between organisations were good at an operational level, although often dependent on long-standing personal relationships. Partnerships with stakeholders were well-established and were maintained through a range of forums.

New models of care were being considered. A phase 1 consultation on transfer of older people's in-patient beds at Bucknall Hospital to better quality wards at Harplands Hospital, and move of rehabilitation beds from Harplands Hospital to community settings was in progress at the time of the review. These proposals had been developed with strong service user and carer, and community engagement.

Good service user and carer engagement was evident throughout the review with particularly good input from the North Staffordshire User Group. This group was funded by the PCTs and the local authority, and provided with accommodation at a variety of bases around North Staffordshire. A carers' group was also running. There was a well-regarded carer support service with robust procedures for offering assessments of carers' needs. Good arrangements for determining service user satisfaction were in place with a positive relationship with PALS and LINks.

Concern

1 **Strategy for older people's and adult mental health services**

Phase 2 of the strategy for older people's and adult mental health services had not yet been developed. A previous Staffordshire strategy was still 'in date' but did not address the modernisation of mental health services, more recent national strategies for mental health and dementia or the latest financial situation. Reviewers met service users, carers and staff who knew that service changes needed to be made and who were anxious about the impact on their care and, for staff, their employment. Given the 2011/12 cost improvement programme facing North Staffordshire Combined Healthcare NHS Trust, decisions about future services will have to be taken quickly. Involvement of all stakeholders, including service users, carers, staff and voluntary organisations, in the agreement of a strategy is needed soon to avoid further distress to service users and carers, loss of staff with skills that will be needed, and changes being made by providers which are not consistent with the eventual strategic direction.

Further Consideration

1 **Phase 2 Strategy**

The PCTs and North Staffordshire Combined Healthcare NHS Trust realised that change was needed to the service configurations, both to address the requirements of a modern service and to achieve necessary efficiency savings. Surveys of service users showed that the current services were valued. The health economy was considering wider involvement of other services and organisations to promote a focus on recovery and reablement.

As part of the development of the phase 2 strategy, reviewers supported the health economy in challenging two areas a) the configuration and function of services available and b) ways of working within these services. With some notable exceptions, service user and staff expectations and the range of services available appeared to be relatively traditional and may be fostering dependence rather than enabling and

encouraging recovery and return to active participation in community activities and employment wherever possible. Reviewers considered that helping service users, carers and staff to see the advantages of new ways of service delivery and new ways of working, and to realise that existing models are unsustainable, will be challenging. The time and effort involved in achieving this cultural change should not be underestimated. Active championing by senior managers in commissioning and provider organisations will be needed. Engagement of service users and carers, similar to that which took place as part of phase 1, will also be required.

2 **Single Points of Access**

The two single point of access services (which operated from three bases) were not reviewed in detail. Feedback from the GPs who met the visiting team was that these services worked in different ways and did not provide effective 'routing' to appropriate services. GPs were particularly concerned about whether issues of mental capacity were being appropriate recognised. As a result of these concerns, the 'single points of access' were often by-passed by GPs. The health economy will need to ensure that these services are included in the phase 2 strategy consideration as they will be crucial to the successful development of responsive, efficient pathways of care. Links with the Crisis Team will also be important.

3 See also health economy-wide comments within the Primary Care-Based Psychological Therapies section of this report.

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MENTAL HEALTH SERVICES

PRIMARY CARE

No specific issues were identified. Issues relating to single point of access services are covered in the health economy section of this report.

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PRIMARY CARE-BASED PSYCHOLOGICAL THERAPIES

Health Economy-wide

Two primary care-based psychological therapy services were reviewed: Services for North Staffordshire were provided by a consortium led by South Staffordshire and Shropshire NHS Foundation Trust which provided clinical leadership. High intensity therapies and an urgent response service were provided by North Staffordshire Combined Healthcare NHS Trust; low intensity therapies were provided by *Mental Health Matters*. Services for Stoke were provided by the *Healthy Minds Network.* All services were beginning to accept self-referrals. Reviewers noted that they did not meet users of either service or have the opportunity for separate discussion with more junior staff. A video of patient feedback on the *Healthy Minds* service was made available.

Further Consideration:

1 The review team commented on the apparent lack of a good working relationship between the two services and suggested that this may be detrimental to the care of clients in both. Commissioners and providers should consider whether action to improve relationships is needed.

2 GPs who met the reviewing team commented that both services met what was required by the service specification but they did not consider that this always met the needs of their patients. In some cases this appeared to be because they did not fully support the model of care being commissioned. For others, it was because of a gap between step 3 of the IAPT services and the care provided by Community Mental Health Teams, with some patients being considered inappropriate for either service.

Healthy Minds Network (Stoke)

General Comments and Achievements

This service presented less evidence of compliance with the Quality Standards and it was not clear that the review process was fully understood. Services were provided in a wide range of locations close to clients' homes, for example, Job Centre Plus and local libraries. The service showed a strong commitment to responding to the needs of local communities. Evidence presented showed good outcomes for service users. The GPs who met with the reviewing team were impressed with the level of information given by the service.

Good Practice

1 Relationships with partner organisations were very good. Everyone who the reviewers met spoke highly about the service and its willingness to respond positively and flexibly to the needs of service users. The

service had provided training for related services. This had helped to improve relationships, clarify the function of the service and increase understanding of who should be referred.

2 Communication with GPs was good. GP communication included information as soon as someone had been referred, information about when they were expected to be seen, regular updates and communication on discharge.

Immediate Risks: None

Concerns

1 **Policies, Clinical Guidelines, Staff Training and Audit**

Operational policies and clinical guidelines were not documented. There was no evidence of a systematic programme of audit of implementation of guidelines. No Mental Capacity Act policy was in place and there was no information on completion of mandatory training on mental capacity.

Further Consideration

1 The proportion of service users who did not attend or who cancelled their appointments appeared high (33%).

2 Reviewers saw no evidence that letters were addressed or copied to the service user as well as to the GP.

North Staffordshire Well-being Service (North Staffs Combined Healthcare NHS Trust)

General comments and achievements

This service had adopted a very thorough approach to preparation for the review. Comprehensive folders of evidence were available. The service had a good training plan and KSF appraisal processes. Compliance with the expected training was good. Data were collected and showed that recovery rate for users accessing the service was above the national average.

Good Practice

1 Robust formal and informal processes for service user involvement were in place, covering both individual treatment planning and organisation of the service.

2 The operational policy was detailed and clear.

Immediate Risks: None

Concerns: None

Further Consideration:

1 The GPs who met the visiting team said that they would like more communication about the outcome of treatment. Reviewers noted that they saw no evidence that letters were addressed or copied to service users as well as to the GP.

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MENTAL HEALTH TRUST-WIDE

NORTH STAFFORDSHIRE COMBINED HEALTHCARE NHS TRUST

General Comments and Achievements

North Staffordshire Combined Healthcare NHS Trust was engaged in a substantial programme of change. As well as preparing to apply for Foundation Trust status and consultation on the Phase 1 strategy of transfer of older people's inpatient beds and move of rehabilitation beds to community settings, the Trust was facing a 10% Cost Improvement Programme. The Trust was preparing its Integrated Business Plan and five year workforce strategy in the absence of the phase 2 strategy for the modernisation of services. It was difficult to see how these plans could reflect consideration of reconfiguration of services or new ways of working. The Health Economy section of this report has already described the extensive work involved in changing expectations in these areas. The organisational and cultural challenges facing the Trust were therefore substantial.

The Trust had recently revised and updated its corporate strategies and procedures. Work on allocating 'care clusters' had also started.

Good Practice

1 The Trust had done good work on developing non-medical prescribers and embedding their work into the clinical teams. Governance arrangements for non-medical prescribing were good.

Immediate Risks: None

Concerns

1 **IT Systems and Care Records**

Reviewers were seriously concerned that the systems for managing and recording information about service users' care did not ensure that staff had access to up to date information. Most clinical records were paper-based and were not always stored where they could be easily accessed, for example by the crisis team, on call psychiatrist or in-patient services. Some services kept separate medical and nursing notes with no overview of care plans. Previous audits from the current CQUIN showed that there was at least a two week turnaround for updating electronic care plans. As a result, the latest risk assessments were not available electronically and the risk assessments which could be accessed electronically across the Trust could be at least two weeks out of date. Health and social care information was recorded on separate systems. Some staff were able to access all relevant information but others had access only to health or social care records and the arrangements for access did not appear to reflect staff roles and the 'need to know'.

Reviewers did not have the time further to investigate this issue and strongly recommended that the Trust investigates and takes appropriate action as soon as possible. Reviewers noted that Trust-wide arrangements for dealing with identified risks seemed robust with good triangulation, involvement of PALS and feedback to clinical teams.

2 **Operational Policies and Clinical Guidelines**

Several services did not have up to date operational policies or clinical guidelines for the therapeutic interventions that were being offered. (Some staff seemed to think that the service specification was their operational policy.) As a result, operational processes and therapeutic interventions offered appeared to be dependent on informal arrangements and personal relationships between staff. Robust audit and monitoring of outcomes achieved compared with those expected could not be undertaken. Many staff had

been in place for several years and relationships, especially within teams, were good – which reduced the risks associated with the informal arrangements. This issue adds, however, to the challenge involved in changing the way that services work.

Further Consideration

1 In addition to the points made in the Health Economy section of this report about the phase 2 strategy, reviewers noticed that services appeared to be working in isolation from each other. Pathways between services were relatively under-developed. As part of its programme of cultural and organisational change, the Trust may wish to consider actively improving links between services and ways to improve pathways for service users, especially where this would contribute to their recovery. This point is particularly relevant to the crisis team and its links with all other services, especially as the function of this team changes in the future (see CR/HT section of this report).

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SPECIALIST MENTAL HEALTH SERVICES

EARLY INTERVENTION SERVICE (EI)

General Comments, Achievements and Good Practice

Feedback from service users and carers about this service was very good. Service users said that they were well supported and that staff were available and accessible and helped them to build their self-esteem. Both service users and carers commented on the person-centred approach taken by the team. Staff were well-motivated and leadership was strong. Good practice was systematically embedded into the work of the team. The service had won awards for innovation.

Links with other services and local communities were good, including with primary care, voluntary sector organisations, Job Centres, colleges and universities, and housing organisations. The small caseload (capped at 1:15) gave staff the time for intensive work with service users. Joint assessments were not time-limited and good support was available for service users with dual diagnoses. There was a strong focus on physical health care, supported by the good links with primary care, including service users being offered regular sexual health checks.

A very good 'Re-connect' DVD had been produced. This was supported by a range of booklets and information for service users and carers.

Outcome measures in use at the time of the review included both general and individual-specific measures.

Robust arrangements for clinical supervision were in place.

Immediate Risks: None

Concerns

1 **IT Systems and Care Records:** See mental health Trust-wide section of this report.

2 **Operational Policies and Clinical Guidelines:** See mental health Trust-wide section of this report.

Further Consideration

1 Senior medical staffing at the time of the review was 0.4 wte consultant and 0.6 wte ST6 doctor for a five day service with out of hours cover from the on call psychiatrist. There was a consultant nurse and the team had two independent prescribers. No CAMHS consultant had time allocated for their work with the Early Intervention Service. The adequacy of the senior staffing of the team should be kept under review.

2 At the time of the review, the service was considering several developments including a) offering additional support to siblings, b) further work on raising awareness in schools and local communities, and c) widening the remit of their work to the care of all young people with mental health problems (i.e. not just those with a first episode of psychosis). It will be important to ensure that these initiatives link effectively with the health economy phase 2 strategy as it is developed.

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COMMUNITY MENTAL HEALTH TEAMS (CMHT), IN-PATIENT CARE AND DAY SERVICES

Four CMHTs, integrated with social care under Section 75 agreements, were reviewed, some of which were co-located with in-patient beds and day services:

Name	CMHT	In-patient Beds	Day Services
Lymebrook	Yes	Yes	Yes
Greenfield	Yes	Summers View 8	No
Bennet	Yes	8	8 per day
Ashcombe	Yes	8	8 per day

In-patient services at Harplands Hospital had been reviewed by the Royal College of Psychiatrists 'AIMS' review programme and so were not reviewed as part of this visit. Reports of the AIMS reviews are available at: www.rcpsych.ac.uk/AIMS

ALL CMHTs

General Comments and Achievements

CMHTs were staffed by closely-knit teams who were highly committed to providing good care for their service users. Two consultants were based with each team. Service user and carer involvement was good in all services, including in the development of the psychosis pathway. Links with social care were good and there were some examples of holistic approaches to care, for example, the Kniveden project which facilitated pottery and woodworking.

Good Practice

1 Arrangements for support to carers were good with a carers' support worker and good arrangements for access to assessments of carers' needs. Information about carers' needs was kept separately from that about the service user.

Immediate Risks: None

Concerns

1 **IT Systems and Care Records:** See mental health Trust-wide section of this report.

2 **Operational Policies and Clinical Guidelines:** See mental health Trust-wide section of this report.

Further Consideration

1 The model of service provision, with co-located in-patient, day services and CMHT care, provided good local access to services and good continuity of care for people needing to move between these services. The expected entry criteria, discharge criteria, therapeutic interventions and outcomes for each type of care were not, however, clear. This point links with issues identified in the health economy and mental health Trust-wide sections of this report about the need for an active focus on recovery, clear operational policies and documented clinical guidelines.

2 Arrangements for clinical supervision were in place but supervision was not always documented. Many staff have worked together for a long time and it may be helpful to consider how appropriate challenge can be brought into clinical supervision arrangements.

3 Arrangements for review and learning at an individual service level could be strengthened, including learning from positive feedback. It may also be helpful to consider strengthening shared learning between the different CMHTs in the Trust.

SPECIFIC CMHTS (In addition to the 'all CMHTs' comments):

Lymebrook Centre

General Comments and Achievements

Lymebrook provided a base for the North Staffordshire service user group and links between this group and the services at Lymebrook worked well.

There was a good outside area accessible by all service users.

Good Practice

1 The reception area was of a high standard and very welcoming. A lot of information was available and there was a cafe. The receptionist was very helpful and thoughtfully responded to service users' enquiries and needs.

Further Consideration

1 Service users received a hand-written copy of clinic letters. It may be helpful to audit the extent to which this is systematically offered and completed. Alternatives to hand-written copy letters may also benefit from further consideration.

2 Care plans were long and service users' goals were not always clearly identified. Medical and nursing notes were kept separately and there was no easily accessible overview of the plan of care for each service user.

Greenfield Centre

General Comments and Achievements

The Greenfield Centre was also the location for the Re-settlement Service and Personality Disorder Service. The Re-settlement Service was actively involved in assessing out of area placements, providing appropriate adult support and DoLS assessments. The Personality Disorder Service was a 'virtual team' which provided training, advice and support to other services.

Notes of CMHT team meetings were easily available to all team members through the shared drive.

Good Practice

1 Light boxes were available for loan to service users with seasonal affective disorder.

Further Consideration

1 It may be helpful to audit the impact of the work of the Personality Disorder Service to ensure that evidence of its effectiveness is available.

2 The CMHT held separate referral and allocation meetings. This may not be the most effective use of time and may benefit from review.

Bennet Centre

Good Practice

1 An electronic 'kiosk' had electronic information about available services and their locations, and incorporated a phone handset.

2 Good links with *Brighter Futures Housing* were in place which enabled proactive work to maintain tenancies and address other housing-related issues.

Further Consideration

1 Service users at the Bennet Centre were particularly keen to be actively engaged in the development and implementation of the phase 2 strategy but were unclear about how they could become involved.

Ashcombe Centre

Further Consideration

1 Service users who met the visiting team at the Ashcombe Centre were concerned that their views did not make any difference to plans for service change.

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ACUTE CARE: CRISIS RESOLUTION HOME TREATMENT SERVICE (CRHT)

General Comments and Achievements

The Crisis Team was well-staffed with senior practitioners. Reviewers met only one service user. The crisis service ran separately from the Single Point of Access services and plans to integrate these teams were under discussion as part of the phase 2 service redesign. The crisis team was accessed by three separate routes: a) through the duty doctor on call during normal working hours for crisis, in-patient wards and CMHTs, b) by direct referral from a GP and c) through the on call psychiatrist out of hours.

Concerns

1 Reviewers had serious concerns about the Crisis Team for a combination of reasons:

a. No consultant psychiatrist had time allocated for their work with the Crisis Team. The Team accessed GPs, the CMHT psychiatrists or the on call consultant psychiatrist when medical input was needed. Reviewers would have categorised this issue as an immediate risk but the level of acuity of crisis team service users appeared relatively low and the access to in-patient beds appeared high. It appeared that some service users may be being admitted in order to access assessment by a psychiatrist. Reviewers were told that, outside normal working hours, service users normally had to attend the in-patient site in order to access a psychiatric assessment.

b. **IT Systems and Care Records:** See mental health Trust-wide section of this report. In particular, at the time of the visit the Crisis Team was not able directly to access social care records and the Emergency Duty team was not able to access health records.

c. **Operational Policies and Clinical Guidelines:** See mental health Trust-wide section of this report

d. Multi-disciplinary input to the work of the team was limited. The team was made up of nurses and STR workers but no staff with specialist social work, psychology, medical or occupational therapy competences had time allocated for their work with the service.

e. The service was undertaking a large number of assessments and was over-performing its contracted number of assessments. GPs appeared to be using the crisis team as an alternative route of entry to services, partly because of dissatisfaction with Single Point of Entry services.

f. AMHPs who were members of the crisis team did not carry out AMHP duties when they were on duty for the crisis team. (A separate AMHP rota was run and Mental Health Act assessments were accessed through the Emergency Duty Team.) As a result, medical and AMHP input to any crisis was from outside the crisis team.

g. The crisis team visited in-patient wards only once a week. As a result, home treatment may not be being offered as early as possible.

Reviewers considered that the crisis resolution / home treatment response, including links with single point of access services, needed significant re-modelling as part of the phase 2 strategy development and implementation.

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ACUTE CARE: LIAISON SERVICE

General Comments, Achievements and Good Practice

The liaison service provided out-patient support for people with deliberate self-harm and for people with some physical illnesses with a mental health component. Assessments and brief interventions were offered. Service users were given good information and 'sign-posted' to other appropriate support. The service, available 8am to 4.30pm Monday to Friday, was staffed by 3.5 wte nurses with support from the Medical Director. Links with staff at University Hospital of North Staffordshire NHS Trust were reported to be good.

Immediate Risks: None

Concerns

1 **IT Systems and Care Records:** See mental health Trust-wide section of this report. Reviewers were told of particular problems in accessing the University Hospital of North Staffordshire NHS Trust computer system for test results as only one member of staff had access.

2 **Access to Medical Staff:** The senior medical staffing available to the service was insufficient for its current role. If the Medical Director was unavailable, the service had to access the duty doctor who was also covering in-patient wards and the crisis team.

Further Consideration

1 The future role of the service needed to be clarified as a matter of urgency, including its relationship with the liaison service at University Hospital of North Staffordshire NHS Trust

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ASSERTIVE OUTREACH SERVICE (AO)

General Comments, Achievements and Good Practice

The Assertive Outreach Service was providing a holistic approach to care which was highly appreciated by service users. Staff were enthusiastic and committed and leads for physical health and for dual diagnosis had been identified. Leadership of the team was strong. Medical staff had specific time allocated for their work with the Assertive Outreach Service. Relationships with housing services and supported housing schemes were very good. A good range of alternatives to admission was available, including a crisis house. The team was good at finding innovative and creative ways to engage with service users. Follow up while service users were in-patients or in prison was good, with regular contact being maintained. The service had an inclusive approach to people with substance misuse problems.

Immediate Risks: None

Concerns:

1 **IT Systems and Care Records:** See mental health Trust-wide section of this report.

2 **Operational Policies and Clinical Guidelines:** See mental health Trust-wide section of this report.

Further Consideration

1 The staffing structure and skill mix of the team may benefit from review. The team had adopted a 'traditional' 12:1 staffing ratio. Staff with specific occupational therapy or psychology competences were

not available within the team and other staff had not developed advanced skills in these areas. The role of the STR workers was not clear.

2 The team manager who has provided strong and consistent leadership for several years was due to retire six months after the review visit. Succession planning will be important to ensure that the good work of the service continues.

3 It may be helpful to consider whether access to employment and training opportunities could be improved.

4 The operational policy was in draft form and did not include any specific time standards. As part of this work, it may be helpful to consider whether the three month handover period for referrals to and from CMHTs could be reduced.

5 Arrangements for review and learning at an individual service level, and links with Trust-wide mechanisms, may benefit from being strengthened.

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COMMISSIONING

NHS STOKE and NHS NORTH STAFFORDSHIRE

General Comments and Achievements

Mental health services for Stoke and North Staffordshire were commissioned by two PCTs and two Joint Commissioning Units. These linked with district and county councils for Staffordshire, and the unitary authority in Stoke. A Joint Strategic Needs Assessment had been undertaken and clear meeting structures were in place. Many commissioners were involved in these arrangements and reviewers considered that this had the potential for duplication and a lack of focus in interactions with providers, especially North Staffordshire Combined Healthcare NHS Trust.

The Specialist Mental Health services sections of this report contain many issues in which commissioners will have an interest, in particular, monitoring that appropriate progress is made. Specific commissioning issues include:

Further Consideration

1 Reviewers suggested that commissioners should consider identifying a lead commissioner for mental health services who would be the focus for the development and implementation of the phase 2 strategy. This may enable the development of more specialist expertise in commissioning mental health services. Commissioners may also then be better able to respond to the more business-like approach being taken by North Staffordshire Combined Healthcare NHS Trust as part of its preparation for Foundation Trust status.

2 See Health Economy section of this report about the need to move forward the development of the phase 2 strategy as quickly as possible. If commissioners are not structured effectively to lead this soon then the main provider will, of necessity, be making changes in the absence of a strategic direction.

3 Specific commissioning issues are identified in the Primary Care-Based Psychological Therapies, Liaison Service and Assertive Outreach sections of this report.

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Health Services for People with Learning Disabilities

Good Practice

1 Strong 'People's Parliaments' and Partnership Boards were running in Staffordshire and in Stoke. Service users were actively involved in these and central to the work being undertaken.

Primary Care

General Comments, Achievements and Good Practice

Two primary care teams covered NHS Stoke and NHS North Staffordshire respectively with three health facilitators in Stoke and one in North Staffordshire. These teams linked effectively with general practices and with specialist learning disability services. A learning disability toolkit had been developed and training had been undertaken to support its implementation in primary care. All practices were involved with producing health action plans and registers had been audited. The health facilitators also provided support to people with complex needs who were living in the community.

Further Consideration

1 Health Action Plans were in a variety of formats but there were plans to develop a more standardised approach. Further work is needed to improve collection of data on the number of people with learning disabilities who have a Health Action Plan, and to improve the timeliness with which Health Action Plans are issued following annual health checks.

Specialist Learning Disabilities Services

General Comments and Achievements

Specialist learning disability services were provided through two community learning disability teams, an 18 bed in-patient unit in Chebsey Close and the assessment and treatment unit (Telford). These services had been through a great deal of change, including organisational change, staff changes, national initiatives and local initiatives. In spite of this change, staff remained very positive about delivering services and about the need for further change.

Advocacy services were well developed and had good links with voluntary groups and volunteering opportunities. Some excellent community-based groups had developed including specific groups for women's health and men's health and also a relationship group which helped service users to manage their emotions more effectively.

The in-patient unit had developed a good relationship with the local GPs. All the residents were registered with a GP which gave them good access to primary care.

The in-patient facility had a multi-sensory room where service users could relax.

Good Practice

1 The activity worker provided very good, person-centred support to give service users, including picture maps and pictures including religious festivals and activities.

2 Several nurse-led initiatives had been developed including primary care liaison, sexual health and gender-specific groups.

Concerns

1 Senior leadership of the services with a clear vision for their future development was not yet in place. Staff who met reviewers were not clear about the strategic leadership above the service level and who was responsible for championing learning disabilities services in terms of appraising the good work taking place as well as the challenges facing the services across the health economy.

2 **Operational Policies and Clinical Guidelines:** See mental health Trust-wide section of this report.

3 In the inpatient unit at Chebsey Close, some service users had been on site for over three years. Some people had been resident since the 1990's even though the unit was for assessment and rehabilitation. Further work needs to be undertaken on the pathway for this group of users, including working with commissioners.

Further Consideration

1 The outcomes and objectives in the care plans seen reviewers seemed to be written for professionals with easy read incorporated for the initial components of the care plan only. Development of a full easy-read care plan should be considered.

2 Arrangements for clinical supervision were in place but supervision was sometimes informal and was not always documented. Many staff had worked together for a long time and it may be helpful to consider how appropriate challenge can be brought into clinical supervision arrangements.

3 The environment in the Assessment and Treatment Unit (Telford) may benefit from some attention in order to improve the service user experience.

COMMISSIONING

NHS STOKE and NHS NORTH STAFFORDSHIRE

General Comments and Achievements

Commissioners had a good understanding of the strengths and weaknesses of the services that were commissioned. Commissioners were aware that a change in approach was needed and a national review had been arranged with the remit to challenge existing models of service provision. Commissioners were involving service users in order fully to understand their requirements of the service. Reviewers supported the approach that was being taken and did not underestimate the amount of work involved in moving to new models of care. There was evidence of good partnership working and collaboration between the commissioners for the two areas. An Autism Partnership Board had been established.

Concern:

1 In the inpatient unit at Chebsey Close, some service users had been on site for over three years. Some people had been resident since the 1990's even though the unit was for assessment and rehabilitation. Further work needs to be undertaken on the pathway for this group of users.

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SERVICES FOR PEOPLE WITH DEMENTIA

MEMORY SERVICES

Two ward areas and one of the five memory clinics were reviewed in detail.

General Comments, Achievements and Good Practice

Services to people with dementia were person-centred and provided by committed and enthusiastic staff. Service users and carers were very positive about the care they received. The service managed to achieve a very flexible response to service users' and carers' needs. Relationships with social care were good. The in-patient assessment ward for people with complex needs was well-organised and had a high rate of enabling people to return home. Specialist support was available for people with substance misuse and for people needing neuropsychiatry.

Good Practice

1 A very good dementia pathway was in place which had been audited. The diagnostic process at the 'hub' was very efficient, including the possibility of buses to the hub.

2 A specific Mental Health and Vascular Well-Being Service was in place with nurses trained in cognitive behavioural therapy.

3 A care home liaison team had undertaken a programme of training for care home staff.

Immediate Risks: None

Concerns: None

Further Consideration

1 The team was considering further improvements to the care provided including the development of a rapid assessment team.

2 Audit of GP pre-referral screening may be helpful to ensure that all GPs are undertaking the expected screening.

3 There were some differences in the pathway between Stoke and North Staffordshire. Further consideration and evaluation of these may be helpful to ensure that the most responsive services are provided for both areas.

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COMMISSIONING

NHS STOKE and NHS NORTH STAFFORDSHIRE

General Comments and Achievements

Several commissioners were involved with commissioning services for people with dementia. A population needs assessment had not yet been undertaken. A Clinical Reference Group was in place and, for Stoke, a Local Implementation Team.

Further Consideration

1 As with mental health services (see above) reviewers considered that the involvement of so many commissioners had the potential for duplication and a lack of focus in interactions with providers, especially North Staffordshire Combined Healthcare NHS Trust. Reviewers suggested that commissioners should identify a lead commissioner for services for people with dementia. Reviewers were concerned that the progress made in improving services for people with dementia would not be sustained without a clear commissioning focus.

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CARE OF VULNERABLE ADULTS IN ACUTE HOSPITALS

UNIVERSITY HOSPITAL OF NORTH STAFFORDSHIRE NHS TRUST

During the visit, reviewers looked at Trust-wide guidelines and policies and tested their implementation in the following clinical areas:

City General: Ward 122 (Frail Elderly Assessment Unit), Ward 123, Ward 108 and Ward 105(day case surgery)

Royal Infirmary: Accident and Emergency and Short Stay Unit Ward 19 (Fracture Neck of Femur Ward, Ward 1 (Neurology)

General Comments and Achievements

Staff were welcoming and passionate about what they were doing, and had pride in their work. Patients appeared well cared for in all the areas visited. The Trust was working well with community groups. For example, the Tissue Viability group was working with local community groups to help raise awareness. The Trust had held several health economy-wide user focus groups 'Big Conversations'. The Safeguarding Nurse had been in place for 12 months and was well known across all sites. Social Workers were based in the Trust which helped with the management of complex discharges. 'Clinical Champions' for vulnerable people had been implemented. A Quarterly safeguarding newsletter was produced. Discharge facilitators were present on the Frail Elderly Admissions Unit and were being introduced into wards. Good use was being made of volunteers. Matrons were giving good leadership. The Trust was going through an organisational change exercise and reviewers recognised that improving achievement of quality indicators was not easy in this climate.

Good Practice

1 The Frail Elderly Assessment Unit was an excellent concept and the unit was working well. Impressive data were available showing that patients were being actively moved out of the acute hospital. The ward environment was designed to focus on rehabilitation and recovery.

2 The 'Missing Patients' policy had clear flow charts covering different types of absences and actions required. The policy covered all patients within the Trust (i.e. not just in-patients).

3 The 'pressure area care' leaflet for patients was very good. It gave clear visible information about what to look out for and who to contact for further advice.

Immediate Risks: None

Concerns

1 Mental health liaison services were limited and, as a result, patients were often admitted while awaiting a mental health assessment. The response for adults aged less than 65 relied on the crisis team attending the acute hospital. Consideration was being given to the development of a mental health liaison service within the acute Trust.

Further Consideration

1 The discharge policy was under review and was not yet explicit about arrangements for discharging people who are particularly vulnerable.

2 Patient information was not easily accessible in the clinical areas visited and it was not clear how those who were not mobile would be able to access the information that was available.

3 A 'Wander guard' was in use but this was not reflected in appropriate Trust policies.

4 There were some examples of good learning and development at an individual service level but this was not evident in all of the clinical areas visited. Further development of local review and learning mechanisms may be helpful, including increasing feedback to staff from root cause analyses.

5 Several different working groups were looking at various care groups. It was not clear that membership and attendance was always appropriate for the work being undertaken and, as a result, expectations may not be achieved.

6 The key performance indicators that were being used were not all consistent and up to date in the areas viewed. It was not clear that staff understood which indicators were relevant to their work.

7 'Comfort rounds' were in place in four areas visited and appeared to be improving care. Evaluation and, if appropriate, implementation across other areas should be considered.

8 Policies were generally quite wordy and may benefit from review to ensure that staff are able to access the information quickly. Policies also often included cross-references to other policies (for example, the section about DoLS in nursing and medical guidelines referred staff to the consent policy) which may make it difficult for staff to understand what was required.

9 Based on the evidence available, medical staff training in safeguarding, MCA and DoLS did not appear to be being robustly implemented and monitored.

10 Competences were available for band 5 staff but not for all other staff. Further work on competences for all staff and mechanisms for ensuring these are achieved may be helpful.

11 Staff were not always clear how to access interpreters outside of normal working hours.

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COMMISSIONING

NHS Stoke and NHS North Staffordshire

No specific commissioning issues were identified.

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APPENDIX 1 MEMBERSHIP OF VISITING TEAM

Dee Roach	Director of Quality, Innovation and Patient Experience	Birmingham & Solihull Mental Health NHS Foundation Trust
Iftikhar Ahmed	Clinical Director - CMHS	Dudley & Walsall Mental Health Partnership NHS Trust
Julie Bone	Clinical Governance & Audit Facilitator	NHS Telford & Wrekin
Marie Campbell	Community Nurse/Care Manager	Sandwell PCT
John Copping	Carer	Carers in Partnership
Felix Davies	Director of Psychological Services	South Staffordshire & Shropshire Healthcare NHS Foundation Trust
Andy Dixon-Smith	Service User	
Lucy Dunstan	Support Worker	Listen Not Label
Kaye Fawcett	Nursing Director	University Hospital Birmingham NHS Foundation Trust
Moni Grizzell	Sister	NHS Wolverhampton
Derek Hammond	Acute Inpatient Service Lead	Worcestershire Health and Care NHS Trust
Nicola Harvey	Carer / Counsellor / Psychotherapist	Carers In Partnership
Amanda Hill	Operational Manager - Rehabilitation, Recovery and Complex Care	Coventry & Warwickshire Partnership NHS Trust
Joy Jeffrey	Head of Nursing	Sandwell PCT
Emma Langford	Clinical Coordinator	Worcestershire Health and Care NHS Trust
Kate Mansell	Ward Manager	South Staffordshire & Shropshire Healthcare NHS Foundation Trust
Dhanjeev Marrie	Locum Consultant Older Adult Psychiatrist	Worcestershire Health and Care NHS Trust
Sundara Moily	Associate Specialist in Psychiatry	Dudley & Walsall Mental Health Partnership NHS Trust
Carol Molloy	Service Lead for Assertive Outreach	South Staffordshire & Shropshire Healthcare NHS Foundation Trust
Lawrence Moulin	Strategic Management Lead for Mental Health and Learning Disabilities	NHS Midlands and East
Siraaj Nadat	Carer	Listen Not Label
Siobhan Perkins	Quality & Safety Manager	Wye Valley NHS Trust
Bobbie Petford	IAPT Training Lead and Course Lead for Postgraduate Certificate in Low indensity Psychological Interventions in Primary Care	
Amarjeet Rebolo	Carer	Carers in Partnership
Diane Rhoden	Adult Safeguarding Lead Nurse	Sandwell & West Birmingham Hospitals NHS Trust

Fiona Ritchie	Associate Director	Worcestershire Health and Care NHS Trust
Kit Roberts	Joint Commissioner - Adults with Learning Disabilities	Telford & Wrekin Council and NHS Telford & Wrekin
Philip Swarbrick	SpeakEasy N.O.W Worcestershire	
Helen Swindlehurst	Commissioner - Partnerships	Shropshire County PCT
Sarah Taylor	Practice Educator - Service User and Carer Promotion	Worcestershire Health and Care NHS Trust
Angela Thompson	Associate Specialist - Palliative Care Lead Paediatrician	Coventry & Warwickshire Partnership NHS Trust
Mark Weaver	Associate Medical Director and Consultant Psychiatrist	Dudley & Walsall Mental Health Partnership NHS Trust
Lois Wilson	Clinical Team Leader	Black Country Partnership NHS Foundation Trust
Amy Wood	CR / HT Team Leader / Occupational Therapist	Worcestershire Health and Care NHS Trust

WMQRS Members

Jane Eminson	Acting Director	West Midlands Quality Review Service
Sarah Broomhead	Quality Manager	West Midlands Quality Review Service
Elaine Woodward	Mental Health, Dementia & Learning Disabilities Lead	West Midlands Quality Review Service
John Levy	Mental Health, Dementia & Learning Disabilities Lead	West Midlands Quality Review Service

APPENDIX 2 COMPLIANCE WITH THE QUALITY STANDARDS

Analyses of percentage compliance with the Quality Standards should be viewed with caution as they give the same weight to each of the Quality Standards. Also, the number of Quality Standards applicable to each service varied depending on the nature of the service provided. Percentage compliance also takes no account of 'working towards' a particular Quality Standard. Reviewers often comment that it is better to have a 'No but', where there is real commitment to achieving a particular standard, than a 'Yes but' – where a 'box has been ticked' but the commitment to implementation is lacking. With these caveats, table 1 summarises the percentage compliance for each of the services reviewed.

Table 1 - Percentage of Quality Standards met

Service	No. Applicable QS	No. QS Met	% met	No. services / clinical areas
Mental Health Services				
NHS Stoke Primary Care General Practice	10	6	60	-
NHS N. Staffordshire Primary Care General Practice	10	6	60	-
North Staffordshire Combined Healthcare NHS Trust (Trust-wide)	11	11	100	-
Primary Care-Based Psychological Therapies: Healthy Minds (Rethink)	30	19	63	1
Primary Care-Based Psychological Therapies: North Staffordshire Wellbeing Service	30	23	77	1
Early Intervention Service	53	44	83	1
Community Mental Health Teams: Lymebrook	55	41	75	1
Community Mental Health Teams: Greenfield	55	44	80	1
Community Mental Health Teams: Bennet	55	39	71	1
Community Mental Health Teams: Ashcombe	55	42	76	1
Crisis Resolution Home Treatment Team	55	32	58	1
Assertive Outreach Service	54	36	67	1
Liaison Service	49	33	67	1
Commissioning - NHS Stoke	14	8	57	-
Commissioning - NHS N. Staffordshire	15	7	47	-
Health Economy	**551**	**391**	**71**	**-**
Health Services for People with Learning Disabilities				
NHS Stoke Primary Care General Practice	9	8	89	1
NHS N. Staffordshire Primary Care General Practice	9	8	89	1
Specialist Learning Disabilities Service	50	33	66	4/4
Commissioning - NHS Stoke	18	15	83	-
Commissioning - NHS N. Staffordshire	18	14	78	-
Health Economy	**104**	**78**	**70**	**-**

Service	No. Applicable QS	No. QS Met	% met	No. services / clinical areas
Dementia Services				
NHS Stoke Primary Care General Practice	**10**	**7**	70	1
NHS N. Staffordshire Primary Care General Practice	10	4	40	1
Memory Service	56	45	80	1
Commissioning - NHS Stoke	17	11	65	-
Commissioning - NHS N. Staffordshire	17	8	47	-
Health Economy	**110**	**75**	**68**	
Care of Vulnerable Adults in Acute Hospitals				
University Hospital of North Staffordshire NHS Trust (Trust-wide)	24	20	83	-
University Hospital of North Staffordshire NHS Trust (Clinical areas): City General Hospital	17	11	65	4
University Hospital of North Staffordshire NHS Trust (Clinical areas): Royal Infirmary	17	11	65	3
Commissioning - NHS Stoke	3	3	100	-
Commissioning - NHS N. Staffordshire	3	3	100	-
Health Economy	**64**	**48**	**75**	-
Totals				
North Staffordshire Combined Healthcare NHS Trust	**578**	**415**	**72**	-
Healthy Minds (Rethink)	**30**	**19**	**63**	-
University Hospital of North Staffordshire NHS Trust	**58**	**42**	**72**	-
NHS Stoke	**81**	**58**	**72**	-
NHS North Staffordshire	**82**	**50**	**61**	-
Health Economy	**829**	**592**	**71**	-

Details of compliance with individual Quality Standards can be found in a separate document.

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