Care Quality Commission

5 Boroughs Partnership NHS Foundation Trust

Quality Report

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Core services inspected	CQC registered location	CQC location ID
Acute wards for adults of working age and psychiatric intensive care unit	Warrington Halton Wigan St Helens	RTV06 RTV03 RTV04 RTV02
Wards for older people with mental health problems	Warrington Halton	RTV06 RTV03
Forensic inpatient/secure wards	Warrington	RTV06
Mental health crisis services and health-based places of safety	Warrington Trust headquarters	RTV06 RTV
Community end of life care	Halewood Health centre Trust headquarters -The Bluebell Centre and the Anita Samuels Centre	RTV30 RTV

This report describes our judgement of the quality of care at this provider. It is based on a combination of what we found when we inspected, information from our 'Intelligent Monitoring' system, and information given to us from people who use services, the public and other organisations.

Summary of findings

Ratings

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

Overall rating for services at this Provider	Good ●
Are services safe?	Good ●
Are services effective?	Good ●
Are services caring?	Good ●
Are services responsive?	Good ●
Are services well-led?	Good ●

Mental Health Act responsibilities and Mental Capacity Act/Deprivation of Liberty Safeguards
We include our assessment of the provider's compliance with the Mental Health Act and Mental Capacity Act in our overall inspection of the core service.

We do not give a rating for Mental Health Act or Mental Capacity Act; however, we do use our findings to determine the overall rating for the service.

Further information about findings in relation to the Mental Health Act and Mental Capacity Act can be found later in this report.

Summary of findings

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Summary of findings

Overall summary

When aggregating ratings, our inspection teams follow a set of principles to ensure consistent decisions. The principles will normally apply but will be balanced by inspection teams using their discretion and professional judgement in the light of all of the available evidence.

Following the most recent inspection in July 2016, we have changed the overall rating for the trust from requires improvement to good because:

- In July 2015, we rated eleven of the thirteen core services as good. We have received no intelligence since to suggest that these services have deteriorated in quality.

- In response to the findings of the July 2016 inspection, we have changed the ratings of a further two core services from requires improvement to good: forensic inpatient/secure wards and community end of life care.

- Following the July 2016 inspection, we have revised the rating of the following key questions from requires improvement to good:

- safe: acute wards for adults of working age and psychiatric intensive care units, forensic inpatient/secure wards and community end of life care

- effective: forensic inpatient/secure wards and community end of life care

- caring: forensic inpatient/secure wards

- responsive: forensic inpatient/secure wards and community end of life care

- well-led: forensic inpatient/secure wards, mental health crisis services and health-based places of safety and community end of life care.

- In community end of life care, we have revised the rating for caring from good to outstanding.
- The trust had taken effective action to meet the requirement notices we issued following our inspection in July 2015.

- The trust had strengthened how it monitored and reported on the quality of care. Monthly operational reports provided details on how each area was performing so that the board had real time reports on quality measures.

- The trust had developed an end of life strategy and framework with an identified board lead.

- Staff felt supported and, particularly in end of life care, were very positive about how the executive team had managed the concerns identified at the last inspection.

However:

- In wards for older people with mental health problems safe remains requires improvement. This is because the bedroom doors had viewing panes that only staff could open and close. During the inspection we saw that these were left open. This meant that patients would have to ask staff to close the viewing panes to ensure privacy in their bedroom. This had been raised as a concern in the inspection in July 2015 and we had told the trust that they should take action to address this.

Summary of findings

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

We always ask the following five questions of the services.

Are services safe?

We rated safe as good because:

- In July 2015, we rated 9 of the thirteen core services as good for the safe key question. The intelligence we have received since that inspection, which includes information reviewed during the course of the 2016 inspection, suggests that the trust has maintained the safety of these services.
- Following the July 2015 inspection, we rated four out of the thirteen core services as requires improvement for safe. This led us to rate the trust as requires improvement overall for this key question. At this July 2016 inspection, we visited the four services rated as requires improvement for safe. In light of the findings, we have revised three of the four ratings to good.

- The staffing of the services was safe. There were sufficient staff to provide safe carewho were trained to perform their roles. Seven per cent of staff posts were vacant. This is better that the trust's target.The trust had set a challenging compliance target of 90% for training and were achieving 90% for core training, 88% for statutory training and 88% for specialist training.
- Staff recognised and reported incidents, and learning was shared.
- Staff followed good practice when they used seclusion. They ensured that patients were secluded for the shortest time possible, that patients were reviewed and records were completed for each episode of seclusion.

- Medicines were stored securely and the trust had effective systems in place to monitor the temperature of rooms where medicines were stored. Staff had been trained to manage medicines. There was an effective audit programme in place to monitor how medicines were handled.

- Patients were cared for in accommodation that met the Department of Health guidelines on mixed sex accommodation. There were lounges for men and women on all the wards we visited. Staff were aware of their responsibilities and when they had to deviate from the guidance due to an emergency admission, they followed a protocol to keep the patient safe.

However:

Good ●

Summary of findings

- Although staff had identified ligature risks in patient bedrooms on Marlowe unit and they were effectively managed, there was no current plan to remove them.
- Viewing panes in bedroom doors on wards for older people with mental health problems were left open. Only staff could close these which meant patients would have to ask for them to be closed to maintain their privacy.

Are services effective?

Good ●

- In July 2015, we rated eleven of the thirteen core services as good for the effective key question. The intelligence we have received since that inspection, which includes information reviewed during the course of the 2016 inspection, suggests that the trust has maintained the effectiveness of these services.
- In July 2016, we inspected and revised ratings for two core services, forensic impatient/secure wards and community end of life care, as good.
- Staff received specialist training to perform their roles and were supervised and appraised. At March 2016, 80% of staff had received an appraisal.
- Staff were delivering care in line with national guidance and best practice.
- Patient outcomes were routinely monitored and used to plan care. On Chesterton unit in forensic inpatient/secure wards, these were used to have meaningful discussions with patients.
- There was effective multi disciplinary team working.

However:

- In community end of life care, we found that anticipatory prescribing for breathlessness was not always evident.

Are services caring?

Good ●

- In July 2015, we rated eleven of the thirteen core services as good for the caring key question. One service was not rated as we had insufficient data. The intelligence we have received since that inspection, which includes information reviewed during the course of the 2016 inspection, suggests that the trust has maintained the effectiveness of these services.
- In July 2016, we inspected and revised ratings for two core services: we rated forensic impatient/secure wards as good and community end of life care as outstanding.

Summary of findings

- Patients told us that staff were caring and supportive. In community end of life care there were examples of staff going the extra mile to support patients. Staff were passionate and committed to providing holistic care to patients and their relatives.
- Patients were involved in the planning of their care and treated as partners.

Are services responsive to people's needs?

Good ●

- In July 2015, we rated eleven of the thirteen core services as good for the responsive key question. The intelligence we have received since that inspection, which includes information reviewed during the course of the 2016 inspection, suggests that the trust has maintained the effectiveness of these services.
- In July 2016, we inspected and revised ratings for two core services, forensic impatient/secure wards and community end of life care, as good.
- There were referral and discharge pathways in place which gave clear criteria for admission and discharge. Discharge planning was evident in care plans.
- The trust was able to support the needs of patients from a diverse background. Staff provided accessible information for patients.
- Complaints were handled effectively and the trust actively sought feedback from patients.

Are services well-led?

Good ●

We rated well-led as good because:

- In July 2015, we rated ten of the thirteen core services as good for the well-led key question. The intelligence we have received since that inspection, which includes information reviewed during the course of the 2016 inspection, suggests that the trust has maintained the safety of these services.
- Following the July 2015 inspection, we rated two out of the thirteen core services as requires improvement for safe(forensic inpatient/secure wards and mental health crisis services and health-based places of safety). We rated well-led as inadequate in community end of life care. This led us to rate the trust as requires improvement overall for this key question. At this July 2016 inspection, we visited the two services rated as requires improvement for safe and the service rated as inadequate. In light of the findings, we have revised all three ratings to good.

Summary of findings

- At this inspection we visited the three core services and also reviewed the trust's governance systems and interviewed members of the executive team.
- The trust had taken effective action to address shortfalls identified at the last inspection. The actions included updating policies, training staff and improving monitoring which meant that the improvements were sustainable.
- The trust had a clear strategy that was communicated clearly to staff. The senior leadership team were visible and were seen as supportive. Staff in end of life care and the forensic service knew who the executive team were and felt that they had managed the post inspection process well, acknowledging their part in the failings and committing to work together.

- Staff vacancies were managed well with vacancies recruited to quickly. Training and appraisal rates were high.

- The systems in place for learning from incidents had been strengthened. The monitoring of delivery of services was also improved. The trust had learnt from the inspection and was more robust in their approach to assurance. The operational reports were an effective way of monitoring performance and providing information to the board and back to the ward.

- There was an end of life strategy in place with an identified executive lead. Policies had been updated and a robust system put in place to ensure that these were reviewed and updated when necessary.

- The trust had checked that eligible staff met the fit and proper person's requirement. There was a system in place to ensure this was checked every year.

However:

- The multi-agency section 136 policies did not reflect the guiding principles of the current Mental Health Act code of practice.

Summary of findings

Our inspection team

Our inspection team was led by:

Team Leader: Sarah Dunnett, inspection manager, Care Quality Commission

The team included seven CQC inspectors, a Mental Health Act reviewer and three specialists: a psychologist, a senior nurse and a district nurse.

Why we carried out this inspection

We undertook this unannounced, focused inspection and well-led review between 04 and 08 July 2016 to find out whether 5 Boroughs Partnership NHS Foundation Trust had made the improvements we required following the comprehensive inspection of the trust that we undertook from 20 to 24 July 2015. We also reviewed the ratings that we had made of the trust's services in light of our latest findings.

At this most recent inspection in July 2016, we assessed the following core services and key questions:

- Acute wards for adults of working age and psychiatric intensive care units (safe key question).

- Wards for older people with mental health problem (safe key question).

- Forensic inpatient/secure wards (safe, effective caring, responsive and well-led key questions).

- Mental health crisis services and health-based places of safety (well-led key question).

- Community end of life care (safe, effective caring, responsive and well-led key questions).

When we inspected in July 2015, we rated the trust as requires improvement overall. We rated the safe and well-led key questions as requires improvement overall and the effective, caring and well-led key questions as good overall. We rated two core services as requires improvement - forensic inpatient/secure wards and community end of life care. We issued five requirement notices.

Following the inspection in July 2015, we told the trust that it must take the following actions to improve.

In acute wards for adults of working age and psychiatric intensive care units:

- The trust must ensure that the blind spot in the seclusion room in Taylor ward is mitigated and there is access to toilet and washing facilities for patients that are secluded.

- The trust must ensure that medicines are administered safely. It must resolve the unsafe storage of medicines on Weaver ward. The ambient room temperature in the clinic room was regularly in excess of 25 C. It must also ensure that staff attend the medicines management training.

- The trust must ensure that there are facilities on Lakeside ward for patients to make a private phone call.

- The trust must resolve the identified ligature risks on Sheridan ward.

In forensic inpatient/secure wards:

- The trust must ensure that staff complete seclusion and Mental Health Act records accurately.
- The trust must ensure that patient records, are complete and accurate and supporting management plans are in place where required. This includes risk assessments, care plans and discharge plans.
- The trust must ensure staff report serious incidents according to trust policy and that learning from incidents is shared with staff.

- The trust must ensure that staff receive appropriate training to perform their role and are up to date with mandatory training.

- The trust must ensure that patients are involved in the planning of their care. Patients must be able to discuss care and treatment choices continually and have support to make any changes to those choices if they wish.

Summary of findings

- The trust must ensure that patients are prescribed medicines in accordance with the forms of authorisation.

In wards for older people with mental health problems:

- The trust must ensure that female only lounge areas are available and clearly identified for patients on all the wards.

In health-based places of safety:

- The trust must review its systems to ensure data is collected, analysed and disseminated to all organisations involved in the application of section136. This review should include the ability of the trust to review assessment periods, length of section136 and equalities data (para 16.64, 16.63 and 16.71 MHA Code of Practice).

In community end of life care:

- The trust must develop and implement a formal strategy, policy and framework for the delivery of end of life care ensuring executive scrutiny.

- The trust must ensure that the management of medicines is safe within the end of life care service, particularly in relation to controlled drugs management.

- The trust must address the low training levels for mandatory medicines management training, end of life care and use of their internal reporting system.

- The trust must implement a standardised approach to care planning for end of life care.

- Improve governance within the end of life care service including monitoring and risk management at all levels.

- The trust must ensure patients receive medication in a timely way when they require it.

- The trust must address the workload of senior managers involved with the delivery of end of life care to ensure this is manageable and safe.

- The trust must ensure that records made by their staff are comprehensive, accurate and contemporaneous.

- The trust must improve their engagement with the public in relation to end of life care services.

How we carried out this inspection

Before visiting, we reviewed a range of information we hold about 5 Boroughs Partnership NHS Foundation Trust and asked the specialist commissioners of secure services to share what they knew. We carried out an unannounced visit from 4 to 8 July 2016.

We visited five acute mental health wards, two wards for older people with mental health problems, four forensic/low secure wards and one health-based place of safety. We also visited three community teams delivering end of life care.

During the inspection visit, the inspection team:

- talked with 26 people who use services

- observed how people were being cared for and carried out two observations using the short observational framework for inspection tool. This is used to capture the experiences of people who use services who may not be able to express this for themselves

- spoke with the managers for each of the wards we visited

- spoke with 60 other staff members from other staff groups including doctors, nurses, support workers, pharmacy, modern matrons, psychologists and occupational therapy

- attended and observed three handover meetings, three multi-disciplinary meetings and two living life well groups and two group supervisions

- attended a debrief following an incident

- carried out a specific check of the medication management and reviewed 122 medication records

- reviewed 54 care or treatment records of people who use services

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

Summary of findings

- interviewed the chief executive, the director of nursing, the director of strategy and organisational effectiveness, the director of finance and the clinical director.

Information about the provider

5 Boroughs Partnership NHS Foundation Trust provides mental health services and learning disability services across the boroughs of Halton, Knowsley, St Helens, Warrington and Wigan to a population of 938,000. It also provides community health services within the borough of Knowsley.

It provides the following core mental health services:

- acute wards for adults of working age and psychiatric intensive care units

- forensic inpatient/secure wards

- child and adolescent mental health wards

- wards for older people with mental health problems

- wards for people with learning disabilities or autism

- community-based mental health services for adults of working age

- mental health crisis services and health-based places of safety

- specialist community mental health services for children and young people

- community-based mental health services for older people

- community mental health services for people with learning disabilities or autism.

The trust also provides the following community health services:

- community health services for adults

- community health services for children, young people and families

- community end of life care.

5 Boroughs Partnership NHS Foundation Trust has a total of nine registered locations serving mental health and learning disability needs and community health services, including hospital sites:

- Hollins Park hospital

- Knowsley resource and recovery centre at Whiston hospital

- Leigh infirmary

- St Helens hope and recovery centre at Peasley Cross hospital

- Brooker centre at Halton hospital

- Fairhaven

The trust also provides community health services from St. Chads clinic, Nutgrove villa and Halewood health centre.

5 Boroughs Partnership NHS Foundation Trust was authorised as a foundation trust in March 2010. The organisation provides services from more than nine locations and has an income of about £152 million. The trust employs more than 3000 staff.

What people who use the provider's services say

Since our last inspection, the CQC have published a survey of patients who receive community services and the trust was performing the same as other trusts for all domains of the survey. During this inspection, patients were positive about the care they received. On the forensic services patients told us they felt safe. Patients were able to talk to staff and felt listened to.

Summary of findings

In community end of life care, patients described staff going the extra mile for them. The feedback was overwhelmingly positive from patients and carers about being involved in their care and feeling listened to.

The friends and family test is a survey which asks people whether they would recommend the service as a place for their family and friends to receive care. Between August 2015 and March 2016, the scores for people being extremely likely or likely to recommend the trust as a place to receive care ranged between 92% and 95%.

Good practice

In acute wards for adults of working age and psychiatric intensive care units:

- All wards had well embedded systems and procedures to monitor and address patient risk. All wards also had a summary and task board that staff used to chart key current key information about patients. This was a dry wipe board and all wards except Sheridan which was electronic. The summary and tasks boards documented key areas relating to patient risk, such as when their risk assessment had last been updated, their current leave status and whether they had received all the appropriate physical health checks. For each ward, a multidisciplinary team made up of nurses, medical staff, a psychologist and modern matron would review the summary and tasks board every morning. This meant that all patient risks were continually being reviewed by the multidisciplinary team involved in their care which meant that patient risks were being addressed and minimised promptly.

In community end of life care:

- The trust had undertaken significant amount of work to improve the service after the last inspection. Staff went above and beyond their duties to ensure patients received excellent care that met their needs. Leaders of the service had supported staff and valued their team highly
- Policies and guidelines to administer diuretics to patients living with end stage heart failure was embedded. The service shared thisevidence based initiative with other trusts who wanted to develop a similar protocol.
- There were four full time advanced care planning facilitators employed within the service. This meant patients had access to staff and ensured advanced care planning was undertaken at an early stage.
- The service had a comprehensive Citizen's Charter, which informed patients of the care they could expect to receive.Patients were involved in their journey and held staff to account for the care they provided.
- The service met the needs of the diverse local population, a recent project carried out devised strategies to engage the homeless population so that they had improved access to end of life care services.

Areas for improvement

Action the provider MUST take to improve

In wards for older people with mental health problems:

- The trust must review the practice of leaving open door observation windows in patients' bedrooms.

Action the provider SHOULD take to improve

In acute wards for adults of working age and psychiatric intensive care units

- The trust should ensure that post-seclusion debriefs are routinely completed with patients and captured in their care records.
- The trust should continue to monitor and address the use of restrictive practices, particularly the use of restraint on Cavendish unit and Sheridan ward, and rapid tranquilisation on Cavendish unit.
- The trust should ensure that patients receive the appropriate physical health checks when being administered high risk medications.

Summary of findings

- The trust should continue to monitor and address safe staffing issues across acute wards for adults of working age.
- The trust should ensure that Cavendish ward is cleaned regularly and kept smoke-free.
- The trust should ensure all ward managers receive information regarding the outcome of serious investigations both internal and external to the service.

In wards for older people with mental health problems:

- The trust should ensure that all patients do not have to pass bedrooms occupied by members of the opposite sex to reach toilet and bathroom facilities.
- On Kingsley ward, the trust should continue to address staffs failure to indicate when a medication has or has not been administered on patients' medication cards.
- The trust should ensure that eligible staff are compliant with mandatory training.

In forensic inpatient/secure wards:

- The trust should provide a more detailed plan for the long term management of the ligature points in Marlowe units' bedrooms.
- The trust should consider how it would increase its compliance with training in the areas that it falls below 85% in particular medication management and immediate life support training.
- The trust should continue with their plans to roll out the 'living life well' programme and review how care plans can be written from a patient perspective.

- The trust should ensure that the most up to date T2 and T3 forms are correctly filed in the medication charts.
- The trust should review the concerns raised by patients about the quality and portion size of the food provided.

In health-based places of safety:

- The trust should ensure they work with partners to update the multi-agency policies on the practical use of section 136 so that they reflect the guiding principles of the current Mental Health Act Code of Practice.

- The trust should ensure that the recording form for recording the use of section 136 contains space for professionals to record any delays of either of the assessing doctors and any reasons where it was not possible to provide patients with their rights.

- The trust should ensure that there is an effective system for ensuring any identified issues highlighted by the police or professionals about the health-based place of safety is addressed in a timely manner.

- The trust should ensure that patients' rights leaflets and a copy of the Mental Health Act Code of Practice are available in the health-based places of safety.

In community end of life care:

The provider should consider working with GPs to improve the prescribing of medications to alleviate breathlessness at the end of life.

5 Boroughs Partnership NHS Foundation Trust

Detailed findings

Mental Health Act responsibilities

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

The trust trained staff on the Mental Health Act and at May 2016, 91% of staff had received training.

Mental Health Act documentation was in place; including section 17 leave forms. In the forensic service, staff regularly explained to patients their rights under the Mental Health Act. This happened on a three monthly basis or when there were changes. In a small number of cases, the records of patients who were cared for under section 136 did not always show that patients had their rights to explained them. There were rights leaflets available on all the wards except in the section 136 suite we visited.

Treatment was given under the appropriate legal authority. Prescription charts had completed forms of authority or consent attached to them, except in one case which was addressed immediately.

There was an independent mental health advocate service available. There was information on the wards informing patients how they could contact advocacy services and patients we spoke with knew who the advocate was and how to access them.

At the last inspection, we found that the trust was not monitoring its use of section 136 as paper records were

held at each place of safety. At this inspection we found that the trust was recording summary information about episodes of section 136 electronically on a database which allowed managers to monitor its use and consider trends and themes.

There were agreed joint agency policies in place for the implementation of section 136 of the Mental Health Act. These had been agreed with each local authority, police authorities in each of the boroughs the trust worked within and the relevant NHS ambulance service. The duties of all agencies were set out to ensure that people received effective and timely assessment. These policies had not been updated to reflect the changes within the revised Mental Health Act Code of Practice. For example there had been minor changes to the guiding principles of the Code; the current policies still reflected the previous Code's guiding principles.

Mental Capacity Act and Deprivation of Liberty Safeguards

The trust trained staff on the Mental Capacity Act and at May 2016, 92% of staff had received training. In forensic services we found that staff had a good understanding of the Mental Capacity Act and were able to give examples of when they had supported patients who lacked capacity. The trust had a form for recording capacity assessments and we saw this was being used.

Are services safe?

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

* People are protected from physical, sexual, mental or psychological, financial, neglect, institutional or discriminatory abuse

Summary of findings

The summary can be located on page 6.

Our findings

Safe and clean care environments

When we inspected in July 2015, we found that the trust did not manage environmental risks consistently in all inpatient settings across the trust. At this visit in July 2016, we found that the trust had taken effective action to address this. All wards had up to date environmental and ligature risk assessments. At handover meetings, staff reading out ligature risks as a standard agenda item in the forensic service. We saw this happening. Bank and agency staff were told about environmental risks as part of their induction to the ward.

We found the trust had put mirrors in place to remove blind spots in seclusion rooms on Taylor Ward and on Chesterton Unit. A blind spot is an area within a room which cannot be viewed from outside. If there are blind spots in seclusion rooms, there is a greater risk that a patient could harm themselves or prepare to attack staff when they enter the room. Risks can be mitigated by using mirrors to allow all areas of the room to be viewed.

The trust had also ensured that ward staff and estates managed environmental risks proactively across the trust. Minutes from the audit committee in April 2016 showed that actions had been monitored and reported to the board. Further assurance was gained by executives during their safety walkabouts when they talked to staff about how they managed environmental risks.

At the July 2015 inspection we found that not all wards for older people had a separate lounge for women. The trust had acted on this and wards now had separate lounges for women. Kingsley ward had 17 bedrooms and admitted men and women. Eight bedrooms were single rooms with en suite shower rooms and one was a double room able to accommodate couples. Eight were single rooms without en

suite facilities. Patients admitted to the ward had an organic illness, most commonly dementia. However, there was a female patient on Kingsley ward who had to pass a male patient's bedroom to access toilets and bathroom. This was an emergency situation and staff thoroughly understood the risk this posed and had taken steps in place to reduce the risk. There was a protocol in place for such a situation which had been followed. Nursing staff were stationed at the end of the bedroom corridor to monitor.

The trust participated in annual patient led assessment of the care environment visits. In the 2015 assessment, the trust scored above the national average in all five areas ('cleanliness', 'food', 'privacy and dignity' 'condition, appearance and maintenance' and 'dementia'.

Wards were clean. There were dispensers at the entrance to all wards with hand sanitizer. Staff were observed using hand sanitizers. All staff observed during the inspection were bare below the elbow in line with trust policy.

Safe staffing

Since April 2014 all hospitals are required to publish information about safe staffing levels on wards, including the percentage of shifts meeting their agreed staffing levels. Since March 2016 the trust was reporting average fill rates of over 100% on all inpatient wards. In May 2016, all wards reported registered nurse fill rates of over 100% except Auden (83%), Halton Bridge (93%), Marlowe (96%) and Sephton (97%). At the last inspection, average fill rates for all staff were over 80%. The trust used bank and agency staff to cover gaps in staffing. Where vacancies were longer term, the trust used block booking to provide consistency of staff. The trust had used bank staff an average of 140 times a month since August 2015. The highest use was February 2016 with 170 shifts filled by bank staff.

At the last inspection, the specialist palliative care team was under establishment by one band 7 nurse. Since the inspection, the trust had appointed to this post and staff felt that their workload was manageable.

The trust had set a target for 95% staff attendance. Staff attendance includes sickness, leave and training. Since

Are services safe?

August 2015, the lowest monthly figure was in February 2016 (93%) and the highest September 2015 (95%). The national figure for absence due to sickness in mental health trusts is 5%.

The trust had set a target of no more than 7% vacant posts and was performing better than this for each month since August 2015. The vacancy rate ranged from 4.3% to 6.3%. The trust monitored and reported time taken to authorise recruitment to offer of post and had set a target of 55 days for this process. The trust had provided extra sessions to improve performance against target as it had been identified that there was a delay in interviewing. Currently the trust was performing against target.

On this inspection, we found that there were sufficient staff to meet the needs of the patients in the services we inspected. Where bank staff were on duty, they knew the service, had received a local induction and felt able to perform their role safely.

In March 2016, 80% of staff had received an appraisal.

Between August 2015 and May 2016, average staff turnover was 12%.

The trust divided training into statutory, core and specialist training. At May 2016, 89% of staff had received core training, 86% of staff had received statutory training and 88% had received specialist training against a trust target of 90%. In statutory training for clinical staff, 80% of staff had received basic life training, with the number of staff having received immediate life support training having dropped to 70% in May - the first time below 75% this year. The trust had identified this drop and was taking action to find a new provider of the training. Specialist training consisted of 16 modules and only one was below 75%, which was breakaway training at 65%. Control and restraint training was at 95%. The trust had identified this as an issue and had plans in place to increase the number of staff trained. The trust had systems in place to ensure that agency staff had received training to carry out their role.

Assessing and managing risk to patients and staff

In June 2014, the Department of Health launched a patient safety campaign with the aim of halving avoidable harm in the NHS over the next three years. In response, the trust had drawn up a Sign Up to Safety improvement plan which was overseen by the Sign up to Safety group. The Sign Up to Safety group provided strategic oversight and analysis of

key issues, themes, progress against actions and actions to improve and mitigate risks. The trust had trained 15 safety ambassadors who supported wards and teams to identify risk themes and develop safety improvement initiatives.

The quality account 2015 to 2016 showed that the trust had met all the safety priorities it had set for the period. Initiatives included the implementation of the Sign up to Safety initiative, the mental health safety thermometer in Warrington services except for forensic services and the self-harm reduction pilot on Cavendish ward had been extended to two further in patient units.

The trust had identified three new priorities in the quality account which would improve safety in the trust: lessons learned strategy, end of life strategy and living life well strategy. Work on sign up to safety was to continue as it was a three year strategy.

Risk assessments were used to monitor patient's risks and we saw that on acute wards for working age and psychiatric intensive care unit, wards for older people with mental health problems and forensic inpatient/secure wards that they were completed and reviewed as necessary for example, following an incident or in response to change in risk.

There were effective systems for managing safeguarding incidents. Staff could identify abuse and knew how to report it. Records showed that staff reported safeguarding appropriately using the electronic system. There was a designated lead for safeguarding and staff knew who this was.

Safeguarding was part of the trust's core training and 89% of staff had been trained in safeguarding adults and 90% in safeguarding children level one and 88% in level two.

At the last inspection we found that in the forensic service, staff had not always completed seclusion records thoroughly. Across the trust there had been 324 incidents of use of seclusion between December 2015 and May 2016. We reviewed seclusion records on acute wards for adults of working age, wards for older people with mental health problems and the forensic inpatient/secure wards service. Staff had completed records thoroughly in all but one set of notes. Staff kept patients in seclusion for the least amount of time. Staff audited seclusion records to monitor compliance the Mental Health Act code of practice.

Are services safe?

The trust was working to reduce the use of restrictive practices. At this inspection, we found that risks were assessed individually. There was a working group who reviewed all blanket restrictions to see whether they were necessary and then develop plans to remove them if they were no longer relevant. For example, at our last inspection we found that there were blanket restrictions in place on Sheridan and Austen ward where patient bedrooms were routinely locked. This was no longer happening.

The trust had a system for managing risk. In the CQC intelligent monitoring report from February 2016, the trust had seven risks and two elevated risks ('Has family intervention ever been offered to the service user?' and 'Patients that die following injury or self-harm within three days of being admitted to acute hospital bed.') out of a possible 75. The trust monitored risk via a monthly operational report. Each risk had an identified executive lead, action plans to improve and these were monitored by the quality committee.

Between December 2015 and May 2016, staff had restrained patients 1044 times. Staff had given rapid tranquillisation on 253 occasions during this period. Rapid tranquillisation is when medicines are given to a person who is very agitated or displaying aggressive behaviour to help quickly calm them. This is to reduce any risk to themselves or others, and allow them to receive the medical care that they need.

Medicines were managed safely. Some 80% of staff had received training in medicines management. Medicines were stored securely. The trust had implemented a protocol to ensure where the temperature in the clinic room exceeded a safe temperature to keep medicines, that action was taken. We reviewed 122 medication records and found that they were well completed. Allergies were noted and staff recorded when medicines were given to patients. The trust audited how medicines were managed and where minor discrepancies were identified, action had been taken which included addressing in supervision with individuals. In community end of life care staff were following the trust protocol for managing controlled medicines.

Track record on safety

Between December 2015 and May 2016 there had been 11 deaths. Of these, one was from natural causes and 10 were recorded as 'suicide, suspected suicide or preventable'. The strategic executive information system records serious incidents and 'never events'.

('Never events' are serious incidents that are wholly preventable as guidance or safety recommendations that provide strong systemic protective barriers are available at

a national level and should have been implemented by all healthcare providers so any 'never event' reported could indicate unsafe care.) Trusts have been required to report

any 'never events' through the strategic executive information system since April 2011. The trust had reported no never events.

We analysed data about safety incidents from three sources: incidents reported by the trust to the National Reporting and Learning system and to the Strategic Executive Information system and serious incidents reported by staff to the trust's own incident reporting system. These three sources are not directly comparable because they use different definitions of severity and type and not all incidents are reported to all sources. For example, the NRLS does not collect information about staff incidents, health and safety incidents or security incidents.

Providers are encouraged to report all patient safety incidents of any severity to the National Reporting and Learning system at least once a month. The average time taken for the trust to report incidents was 29 days which means that the trust was considered a consistent reporter.

The trust reported a total 2,913 incidents between 1 April 2015 and 30 September 2015. Of the reported incidents, 74% resulted in no harm, 22% in low harm, and 3% in moderate harm, 0.5% in severe harm and 0.7% in death. The National Reporting and Learning system considers that trusts that report more incidents than average and have a higher proportion of reported incidents that are no or low harm have a maturing safety culture.

The incident category which was most frequently reported was 'self-harming behaviour' which accounted for 23% of the incidents reported followed by 'disruptive, aggressive behaviour (including patient-to-patient)' and 'patient accident' with 11% and 'medication' 14%.

Are services safe?

In the NHS Staff Survey 2015, the trust were about the same as other mental health/learning disability trusts for questions related to staff witnessing potentially harmful errors, near misses or incidents in last month.

The Courts and Tribunals judiciary publish 'Reports to Prevent Future Death', which contain recommendations which have been made by coroners with the intention of learning lessons from the cause and prevention of deaths. The trust had received three reports since August 2015. The trust had to submit information to the coroner as instructed under Regulation 28, to identify actions it intended to take to address the recommendations made by the coroner. The trust then monitored the action plans through their governance system. On this inspection, we found that actions had been taken and there was a system in place to share learning. Staff across the core services we inspected were carrying out actions that had come out of the recommendations. Regulation 28 can be issued to providers of services by a coroner in relation to the death of a patient in receipt of services.

Reporting incidents and learning from when things go wrong

At the last inspection, the trust had recognised that it needed to improve its performance in investigating and learning from incidents.

At this inspection, we found that the trust had taken action which had improved how the trust learnt lessons. There was a trust wide lessons learned forum which staff could attend. Information was shared from senior management teams across boroughs and to the wards. Incidents were a standing agenda at team meetings. Staff told us they received information by email and through trust updates. In the forensic service, staff shared examples of local events to share learning. The senior managers of the service had attended a meeting and shared the investigation report. Staff felt this was positive and valued the open approach.

Staff we spoke with knew how to report incidents. The trust had a model for debriefing following incidents which included staff and patients. Records reviewed showed that these were meaningful and reflective. Staff were able to

provide examples of where changes had been made following incidents. Staff in the services we visited knew how to report incidents. The trust had identified improving learning from incidents as quality and safety priority in the quality account. It was also included as a standard item in the executive team's safety walkabouts.

The trust had also improved the quality and consistency of investigations, work which had just begun at the last inspection. To further strengthen this process, the trust had recently appointed three staff whose role was to investigate incidents and further embed learning.

Duty of Candour

The statutory duty of candour was introduced for NHS bodies in England from 27 November 2014. The obligations associated with the duty of candour are contained in regulation 20 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. The key principles are that NHS trusts have a general duty to act in an open and transparent way in relation to care provided to patients. This means that an open and honest culture must exist throughout the organisation. Appropriate support and information must be provided to patients who have suffered (or could suffer) unintended harm while receiving care or treatment.

The trust had a strategy in place to ensure that it was meeting the regulation. The trust had a "Being Open Policy" which met the duty of candour requirement. There was a designated operational lead. Staff understood the underlying principles and how it applied in their workplace.

Staff were aware of their responsibilities under Duty of Candour. The trust had incorporated staff understanding as part of the executive walkarounds and checked whether staff knew what they should do when things went wrong.

Anticipation and planning of risk

The trust had policies and procedures which set out how the trust would continue to provide services during an emergency situation. The policies and procedures were monitored by the trust local resilience forum. There was an identified executive lead in case of an emergency.

Are services effective?

Good ●

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

Summary of findings

The summary can be located on page 6.

Our findings

We reviewed the ratings of two core services only: forensic inpatient/secure wards and community end of life care. Detailed findings can be found in the core service reports.

Good 🟢

Are services caring?

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

Summary of findings

The summary can be located on page 6.

Our findings

We reviewed the ratings of two core services only: forensic inpatient/secure wards and community end of life care. Detailed findings can be found in the core service reports.

Are services responsive to people's needs?

Good ●

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

Summary of findings

The summary can be found on page 6.

Our findings

We reviewed the ratings of two core services only: forensic inpatient/secure wards and community end of life care. Detailed findings can be found in the core service reports.

Are services well-led?

By well-led, we mean that the leadership, management and governance of the organisation assure the delivery of high-quality person-centred care, supports learning and innovation, and promotes an open and fair culture.

Summary of findings

Our findings

Vision, values and strategy

The trust had five values which were

- We value people as individuals ensuring we are all treated with dignity and respect.

- We value quality and strive for excellence in everything we do.

- We value, encourage and recognise everyone's contribution and feedback.

- We value open, two-way communication to promote a listening and learning culture.

- We value and deliver on the commitments we make.

To underpin and support the embedding of the values, in 2014 the trust began to recruit using the trust values and NHS England's 6 Cs:

- care
- compassion
- commitment
- courage
- communication
- competence

This approach aimed to identify staff with both the right skills and values for appointment into all roles.

The trust had embedded the values across the trust using a number of methods.

- the visions and values of the trust were displayed in all the services we visited.
- the values were displayed as a splash screen on computers
- the values were linked to staff appraisals
- recruitment processes included trust values

The trust quality strategy 2015 to 2018 introduced the living life well strategy which set out the trust's approach to ensure that people's care was equitable, inclusive and reflected strong social values. This was based on a set of principles that fitted with the trust's values. There were lead members identified within each leadership team to ensure that the strategy was used across the trust. Living life well was in the process of being rolled out across services. On Chesterton unit, in low secure services, staff were planning and delivering care in line with the living life well strategy. Patients, with staff support, completed living life well booklets which set out their goals and recovery. There were daily living life well meetings where all staff contributed to discussions about the patient's wellbeing.

Good governance

The trust had an effective board assurance framework in place. The board assurance framework was a live, dynamic document which focused on all risks with a current score of 12 and above with fair or limited controls. The framework included operational and strategic risk.

Risks were reviewed and updated at least every quarter. The board assurance framework included a review date and action plan for each identified risk. It was reviewed by the trust board at alternate meetings along with risks from the corporate risk register.

The framework was supported by a performance operational report which provided assurance to the board on progress against a number of key performance indicators, which included national and local priorities. Since our last inspection, the trust had restructured into boroughs. The performance report contained data at borough and ward level which was improving local ownership of quality monitoring.

The trust had submitted an action plan following the last inspection and had completed all actions at this inspection. For example, in end of life care, the trust had developed an end of life care strategy and framework with an identified executive lead. Progress against key aspects

Are services well-led?

of this strategy was monitored through a number of meetings and forums and frontline staff were engaged in this process. Staff were able to tell us about the strategy and work streams.

In health-based places of safety, the trust had put a system in place to gather information about the use of section 136. This enabled them to audit and monitor for themes and trends which the trust then shared at multi-agency meetings. However, the multi-agency 136 policies did not reflect the guiding principles of the Mental Health Act code of practice. We also found that in one section 136 suite, staff had not acted to address minor maintenance problems in a timely manner.

In the forensic service, the actions taken had led to much improved care for patients on Chesterton and Tennyson unit. Staff had been supported to access training required to perform their role.

Quality and safety meetings were held at borough level. The quality and safety meeting reviewed risk management and mitigation across the trust. The director of strategy and organisation effectiveness chaired the group. The chair reported any areas of concern to the quality and audit committees and where appropriate commissioned reviews and discussion at borough quality and safety meetings.

Since the last inspection, the trust had appointed assistant clinical directors in all boroughs. This had strengthened the quality agenda and clinical ownership of quality. The role of the matron was identified as pivotal in ensuring that there was a consistent quality of care across the trust.

The senior executive team showed a good understanding and awareness of risks within the organisation and actions being taken to address them.

We found that the staff working in end of life care and forensic services, were able to describe what they were responsible for and felt able to contribute to local risk registers which enabled local issues to be appropriately escalated and managed.

NHS Improvement rated the trust's governance system as green, with a financial sustainability rating of four which indicates the least risk.

Fit and Proper Person test

The trust had a system to ensure that directors were fit for their role. At this inspection we reviewed the annual assurance and saw that the trust was following its policy to ensure directors remained fit for their role.

Leadership and culture

Following the last inspection, staff working in services rated as requires improvement described feeling supported by senior management. The executive team had been visible and had taken responsibility for shortfalls and committed to work with staff to improve care. Staff told us they had found this approach very helpful and did not feel blamed.

In the NHS staff survey 2015, the trust scored above the national average in 12 out of 32 questions:

- staff ability to contribute towards improvements at work
- percentage of staff suffering work related stress in last 12 months
- percentage of staff/colleagues reporting most recent experience of violence
- percentage of staff/colleagues reporting most recent experience of harassment, bullying or abuse
- percentage of staff reporting errors, near misses or incidents witnesses in the last month
- organisation and management interest in and action on health and well being
- percentage of staff appraised in last 12 months
- percentage working extra hours
- percentage experiencing discrimination at work in last 12 months
- recognition and value of staff by managers and the organisation
- support from immediate managers
- percentage of staff believing the organisation provides equal opportunities for career progression/promotion.

The trust scored below the national average in four questions:

- percentage agreeing that their role makes a difference to patients/service users
- percentage of staff satisfied with the opportunities for flexible working patterns
- percentage witnessing potentially harmful errors, near misses or incidents in last month
- quality of appraisals.

Are services well-led?

The overall staff engagement indicator combines four questions from the survey and the trust had improved its performance in all of them from the 2014 survey. The trust had improved significantly in 10 of the 32 items on the survey and no items had decreased significantly.

All trust policies and major service reviews had an equality impact assessment before ratification.

The equality delivery system 2 assessment for 2015 rated the trust as achieving three of the four identified goals: better health for all, a representative and supported workforce and inclusive leadership. The trust was rated as developing for improved patient access and experience.

Engagement with the public and with people who use services

The trust continued to have effective systems to engage with people who use the services. There was an involvement scheme which allowed service users, carers and volunteers to be involved in a number of pieces of work across the trust including recruiting staff, internal quality inspection teams, training staff, co-producing the service user and carer magazine and participating in task and finish groups.

The trust had an equality diversity and inclusion team. Large events were held which were open to all and included the annual involvement event, ignite your life and an arts festival. The trust had also reviewed its service user and carer fora to improve its ability to engage with these groups.

The trust gathered patient and carer views in a number of ways. On Chesterton unit, patients had the facility to provide feedback via hand held electronic devices on a daily basis. The trust used comments from the friends and family test to feed directly into service improvements. The trust had 'you said and together we did' posters which we saw displayed on wards along with a section on the website. The trust continued to run the six weekly 'next steps carers group'. The trust had carried out two carer surveys since our last inspection.

In 2015 to 2016 seven community health services undertook a patient experience survey with a total of 1256 completed surveys. Following feedback, localised action plans were put in place to make any identified improvements. In community end of life services there was a citizen's charter which informed patients of the care they could expect. The charter helped involve patients in care as well as holding staff to account for care they provided.

Quality improvement, innovation and sustainability

The trust had undertaken significant amount of work to improve following the last inspection. The improvements made were supported by improvements in monitoring and oversight which had

There were six wards which had achieved accreditation for inpatient mental health wards:-

- Byron unit, Hollins Park Hospital
- Rivington unit, Leigh Infirmary
- Coniston unit, Whiston Hospital
- Grasmere unit, Whiston Hospital
- Lakeside ward, Leigh Infirmary (accredited as excellent)
- Taylor ward, St Helens hope and recovery centre.

In end of life care, the service had implemented a policy and guideline to administer diuretics to patients living with end stage heart failure. This was an innovative and evidence based initiative which the trust was sharing with other providers who wanted to develop a similar protocol.

Since our last inspection the trust had completed the Future Fit transformation programme and services were now delivered from a borough based model. The trust was rolling out the living life well programme which aimed to improve involvement and outcomes for patients.

Requirement notices

Action we have told the provider to take

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

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Treatment of disease, disorder or injury	Regulation 10 HSCA (RA) Regulations 2014 Dignity and respect **In wards for older people with mental health problems:** Staff left open door observations windows into patients bedrooms as a default position. We raised this concern during our last inspection of wards for older people with mental health problems in July 2015, but the provider had not addressed this at the time of this inspection. This was a breach of regulation 10(2)(a)