Coventry and Warwickshire Partnership NHS Trust

Inspection report

Trust Headquarters, Wayside House
Wilsons Lane
Coventry
West Midlands
CV6 6NY
Tel: 02476362100
www.covwarkpt.nhs.uk

Date of inspection visit: 06 Aug to 04 Oct 2018
Date of publication: 21/12/2018

We plan our next inspections based on everything we know about services, including whether they appear to be getting better or worse. Each report explains the reason for the inspection.

This report describes our judgement of the quality of care provided by this trust. We based it on a combination of what we found when we inspected and other information available to us. It included information given to us from people who use the service, the public and other organisations.

This report is a summary of our inspection findings. You can find more detailed information about the service and what we found during our inspection in the related Evidence appendix.

Ratings

Overall rating for this trust	Good
Are services safe?	**Requires improvement**
Are services effective?	**Good**
Are services caring?	**Good**
Are services responsive?	**Good**
Are services well-led?	**Good**

We rated well-led (leadership) from our inspection of trust management, taking into account what we found about leadership in individual services. We rated other key questions by combining the service ratings and using our professional judgement.

Summary of findings

Background to the trust

Coventry and Warwickshire Partnership NHS Trust provides a range of mental health and learning disability services for people of all ages in Coventry and Warwickshire. The trust provides a range of community physical health services to people in Coventry. The trust provides specialist services to people who also live outside of the region, and community and day clinics to people who live in Coventry, Warwickshire and Solihull.

Coventry and Warwickshire Partnership NHS Trust was formed in 2006 and integrated with community services from NHS Coventry in April 2011. The organisation now provides services from more than 60 locations with an income of about £200 million, and employs more than 4,000 dedicated staff.

The Trust has three core operational service areas:

- Acute Services
- Child and Family Services
- Integrated Community Services

The trust delivers the following mental health services:

- Community-based mental health services for older people
- Long stay/rehabilitation mental health wards for working age adults
- Acute wards for adults of working age and psychiatric intensive care units
- Wards for older people with mental health problems
- Community-based mental health services for adults of working age
- Mental health crisis services and health based places of safety
- Community mental health services for people with learning disabilities
- Wards for people with learning disabilities
- Forensic inpatient/secure wards
- Specialist community mental health services for children and young people

The trust also provides an inpatient eating disorder unit and a community eating disorders service. The trust works in a partnership arrangement with other NHS trusts, NHS England and third party organisations to provide mental health services for armed forces veterans.

The trust provides the following community health services:

- Community health services for adults
- Community health services for children, young people and families
- End of life care
- Community dental services

In addition, the trust also runs the following residential services regulated by CQC as adult social care services.

- Wall Hill Road

Summary of findings

- Shirlett Close
- Park Paling

The trust forms part of the Coventry and Warwickshire Sustainability and Transformation Partnerships, working with the following organisations:

- Coventry and Rugby Clinical Commissioning Group
- Coventry City Council
- George Eliot Hospital NHS Trust
- South Warwickshire CCG
- South Warwickshire NHS Foundation Trust
- University Hospitals Coventry and Warwickshire NHS Trust
- Warwickshire County Council
- Warwickshire North Clinical Commissioning Group
- There was further engagement in the design plans for the Sustainability and Transformation Partnerships with voluntary groups, Healthwatch, GPs and social care leads.

We carried out a focused inspection on wards for older people with mental health problems in November 2017, to see if the trust had carried out the necessary actions they were required to take. We found that the trust had made a number of improvements to address the issues contained in the Warning Notice and the report was published in February 2018.

Community health services for adults, community health services for children, young people and families, and end of life care services were inspected in April 2016 and the reports were published in July 2016. Community dental services were inspected in June 2017 and the report published in November 2017. A follow-up focussed inspection of the eating disorders inpatient unit was carried out in February 2018 and the report published in April 2018.

Overall summary

Our rating of this trust improved since our last inspection. We rated it as Good

What this trust does

Coventry and Warwickshire Partnership NHS Trust provides mental health services to all ages across Coventry and Warwickshire. It also provides community physical health services to the people of Coventry.

Key questions and ratings

We inspect and regulate healthcare service providers in England.

To get to the heart of patients' experiences of care and treatment, we ask the same five questions of all services: are they safe, effective, caring, responsive to people's needs, and well-led?

Where we have a legal duty to do so, we rate the quality of services against each key question as outstanding, good, requires improvement or inadequate.

Where necessary, we take action against service providers that break the regulations and help them to improve the quality of their services.

Summary of findings

What we inspected and why

We plan our inspections based on everything we know about services, including whether they appear to be getting better or worse.

We inspected seven complete core services:

- Community-based mental health services for older people
- Acute wards for adults of working age and psychiatric intensive care units
- Wards for older people with mental health problems
- Mental health crisis services and health based places of safety
- Specialist community mental health services for children and young people
- Community health services for adults
- End of life care

Our comprehensive inspections of NHS trusts have shown a strong link between the quality of overall management of a trust and the quality of its services. For that reason, we also inspected the well-led key question for the trust overall. We summarise what we found in the section headed Is this organisation well-led?

What we found

Overall trust

Our rating of the trust improved. We rated the trust as good because:

- The trust had made a number of improvements since the previous inspection in June 2017. We rated effective, caring, responsive and well-led as good, and safe as requires improvement. Our rating of effective, responsive and well-led had improved from requires improvement to good from the previous inspection in June 2017.
- We rated five of the trust's seven core services as good and two services as requires improvement that we inspected on this occasion. In rating the trust, we took into account the previous ratings of the seven core services not inspected this time.
- There was improved collective leadership and the trust had worked with and learnt from other NHS trusts to develop a culture of quality improvement. The trust had embedded a number of initiatives since the previous inspection of June 2017 that included; its vision and values, a workforce strategy, an electronic patient records system, and staff recognition and rewards.
- The trust had worked with NHS Improvement and clinical commissioning groups specifically to reduce the waiting lists for some children and young people with mental health problems and plan the upgrade of wards to reduce risk in acute mental health wards for adults of working age.
- The trust had identified three empty wards and had worked with NHS partners to design safer adult mental health wards for adults of working age. The work had started and there were clear plans in place for completion. To make patients safer, the trust and staff had robust risk assessments and care plans in place to reduce the risk of patients tying a ligature and in the use of seclusion.

Summary of findings

- For children and young people with mental health problems, the trust had significantly improved triage processes since the previous inspection in June 2017. This meant referrals were reviewed more quickly. The trust was working with partners across local the health and social care economy to reduce the impact on children and families who were waiting for treatment. Systems and processes were in place to monitor assessment and treatment times. However, there was further work to undertake to reduce waiting times for treatment, especially in neurodevelopment services.
- The trust had good awareness of risk and was working collectively to monitor and address the main risks to the trust. Risks included the recruitment and retention of staff, financial sustainability whilst maintaining quality and safety to patients, and the upgrade of existing buildings and wards.
- The trust had improved the way it worked with stakeholders across the health and social care economy of Coventry and Warwickshire. The trust continued to work with the public to design and improve services as part of its equal partners strategy. This had supported the Board's awareness of local priorities to support care to local people. The trust continued to work with neighbouring mental health NHS trusts to develop new models of care to improve quality and safety.
- The trust had further work to complete to support staff from minority or diverse groups. However, the experience of staff from these groups had shaped the development of specific support groups to black and minatory ethnic staff, LGBT staff and those staff who have a disability.
- The trust had planned and was making effective use of technology to improve quality and safety to patients. There was outstanding use of medically certified technology in older people's mental health wards and innovative approaches when working with stakeholders across Coventry. The IT department were leading the drive to make access to patient clinical records timely between the trust and GP services.

However:

- There were still problems with medicines management across the trust. Not all areas across the trust stored and administered medicines safely. Although the trust had introduced new processes and equipment since the last inspection in June 2017, not all staff or teams adhered to safe medicines management.
- Some wards did not have enough regular staff to meet the needs of patients. This meant that activities and leave were cancelled and it had an impact on the morale of permanent staff. However, the trust recognised this was a risk and had improved ways to recruit and retain staff.
- We found that further improvements needed to be made to support managers to access information related to training, supervision, risk and audit.

Our full Inspection report summarising what we found and the supporting Evidence appendix containing detailed evidence and data about the trust is available on our website – www.cqc.org.uk/provider/RYG/reports.

Are services safe?

Our rating of safe stayed the same. We rated safe as requires improvement because:

- We found a number of concerns related to the management of medicines across the trust. Across mental health wards for older people, acute wards for adults of working age and crisis teams, where medicines were stored, staff did not implement effective actions to keep room temperatures within the recommended range. This is what we also found at the previous inspection in June 2017.
- We had concerns about the low numbers of permanent staff in core services and the reliance of bank and agency staff to cover shifts. This was most noticeable in acute mental wards for adults of working age, community health services

for adults and wards for older people with mental health problems. There were a high number of staff vacancies in these services. This had an impact on staff morale in acute mental wards for adults of working age. However, the trust where possible, used regular bank staff to cover shifts. The trust, as part of the MERIT Vanguard, was working with three partner NHS trusts to recruit staff. This trust was employing innovative ways to recruit and retain staff.

- In community health services for adults, safety checks on a number of items of equipment had not been undertaken by the trust. We told the trust and they were addressing the problem. In other core services managed by the trust, staff had undertaken the necessary checks.

However:

- Since the last inspection in June 2017, the trust had improved the way it managed the risks to children and young people who accessed specialist community mental health services. The trust had a central safeguarding team in place that supported staff to report, manage and reduce risk consistently.
- There were clear plans in place to reduce the risks to adults of working age who were admitted to acute mental health wards and psychiatric intensive care units. This included the re-design and refurbishment of wards to make them safer and robust risk assessments across clinical teams.
- Staff undertook thorough risk assessments that considered all relevant factors. Risk assessments across the trust were up to date and met the needs of patients, families and staff. There was effective collaboration between multidisciplinary staff when risk was assessed. There were regular handovers between shifts and staff huddles to discuss risk regularly. Staff also used patient status at a glance boards to display important patient information that supported their role.
- Staff knew how to identify and report risk to managers. We saw learning shared from incidents across teams and robust systems were in place to monitor and reduce risk. The trust had a dedicated quality and safety team that linked positively with clinical teams and supported staff to deliver safe care and treatment.

Are services effective?

Our rating of effective improved. We rated services as good because:

- Following the previous CQC inspection in June 2017, the trust had improved the monitoring of physical healthcare on wards for older people with mental health problems. The trust had improved the access to, and the quality of training, in dementia and physical healthcare across the trust. Staff monitored patients' physical healthcare across the trust.
- Following the previous CQC inspection in June 2017, the trust had improved access to clinical supervision for staff. Staff reported in most services that they had received clinical supervision. The trust did not have an effective mechanism to capture this data but were introducing a new IT system that would support managers' monitoring this data. Staff working in acute wards for adults of working age and psychiatric intensive care units did not always receive clinical supervision because of staff shortages.
- The trust had improved access to Mental Health Act and Mental Capacity Act training across the trust since the last inspection in June 2017. The trust trajectory for training in these areas was 95% by December 2018 and completion by the end of March 2019. The trust average for training the Mental Health Act in June 2018 was 66% however, the average for staff working in clinical areas was above 75%. Training figures in community health services for adults in the Mental Capacity Act were low. There was good staff awareness and knowledge of the Mental Health Act and Mental Capacity Act cross the trust. We found evidence of discussions related to these Acts in patient records. Staff working in community mental health services for children and young people had a good understanding of Gillick competence.

Summary of findings

- Most staff had the necessary skills to provide care that was safe. Staff were able to deliver treatment and therapy to meet the needs of patients. Staff used a range of recognised rating scales to assess and record severity and outcomes for patients. Most core services undertook audits to monitor the effectiveness of clinical outcomes and shared the learning within their teams. However, the trust needed to strengthen the use of audits in end of life services and community health services for adults.

However:

- We could not find recorded evidence of capacity assessments in wards for older people with mental health problems and acute wards for adults of working age and psychiatric intensive care units, in line with trust policy and national guidance. Although we could not find evidence of any impact to patient care or welfare, staff should have recorded the decisions they made on an individual's mental capacity.

Are services caring?

Our rating of caring stayed the same. We rated services as good because:

- Staff were compassionate, kind, caring and worked hard in their roles. Staff were discreet when they needed to be and placed the patient at the centre of their care pathway. Some staff went above and beyond in the work they did with patients and this was observed in community based mental health services for older people.
- Staff met the emotional, physical, social and mental health needs of patients. Staff recognised the importance of diversity in planning care, including, cultural, religious and gender. Where there was a gap, staff acted quickly to ensure the needs were highlighted. For example, to meet the needs of older people of the LGBT community, a poster from a national charity was prominent on the ward highlighting what could be expected from services. Staff in community based services for older people showed exceptional skills when communicating with patients, involving families, especially when distressing information was relayed.
- Staff supported patients and carers to participate in the planning of their care. Patients regularly told us about the detail within care plans and what their discharge arrangements were. Patients and carers knew who to contact in an emergency. Care plans for children and young people using mental health services were specific to this age group and placed them at the centre of their care.
- The trust worked with partners across the health and social care economy to involve patients and carers. The equal partners strategy was embedded and this led to greater collaboration when designing services specifically for patients and carers. The local branch of a national charity had been involved in redesigning and running services for children and young people with mental health problems.

However:

- Not all patients and carers were given a copy of their care plan, including mental health crisis teams and older people's mental health wards.
- Some patients in end of life care services who required equipment to support them had delays in the delivery of equipment. This was because specialist palliative care staff had to refer patients to the community nursing teams solely to order equipment rather than ordering themselves.

Are services responsive?

Our rating of responsive improved. We rated services as good because:

- Patients had access to assessment and treatment in line with national guidelines. Patients and families knew who to contact in an emergency and systems were in place to contact patients who did not attend appointments.

Summary of findings

- Following the previous CQC inspection in June 2017, the trust had reduced the number of patients having to move wards, called sleepovers, whilst treated on acute wards for adults of working age. Patients were consulted about any transfers and these discussions were recorded. At the last inspection, sleepovers had an impact on long stay rehabilitation wards for adults of working age because patients moved from acute mental health beds to these wards. We did not inspect long stay rehabilitation wards at this inspection but the reduction in sleepovers of patients from acute mental health wards meant there was less pressure on this core service. As part of the MERIT Vanguard, the trust had worked with three neighbouring NHS mental health trusts to develop a system where bed availability was monitored across all acute inpatient beds. This meant patients could access an acute mental health bed in their region even if there was not one in their local area. This meant patients were not always placed a long way from their home and community.
- We saw many improvements in the care pathways for children and young people, including triage and assessment. Post assessment, the trust had introduced workshops for parents in the neurodevelopment pathway to access learning about key issues, including how to manage relationships and access family support. Local and operational managers, and the trust board, were aware of the waiting lists and were actively working with local partners to reduce these lists. This included weekly meetings with local commissioners to monitor waiting lists and partnership working with the local authority and education services. However, there was further work to undertake to reduce waiting times for treatment, especially in neurodevelopment services.
- The trust provided services that reflected the needs of the local population. Staff adapted their approach depending on the needs of patients and families. Facilities were appropriate for patients. Wards for older people with mental health problems had been adapted to make them more dementia friendly. Information was available for patients in various formats that was easy to read and accessible. Information packs for patients and carers were detailed and included how to access services, how to make a complaint, how to access advocacy and other important details. The trust was proud of their engagement with diverse groups across Coventry and Warwickshire.
- The trust recorded, highlighted and shared information with others when required, and gained consent when they did so. Staff had access to IT systems that enabled quick access to path results following routine investigations. The trust was leading the work with partners across Coventry to share information in a digital format that would improve the timeliness of clinicians receiving essential clinical information.

Are services well-led?

Our rating of well-led improved. We rated the trust as good because:

- Since the previous inspection in June 2017, the trust board had strengthened the governance of the trust. The trust had worked towards collective leadership and we saw cohesive working across the board and senior leadership team.
- Following the last inspection in June 2017, the trust worked quickly to address the concerns in the warning notice we issued to wards for older people with mental health problems. We undertook a focussed inspection in November 2017 and found improvements had been made that meant we changed our rating to requires improvement. At this inspection, we found that the trust had continued to improve physical health care and monitoring of patients.
- The trust board and senior leaders had the skills, knowledge, experience and integrity to fulfil their roles. They understood the challenges to quality and safety within the trust and were key partners across the local health and social care economy in the sustainability and transformation programme. Board members and senior leaders were visible across the trust.
- There was a clear vision and a set of values that the board, senior leaders and staff believed in that focussed on being a “great place to care”. The strategy for the trust was aligned to the wider health and social care system and services were planned to meet the local population. The board monitored progress against the delivery of the strategy.

Summary of findings

- There was a strong culture of supporting staff and promotion of their well-being that was reflected in their workforce strategy. However, the trust was disappointed by the outcomes of their last staff survey, in particular how staff from a black and minority ethnic (BAME) background felt they were treated. As a result, the trust had undertaken a lot of co-production work with diverse groups and we saw innovative ways that the trust supported BAME and LGBT staff, and those staff who had a disability.
- There were assurance systems in place to monitor risk and performance and these were regularly reviewed and revised. For example, the responsibility for financial governance moved this year from one sub-committee of the trust board to the financial planning and infrastructure committee. There was detailed discussion at board meetings that ensured executives and non-executives understood the financial plan and risks. The safety and quality operational group provided oversight of risk and reported directly to the board. Sixteen sub-groups provided detail to the safety and quality operation group that included information governance, mortality, serious incidents, complaints, and research and innovation. The trust board and senior leaders were aware of the main risks to the trust that included staff recruitment and retention, delivering cost improvements programmes whilst maintaining quality and safety, and maintaining building and IT infrastructures.
- There was a comprehensive and detailed medicines optimisation strategy, which drew on issues raised by the CQC and incorporated external engagement opportunities. This was presented to the trust board by the Chief Pharmacist as part of the annual medicines report. The trust had a programme of clinical audits around medicines' safe storage, medicine administration-missed doses and controlled drugs to identify areas of good practice and concern. Some of these concerns had been actioned, though others were still outstanding at the time of the inspection.
- The board met every two months and had access to the information they required to make decisions. There was discussion in points in the board meeting that were not made public however we questioned whether they should be in the public eye. The trust said they were reviewing aspects of their board meetings and what would be relevant to discuss in public. The board had a plan of visits to clinical services that they undertook bi-monthly. Appropriate governance arrangements were in place in relation to Mental Health Act administration and compliance.
- The trust had completed the roll out of a new electronic patient record system. It was embedded in those services who were first to receive the electronic system.

However:

- Although there were processes in place for the board to have oversight of the quality and safety of care delivery but we found a number of concerns across core services that required improvement and further scrutiny at a local level would support identification of risk issues. For instance, the trust had introduced equipment to improve medicines management but we found mistakes occurring across a number of core services. Also, not all local managers could describe local risk within their services.
- We found concerns about the levels of morale of staff on some acute mental health wards due to low levels of permanent staff and the uncertainty of staff moves when refurbished wards are opened at the Caludon Centre. However, we recognised the work the trust had undertaken to increase staffing levels and engagement with staff to discuss future moves.
- The trust had not addressed environmental risks such as ligature risks and the layout of a seclusion room since the last inspection in June 2017. This meant there was still a risk of patients tying a ligature and patients and staff being harmed whilst moving a patient into seclusion. However, the trust had clear plans in place, alongside NHSI and clinical commissioning groups, to renovate three empty wards, with the work having already started. We found that the trust and ward staff had reduced risk through assessment and care planning.
- Although the trust had introduced improved access to training in the Mental Health Act and the Mental Capacity Act, the levels of compliance had not reached the level expected for staff working across its services.

Summary of findings

Ratings tables

The ratings tables in our full report show the ratings overall and for each key question, for each service, hospital and service type, and for the whole trust. They also show the previous ratings for services or parts of them not inspected this time. We took all ratings into account in deciding overall ratings. Our decisions on overall ratings also took into account factors including the relative size of services, and we used our professional judgement to reach fair and balanced ratings.

Outstanding practice

We found examples of outstanding practice in the following core services:

- Community end of life services
- Wards for older people with mental health problems
- Community-based mental health services for older people
- Specialist community health services for children and young people
- Mental health crisis services and health-based places of safety

For more information, see the Outstanding practice section of this report.

Areas for improvement

We found areas for improvement including five breaches of legal requirements that the trust must put right. We found 33 things that the trust should improve to comply with a minor breach that did not justify regulatory action, to prevent breaching a legal requirement, or to improve service quality.

For more information, see the Areas for improvement section of this report.

Action we have taken

We issued five requirement notices to the trust. That meant the trust had to send us a report saying what action it would take to meet these requirements.

Our action related to breaches in five core services.

For more information on action we have taken, see the sections on Areas for improvement and Regulatory action.

What happens next

We will make sure that the trust takes the necessary action to improve its services. We will continue to monitor the safety and quality of services through our continuing relationship with the trust and our regular inspections.

Outstanding practice

We found the following outstanding practice:

Trust wide

- The trust was listed in the Best Employers for Race in 2017, as organised by Business in the Community and as part of the Prince of Wales responsible business network. The trust was the only NHS employer to achieve this award.

Summary of findings

- The trust won the Large Employer of the Year Award in 2017 for its apprentice scheme, that was run by Coventry College.
- The trust continued to promote and support the campaign to raise awareness of men's mental health, called "It Takes Balls to Talk". Started in the trust by an employee, the campaign had the support of local organisations including nationally recognised sports club from rugby and football. The campaign won the regional healthier communities award in the NHS 70 Parliamentary awards.
- The trust was leading the design and implementation of the digital roll out of shared patient records systems as part of the sustainability and transformation programme.
- The trust was part of the MERIT Vanguard programme with three local mental health NHS trusts. As part of this work of shared learning, the trust was able to share bed vacancies with the other trusts to identify a bed for patients urgently in need of support.
- The trust had piloted the use of medically certified technology in older people's mental health wards and based on the outcomes, was rolling it out into acute mental health wards.
- The criminal justice liaison and diversion service was recognised as the winner in the liaison and diversion category for its work by a national penal reform charity in 2017.
- The partnership working with a locally run national charity led to two RISE community hubs being opened. This supported children and young people with mental health problems and their families to access information and guidance.

Community end of life services

- We observed some outstanding interactions between student nurses, staff, and patients.
- The palliative care support workers and support sisters were extremely knowledgeable about the sensitive and dignified way in which a body should be cared for once a patient had died. Support workers told us they continued to call the patient by their name and informed them of what they were going to do. For example, when they repositioned a body. Dignity and privacy remained a priority of staff once a patient had died.

Wards for older people with mental health problems

- Pembleton and Stanley wards had been involved in a pilot scheme to install infrared sensors in some patent bedroom. The sensors detect changes in patients' movement and vital signs. The technology aimed to support staff to changes in patients'' vital signs. Staff had identified a reduction in falls since the technology had been introduced.

Community-based mental health services for older people

- Feedback from carers on the dedication, skills of individual staff who they were in contact with was consistent and overwhelmingly positive. There were frequent references such as staff 'going the extra mile', and the service being 'a life saver'.

Specialist community health services for children and young people

- The service had developed its own Dimensions tool, in conjunction with parents and carers, referrers and clinical staff. This was a web-based application that offered a symptom checker and advice on sources of help. It directed people to specific sources of support specific to their individual needs. This encouraged the involvement of young people and their carers in their care planning and therapy

Mental health crisis services and health-based places of safety

Summary of findings

- The trust had developed an electronic matrix that meant managers were able to monitor and allocate visits, identify risk and warning signs, and ensure urgent referrals were seen quickly.

Areas for improvement

Action the trust MUST take is necessary to comply with its legal obligations. Action a trust SHOULD take is because it was not doing something required by a regulation but it would be disproportionate to find a breach of the regulation overall, to prevent it failing to comply with legal requirements in future, or to improve services.

Action the trust **must** take to improve

We told the trust that it must take action to bring services into line with five legal requirements. This action related to the trust and four services.

Trust wide

- The trust must ensure that it makes the necessary improvements to core services where we identified risk for example, poor medicines management in core services.
- The trust must ensure that staff participate in essential training for example, Mental Capacity Act, Mental Health Act and safeguarding level 3.
- The trust must ensure that training and supervision is accurately recorded.

Community health services for adults

- The trust must ensure that all equipment in use is fit for purpose and is within the expiry date for testing in line with policy. The service must ensure there is an effective process for monitoring the regular testing all clinical equipment in line with policy.
- The trust must ensure that Mental Capacity Act training compliance is improved and meets the trust target.

Acute wards for adults of working age and psychiatric intensive care units

- The trust must ensure that changes are made to the seclusion room to prevent the risk of injury to patients and staff.
- The trust must ensure all staff that require it are trained in the Mental Health Act and Mental Capacity Act to support them in their roles.
- The trust must ensure they have effective systems in place to check that all issues relating to the management of medication including room, fridge temperatures and the administering of medications is safe.
- The trust must ensure that all Mental Health Act paperwork is completed correctly and in line with the guidance given in the code of practice.
- The trust must ensure they continue to address the staffing issues so that wards can operate in a way that is safe for both staff and patients.
- The trust must ensure that managers have the time required to manage wards and improve the levels of governance on the wards.

Mental health crisis services and health-based places of safety

- The trust must ensure they have effective systems in place to check that all issues relating to the management of medication is safe.

Summary of findings

Wards for older people with mental health problems

- The trust must ensure that rooms where medicines are stored operate within the recommended temperature range.
- The trust must ensure that staff follow trust policy and procedures with respect to covert medication administration and that these decisions are evidenced effectively.

Action the trust **should** take to improve

This action related to seven services.

Trust wide

- The trust should consider the information it discussed at the confidential part of board meetings to make it more accessible to the public.
- The trust should ensure that systems are in place to record data quality and make more efficient use of data.
- The trust should ensure it continues its work to embed quality improvement across all of its services.
- The trust should ensure that it continues to work with staff groups to improve staff survey results.
- The trust should consider devolving risk registers to ward and team level to improve understanding of risk.
- The trust should ensure it continues to engage with staff about future proposed moves from St Michaels Hospital to the Caludon Centre**.**
- The trust should continue to improve compliance in staff training in the Mental Health Act and the Mental Capacity Act.
- The trust should ensure it records decisions on mental capacity across core services in line with trust policy and national guidance.

Community health services for adults

- The trust should ensure that it continues to address staffing shortages so that there is no harmful impact on patient care.
- The trust should ensure that it develops systematic processes to use safety monitoring, audit and outcome data in a consistent way so that data is collected, reported, monitored and used to drive improvements in the quality of patient care and treatment.
- The trust should ensure that it monitors waiting times in services where targets are not being met to improve timely access to services.
- The trust should ensure that it reviews how safety and performance information is cascaded throughout the team to support learning and improvements.

Community end of life services

- The trust should ensure that all incidents and risks are identified, discussed and reported so lessons are learned.
- The trust should ensure that all equipment is ordered for patients in a timely manner to prevent delays.
- The trust should ensure that is monitors the quality of the service and patient outcomes and consider developing a local audit plan to include documentation audits.

Acute wards for adults of working age and psychiatric intensive care units

- The trust should ensure that all staff receive regular supervision in line with the trusts policy.

Summary of findings

- The trust should ensure that Willowvale ward does not continue to use restrictive practices when supporting informal patients who want to take leave from the ward.
- The trust should ensure they record how mental capacity assessments are carried out.
- The trust should ensure that staff have the knowledge and skills to adhere to infection control principles when using protective clothing to prevent the risk of cross infection.

Mental health crisis services and health-based places of safety

- The trust should ensure that staff evidence patient involvement in care planning.

Wards for older people with mental health problems

- The trust should ensure that when staff assess that a patient lacks mental capacity for a specific decision, they have recorded how they reached this conclusion, in line with the Mental Capacity Act 2005 Code of Practice.
- The trust should ensure a speedy response when ward staff identify equipment faults, particularly with respect to the integrity of medicines storage or other areas where patient safety could potentially be affected.
- The trust should ensure that patients prescribed rapid tranquillisation have an associated care plan, which clearly evidences the treatment plan.
- The trust should ensure that all patients who require them, have personal emergency evacuation plans for staff to refer to in the event of an emergency.
- The trust should ensure that vacancies within the psychology service are managed to ensure all patients who would benefit, are given speedy access to psychological assessment.
- The trust should consider how staff evidence that they have offered patients a copy of their care plan. The electronic records system does not record this and the paper copy care plans have space for patients to sign but no marker to identify if the patient has been offered a copy.
- The trust should consider how they manage rumours about the future of the service to reduce the effect on staff morale.

Community-based mental health services for older people

- The trust should ensure the trust data it provides in respect of training, supervision and appraisals accurately reflects the situation within the service.

Specialist community health services for children and young people

- The trust should ensure that it continues to monitor and address waiting lists to reduce the time it takes for children and young people to receive treatment.
- The trust should ensure that staff clean toys regularly and maintain records.
- The trust should ensure that all staff receive their mandatory training, and improve the training compliance rates for safeguarding level 3 and information governance.
- The trust should ensure that staff receive their annual appraisals.
- The trust should ensure that there is a consistent way of recording and monitoring supervision across the service.

Summary of findings

Is this organisation well-led?

Our comprehensive inspections of NHS trusts have shown a strong link between the quality of overall management of a trust and the quality of its services. For that reason, we look at the quality of leadership at every level. We also look at how well a trust manages the governance of its services – in other words, how well leaders continually improve the quality of services and safeguard high standards of care by creating an environment for excellence in clinical care to flourish.

We rated well-led at the trust as good because:

- Since the previous inspection in June 2017, the trust board had strengthened the governance of the trust. The trust had worked towards collective leadership and we saw cohesive working across the board and senior leadership team.
- Following the last inspection in June 2017, the trust worked quickly to address the concerns in the warning notice we issued to wards for older people with mental health problems. We undertook a focussed inspection in November 2017 and found improvements had been made that meant we changed our rating to requires improvement. At this inspection, we found that the trust had continued to improve physical health care and monitoring of patients.
- The trust board and senior leaders had the skills, knowledge, experience and integrity to fulfil their roles. They understood the challenges to quality and safety within the trust and were key partners across the local health and social care economy in the sustainability and transformation programme. Board members and senior leaders were visible across the trust.
- There was a clear vision and a set of values that the board, senior leaders and staff believed in that focussed on being a “great place to care”. The strategy for the trust was aligned to the wider health and social care system and services were planned to meet the local population. The board monitored progress against the delivery of the strategy.
- There was a strong culture of supporting staff and promotion of their well-being that was reflected in their workforce strategy. However, the trust was disappointed by the outcomes of their last staff survey, in particular how staff from a black and minority ethnic (BAME) background felt they were treated. As a result, the trust had undertaken a lot of co-production work with diverse groups and we saw innovative ways that the trust supported BAME and LGBT staff, and those staff who had a disability.
- There were assurance systems in place to monitor risk and performance and these were regularly reviewed and revised. For example, the responsibility for financial governance moved this year from one sub-committee of the trust board to the financial planning and infrastructure committee. There was detailed discussion at board meetings that ensured executives and non-executives understood the financial plan and risks. The safety and quality operational group provided oversight of risk and reported directly to the board. Sixteen sub-groups provided detail to the safety and quality operation group that included information governance, mortality, serious incidents, complaints, and research and innovation. The trust board and senior leaders were aware of the main risks to the trust that included staff recruitment and retention, delivering cost improvements programmes whilst maintaining quality and safety, and maintaining building and IT infrastructures.
- There was a comprehensive and detailed medicines optimisation strategy, which drew on issues raised by the CQC and incorporated external engagement opportunities. This was presented to the trust board by the Chief Pharmacist as part of the annual medicines report. The trust had a programme of clinical audits around medicines’ safe storage, medicine administration-missed doses and controlled drugs to identify areas of good practice and concern. Some of these concerns had been actioned, though others were still outstanding at the time of the inspection.

Summary of findings

- The board met every two months and had access to the information they required to make decisions. There was discussion in points in the board meeting that were not made public however we questioned whether they should be in the public eye. The trust said they were reviewing aspects of their board meetings and what would be relevant to discuss in public. The board had a plan of visits to clinical services that they undertook bi-monthly. Appropriate governance arrangements were in place in relation to Mental Health Act administration and compliance.
- The trust had completed the roll out of a new electronic patient record system. It was embedded in those services who were first to receive the electronic system.

However:

- There were processes in place for the board to have oversight of the quality and safety of care delivery but we found a number of concerns across core services that required improvement and further scrutiny at a local level would support identification of risk issues. For instance, the trust had introduced equipment to improve medicines management but we found mistakes occurring across a number of core services. Also, not all local managers could describe local risk within their services.
- We found concerns about the levels of morale of staff on some acute mental health wards due to low levels of permanent staff and the uncertainty of staff moves when refurbished wards are opened at the Caludon Centre. However, we recognised the work the trust had undertaken to increase staffing levels and engagement with staff to discuss future moves.
- The trust had not addressed environmental risks such as ligature risks and the layout of a seclusion room since the last inspection in June 2017. This meant there was still a risk of patients tying a ligature and patients and staff being harmed whilst moving a patient into seclusion. However, the trust had clear plans in place, alongside NHSI and clinical commissioning groups, to renovate three empty wards, with the work having already started. We found that the trust and ward staff had reduced risk through assessment and care planning.
- Although the trust had introduced improved access to training in the Mental Health Act and the Mental Capacity Act, the levels of compliance had not reached the level expected for staff working across its services.

Ratings tables

Key to tables					
Ratings	Not rated	Inadequate	Requires improvement	Good	Outstanding
Rating change since last inspection	Same	Up one rating	Up two ratings	Down one rating	Down two ratings
Symbol *	➔➔	↑	↑↑	↓	↓↓
Month Year = Date last rating published					

* Where there is no symbol showing how a rating has changed, it means either that:

- we have not inspected this aspect of the service before or
- we have not inspected it this time or
- changes to how we inspect make comparisons with a previous inspection unreliable.

Ratings for the whole trust

Safe	Effective	Caring	Responsive	Well-led	Overall
Requires improvement ➔➔ Dec 2018	Good ↑ Dec 2018	Good ➔➔ Dec 2018	Good ↑ Dec 2018	Good ↑ Dec 2018	Good ↑ Dec 2018

The rating for well-led is based on our inspection at trust level, taking into account what we found in individual services. Ratings for other key questions are from combining ratings for services and using our professional judgement.

Ratings for community health services

	Safe	Effective	Caring	Responsive	Well-led	Overall
Community health services for adults	Requires improvement ➔➔ Dec 2018	Requires improvement ➔ Dec 2018	Good ➔➔ Dec 2018	Good ➔➔ Dec 2018	Good ➔➔ Dec 2018	Requires improvement ➔ Dec 2018
Community health services for children and young people	Good ➔➔ Jul 2016	Good ➔➔ Jul 2016	Outstanding ➔➔ Jul 2016	Good ➔➔ Jul 2016	Good ➔➔ Jul 2016	Good ➔➔ Jul 2016
Community end of life care	Good ➔➔ Dec 2018	Good ➔➔ Dec 2018	Good ➔ Dec 2018	Good ➔➔ Dec 2018	Good ➔➔ Dec 2018	Good ➔➔ Dec 2018
Community dental services	Good ➔➔ Jul 2016	Good ➔➔ Jul 2016	Good ➔➔ Jul 2016	Good ➔➔ Jul 2016	Good ➔➔ Jul 2016	Good ➔➔ Jul 2016

*Overall ratings for community health services are from combining ratings for services. Our decisions on overall ratings take into account the relative size of services. We use our professional judgement to reach fair and balanced ratings.

Ratings for mental health services

	Safe	Effective	Caring	Responsive	Well-led	Overall
Acute wards for adults of working age and psychiatric intensive care units	Requires improvement →← Dec 2018	Requires improvement ↓ Dec 2018	Good →← Dec 2018	Good ↑ Dec 2018	Requires improvement ↓ Dec 2018	Requires improvement →← Dec 2018
Long-stay or rehabilitation mental health wards for working age adults	Good →← Nov 2017	Good →← Nov 2017	Good →← Nov 2017	Requires improvement →← Nov 2017	Good →← Nov 2017	Good →← Nov 2017
Forensic inpatient or secure wards	Good →← Nov 2017	Good →← Nov 2017	Good →← Nov 2017	Good →← Nov 2017	Good →← Nov 2017	Good →← Nov 2017
Wards for older people with mental health problems	Requires improvement →← Dec 2018	Good ↑ Dec 2018	Good →← Dec 2018	Good ↑ Dec 2018	Good ↑ Dec 2018	Good ↑ Dec 2018
Wards for people with a learning disability or autism	Requires improvement →← Nov 2017	Good →← Nov 2017	Good →← Nov 2017	Good →← Nov 2017	Good →← Nov 2017	Good →← Nov 2017
Community-based mental health services for adults of working age	Good →← Nov 2017	Good →← Nov 2017	Good →← Nov 2017	Good →← Nov 2017	Good →← Nov 2017	Good →← Nov 2017
Mental health crisis services and health-based places of safety	Requires improvement →← Dec 2018	Good ↑ Dec 2018	Good →← Dec 2018	Good →← Dec 2018	Good ↑ Dec 2018	Good ↑ Dec 2018
Specialist community mental health services for children and young people	Good ↑ Dec 2018	Good →← Dec 2018	Good →← Dec 2018	Good ↑↑ Dec 2018	Good ↑ Dec 2018	Good ↑ Dec 2018
Community-based mental health services for older people	Good →← Dec 2018	Good ↑ Dec 2018	Outstanding ↑ Dec 2018	Good ↑ Dec 2018	Good ↑ Dec 2018	Good ↑ Dec 2018
Community mental health services for people with a learning disability or autism	Good →← Nov 2017	Good →← Nov 2017	Good →← Nov 2017	Requires improvement →← Nov 2017	Good →← Nov 2017	Good →← Nov 2017

Overall ratings for mental health services are from combining ratings for services. Our decisions on overall ratings take into account the relative size of services. We use our professional judgement to reach fair and balanced ratings.

Community health services

Background to community health services

The trust provides community health services for the people of Coventry. The trust provides all four core community health services from two locations. It has a substantial community end of life care service, working closely with the local hospice.

Summary of community health services

Good

The summary of two services appears in the overall summary of this report.

Community end of life care

Good

Key facts and figures

Care for patients approaching the end of life was provided by the trust's specialist palliative care team. The specialist palliative care team supported community nurses who worked in integrated community teams to provide end of life care services to patients in their own homes, hospices, care homes and nursing homes.

End of life care was available to all patients who were assessed as being in their last 12 months of life. Cancer patients formed the largest proportion of the trust's end of life care patients (68%).

From July 2017 to June 2018, the trust's specialist palliative care team received 787 referrals. 532 of these patients were cancer patients and 255 had other life limiting conditions.

During our inspection we spoke with 23 members of staff. 15 of which worked within the specialist palliative care team and eight members of staff worked within the communiety nursing team. This included a consultant, a registrar, the head of service, two palliative support sisters, four healthcare support workers, and four palliative community nurse specialists, therapists, administrators, community nurses, and a student nurse. We also spoke with staff from external organisations such as a local hospice. We gained consent to speak with and observed the care of 12 patients and their relatives.

Summary of this service

Our rating of this service stayed the same. We rated it as good because:

- The service had enough staff with the right qualifications, skills, training and experience to keep people safe from avoidable harm and abuse and to provide the right care and treatment.
- The service provided mandatory training in key skills to staff and most staff had completed it. Staff understood how to protect patients from abuse and the service worked well with other agencies to do so.
- The service-controlled infection risk well. The service prescribed, gave, and recorded medicines well. Staff kept appropriate records of patients' care and treatment.
- The service managed and reported patient safety incidents well most of the time. Staff recognised most incidents and reported them appropriately.
- The service provided care and treatment based on national guidance and evidenced some areas of its effectiveness. Staff assessed nutrition and hydration and provided advice to meet patients' needs and improve their health. Pain was assessed appropriately.
- The service made sure staff were competent for their roles. Staff worked together as a team to benefit patients.
- Staff cared for patients with compassion. Feedback from patients confirmed that staff treated them well and with kindness. Staff involved patients and those close to them in decisions about their care and treatment.
- Services were planned and delivered to meet the needs of patients and their relatives. The service took account of patients' individual needs. People could access the service when they needed it.
- The service treated concerns and complaints seriously. Complaints were investigated when received. Lessons learned were shared with all staff.

Community end of life care

- The service had managers at all levels with the right skills and abilities to run a service providing high-quality sustainable care.
- There was an effective governance structure in place. Processes and systems of accountability supported the delivery of the end of life care strategy.
- Managers across the service promoted a positive culture that supported and valued staff, creating a sense of common purpose based on shared values. There was a strong sense of culture that was centred on the needs of patients at the end of their life.

However,

- The service had suitable equipment but did not always use the equipment in line with national guidance. For example, syringe drivers were not routinely stored in the plastic lockable cases when in use. The service took action to resolve this when we raised it. Not all incidents identified in relation to syringe drivers had been reported as an incident.
- The quality of records had not been routinely audited.
- The service did not have a clear audit plan in place. The service did not have any mechanisms in place to monitor their results and benchmark against other similar services.
- Post-bereavement services feedback data was slightly worse than the previous year. Some patients' equipment was delayed due to the specialist palliative care team referring patients to the community nursing teams solely for the ordering of equipment.
- Systems to review risks, planning to eliminate or reduce them, and coping with both the expected and unexpected were in place but risks were not always identified and there was no evidence of risks being discussed.

Is the service safe?

Good

Our rating of safe stayed the same. We rated it as good because:

- The service provided mandatory training in key skills to staff and most staff had completed it. Staff received mandatory training on a rolling annual programme which was provided through a mix of classroom-based sessions and e-learning.
- Staff understood how to protect patients from abuse and the service worked well with other agencies to do so. Most staff had received training on how to recognise and report abuse and they knew how to apply it in practice.
- The service controlled infection risk well. Staff kept themselves and equipment clean. They used control measures to prevent the spread of infection in the community. The trust had an infection prevention and control (IPC) policy and all staff received mandatory training relating to this.
- The service had systems in place to ensure the safety of patients. This included risk assessments and monitoring of clinical conditions.
- The service had enough staff with the right qualifications, skills, training and experience to keep people safe from avoidable harm and abuse and to provide the right care and treatment.
- Staff kept appropriate records of patients' care and treatment. Records were clear, up-to-date and available to all staff providing care.

Community end of life care

- The service prescribed, gave, and recorded medicines well. We looked at 13 prescription charts and medicines records. All records reviewed documented the allergy status of patients. Medicine reconciliation records were completed, including for controlled drugs. Medicines were appropriately prescribed in line with national guidance.
- The service used some safety monitoring results well. Staff collected some safety information and shared it with staff.
- The service managed and reported patient safety incidents well most of the time. Staff recognised most incidents and reported them appropriately. Managers investigated incidents and shared lessons learned with the whole team and the wider service. When things went wrong, staff apologised and gave patients honest information and suitable support.

However:

- The service had suitable equipment but did not always use the equipment in line with national guidance. For example, syringe drivers were not routinely stored in the plastic lockable cases when in use. The service took action to resolve this when we raised it.
- The quality of records had not been routinely audited.
- Not all incidents identified in relation to syringe drivers had been reported as an incident.

Is the service effective?

Good

Our rating of effective stayed the same. We rated it as good because:

- The service provided care and treatment based on national guidance and evidenced some areas of its effectiveness. Palliative care for patients was managed in accordance with national guidelines, which formed the basis of trust policies and the end of life care strategy. These were accessible electronically for all staff. All policies reviewed were up to date.
- Staff assessed nutrition and hydration and provided advice to meet patients' needs and improve their health.
- Pain was assessed appropriately. Staff also assessed the type and duration of pain as well as exploring factors that made it better or worse.
- The service monitored some aspects of the effectiveness of care and treatment. Audits had relevant action plans and were completed in a timely way.
- The service made sure staff were competent for their roles. Managers appraised staff's work performance and held supervision meetings with them to provide support and monitor some aspects of the effectiveness of the service. Staff provided training in their areas of expertise to staff across the trust and healthcare professionals across the county.
- Staff worked together as a team to benefit patients. Medical staff, nurses and other healthcare professionals supported each other to provide good care.
- Staff understood their roles and responsibilities under the Mental Capacity Act 2005. They knew how to support patients experiencing mental ill health and those who lacked the capacity to make decisions about their care.

However:

- The service did not have a clear local audit plan in place to monitor infection prevention and control, and they did not regularly complete records audits.

Community end of life care

- The service did not have any mechanisms in place to monitor results of audits undertaken by community health services for adults or mechanisms to benchmark against other similar end of life care services.

Is the service caring?

Good

Our rating of caring went down. We rated it as good because:

- Staff cared for patients with compassion. Feedback from patients confirmed that staff treated them well and with kindness.
- Staff provided emotional support to patients to minimise their distress. Staff understood and respected the emotional, personal, cultural and social needs of patients. They took this into account when interacting with patients and care planning.
- Staff involved patients and those close to them in decisions about their care and treatment. Relatives of patients told us they felt involved in decisions. We observed staff communicated with patients and their relatives in a way which they could understand, and they asked patients if they understood what had been discussed.

However:

- Post-bereavement services feedback data was slightly worse than the previous year.
- There were instances whereby the SPCT could have ordered equipment for patients but instead asked the community nursing team to do this which delayed a patient in receiving their required equipment.

Is the service responsive?

Good

Our rating of responsive stayed the same. We rated it as good because:

- Services were planned and delivered to meet the needs of patients and their relatives. Staff told us how they focused on the needs of individuals within the local community and ensured that care was delivered as close to home, family and friends as possible. The specialist palliative carte team were dedicated to ensuring patients were cared for in their preferred place of care and death wherever possible.
- The service took account of patients' individual needs. Interpreters could be accessed. Staff across the service were aware of the importance of involving families and carers in the care of those with a learning disability. Services were accessible to all members of the community such as patients living with dementia.
- People could access the service when they needed it. Waiting times from referral and arrangements to admit, treat and discharge patients were in line with good practice. Patients had timely access to initial assessment and support.
- The service treated concerns and complaints seriously. Complaints were investigated when received. Lessons learned were shared with all staff. End of life care services received one complaint between 1 May 2017 and 30 April 2018. The complaint was in relation to the delay in providing care in the community.

Community end of life care

Is the service well-led?

Good

Our rating of well-led stayed the same. We rated it as good because:

- The service had managers at all levels with the right skills and abilities to run a service providing high-quality sustainable care. The service was led by a consultant in palliative medicine and managed by a head of service who was also a senior nurse.
- The service had a vision for what it wanted to achieve and workable plans to turn it into action developed with involvement from staff, patients, and key groups representing the local community. The service had a strategy and progress against the delivery of the strategy was monitored and reviewed with the use of an action plan.
- Managers across the service promoted a positive culture that supported and valued staff, creating a sense of common purpose based on shared values. There was a strong sense of culture that was centred on the needs of patients at the end of their life. All staff we spoke with in the specialist palliative care team felt supported, respected and valued. Staff said they felt extremely proud to work for the service and said they were honoured and privileged to be involved in the last stage, and at times, last moments of a patient's life.
- There was an effective governance structure in place. Processes and systems of accountability supported the delivery of the end of life care strategy.
- The trust generally collected, analysed, managed and used information well to support all its activities, using secure electronic systems with security safeguards. There was a holistic understanding of performance which integrated people's views with the limited performance data.
- The trust engaged well with patients, staff, the public and local organisations to plan and manage appropriate services and collaborated with partner organisations effectively.
- The service was committed to improving services by learning from when things go well, promoting training, research and innovation. Leaders encouraged continuous improvement amongst staff through shared learning.

However:

- Systems to review risks, planning to eliminate or reduce them, and coping with both the expected and unexpected were in place but risks were not always identified and there was no evidence of risks being discussed.

Outstanding practice

We found examples of outstanding practice in this service. See the Outstanding practice section above.

Areas for improvement

We found areas for improvement in this service. See the Areas for Improvement section above.

Community health services for adults

Requires improvement

Key facts and figures

The trust provided a range of community physical health services for people in Coventry. Community physical health services for the people of Warwickshire were provided by a neighbouring trust.

The core service of community health services for adults covers any services provided to adults in their homes or in community-based settings. The services are focused on providing planned care, rehabilitation following illness or injury, ongoing and intensive management of long-term conditions, coordination and management of care for people with multiple or complex needs, acute care delivered in people's homes and health promotion. The core service includes community nursing services, integrated care teams, community matrons and specialist nursing services, community therapy and rehabilitation services, community intermediate care, and community assessment services (clinics).

Multiple locations are used to provide community health services and home visits are also carried out.

We last inspected this service in April 2016, when it was rated as good overall. Safe was rated as requires improvement and the other four key question (effective, caring, responsive and well led) were all good.

We carried out an unannounced inspection (staff did not know we were coming) from 7 August 2018 to 9 August 2018 and on 15 August 2018. We visited a range of services including clinical assessment services, wheelchair services, multidisciplinary teams, physiotherapy services, specialist nursing services and podiatry. As part of our inspection process, we spoke to 41 members of staff including clinical and operational service leads, nursing staff, allied health professionals, and support staff. We spoke with 36 patients and relatives and reviewed 15 patient care records. We also observed patient care in clinics and on home visits, attended multidisciplinary team meetings and reviewed information including meeting minutes, policies, action plans and training records.

Summary of this service

Our rating of this service went down. We rated it as requires improvement because:

- The service did not have always have enough staff with the right qualifications, skills, training and experience to keep people safe from avoidable harm and abuse and to provide the right care and treatment. There were high vacancy levels for nursing staff and a dependence on bank and agency staff to cover shifts. However, the trust was aware of the issues and had put strategies in place to try and address this problem
- The service generally had suitable premises but did not always have equipment that was regularly maintained. There were large amounts of equipment used in the community nursing service that were out of date for annual testing. We raised this with the trust who took action to address this.
- Staff understood how to protect patients from abuse and they were aware of the requirement to work well with other agencies to do so. However, not all staff were up to date with training on how to recognise and report abuse.
- The service did not use safety monitoring results well. Although staff collected safety information and shared it with staff, there was limited evidence of how the service used information to improve the service.

Community health services for adults

- The service did not routinely monitor the effectiveness of care and treatment and generally did not use audit findings or analyse outcomes to improve services. There was not a systematic approach to reviewing patient outcomes. There was some comparison of national audit results with those of other similar services. Audit outcomes were not routinely used to drive improvements.
- Staff generally understood their roles and responsibilities under the Mental Capacity Act 2005. However, there was poor compliance with MCA training within the service.
- There were some services which were unable to meet targets for waiting times due to capacity issues within services.
- There was not a consistent approach to improving the quality of services and safeguarding high standards of care through use of clinical audit systems and clinical outcomes.

However:

- The service provided mandatory training in key skills to all staff and made sure most people completed it and remained up to date.
- The service controlled infection risk well most of the time. Staff generally kept themselves, equipment and the premises clean. They usually used control measures to prevent the spread of infection.
- Staff kept appropriate records of patients' care and treatment. Records were clear, up-to-date and available to all staff providing care.
- The service provided care and treatment based on national guidance and evidence of its effectiveness. Managers checked to make sure staff followed guidance.
- The service made sure staff were competent for their roles. Managers appraised most staff's work performance and held supervision meetings with them to provide support and monitor staff progress with personal objectives set at annual performance and development reviews.
- Staff cared for patients with compassion. Feedback from patients confirmed that staff treated them well and with kindness.
- Staff provided emotional support to patients to minimise their distress.
- Staff involved patients and those close to them in decisions about their care and treatment
- The trust planned and provided services in a way that met the needs of local people.
- The service took account of patients' individual needs.
- People could usually access services when they needed to. Waiting times from assessment to treatment, were generally in line with good practice.
- The service treated concerns and complaints seriously, investigated them and learned lessons from the results, which were shared with all staff.
- The service had managers at all levels with the right skills and abilities to run a service providing high-quality sustainable care.
- The service generally had effective systems for identifying risks, planning to eliminate or reduce them, and coping with both the expected and unexpected.
- Managers across the service promoted a positive culture that supported and valued staff, creating a sense of common purpose based on shared values.

Community health services for adults

- The service generally engaged well with patients, staff, the public and local organisations to plan and manage appropriate services and collaborated with partner organisations effectively.

Is the service safe?

Requires improvement

Our rating of safe stayed the same. We rated it as requires improvement because:

- The service generally had suitable premises but did not always have equipment that was regularly maintained. There were large amounts of equipment used in the community nursing service that were out of date for annual testing. We raised this with the trust who took action to address this.
- The service did not have always have enough staff with the right qualifications, skills, training and experience to keep people safe from avoidable harm and abuse and to provide the right care and treatment. There were high vacancy levels for nursing staff and a dependence on bank and agency staff to cover shifts. However, the trust was aware of the issues and had put strategies in place to try and address this problem.
- The service did not use safety monitoring results well. Although staff collected safety information and shared it with staff, there was limited evidence of how the service used information to improve the service.

However:

- The service provided mandatory training in key skills to all staff and made sure most people completed it and remained up to date.
- Staff understood how to protect patients from abuse and they were aware of the requirement to work well with other agencies to do so. However, not all staff were up to date with training on how to recognise and report abuse.
- The service controlled infection risk well most of the time. Staff generally kept themselves, equipment and the premises clean. They usually used control measures to prevent the spread of infection.
- Staff kept appropriate records of patients' care and treatment. Records were clear, up-to-date and available to all staff providing care.

Is the service effective?

Requires improvement

Our rating of effective went down. We rated it as requires improvement because:

- The service did not routinely monitor the effectiveness of care and treatment and generally did not use audit findings or analyse outcomes to improve services. There was not a systematic approach to reviewing patient outcomes. This meant that the service was not monitoring the effectiveness of care provided and therefore could not demonstrate that people's needs and treatment goals were being met. Quality and outcome information was not routinely used to drive improvements in the service. There was some comparison of national audit results with those of other similar services.
- Staff generally understood their roles and responsibilities under the Mental Capacity Act 2005. However, there was poor compliance with MCA training within the service.

However:

Community health services for adults

- The service provided care and treatment based on national guidance and evidence of its effectiveness. Managers checked to make sure staff followed guidance.
- The service made sure staff were competent for their roles. Managers appraised most staff's work performance and held supervision meetings with them to provide support and monitor staff progress with personal objectives set at annual performance and development reviews.
- Staff worked with patients in the community to monitor that they had enough food and drink to meet their needs and improve their health.
- Pain relief was managed well. Patient's pain was assessed and managed effectively using appropriate assessment tools and care plans.
- Staff in different clinical roles worked together as a team to benefit patients. Doctors, nurses and other healthcare professionals supported each other to provide good care. Staff worked with other providers, such as the local hospital and GP surgeries to ensure patients were seen by the most appropriate service. There were effective communication systems and clear referral processes in place.
- The service supported people to live healthier lives and care was planned holistically using health assessments where appropriate.
-

Is the service caring?

Good

Our rating of caring stayed the same. We rated it as good because:

- Staff cared for patients with compassion. Feedback from patients confirmed that staff treated them well and with kindness.
- Staff provided emotional support to patients to minimise their distress.
- Staff involved patients and those close to them in decisions about their care and treatment

Is the service responsive?

Good

Our rating of responsive stayed the same. We rated it as good because:

- The service planned and provided services in a way that met the needs of local people.
- The service took account of patients' individual needs.
- The service treated concerns and complaints seriously, investigated them and learned lessons from the results, which were shared with all staff.

However:

- People could usually access services when they needed to. Waiting times from assessment to treatment, were generally in line with good practice. However, there were some services which were unable to meet targets for waiting times due to capacity issues within services.

Community health services for adults

Is the service well-led?

Good

Our rating of well-led stayed the same. We rated it as good because:

- The service had managers at all levels with the right skills and abilities to run a service providing high-quality sustainable care.
- Managers across the trust promoted a positive culture that supported and valued staff, creating a sense of common purpose based on shared values.
- The service had a vision for what it wanted to achieve and workable plans to turn it into action.
- The service generally engaged well with patients, staff, the public and local organisations to plan and manage appropriate services and collaborated with partner organisations effectively.
- The service had a governance framework which set out to ensure quality and risks were understood and managed. There was a systematic approach to monitoring service delivery and sharing information. There were clear accountability arrangements in place.
- The service generally had effective systems for identifying risks, planning to eliminate or reduce them, and coping with both the expected and unexpected.
- The service collected, analysed, managed and used information to support its activities, using some secure electronic systems to support this.
- The service was committed to improving services by learning from when things go well and when they go wrong, promoting training, research and innovation.

However,

- There was not a consistent approach to improving the quality of services and safeguarding high standards of care through use of clinical audit systems and clinical outcomes.
- There was limited evidence that the service's vision had been developed with involvement from staff, patients, or key groups representing the local community.

Areas for improvement

We found areas for improvement in this service. See the Areas for Improvement section above.

Mental health services

Background to mental health services

The trust provides all 10 core mental health services over 13 locations. Its biggest service cares for patients with mental health problems, with 22 wards over five locations. It provides secure care and assessment and treatment beds for people with a learning disability or autism at one location and admits people from outside of the county. It also provides a specialist eating disorders service, which takes patients from all over the country.

Summary of mental health services

Good

The summary of five services appears in the overall summary of this report.

Community-based mental health services for older people

Good ↑

Key facts and figures

Community-based mental health services for older people are part of the Coventry and Warwickshire Partnership NHS trust. The service provides assessment and diagnosis for people with memory or other cognitive problems, and community interventions for people with a diagnosis of dementia, who are experiencing difficulties with managing their lives. In the twelve months to June 2018, the service undertook 2135 assessments and completed 2387 annual reviews.

The service has five bases across Coventry and Warwickshire:

- Rugby and Nuneaton, covering north Warwickshire
- Stratford and Leamington, covering south Warwickshire
- Coventry, covering Coventry and the immediate surrounding area.

We inspected all the five domains and visited all five teams over three days.

Our inspection was unannounced (staff did not know we were coming) to enable us to observe routine activity.

Our team consisted of two inspectors and two specialist professional advisors.

During our visit we spoke with:

- Three team managers, one deputy manager and the service manager
- Twenty-seven further staff members including doctors, nurses, support workers, social workers, occupational therapists and administrative staff
- One patient and two carers face to face
- Fourteen carers by phone.

We observed:

- One home visit
- Two assessment clinics
- One assessment presentation/discussion
- One multi-disciplinary meeting

We reviewed;

- Thirty patient care records
- Five multi-disciplinary meetings
- Five supervision records of staff

Summary of this service

Our rating of this service improved. We rated it as good because:

Community-based mental health services for older people

- There were sufficient staff to meet the needs of patients; to assess, diagnose, treat and support them in a timely manner. Monitoring and reviews took place in a timely manner, and changes and concerns were responded to promptly. Patient and carer feedback about the approach and support of staff was consistently positive.
- Staff showed a good understanding of how to support people in making decisions, when support was needed, and the appropriate steps to take when decisions were made for people.
- Patients and carers were fully involved in comprehensive assessments which were patient focused and took account of physical health, mental well-being, their environment and all other relevant factors. Patients were well supported through assessment and diagnosis by skilled and sensitive staff, who re-assured patients and conveyed information effectively. Information and advice was made available to help patients and carers live with dementia and assist patients to access opportunities in the wider community.
- Teams had a wide range of skills, qualifications and experience, and worked together well to ensure any delays or deficits were minimal. Teams worked well with other agencies to ensure good support was available when needed.
- The service addressed the wide range of needs in the diverse communities they served.
- Staff and managers all worked together well and positively and flexibly to ensure that the service worked effectively under pressure to meet patient need. Staff were confident and were positive about their experience within the teams.

Is the service safe?

Good

Our rating of safe stayed the same. We rated it as good because:

- There were sufficient staff to meet the needs of patients, with teams able to be flexible to cover any shortfalls. Vacancies, sickness and staff turnover were within or below trust targets.
- There were no waiting lists. Caseloads were within a manageable range. Patients were seen for assessment and onset of treatment within six weeks of their initial triage referral from the trust's central booking system. This minimised the risk of additional risk developing whilst waiting for assessment. If the service became aware of additional risk, assessments could be brought forward.
- Staff did a risk assessment of each patient at initial triage/assessment and updated it regularly, using recognised risk assessment tools. The service responded promptly to concerns raised about patients. Staff could get advice and support promptly from consultants.
- Staff had good lone working practices for home visits, which were adhered to and monitored. On site rooms used for interviews were clean and well -maintained
- The service stored and managed patient information safely and securely and staff could access such information when required.
- Staff raised safeguarding alerts appropriately. Staff learned from serious incidents reported within the trust. There had been no serious incidents regarding this service within the past twelve months.

Is the service effective?

Good

Community-based mental health services for older people

Our rating of effective improved. We rated it as good because:

- Patients and carers were fully involved in assessments which included physical health, mental well-being, environment and all relevant factors. Recognised monitoring and assessment tools were used.
- Staff interaction with patients and carers was effective and supported them though the diagnosis and next steps. Care plans which followed diagnosis were reviewed and kept up to date to reflect any changes.
- Staff helped patients and carers with advice, contacts and direct support in helping them live with dementia. Group support and therapy sessions were offered.
- One team had just achieved accreditation in the Memory Service Accreditation Programme, run by the Royal College of Psychiatrists. The other teams in the service were preparing to apply for this. The service ran clinical audits to improve aspects of the service.
- Staff had the right skills, qualifications and knowledge to meet the needs of the patient group. The teams included, or had access to, a good range of specialists required to meet the needs of patients.
- The service held effective multi-disciplinary team meetings, and worked effectively with other agencies to support patients and carers.
- Staff showed a good understanding of the Mental Health Act and could get additional advice when needed. Staff showed a good understanding of the Mental Capacity Act. We saw good examples of patients being supported to make decisions, and of appropriate

best interest decisions.

However:

- Although staff received appropriate training and appraisals and managers were able to show us records of training, supervision and appraisals, trust-wide data did not always accurately reflect this.
- Only three of the five teams had access to support workers. These three teams said the support workers were invaluable for taking on tasks of monitoring patients who need regular support for specific periods. However, the service was looking at providing this support across all teams.

Is the service caring?

Outstanding ☆ ↑

Our rating of caring improved. We rated it as outstanding because:

- We observed clinics and home visits where clinicians and nurses showed exceptional skills in communicating with patients, fully involving them and carers in assessments, gaining the necessary information, whilst ensuring all were re-assured, had understanding and understood information and advice. This was often in the context of potentially distressing circumstances.
- Staff were highly motivated, promoted patients' dignity and offered care that was kind. These values were shared by all staff and promoted by managers across the service.
- Responses from all carers we spoke with were extremely positive in all areas. Carers frequently commented that staff who visited them 'went the extra mile' and ensured they knew who or where to contact for additional help. Carers felt that their family who were using this service mattered.

Community-based mental health services for older people

- The service recognised carers' and patients' emotional and social needs as being as important as their physical needs. Staff recognised the importance of taking into account the cultural, religious and social needs of people.
- Carers told us they were given all necessary information and contacts and felt supported. One referred to staff as 'a life saver'. Several named staff by name, showing they had consistent contact, and where carers said that some other services had been slow to respond, they added that staff at the memory service had helped them get what they needed.

Is the service responsive?

Good ↑

Our rating of responsive improved. We rated it as good because:

- The service was assessing, diagnosing and treating people referred to it in a timely manner, well within the trust target times of 12 weeks.
- The service responded promptly to concerns about patients by phone or by arranging visits as required. Home visits were arranged when needed. Appointments were flexible to accommodate the needs of patients and carers.
- The service helped patients engage with the wider community by providing information and links with other agencies and networks available to people living with dementia. Patients we spoke with commented positively on the information and 'signposting' provided by the service. The service had ready access to interpreters and information in different languages so it could meet the diverse needs of the people requiring the service.
- Although the service received very few complaints, people using the service were confident of being able to raise any concerns they might have.

Is the service well-led?

Good ↑

Our rating of well-led improved. We rated it as good because:

- Staff felt well supported and led, were very positive about their role and the support within teams, and worked positively with other teams and outside agencies
- Managers felt they had sufficient authority and autonomy to fulfil their role.
- Staff felt able to raise concerns if they had them.
- The service was engaged in research and improvement projects. One team had recently achieved accreditation with the body promoting good practice in memory services; the other teams were preparing to apply for accreditation.

However:

- Satisfactory training, supervision and appraisal rates within teams were not always accurately reflected in trust wide data.

Outstanding practice

We found examples of outstanding practice in this service. See the Outstanding practice section above.

Community-based mental health services for older people

Areas for improvement

We found areas for improvement in this service. See the Areas for Improvement section above.

Acute wards for adults of working age and psychiatric intensive care units

Requires improvement

Key facts and figures

We inspected six acute wards and two psychiatric intensive care wards based across two sites, the Caludon centre in Coventry and St Michaels Hospital in Warwick.

The Caludon centre is in Coventry and provides four acute wards for adults of working age. They are

- Westwood Ward for female patients (20 beds)
- Beechwood Ward for male patients (20 beds)
- Swanswell Ward (previously Spencer Ward) for female patients (22 beds)
- Hearsall Ward for male patients (20 beds)

The Caludon centre also has a Psychiatric intensive care unit.

- Sherbourne Ward for male patients (11 beds)

St Michaels Hospital in Warwick provides two acute wards and one PICU

- Larches Ward for male patients (20 beds)
- Willowvale Ward for female patients (16 beds)
- Rowans PICU for female patients (5 beds)

Our inspection was unannounced (staff did not know we were coming) to enable us to observe routine activity. We inspected all five domains in this core service as part of our planned inspection programme.

The acute wards for adults of working age and psychiatric intensive care units were last inspected in June 2017. We rated them as requires improvement overall with effective, caring and well led rated as good and requires improvement for safe and responsive.

During the inspection in June 2017 we found the following

Action the provider MUST take to improve

- The trust must ensure that ligature risks are reduced, and that where they exist. Staff adhere to plans to mitigate them.
- The trust must ensure that patient well-being is not adversely affected by the practice of 'sleepovers', and that this practice occurs only to meet patient need
- The trust must improve the narrow entrance to the seclusion room as its posed a potential risk to patients and staff

Action the provider SHOULD take to improve

- The trust should ensure that staff in acute and PICU wards receive up to date Mental Health Act training to equip them for their current roles.

Before the inspection visit, we reviewed information that we held about these services and information requested from the trust.

Acute wards for adults of working age and psychiatric intensive care units

During the inspection visit, the inspection team

- spoke with 12 patients and 2 carers
- visited all eight wards and spoke to the ward managers, acting ward managers and their deputies
- spoke with 30 other staff members including doctors, nurses, healthcare assistants, activity coordinators, ward clerks and housekeepers
- reviewed 28 sets of patient records, 16 sets of Mental Health Act paperwork and 39 prescription charts.

Summary of this service

Our rating of this service stayed the same. We rated it as requires improvement because:

- The trust had not made changes to the entrance to the seclusion room which they had been required to do following the inspection in June 2017. We also found the door locking mechanism was not substantial and could be forced open. This meant there was still a risk to patient and staff safety when the room was in use.
- Wards did not have enough permanent staff and relied heavily on bank and agency staff. This meant that at times staff reported the wards felt unsafe and they could not always give patients one to one time or escorted leave.
- Staff training figures in the Mental Health Act and Mental Capacity Act were low and staff required this training to support them in their roles.
- Staff did not always store medication safely. Room temperatures on some wards were above the recommended levels and on one ward the fridge temperatures had not been checked daily. This meant it was not possible for staff to know when medication was no longer safe to use.
- Staff did not always complete physical health monitoring for patients after medication had been administered and this was required. One patient had an additional antipsychotic medication prescribed other than the one agreed on their consent to treatment form. The box indicating patients had a known allergy had not always been ticked and staff had used abbreviations instead which could be confusing for new staff or those from agencies.
- The Mental Health Act paperwork had not always been completed correctly. We found consent to treatment forms were missing and in one case the writing was illegible so staff could not follow the instructions on it. Section 17 leave paperwork was completed but stated leave was at nurses' discretion which is not in line with guidance from the Mental Health Act code of practice.
- Governance on the wards was not robust. Managers had to continually manage issues relating to staff shortages and at times they had to be part of the clinical team supporting the patients. Supervision levels and training was not always at a consistently good level and managers did not always have oversight of routines such as the checks in the clinic room.
- Due to staff shortages supervision rates were low on some wards. Staff stated they felt supported by managers but supervision did not take regularly due to the demands of the wards and the needs of the patients.
- Although staff wrote about a patient's mental capacity in the daily notes we could not find any paperwork which indicated formal mental capacity assessments and best interests decisions had taken place for individual patients.
- On Willowvale Ward we observed informal patients being told they could only leave the ward at certain times. This meant staff were restricting their rights as informal patients to leave the ward when they wanted to.

- Staff did not always adhere to infection control principles when removing protective clothing which they did in an area used by staff for storing their belongings while on shift. This increased the risk of cross contamination.

However:

- Staff ensured that patients had good access to other services such as spiritual support and advocacy. Activity programmes were in place and occupational therapists took an active role on the wards to ensure patients were supported to build skills ready for being discharged.
- Staff supported patients in a way that was kind and caring. All wards provided support for carers and staff understood why this was important for helping to maintain the wellbeing of their patients.
- Staff stated they were supported by managers locally and found they were approachable and helpful. Staff knew how to raise concerns if they needed to and understood the role of the Freedom to Speak Up Guardian within the trust.

Is the service safe?

Requires improvement

Our rating of safe stayed the same. We rated it as requires improvement because:

- The trust had not addressed the issue of access in to the seclusion room through an area which was too narrow for staff and patients to enter without the potential for injury. The seclusion room locking mechanism was not robust and could be forced open meaning that staff and patient's safety could be at risk.
- A lack of permanent staff meant wards had high use of bank and agency staff. Some wards had very few members of staff who were in permanent roles. Staff reported that patients did not always have a named nurse and that patient one to one time was compromised by the lack of regular staff.
- Staff did not always routinely check fridge temperatures on Swanswell Ward and on other wards the room temperatures had regularly been above the recommended level for safe storage of medicines. Staff reported this and some medication had the expiry dates shortened to mitigate this but it was not clear that this action had been taken in all clinic rooms.
- Staff did not always monitor physical health signs for patients after certain types of medication. Several patients had consent to treatment forms completed which did not match the medication being given or written on the medication charts. Staff wrote allergies as abbreviations which made it difficult for new or agency staff if they did not know the system the wards used.
- Infection control measures were not always followed on Sherbourne PICU where staff used protective clothing. They used staff areas to remove the clothing and this could lead to the possibility of cross contamination of infection.

However:

- Staff completed a risk assessment for patients on admission. These were detailed and staff updated them regularly as a patient's level of risk changed.
- Staff understood about safeguarding. They knew who to contact within the trust for support and demonstrated through examples that they were confident in their knowledge of making referrals and why these were needed.
- Housekeeping staff ensured wards were clean. Furnishings were well maintained and functional. On some wards such as Westwood Ward staff had designed areas so that they were more comfortable and relaxing for patients.

Acute wards for adults of working age and psychiatric intensive care units

- Some wards still had ligature points but these were mitigated by ligature risk assessments being in place and staff told us how they managed these areas to keep patients safe.

Is the service effective?

Requires improvement

Our rating of effective went down. We rated it as requires improvement because:

- Not all staff had completed Mental Health Act training or Mental Capacity Act training. Levels for this on some wards was low. Staff needed to be competent in these areas to carry out their roles and support patients. This meant that not all Mental Health Act paperwork had been completed properly. Section 17 leave forms stated leave was at the discretion of the nurses which is not in line with guidance from the Mental Health Act code of practice. Consent to treatment forms were missing for some patients and one had handwriting which staff could not read.
- Informal patients on Willowvale Ward could not leave the ward when they wanted to. We saw staff telling patients they could only have time off the ward at certain times which meant they had restrictions placed on them.
- Patient records showed that mental capacity was considered on a daily basis but we could not find any record of how formal capacity assessments and best interest decisions had been made.
- Not all staff had received regular supervision due to staff shortages and the needs of patients on the wards.

However:

- Staff monitored the physical health of patients on admission and continued this during their stay on the wards. They made referral for patients to see other specialists when required.
- The wards worked well with other team s within the trust such as the crisis and community teams and those responsible for bed management.

Is the service caring?

Good

Our rating of caring stayed the same. We rated it as good because:

- Staff supported patients in a way that was kind and caring. Permanent staff knew the patients well and used this knowledge to ensure patients got the help that they needed.
- Staff ensured that patient's information was kept confidential. They did not share this with anyone including families without the consent of the patient.
- Staff understood the importance of supporting families and carers. They made time for them when they visited the wards so they could answer questions and listened to their concerns about their relatives. Staff made referrals for carers assessments and made sure information was available for carers on the wards.

Is the service responsive?

Good

Acute wards for adults of working age and psychiatric intensive care units

Our rating of responsive improved. We rated it as good because:

- The practice of asking patients to 'sleepover' on other wards at short notice so new patients could be admitted had improved. The trust had changed its policy so that each day wards identified potential patients who could move based on clinical need and then this was discussed individually with the patient who could chose this as an option. All wards reported that this was now a rare occurrence and we only found one example of where this had happened recently.
- Wards had rooms available for patients to use. These included quiet areas, lounges and activity spaces. On wards where space was limited staff used areas such as the dining rooms which were only in use at mealtimes.
- Patients had access to a range of leaflets and these could be made available in other languages or an easy read format. Staff regularly used interpreters and understood the need for this to be someone independent of the patient and the hospital. They could also access signers for those patients with hearing loss.
- Patients knew how to complain and staff understood how to support them to do this. Staff received feedback about complaints through team meetings and productive learning days.

Is the service well-led?

Requires improvement

Our rating of well-led went down. We rated it as requires improvement because:

- Overall governance of the wards was not as strong as it needed to be. Managers had to manage staff shortages alongside the needs of the patients and at times had to work within the staffing numbers on the wards as they were the only qualified member of staff on duty. This took time away from managing staff and ensuring that the checks and administration of the ward was as up to date as it needed to be.
- Managers had not always checked that staff had fully completed tasks. Fridge temperatures had not been properly monitored on all wards, physical health monitoring for patients where it was required after medication had been administered were not always completed and consent to treatment forms were not always available for some patients.
- Staff felt supported by managers but the compliance rates for supervision were low and this along with shortages of permanent staff affected staff morale.

However:

- Staff felt well supported by managers and they could ask for support when they needed to. Managers appreciated the meetings they had with senior management as this gave them the opportunity to feedback and raise concerns about the wards.
- Wards used monthly governance meetings to look at incidents and complaints and issues for the trusts main risk register.
- Wards had been working towards the accreditation for inpatient mental health services as part of their ongoing commitment to quality improvement.

Areas for improvement

We found areas for improvement in this service. See the Areas for Improvement section above.

Wards for older people with mental health problems

Good ↑

Key facts and figures

Coventry and Warwickshire Partnership NHS Trust has four wards that provide care and treatment for older people with mental health problems.

Stanley and Pembleton wards are based at Manor Hospital in Nuneaton. They provide inpatient assessment and treatment for people with dementia. Stanley ward has 12 beds for male patients.

Pembleton ward has 12 beds for female patients. These wards are age independent. They provide care and treatment for people of any age requiring care and treatment for dementia.

Ferndale ward is based at St. Michael's Hospital in Warwick and has 21 beds for male patients. Woodloes Avenue (known as Woodloes House) is based in Warwick and has 15 beds for female patients. Ferndale ward and Woodloes House are age independent wards. They provide inpatient assessment and treatment for people with complex psychiatric and physical health conditions. These wards were also relocated from the Caludon Centre in Coventry while building safety work was carried out. At the time of this inspection, it was expected that Ferndale ward would remain at St Michael's Hospital and Woodloes House would be relocated to St Michael's Hospital. No date had been set for this relocation.

Before the inspection visit, we reviewed information we held about the service and information supplied by the trust.

This was an unannounced inspection. The service did not know we were going, which meant we were able to observe routine activity on the wards.

The team inspecting this service comprised three CQC inspectors, one CQC inspection manager, an expert by experience (a person using or caring for someone using a similar service) and four specialist advisors working in similar services elsewhere.

During the inspection visit, the inspection team:

- visited all four wards to look at the quality of the environment and observe how staff were caring for patients
- spoke with 21 patients
- reviewed four patient comment cards
- spoke with 15 carers and relatives using a combination of face to face and telephone interviews
- looked at the care and treatment records of 24 patients
- spoke with two ward managers, the modern matron and the general manager
- spoke with 22 other staff members; including healthcare support workers, doctors, nurses, housekeepers an occupational therapist, a pharmacist and an activities co-ordinator
- attended and observed two shift handover meetings
- observed two patient therapeutic activity sessions
- looked at 28 patient prescription charts
- carried out a specific check of medicines management on each ward; and

Wards for older people with mental health problems

- looked at a range of policies, procedures and other documents relating to the running of the service.

Summary of this service

Our rating of this service improved. We rated it as good because:

- Patients had thorough assessments covering both their mental and physical health. Staff reviewed and updated risk assessments and care plans in a timely manner. Patients and relatives were positive about the quality of care and treatment that staff delivered. Vacancies remained high in the nursing teams across the service but managers filled most posts with regular temporary staff who were known to the service. There were sufficient staff of the right grades and professions to assess, treat and support patients.
- Patient care was delivered by a multi-disciplinary team involving a wide range of professionals who worked well together. Patients had access to good support to identify and manage physical health problems. Patients could access the right care at the right time.
- Patients and relatives told us that staff were kind, treating them with dignity and respect. Staff encouraged patients to give feedback about the service they delivered. They tailored these opportunities to meet patients' communication abilities.
- Patients did not experience delays in their discharge. Any delays were outside of the control this service. Most patients who experienced delays were waiting for a community support package or new housing.
- Ward managers led their service well. They carried out regular audits to provide assurance about the quality of care provided by the service. Middle managers involved staff in service development. Staff received regular supervision and appraisals. They had opportunities for career development and good access to specialist training. Senior managers made visits to the wards so they were visible to staff. Staff knew how to contact senior managers if they wanted to raise concerns. The service was working toward accreditation with the Royal College of Psychiatrists' Quality Network for Older Adults Mental Health Services and the Triangle of Care.

However:

- Room temperatures where medicines were stored regularly exceed the recommended range on three out of the four wards. The trust had supplied some wards with air-conditioning units and these were being used correctly. Staff had to wait six weeks for a faulty medicines fridge to be replaced on Pembleton ward. Not all wards had personal emergency evacuations plans for patients who needed them. Staff on Pembleton ward had not followed trust policy or best practice when covertly administering medicines for a patient.
- Staff routinely completed mental capacity assessments when they needed to, but did not always use trust documents to evidence the assessments. Patients on Pembleton and Stanley wards had limited access to psychological assessment and formulation because the trust had struggled to recruit a psychologist.
- There was nowhere other than the daily records for staff to record that they had offered patients a copy of their care plan.
- Morale amongst some of the nursing teams was poor due to rumours about the future of the service and the number of vacant posts within the service.

Wards for older people with mental health problems

Is the service safe?

Requires improvement

Our rating of safe stayed the same. We rated it as requires improvement because:

- In rooms where medicines were stored, temperatures regularly exceed the recommended range on three out of the four wards. The trust had supplied either fixed or mobile air-conditioning units.
- One patient record on Pembleton ward did not contain evidence of the decision making process required to evidence robust care planning before administering medicines covertly for the patient. There was no record that all relevant parties had been part of the decision making process and no covert medicines plan attached to the drug chart.
- The fridge on Pembleton ward was not functioning effectively for six weeks before it was replaced.
- Not all patients who needed them had personal emergency evacuation plans, this included some who would not be able to get out of the building in an emergency because of their physical or cognitive impairment.

However:

- The wards were visibly clean and clutter free.
- Staff carried out mental health risk assessments for each patient, which they updated when risks changed. They carried out specialist physical health assessments to identify and manage physical health needs.
- Patients and staff had call alarm systems to summon assistance when they needed it.
- Staff knew how to protect patients from avoidable harm. The service had policies to protect staff and patients from avoidable harm.
- Staff understood how to recognise and report safeguarding concerns.
- Staff completed their mandatory training and managers monitored their attendance to ensure compliance. Compliance rates were good at 84% but below the trust target.
- Staff knew how to report incidents or risks of harm. Staff reported incidents and managers investigated them.
- Patient records systems were accessible to staff who could get information when they needed it.
- Staffing vacancies remained high but the service used regular temporary staff to cover nursing shifts.

Is the service effective?

Good

Our rating of effective improved. We rated it as good because:

- The multidisciplinary team planned and delivered patient care and treatment in line with current guidelines, such those from the Royal College of Psychiatrists and the National Institute for Health and Care Excellence (NICE).
- In line with NICE guidelines and the Mental Health Act Code of Practice (2015), patients received thorough physical health checks on admission along with ongoing medical support during their admission, to promote their overall wellbeing.

Wards for older people with mental health problems

- The wards provided a multidisciplinary service by employing a range of professionals to meet the needs of their patients. The service had a mix of staff including nurses, healthcare support workers, occupational therapists, a dietitian, a speech and language therapist, physiotherapists, activity workers, junior doctors and psychiatrists. Patients on two wards had access to an art psychotherapist.
- Staff developed patient care plans for a wide range of individual needs. They regularly reviewed and updated them.
- Staff used recognised outcome measures to monitor patient progress.
- Staff stored confidential and legal paperwork correctly and safely. They routinely obtained patient consent to treatment, then effectively recorded and stored it.

However:

- Although staff across the service routinely considered patients' mental capacity for specific decisions, there was little evidence that staff recorded mental capacity assessments in line with trust policy or the Mental Capacity Act 2005. Capacity assessments were carried out by the multidisciplinary team but were mostly recorded in the patients' daily records and not on standardised assessment documents. This meant they were not easy to refer back to in the patient records.
- Patients at Ferndale ward and Woodloes House had access to art therapy and psychology. However, patients on Stanley and Pembleton wards could be referred for psychological assessment but their access was more limited because the psychology post had been vacant for some time.

Is the service caring?

Good

Our rating of caring stayed the same. We rated it as good because:

- Patients and relatives told us that staff were kind, genuinely interested in their wellbeing and treated them with dignity and respect. They were overwhelmingly positive about the care and treatment they received.
- We observed staff supporting patients with kindness and treating them with dignity and respect.
- Patients who could tell us, understood their care and treatment plans and their discharge plans.
- Staff encouraged patients and carers to have a say in the running of the wards. They arranged community meetings for patients to share their views and give their suggestions for things like activities and menus. Staff on the dementia wards encouraged patients to give their views in forums suited to their abilities.
- There was an advocacy, an independent mental health advocacy and independent mental capacity advocacy service. Staff referred patients for advocacy support if they believed the patient would benefit but was not able to refer themselves.

However:

- There was no evidence in patient records that staff offered patients a copy of their care plan. Patients and relatives told us they had not seen a copy of their care plan but they did understand their care and treatment.

Is the service responsive?

Good

Wards for older people with mental health problems

Our rating of responsive improved. We rated it as good because:

- Staff assessed patients for the service in a speedy and timely manner.
- Staff supported patients and relatives to understand their condition and to set achievable goals.
- Staff had made improvements to Stanley and Pembleton wards to make them more “dementia friendly”. Signage was improved and there were dementia specific environmental stimuli such as fiddle boards and dementia pods.
- The pathway toward discharge was clear for patients and their families to understand. Delays in discharge were not within the control of this service.
- Patients could access the right care at the right time because they had a range of multi-disciplinary professionals available to support them.
- Patients could personalise their bedrooms to suit their own tastes if they wanted to and some were involved in designing signage for communal areas.
- The chaplaincy service was easily accessible to staff and patients. Members of the chaplaincy team regularly visited the wards.
- Patients and their families did not recall having been given information about how to make a complaint but they all knew they could complain to ward staff. They were confident staff would deal with issues or complaints effectively.

Is the service well-led?

Good

Our rating of well-led improved. We rated it as good because:

- Local managers demonstrated the skill and experience to lead the service well.
- The leadership, governance and culture within the service was open. It promoted patients, relatives and staff to speak up about the quality of care and share concerns.
- Local managers were visible and available to staff, relatives and patients. Senior managers regularly visited the wards. Senior trust managers had a number of systems in place to encourage staff to contact them if they wanted to share concerns or ideas.
- Staff told us they were confident they would speak up if they had concerns. They felt their managers and senior leaders would listen and support them. There was no fear of recrimination.
- The service shared information from across the trust to improve practice.
- We saw examples of how staff demonstrated the duty of candour and informed patients and relatives if something had gone wrong.
- Managers dealt with staff performance issues effectively and had access to a trust wide human resources department when they needed it.
- The trust carried had improved local governance systems to audit the quality of care provided in the service. They carried out regular audits, which were scrutinised locally, and by senior leaders.
- Managers had introduced innovative measures to improve recruitment within the nursing and psychology teams. These had led to increases in recruitment with a large number of new staff due to start within a few weeks of the inspection.

Wards for older people with mental health problems

- Staff on the dementia wards were committed to using technology to support patient care. They were keen to use innovation for the benefit of patient care.
- Just before this inspection took place, the trust had implemented a programme to audit the quality of mental capacity assessments in the service. The audit tool was robust and two out of the four wards had been audited. However, the trust had been slow to implement this programme because CQC had first identified this as an area for improvement in 2016 and again in 2017.
- The service was committed to achieving accreditation with the Royal College of Psychiatrists' Quality Network for Inpatient Mental Health Services Wards for Older People and the Triangle of Care.

However:

- Morale amongst some staff in the service was low. Some staff felt uncertain about the future of the service and also cited vacancies in the nursing team as a reason for low morale.

Outstanding practice

We found examples of outstanding practice in this service. See the Outstanding practice section above.

Areas for improvement

We found areas for improvement in this service. See the Areas for Improvement section above.

Mental health crisis services and health-based places of safety

Good ↑

.

Key facts and figures

Coventry and Warwickshire Partnership NHS trust provides crisis home treatment and psychiatric services for people aged 16 and over. Patients are usually seen at home and as an alternative to hospital admission. The health based place of safety provides services for people who require assessment under Section 136 or 135 of the Mental Health Act 1983.

We inspected the whole core service which included three home treatment teams; Coventry City, North Warwickshire and South Warwickshire. The psychiatric liaison teams known as the Arden assessment mental health teams based at University Hospital Coventry, George Elliott Nuneaton and South Warwickshire hospital in Warwick. The health based place of safety was based at the Caludon mental health hospital site in Coventry.

Care Quality Commission (CQC) last inspected the mental health crisis teams and the health-based place of safety in June 2017 as part of a comprehensive inspection of Coventry and Warwickshire Partnership NHS Trust.

Our inspection was announced one working day before we visited (staff knew we were coming) to ensure that everyone we needed to talk to was available.

The team included four inspectors and three specialist advisers.

Specialist advisers are experts in their field who we do not directly employ.

During the inspection visit, the inspection team:

- spoke to the managers of the teams
- spoke with eight patients who were using the service
- spoke with four carers
- spoke with 30 other staff members including doctors, nurses, occupational therapists, psychologists, social workers, health care assistants and administration staff
- spoke with 25 staff from the acute hospitals
- attended and observed ten meetings including handovers, multidisciplinary and management meetings
- attended and observed six home visits
- looked at the environment of the health-based place of safety
- looked at 10 medicine charts of patients in the home treatment team
- looked at 19 patient records within the home treatment team, four within the health-based place of safety and 14 within the psychiatric liaison teams.
- carried out a specific check of the medication management of the home treatment teams.
- looked at a range of policies, procedures and other documents relating to the running of the service.

Mental health crisis services and health-based places of safety

Summary of this service

Our rating of this service improved. We rated it as good because:

- We rated effective, caring, responsive and well-led as good and safe as requires improvement.
- The service kept people safe from avoidable harm by ensuring sufficient staff with the right training, supervision, knowledge and skills. Risk assessments were thorough and staff planned patient care around their needs. Staff had good awareness of safeguarding issues, followed the trust lone working policy, incidents were reported, and lessons learnt were cascaded to staff.
- Staff used best practice and national guidance to complete comprehensive assessments of their patients, and communicated their needs within the multidisciplinary team, the wider trust and with their external partners to ensure patients received effective and consistent care and treatment.
- Patients told us staff treated them respectfully and they were involved in their own care. They felt they were listened to and both patients and carers were provided with relevant information and support to manage their condition.
- The teams responded to patients quickly and managed their caseload effectively to ensure they could provide care when the patient required it. Teams were meeting their targets and dealt with complaints effectively.
- There were good governance arrangements in place and experienced managers and staff monitored the quality of the service they provided through the use of audits, patient feedback, incidents and complaints and key performance indicators. Staff were positive about the trust and their managers.

However:

- We found that processes and procedures for medicines management were not in place to adequately safeguard against abuse, ensure they were safe to use so patients were protected against harm.
- Staff could not easily identify when patients had been involved within their care plan and had received a copy, however patients and carers we spoke with felt they had sufficient information about their plan of care and treatment.

Is the service safe?

Requires improvement

Our rating of safe stayed the same. We rated it as requires improvement because:

- There was no regular pharmacy input into the teams and we saw numerous examples of staff not following trust medicines policies and effective medicines management systems were not working efficiently or were not in place.

However:

- Staff were aware of what and when they needed to report incidents and staff and managers received appropriate feedback. Incidents were reviewed by senior managers and lessons learnt were cascaded to staff regularly.
- Staff followed the trust lone working policy and ensured they knew of their colleague's whereabouts.
- Staff assessed and monitored patients' physical health regularly using a range of tools and techniques.
- Staff always undertook a thorough risk assessment of each patient and discussed patients' risks at each handover and clinical review, planning care and treatment appropriately.

Mental health crisis services and health-based places of safety

- We saw that staffing was sufficient to provide patients with safe care, and the majority of staff had received and were up to date with their training requirements.
- The health based place of safety was clean and appropriately furnished. Staff managed patients' risks by providing adequate staffing, completing risk assessments of the patient and the environment and patient observation.

Is the service effective?

Good ↑

Our rating of effective improved. We rated it as good because:

- Staff completed thorough and comprehensive assessments of their patients which led to holistic needs based care plans.
- There was good communication between all members of the multidisciplinary team and colleagues within the wider trust and their external partners, which ensured staff gave consistent care and treatment to their patients.
- The teams used audits to identify areas of good practice and where they could make improvements. Staff followed national guidance and best practice, and outcomes were monitored using recognised rating scales.
- Staff received regular supervision and were given opportunities to improve their skills and knowledge through training courses and education. Staff were compliant with training in the Mental Health Act and the Mental Capacity Act.
- Managers monitored data from the health based place of safety to ensure staff followed guidance set out in the Code of Practice.

Is the service caring?

Good → ←

Our rating of caring stayed the same. We rated it as good because:

- Staff were kind, caring and respectful. Patients felt included in their care and told us staff had supported them to manage their condition.
- Carers felt listened to and staff sought their views. They were provided with relevant information so they felt involved in the planning of care.
- Staff across all the teams encouraged patient and carer feedback and the trust would collate responses received and provide staff with comments made.

However:

- Staff could not easily identify when patients had been involved within their care plan and had received a copy, however patients and carers we spoke with felt they had sufficient information about their plan of care and treatment.

Mental health crisis services and health-based places of safety

Is the service responsive?

Good ➔➔

Our rating of responsive stayed the same. We rated it as good because:

- Staff responded to all referrals to the crisis team quickly and triaged them appropriately. The home treatment team were flexible and offered patients choice with their appointment times and where they wanted to be seen.
- Staff responded quickly to telephone calls and patients in crisis and were available 24 hours a day. The crisis teams had developed an effective system to coordinate tasks and assessments which meant they could be responsive to the needs of their patients.
- The health-based place of safety completed 100% of Mental Health Act assessments within 24 hours in line with Mental Health Act law and escalated any delays appropriately.
- Patients were given a range of information and the teams dealt with any complaints effectively.
- The health-based place of safety environment was secure and promoted comfort, dignity and privacy.

Is the service well-led?

Good ↑

- Our rating of well-led improved. We rated it as good because:
- The trust had developed an electronic matrix that meant managers were able to monitor and allocate visits, identify risk and warning signs, and ensure urgent referrals were seen quickly.
- Managers were suitably skilled, knowledgeable and experienced to effectively lead and manage staff, ensuring they received the right training, supervision and information to provide good quality care to their patients.
- Staff told us they were aware of the trust vision and values and felt respected and valued by senior managers. The trust promoted a positive culture and staff were recognised for good work by managers.
- Staff received feedback on complaints, incidents and changes being made to the service and lessons learnt had been embedded within the service.
- Staff monitored the quality of the service through the use of key performance indicators, audits and staff and patient feedback. Action plans were in place and senior managers monitored and scrutinised results in regular manager meetings.
- The Arden mental health assessment team was working towards accreditation with the Psychiatric Liaison Accreditation Network.

However,

- There were significant governance issues relating to medicines management.

Outstanding practice

We found examples of outstanding practice in this service. See the Outstanding practice section above.

Mental health crisis services and health-based places of safety

Areas for improvement

We found areas for improvement in this service. See the Areas for Improvement section above.

Specialist community mental health services for children and young people

Good

Key facts and figures

Coventry and Warwickshire Partnership NHS Trust provides a range of specialist community mental health services for children and young people in Coventry and Warwickshire. Staff have access to team bases in Coventry, Nuneaton, Rugby, Leamington Spa and Stratford.

The provision of children and young people's mental health services are usually described as tiers:

- Tier 1 are universal services which are accessible to all, for example, GPs, school nurses, health visitors.
- Tier 2 are more targeted services around general wellbeing and mental health.
- Tier 3 is specialist community-based mental health intervention, which includes specialised assessment, and treatment of complex and co-morbid mental health difficulties in children and young people.
- Tier 4 describes inpatient mental health services.

At the time of our inspection, the trust provided a wide range of specialist community mental health services for children and young people. The services were commissioned by five different clinical commissioning groups, which resulted in some variation in service configuration. The service had developed nine clinical pathways to help ensure equitable and consistent access to services across Coventry and Warwickshire. The pathways included eating disorders, generic mood, acute liaison, neurodevelopment, early intervention, learning disability, complex personality presentation and attachment. The service also had a primary care team, and operated a navigation hub, which provided a single point of access. Each pathway provided assessment and access to specific interventions and therapies according to each individual patient's needs. Interventions and therapies were individual, family or group-based. The service had teams based in different locations throughout Coventry and Warwickshire. The main services provided are described below.

- **Navigation hub** – the service operated a single point of entry for all referrals for tier 1-3 mental health services. The hub staff processed and triaged all the referrals they received.
- **Core child and adolescent mental health services** – the teams offered interventions and therapies to children and young people mental health conditions such as depression, anxiety and self-harm.
- **Acute liaison team (ALT)** – staff on this team provided urgent mental health assessments to patients referred by the navigation hub. They also provided assessment, short-term interventions and seven-day follow up to children and young people with mental health needs admitted to a paediatric ward.
- **Primary mental health team** - staff provided mental health expertise and knowledge to other services and agencies who worked with children and young people with low-level (tier 2) mental health needs. They ran workshops, training, gave general advice and offered one-to-one case consultation.
- **Neurodevelopmental team** – staff provided specialist neurodevelopment assessments for the specific conditions of Autism Spectrum Disorder (ASD), Attention Deficit Hyperactivity Disorder (ADHD), Tourette's Syndrome and Dyspraxia (as a co-occurring disorder).
- **Eating Disorders Team** – staff work in collaboration with children, young people and their families to offer specialist treatment to restore patients' physical and psychological wellbeing.

Specialist community mental health services for children and young people

- **Learning Disability team** – a small dedicated team that provided support to children with learning disabilities and their families.
- **Looked After Children (LAC)** team is a dedicated team commissioned by Coventry Clinical Commissioning Group for patients residing in Coventry.

At our last inspection in June 2017, we rated specialist community mental health services for children and young people as requires improvement overall with inadequate in the responsive domain, requires improvement in the safe and well led domains and a rating of good in the effective and caring domains. We told the trust that it must:

- ensure that all referrals are clinically triaged on the day of receipt to ascertain urgency of follow up and level of risk.
- ensure that the single point of entry standard operating policy is reviewed and fully completed.
- ensure that staff report all incidents on the electronic reporting system.
- ensure that the safeguarding policy is reviewed and updated in line with current national guidance.
- ensure that referral to treatment waits for all patients are reduced to comply with the NHS waiting time target of 18 weeks.
- ensure that waiting lists and length of waits for follow up interventions are reduced.
- ensure that the staff actively monitor patients on waiting lists and not rely on patient, family and or carers, or referrers to contact the service.

We undertook this inspection to find out whether the trust had made improvements since our last inspection. Before our inspection visit, we reviewed the information that we held about these services and asked a range of other organisations for information.

During the inspection visit, the inspection team:

- visited four team bases and reviewed the quality of the environment
- interviewed team leaders and service managers
- spoke to 54 staff members including doctors, clinical leads, nurses, psychologists, social workers, psychotherapists, occupational therapists, art therapists, and administrative staff
- reviewed 22 care records
- spoke with one young person and nine carers of young people that were using the service
- reviewed a number of policies, minutes of meeting and other documents related to the running of the service
- observed staff members working with the children and young people and their carers in three individual and group sessions.
- attended and observed a senior managers management meeting.

Summary of this service

Our rating of this service improved. We rated it as good overall. We rated safe, effective, caring, responsive and well-led as good.

Specialist community mental health services for children and young people

- For children and young people with mental health problems, the trust had significantly improved triage processes since the previous inspection in June 2017 that meant referrals were reviewed quickly. The trust was working with partners across local the health and social care economy to reduce the impact on children and families who were waiting for treatment. Systems and processes were in place to monitor assessment and treatment times. However, there was further work to undertake to reduce waiting times for treatment, especially in neurodevelopment and child and adolescent mental health services.
- Staff received training on an extensive range of therapeutic interventions and provided care in line with National Institute for Health and Care Excellence guidelines.
- Care plans captured the voice of the young person and placed them at the centre of their care. Young people were actively involved in reviewing their progress towards their goals and outcomes.
- Staff reviewed complex cases using a multidisciplinary approach, were able seek support and guidance to ensure risks were appropriately managed. Care records contained up to date individual risk assessments and management plans.
- Staff morale was good and staff felt positive about their teams. The managers promoted a positive culture that supported and valued staff, creating a sense of mutual purpose based on shared values.
- Staff knew how to identify abuse and safeguard young people in line with current recognised guidance and trust policy. Staff followed safeguarding processes and ensured that they highlighted any safeguarding information on the electronic recording system.
- Young people felt that staff listened to them and provided them with appropriate emotional and practical support. Young people described the staff as caring, supportive and non-judgemental.
- Staff reported incidents appropriately and shared lessons learnt from the investigations. The teams had regular and effective multidisciplinary team meetings and worked well with other external organisations.
- The trust demonstrated how it was working to meet the recommendations of the previous inspection and how it was addressing the issues identified. Managers and commissioners were working together to reduce waiting lists and ensure that the service met the needs of children and young people locally.

However:

- Although we found that staff received regular supervision, the trust did not have a consistent and effective system for collating and monitoring supervision data.

Is the service safe?

Good ↑

Our rating of safe improved. We rated it as good because:

- Care records contained up-to-date individual risk assessments and management plans. The risk assessments and crisis plans were comprehensive and completed fully.
- Staff ensured incidents were consistently reported. Managers investigated the incidents, shared the outcomes with staff and made changes where needed to improve practice. Staff received debrief and support after a serious incident.
- Staff demonstrated an awareness of how to protect children and young people that were at any risk of abuse. Safeguarding information was clearly highlighted on the electronic recording system.

Specialist community mental health services for children and young people

- There was an effective process of triage, which enabled the staff to identify higher risk referrals. The service had systems in place for routinely monitoring the risks of young people on the waiting list for treatment.

However:

- Mandatory training for information governance and safeguarding level 3 was below 63%, which meant that not all staff were up to date with their mandatory training. However, we did not see an adverse impact on practice.
- Staff did not maintain cleaning rotas for toys used by the young people.
- Staff did not store care plans consistently on the electronic system.

Is the service effective?

Good

Our rating of effective stayed the same. We rated it as good because:

- Staff used a range of recognised assessment tools and outcome measures to support their practice. Improved Access to Psychological Therapies programme outcome measures were used and these were audited for their completion and effectiveness.
- The service had strong culture of continuous learning and development. Staff had access to additional training relevant to their roles.
- Staff had good knowledge of Gillick competence and the Mental Capacity Act, and recorded decisions about capacity fully and appropriately.
- All teams had regular and effective multidisciplinary team meetings. Staff worked closely with schools, social services, and other local independent services, for example, MIND.
- The service had well defined clinical care pathways with clear goal-based outcomes. Engagement with stakeholders informed the direction of the service.
- The navigation hub provided a single point of access for all referrals to ensure that children and young people had access to the right support from the point of referral.

However:

- There was no common system in place for the trust to capture supervision rates.
- Appraisal rates for staff had received their annual appraisals were below 60%.

Is the service caring?

Good

Our rating of caring stayed the same. We rated it as good because:

- Staff demonstrated understanding of young people care needs and showed an encouraging, sensitive and supportive attitude. Feedback from young people confirmed that staff treated then with kindness felt staff listened to them and provided them with appropriate emotional and practical support.

Specialist community mental health services for children and young people

- Children and young people using services were partners in their care. We saw that care plans were written in a way that captured the voice of the young person and placed them at the centre of their care.
- Staff included parents and carers in the care of the young people and provided them with training in therapeutic interventions via groups and online resources.

Is the service responsive?

Good ↑↑

Our rating of responsive improved. We rated it as good because:

- For children and young people with mental health problems, the trust had significantly improved triage processes since the previous inspection in June 2017. This meant referrals were reviewed more quickly. The trust was working with partners across local the health and social care economy to reduce the impact on children and families who were waiting for treatment. Systems and processes were in place to monitor assessment and treatment times. However, there was further work to undertake to reduce waiting times for treatment, especially in neurodevelopment services.
- Service managers were working proactively with commissioners to ensure care pathways met local needs.
- There was a clear criterion for which young people would be offered a service and the service worked closely with other organisations to be signposted to the most appropriate service to meet their needs.
- Staff knew how to handle complaints and there was information about how to make a complaint in all the waiting rooms.

Is the service well-led?

Good ↑

Our rating of well-led improved. We rated it as good because:

- Since the previous inspection in June 2017, the service had worked hard in collaboration with their commissioners to ensure that all of the young people on the waiting lists were appropriately triaged according to their risk.
- Managers had a thorough understanding of issues and challenges the service faced and how these aligned with the priorities of their local population.
- Managers took a systematic approach to working with other organisations such as MIND to improve care outcomes for young people. Strategies and plans were fully aligned with commissioners and demonstrated a commitment to system-wide collaboration.
- Staff were aware of the whistleblowing policy and were confident they would use it if needed. Staff were enthusiastic and motivated. Morale was good and staff felt positive about their team and senior managers.

However:

Although we were assured that staff were receiving regular managerial supervision from their manager and clinical supervision from their peers and in line with their own professional guidance. There was inconsistency in the recording of supervision documentation and rates across the core service. The trust were unable to track supervision data.

- Not all staff were up-to-date with their mandatory training (information governance, safeguarding level 3), or their annual appraisals.

Specialist community mental health services for children and young people

Outstanding practice

We found examples of outstanding practice in this service. See the Outstanding practice section above.

Areas for improvement

We found areas for improvement in this service. See the Areas for Improvement section above

This section is primarily information for the provider

Requirement notices

Action we have told the provider to take

The table below shows the legal requirements that the service provider was not meeting. The provider must send CQC a report that says what action it is going to take to meet these requirements.

For more information on things the provider must improve, see the Areas for improvement section above.

Please note: Regulatory action relating to primary medical services and adult social care services we inspected appears in the separate reports on individual services (available on our website www.cqc.org.uk)

This guidance (see goo.gl/Y1dLhz) describes how providers and managers can meet the regulations. These include the fundamental standards – the standards below which care must never fall.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Assessment or medical treatment for persons detained under the Mental Health Act 1983 Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Assessment or medical treatment for persons detained under the Mental Health Act 1983 Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 15 HSCA (RA) Regulations 2014 Premises and equipment

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Assessment or medical treatment for persons detained under the Mental Health Act 1983 Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 18 HSCA (RA) Regulations 2014 Staffing

Regulated activity	Regulation

This section is primarily information for the provider

Requirement notices

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 11 HSCA (RA) Regulations 2014 Need for consent
Assessment or medical treatment for persons detained under the Mental Health Act 1983	
Diagnostic and screening procedures	
Treatment of disease, disorder or injury	

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 9 HSCA (RA) Regulations 2014 Person-centred care
Assessment or medical treatment for persons detained under the Mental Health Act 1983	
Diagnostic and screening procedures	
Treatment of disease, disorder or injury	

Our inspection team

Kathryn Mason, Head of Hospitals Inspection, led the well-led inspection. The well-led inspection team included two executive reviewers, two specialist advisers, one inspection manager, two mental health inspectors, one CQC pharmacist, one Mental Health Act reviewer and one assistant inspector. One person from NHS Improvement supported our inspection of well-led overall. The well-led inspection team reviewed information governance, finance, safeguarding and serious incidents, medicines management, equality and diversity, mortality, patient and staff experience and complaints.

Paul Bingham, Inspection Manager, led the core service inspections. The inspection team across seven core services included three inspection managers, 11 mental health inspectors, three acute inspectors, two pharmacists, and 14 specialist advisers. One expert by experience supported the inspection of wards for older people with mental health problems. Experts by experience are people who have personal experience of using or caring for someone who uses mental health services that we regulate.

Executive reviewers are senior healthcare managers who support our inspections of the leadership of trusts. Specialist advisers are experts in their field who we do not directly employ.