NHS
Herefordshire and Worcestershire
Health and Care
NHS Trust

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Healthwatch Worcestershire
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Dear Mr Gallagher

Healthwatch Service User and Carer Experience Report 2021

Thank you for the final version of the Healthwatch Service User and Carer Experience of South Worcestershire Community and Recovery (CARS) Report. The Community Assessment and Recovery Service welcome and value the Healthwatch report and findings in order to continually improve our services. The CARS service has had an opportunity to review the report and would like to respond to the findings and recommendations.

The report's recommendations covered three main areas:

- Care Coordination and Care Planning
- Communication
- Carers

Each specific recommendation will be addressed below:

- **Ensure all Service Users are allocated and have continual support of a Care Coordinator throughout their time with CARS.**

The Care Programme Approach (CPA) describes a framework originally introduced in the 1990s to ensure that the care of people with severe mental health problems was effectively coordinated within secondary mental health services.

In March 2008 the Department of Health issued updated guidance called 'Refocusing the Care Programme Approach Policy and Positive Practice Guidance' which took account of the move towards a 'personalised' approach to community mental health services.

CPA should be viewed as an approach to working in situations where more than one professional or agency is involved and clarity is therefore needed about whom does what.

The Care Programme Approach is used in secondary mental health care to assess, plan, review, and co-ordinate the range of treatment, care and support needs for people in contact with secondary mental health services that have complex characteristics.

The revised guidance outlined the distinction between the two levels of mental health care/recovery planning:

- Care Programme Approach (CPA) for patients who need multi-agency support; active engagement; intense intervention; support with dual diagnoses; and who are at higher risk, requiring the support of a Care Coordinator
- Non CPA the term used to reflect the service needs described in the Department of Health's 2008 'Refocusing the Care Programme Approach' for patients with less complex needs, requiring the support of a Lead Clinician.

The Community Assessment and Recovery Service (CARS) offer both these care pathways, with suitability of patients being identified through a Multi-Disciplinary Team (MDT) meeting. Consequently CARS would not offer a Care Coordinator (CC) to every patient receiving a service from them. It should be noted that only patients on the Care Programme Approach (CPA) will have an allocated Care Coordinator as all other patients would be supported by a Lead Clinician as described above.

Where there may be changes in the level in the complexity of need and support required by the patient, Lead Clinicians can discuss the patient at the MDT meeting and changes in the level of CPA can be made if appropriate.

The CARS Teams have processes in place to expedite the timely allocation of patients to either Care Coordinators or Lead Clinicians within timescale not expected to exceed 7 days.

The current CARS caseload for CPA/Non CPA is 297/1268.

- **Ensure all Service Users have a written, up to date, holistic Care Plan and that they and their Carers are fully involved in its development.**

Patients within CARS who are seen in medical outpatients by the Psychiatrist do not, generally, receive a Care Plan. Developments in their care are usually communicated directly to the patients GP by the Psychiatrist and junior medical team. All patients on CPA will have a comprehensive recovery plan which also generates, at the least, an annual Care Plan review.

CARS Operational Managers and Clinical Leads undertake a monthly documentation audit. This report measures a number of key standards and expectations related to the completion of assessments and the development of recovery plans. Recent positions demonstrate that 95% of the caseload has an up to date recovery/care plan in place. The current documentation audit tool also assesses the level of service user and carer involvement in the developing of the recovery plan, by using standards associated with

the 'Personalisation' of the recovery/care plan, with a recent position demonstrating 95% compliance with these standards.

It is recognised that the audit tool does not demonstrate if the recovery/care plan is shared in written form with the patient or their carers. These standards can be added to the audit though it must be recognised that not all patients want their carers to be involved and this decision must be respected.

Action: **CARS Senior Clinical Lead to liaise with Carenotes team to add care plan sharing section and review the current audit tool to incorporate questions to measure the sharing of the recovery/care plan**

Documents Completed	% Completed Baseline (November 2019)	% Completed Position (December 2020)	% Completed Current Position (January 2021)
Needs Assessment	28.3	95	100
Personalised	24.4	80	95
Recovery Plan	24.5	85	95
Crisis Plan	46.7	95	100
GRIST (Risk Assessment)	37	100	95
MH Risk & Safety Management Plan	13	100	95

- **Plan to ensure continuity of service when staff leave.**

Continuity of care is an essential part of providing safe and effective services; all community mental health teams have a number of processes in place to ensure service continuity. All clinical services are expected to have up to date business continuity and recovery plans, that are reviewed at least annually, and that outline measures to be taken for when staff leave or if they are unavailable to work for short or long term periods. This would include 'The Associate Worker Policy'. This policy contains provisions including;

- If a staff member is absent then they have 2 nominated and assigned workers to pick up any planned work or additional work if a patient is in a crisis
- If a staff member is leaving the service; the team will write to all the patients on that staff member's caseload to inform them of the departure and the patients are provided contact details for the team and also the crisis team number.

When a team member leaves the CARS Operational Manager and Clinical Leads complete an in depth caseload review and reallocation, which includes a handover of clinical care to the new care coordinator.

Additionally the CARS team have a "Daily Huddle" every morning and this is an opportunity for staff to discuss patients that they are concerned about and workload pressures or concerns such as staff sickness. This is to ensure that the Team has oversight of all the immediate clinical and operational issues within the team.

The role of the Multidisciplinary Team Meetings (MDT) in both Worcester City and Evesham is also key to ensuring a level of clinical continuity for all service users. Patients who have been in crisis or had contact from the Home Treatment Team (HTT) overnight will be discussed in the MDT and are added to the daily huddle discussion which may lead to a follow up contact.

There is a duty system in place for patients between the hours of 09:00 -17:00 from Monday – Friday. If these cases require further discussion then it will be added to the next MDT or escalated to a duty psychiatrist for immediate consideration.

- **Ensure that all Service Users have their communication needs recorded and adhered to as per the NHS Accessible Information Standard. For example, an alternative communication channels other than telephone for Service Users who have a hearing impairment.**

The Trust has an Accessible Information Policy and an Interpreting and Translation Policy which all clinical staff are expected to be aware of. These policies outline the expected standards for assessing and supporting people with communication needs.

The current CARS process requires that a communication needs form is completed by the referral triage team at the Single Point of Access which is then sent to the relevant team. The form is reviewed and updated by the accepting team as necessary. Communication alerts can also be added onto the electronic patient record system and care plans to support communication can be developed where required.

Accessible Information Standards performance data is collected and reported on a monthly basis within the SDU performance meetings

Action: **CARS Operational Manager to circulate the Accessible Information Policy and an Interpreting and Translation Policy to clinical staff within CARS.**

Complete x3 Monthly Accessible information Standards audits to demonstrate increased adherence with the policy

Clinical leads to outline how to access interpreting services to staff in Business meeting and individual line management supervision.

- **Provide information to all Service Users and their Carers on referral to CARS, detailing the service they have been referred to and what they can expect from the service. This should include time scales, contact information including crisis contact details and the complaints process.**

The initial appointment letter contains information on the CARS service, including service contact numbers, the crisis number and the Patient Advice and Liaison Service (PALS) contact details should they need support with a query or they wish to make a complaint. In the most recent Assessment clinic patient survey (April 2021) and the Step Forward to Recovery Clinic Survey (April 2021) 100% of patients in both surveys knew who to contact out of hours if they were in a crisis.

CARS see all new patients within 4 weeks waiting time which is significantly shorter than the 18 week commissioned target. All new assessments are undertaken by Medical staff and a nurse from the CARS Team. Following the assessment the clinicians make a formulation and recommendations which are then discussed in MDT. This ensures that the treatment recommendations are made collaboratively with the involvement of several CARS clinicians. The treatment plan is then shared with the service user and the service user's GP within 14 days of the assessment. If the patient's clinical needs can be better

met by another service then they are signposted to that service. As has been discussed earlier in this response, consent to share with carers is required before any information can be shared.

To ensure alignment with ACHOMS (The Accreditation of Community Mental Health Services) the CARS teams will produce a leaflet for carers that will include information about the Worcestershire Association of Carers, their entitlement to a Carers Assessment and information about the Jigsaw Carer Support Group.

Action: Production of a CARs service user leaflet and a leaflet for Carer's.

- **CARS should review their response rates to calls given the comments we received about the difficulty Service Users, Carers and on occasion their GP's had contacting the service.**

In the last 4 months there has been a significant issue with the phone line at Studdert Kennedy House which has resulted in callers gaining the impression that the phones are just ringing out unanswered. This occurs when all lines are in use and callers do not obtain an engaged signal. The building is owned and managed by Worcestershire County Council and this issue has been repeatedly escalated to their telephone communications department.

All service users should have access to the Crisis number and this is on all letter templates. The report suggested the service do not use Zoom or Skype however, the Trust use similar software called WebEx.

GPs are very welcome to attend the MDT meetings. The Associate Medical Director for Worcestershire has been working with local GPs to develop a guidance process for them.

- **Ensure the routine and systematic capture of Carer/Supporter details of all CARS Service Users**

The Administration Management Lead is currently developing a Minimum Data Set (MDS) for the Trust. The MDS would include next of kin and carer details. On completion this will enable regular reporting on completion and enable improvement plans to be developed where necessary. CARS Team reception staff are tasked with asking all patients to update the details when attending clinics for appointments.

Action: Develop Minimum Data Set form for the trust which will capture carer support details along with NOK details

The CARS Service Managers would like to take this opportunity to thank those at Healthwatch for their supportive 'critical friend' approach and their ongoing candour. We firmly believe that the process of continuous improvement relies, very much on organisations opening themselves up to being reviewed and monitored by interested parties who have the needs of the service user and their carers and families at the heart of what they do.

It is in this spirit that the service is embarking on the journey towards Royal College of Psychiatrist Accreditation of Community Mental Health Teams (ACOMHS).

We feel that the regular the oversight of Healthwatch has helped improve our service over the years and has put us in good stead for this new stage of our development and we look forward to reporting on a very much improved picture following our next Healthwatch review.

Yours sincerely

Derek Hammond
Community Service Manager (Worcestershire)

Healthwatch's Service User and Carer Experience Report Action Plan CARS 2021

Recommendation	Action	Responsibility	Target date
Ensure all Service Users are allocated and have continual support of a Care Coordinator throughout their time with CARS.	Action complete – Assurance contained within the report.		
Ensure all Service Users have a written, up to date, holistic Care Plan and that they and their Carers are fully involved in its development.	CARS Senior Clinical Lead to liaise with Carenotes team to develop a care plan sharing section to enable the generation of audit reports CARS Senior Clinical Lead to review monthly audit tool to demonstrate evidence of the Recovery/care plan being shared with the service user and/or their carers.	CARS Clinical Lead CARS Clinical Lead	30/08/21 30/08/21
Plan to ensure continuity of service when staff leave.	Action complete – Assurance contained within the report.		
Ensure that all Service Users have their communication needs recorded and adhered to as per the NHS Accessible Information Standard. For example, an alternative communication channels other than telephone for Service Users who have a hearing impairment.	CARS Operational Manager to circulate the Accessible Information Policy and an Interpreting and Translation Policy to clinical staff within CARS. Complete x3 Monthly Accessible information Standards audits to demonstrate increased adherence with the policy Clinical leads to outline how to access interpreting services to staff in Business meeting and individual line management supervision.	CARS Ops Manager CARS Clinical Lead CARS Ops Manager	30/06/21 30/09/21 30/09/21
Provide information to all Service Users and their Carers on referral to CARS, detailing the service they have been referred to and what they can expect from the service. This should include time scales, contact information including crisis contact details and the complaints process.	Production of a CMHT service user and carers leaflet.	CARS Clinical Lead	31/08/21

Recommendation	Action	Responsibility	Target date
CARS should review their response rates to calls given the comments we received about the difficulty Service Users, Carers and on occasion their GP's had contacting the service.	CARS to formulate a revised service spec for GP's relating to access / contacting the service. Service provision spec to be shared with GP's For service users and carers this will be incorporated with the CARS leaflet.	CARS Clinical Lead	31/08/21
Ensure the routine and systematic capture of Carer/Supporter details of all CARS Service Users	Develop Minimum Data Set form (MDS) for the trust which will capture carer support details along with NOK details	CARS Admin Lead	31 August 2021