North Staffordshire Combined Healthcare NHS Trust

Quality Report

Trust Headquarters
Bellringer Road
Trentham Lakes South
Stoke-On-Trent
Staffordshire
ST4 8HH
Tel: 01782 273510
Website: www.combined.nhs.uk

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Core services inspected	CQC registered location	CQC location ID
Acute wards for adults of working age and psychiatric intensive care units	Harplands Hospital Hilton Road Stoke-on-Trent Staffordshire ST4 6TH	RLY88
Long stay/rehabilitation mental health wards for working age adults	Summer View Furlong Road Stoke On Trent Staffordshire ST6 5UD Florence House 57 Belgrave Road Stoke-on-Trent Staffordshire ST3 4PN	RLY87 RLY39
Child and adolescent mental health wards	Darwin Centre 167 Queens Road Penkhull Stoke-on-Trent Staffordshire	RLY86 RLY36

Summary of findings

	ST4 7LF Dragon Square Community Unit 4-5 Dragon Square Chesterton Newcastle-under-Lyme ST5 7HL	
Wards for older people with mental health problems	Harplands Hospital Hilton Road Stoke-on-Trent Staffordshire ST4 6TH	RLY88
Wards for people with learning disabilities or autism	Harplands Hospital Hilton Road Stoke-on-Trent Staffordshire ST4 6TH	RLY88
Community-based mental health services for adults of working age	Harplands Hospital Hilton Road Stoke-on-Trent Staffordshire ST4 6TH	RLY88
Mental health crisis services and health-based places of safety	Harplands Hospital Hilton Road Stoke-on-Trent Staffordshire ST4 6TH	RLY88
Specialist community mental health services for children and young people	Darwin Centre 167 Queens Road Penkhull Stoke-on-Trent Staffordshire ST4 7LF Dragon Square Community Unit 4-5 Dragon Square Chesterton Newcastle-under-Lyme ST5 7HL	RLY86 RLY36
Community-based mental health services for older people	Harplands Hospital Hilton Road Stoke-on-Trent Staffordshire ST4 6TH	RLY88

Summary of findings

Community mental health services for people with learning disabilities or autism	Harplands Hospital Hilton Road Stoke-on-Trent Staffordshire ST4 6TH	RLY88
Substance Misuse Services	Harplands Hospital Hilton Road Stoke-on-Trent Staffordshire ST4 6TH	RLY88

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?	Requires improvement
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

Following the inspection in September 2016, we have changed the overall rating for North Staffordshire Combined Healthcare NHS Trust from requires improvement to **good** because:

- The trust had made considerable improvements to the quality of care and to the governance mechanisms that underpin and provide assurance since our last inspection in September 2015. The trust board had become more settled with an increased number of directors in substantive rather than interim posts and this had helped to ensure that governance systems were embedded.
- Since our inspection in September 2015, the trust had made significant improvements to the quality of care plans and risk assessments. Documentation consistently showed a collaborative approach to care that involved staff, patients, carers and families.
- The staff throughout the trust displayed a caring attitude towards people who used the services. We saw several examples of staff showing kindness, empathy and putting peoples' needs first. Feedback from patients, carers and families was also very positive and staff ensured that delivery of care was carried out in a co-productive manner.
- The majority of the core services were responsive to the needs of the people who used them. We saw some excellent examples of where staff had addressed issues with high 'did not attend' appointment rates in community teams by adapting the service to meet the needs of the patients and carrying out the appointments at a location that suited them.
- In most of the services that we visited, staff reported good morale and that they were supported by managers to carry out their roles effectively. The leadership across the trust had improved greatly since our last inspection and there was a sense of cohesion and determination among managers to continue in this vein.

However:

- Although some improvements had been made to waiting lists and the monitoring of them in the specialist community mental health teams for children and adolescents, we found that a great deal more work was required to continue to improve and to assure the safety of those young people who had been assessed and were awaiting treatment.
- In some teams, the storage of medicines was not always safe and we found that regular checks were not always being carried out to monitor rooms or fridges where medicines were kept.
- In some services, physical health checks were not consistently being carried out following the administration of rapid tranquilisation.

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?

Requires improvement

We rated North Staffordshire Combined Healthcare NHS Trust as **requires improvement** for safe because:

- In some teams, the storage of medicines was not always safe and we found that regular checks were not always being carried out to monitor rooms or fridges where medicines were kept.
- Out of hours or rapid access to a doctor was not always available in the mental health crisis and health based places of safety teams.
- The systems for monitoring young people on waiting lists for treatment in the specialist mental health teams for children and adolescents was inconsistent. We found that although the trust policy stated that letters should be sent to those on the waiting list on a monthly basis, this was happening sporadically.

However:

- The trust had implemented a system of environmental and ligature risk assessments that identified and provided mitigation to protect people at risk of self-injurious behaviour.
- We found that risk assessments were consistently robust, regularly reviewed and person centred in order to take into account the individual needs of those using services.
- Staffing levels across the trust were safe in the majority of services. The trust had been proactive in the 12 months prior to the inspection in embarking upon a focussed recruitment drive for key staffing areas such as registered nurses and healthcare support workers.

Are services effective?

Good

We rated North Staffordshire Combined Healthcare NHS Trust as **good** for effective because:

- Care plans were consistently comprehensive, holistic and recovery focused in all of the teams that we visited. Clinical audits were effective in assuring the quality and person centred approach to the care planning process.
- We found evidence of a multi-disciplinary approach to peoples care delivery which included external professionals such as Police, local authorities, GP's and third sector and voluntary agencies

Summary of findings

- Staff were skilled in order to carry out their roles. The trust had embarked upon a process of improving both mandatory and specialised training and development.
- Physical health checks were carried out at initial assessment and on an ongoing basis across all services. Physical health needs were clearly documented in care plans.
- Staff were involved in a range of clinical audits to monitor the effectiveness of the services provided. These included audits of; care records, medicines, infection control and prevention, health and safety and physical health. The trust were also involved in several national audit programmes such as the national audit of schizophrenia and prescribing for attention-deficit hyper activity disorder.

Are services caring?

Good

We rated North Staffordshire Combined Healthcare NHS Trust as **good** for caring because:

- The trust's overall score for privacy, dignity and wellbeing in the patient led assessments of the care environment (PLACE) 2015 was 96.4%, which was around 6.5% higher than the England average of 86%. All trust services scored above the national average.
- Throughout the inspection, staff were found to be caring, empathic and considerate towards patients. Feedback from patients, carers and families was consistently positive regarding the quality of care and how staff treated them.
- Patient involvement was evident in all of the services that we visited. We saw good use of patient surveys, feedback from families and carers and community meetings.
- The trust had developed several service user and carer forums within service to enable and promote involvement in service changes, recruitment and practice developments.

Are services responsive to people's needs?

Good

We rated North Staffordshire Combined Healthcare NHS Trust as **good** for responsive because:

- Most teams were responsive to the needs of patients who required access to services during periods of crisis or for routine appointments. Staff rarely cancelled appointments and demonstrated flexibility with meeting peoples' individual needs or circumstances.
- PLACE data in relation to the quality of food offered by the trust was 93%. This was 6% higher than the national average and was replicated across all trust sites

Summary of findings

- All services were effective in displaying information in different languages and in easy read format at main receptions and notice boards around trust buildings.
- All services had access to interpreters and staff could describe how to access these when required. Staff in some teams were trained in British sign language (BSL) to enable effective communication with some patients'.
- The trust's approach to managing and investigating complaints was effective and confidential involving a patient experience team, patient advice and liaison service (PALS) and a patient and organisational change team. The organisation disseminated lessons learned from complaints through a process that included the circulation of a newsletter to all staff and through team meeting discussions.
- The trust received 151 compliments in the 12 months from April 2015 to March 2016. Community adult teams received the highest number of compliments with 33 (22%) followed by older adult inpatient wards with 27 (18%).

However:

- Waiting times from initial assessment to treatment in some of the speciality community mental health teams for children and adolescents were long. At the time of the inspection, some young people had been on the waiting list since January 2014.

Are services well-led?

Good

We rated North Staffordshire Combined Healthcare NHS Trust as **good** for well led because:

- The trust had developed a strategy, which included key elements of local and national policy drivers such as to meet local community need, improvements based on the previous CQC inspection and implementation of the NHS England five-year forward view. It was evident that the trust had worked hard to develop a bottom up approach with staff and directorates contributing to policy development and local GPs had been involved.
- Trust services were consistently well led at a local level. Staff told us that they were able to raise concerns without fear of victimisation.
- The organisation had robust systems, processes and controls in place concerning information governance and records in most of the services that we visited. There had been no information governance incidents reported in the trust since March 2014.

Summary of findings

- The organisation had strengthened the leadership since the previous inspection in September 2015 by recruiting substantively to several director and executive level roles. The trust had also undertaken significant change in leadership at a middle managers level.
- Nursing staff unanimously spoke very highly of the new substantive director of nursing. Staff told us that they now felt they had strong nursing leadership at a senior level in the organisation that was committed to clinical and leadership development.

However:

- During inspection, there was a degree of inconsistency found in the performance data held at local service level by the performance team and at senior level in the organisation, specifically concerning the community child and adolescent mental health services (CAMHS). Community CAMHS was experiencing excessive waiting lists at the time of inspection, for which locally, management and staff described mechanisms for monitoring and reviewing all young people waiting. However, we found no evidence in the files that we inspected. Through a 'listening into action' event prior to the inspection, CAMHS managers had highlighted inaccuracies in performance data and a lack of reported data regarding referrals, did not attend (DNA) figures, discharges, number of sessions available from the teams, number of initial assessments both routine and urgent. At the time of inspection, this remained unresolved.
- Processes for assuring that directors were 'fit and proper' were unclear and inconsistent. We raised these issues with the trust at the time of the inspection and immediate action was taken.

Summary of findings

Our inspection team

Our inspection team was led by:

Chair: Beatrice Fraenkel, Chairman, Mersey Care NHS Foundation Trust.

Team Leader: James Mullins, Head of Hospitals Inspections, Care Quality Commission

Inspection Manager: Kathryn Mason, Inspection Manager, Care Quality Commission

The team of 64 people included:

- 15 CQC inspectors
- two CQC assistant inspectors
- two allied health professionals
- one analyst
- two recorders
- four experts by experience who have personal experience of using, or caring for someone who uses, the type of services we were inspecting
- five Mental Health Act reviewers
- 15 nurses from a wide range of professional backgrounds
- one planner
- one pharmacist
- six senior doctors
- five social workers
- nine people with governance experience.

Why we carried out this inspection

We undertook this inspection to find out whether North Staffordshire Combined Healthcare NHS Trust had made improvements to its services since our last comprehensive inspection on 7 -11 September 2015 where we rated the trust as **requires improvement** overall.

When we inspected the trust in September 2015 we rated:

- The acute wards for adults of working age and psychiatric intensive care units as requires improvement overall. We rated this core service as requires improvement for safe, requires improvement for effective, good for caring, requires improvement for responsive and requires improvement for well led.
- The long stay / rehabilitation mental health wards for working age adults as requires improvement overall. We rated this core service as requires improvement for safe, requires improvement for effective, good for caring, requires improvement for responsive and requires improvement for well led.
- Substance misuse services as requires improvement overall. We rated this core service as requires improvement for safe, requires improvement for effective, good for caring, good for responsive and requires improvement for well led.
- Child and adolescent mental health wards as requires improvement overall. We rated this core service as requires improvement for safe, requires improvement for effective, good for caring, requires improvement for responsive and requires improvement for well led.
- The wards for older people with mental health problems as good overall. We rated this core service as good for safe, good for effective, good for caring, good for responsive and good for well led.
- The wards for people with learning disabilities or autism as good overall. We rated this core service as requires improvement for safe, good for effective, good for caring, good for responsive and good for well led.
- The community based mental health services for adults of working age requires as improvement overall. We rated this core service as requires improvement for safe, requires improvement for effective, good for caring, requires improvement for responsive and requires improvement for well led.
- The mental health crisis services and health based place of safety as inadequate overall. We rated this core service as inadequate for safe, inadequate for effective, requires improvement for caring, requires improvement for responsive and requires improvement for well led.
- The specialist community mental health services for children and young people (CAMHS) as inadequate

Summary of findings

overall. We rated this core service as inadequate for safe, inadequate for effective, good for caring, requires improvement for responsive and requires improvement for well led.
- The community based mental health services for older people as good overall. We rated this core service as good for safe, requires improvement for effective, good for caring, good for responsive and good for well led.
- The community mental health services for people with learning disabilities or autism as good overall. We rated this core service as good for safe, requires improvement for effective, good for caring, outstanding for responsive and good for well led.

In September 2015, we issued the trust with eight requirement notices that affected all wards with the exception being the wards for older people with mental health problems. These related to the following regulations under the Health and Social Care Act (Regulated Activities):

- Regulation 9: Person-centred care
- Regulation 10: Dignity and respect
- Regulation 11 Need for consent
- Regulation 12 Safe care and treatment
- Regulation 13: Safeguarding service users' from abuse and improper treatment
- Regulation 15: Premises and equipment
- Regulation 17: Good governance
- Regulation 18: Staffing

At the time of inspection in September 2015, we issued the trust with one warning notice that affected the specialist community mental health services for children and young people. These related to the following regulations under the Health and Social Care Act (Regulated Activities):

- Regulation 9: Person-centred care
- Regulation 12 Safe care and treatment
- Regulation 17: Good governance
- Regulation 18: Staffing

The trust received an unannounced inspection of its community child and adolescent mental health services (CAMHS) on 27 April 2016. This core service had received an overall rating of inadequate in September 2015. The inspection team completed a focused inspection that looked at whether the trust had responded appropriately to the regulatory breaches. We found that the trust had addressed the issues in line with its action plan. This inspection did not result in a rating.

The current inspection took place six months following the publication of the comprehensive inspection report. We have re-rated all core services as part of this comprehensive inspection (September 2016).

How we carried out this inspection

To get to the heart of the experience of people who use services, we always ask the following five questions of every service and provider:

- Is it safe?
- Is it effective?
- Is it caring?
- Is it responsive to people's needs?
- Is it well-led?

Before the inspection visit the inspection team:

- Requested information from the trust and reviewed the information we received.
- Asked a range of other organisations for information including the Trust Development Authority, NHS England and clinical commissioning groups, Health watch, Health Education England, and Royal College of Psychiatrists, other professional bodies, user and carer groups. We met with 12 representatives from these groups before inspection.
- Sought feedback from six patients' and carers through attending a user and carer group
- Received information from patients', carers and other groups through our website

During the announced inspection from 12 September to 16 September 2016 the inspection team:

- visited 37 wards, teams and clinics
- spoke with 151 patients', three former patients', three young person's council members and 38 relatives and carers who were using the service
- collected feedback from 199 patients', carers and staff using comment cards
- spoke with 303 staff members

Summary of findings

- attended and observed 26 handover meetings and multidisciplinary meetings
- joined care professionals for 23 home visits and clinic appointments
- attended 18 focus groups attended by 128 staff
- interviewed 39 senior managers, executive and board members
- looked at 243 treatment records of patients' including risk assessments
- carried out a specific check of the medication management across a sample of wards and teams and looked at 151 prescription and administration charts
- looked at a range of policies, procedures and other documents relating to the running of the service
- requested and analysed further information from the trust to clarify what was found during the site visits.

We also carried out unannounced visits to the access team in the 10 days following the comprehensive inspection.

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

Information about the provider

North Staffordshire Combined Healthcare NHS Trust was established in 1994. The trust provides services across North Staffordshire to a population of 464,000 people. The trust provides a range of inpatient and community mental health services to adults, older people and children.

The trust provides the following core services:

- acute wards for adults of working age and psychiatric intensive care units
- wards for older people with mental health problems
- wards for people with learning disabilities
- long stay/rehabilitation mental health wards for working age adults
- children and adolescent mental health wards
- mental health crisis services and health based places of safety
- community-based mental health services for older people
- specialist community mental health services for children and young people
- community-based mental health services for adults of working age
- community mental health services for people with learning disabilities

The trust also provides the following specialist services:

- substance misuse treatment services.

The trust operates from one hospital site (Harplands Hospital) and approximately 30 community-based premises. Harplands Hospital opened in 2001 and holds most of the inpatient units. All corporate staff are based at Lawton House, the current trust headquarters.

The trust has approximately 1,216 whole time equivalent (WTE) and 1,451 (headcount) staff serving a population of approximately 464,000 people from a variety of diverse communities across northern Staffordshire. The trust's closing income for 2014-15 was £75.5m. It currently does not have foundation trust status.

The trust's main NHS partners are the two clinical commissioning groups (CCGs) – North Staffordshire CCG and Stoke-on-Trent CCG.

The trust also works closely with agencies which support people with mental health problems, such as the North Staffs Users' Group, Approach, ASIST, Brighter Futures, Changes, EngAGE, North Staffs Huntington's Disease Association, Mind, North Staffs Carers Association, Reach and the Beth Johnson Association.

Mental Health Act reviewers have visited the trust on 12 occasions since May 2015.

Summary of findings

What people who use the provider's services say

Before the inspection took place, we met with a group of service users' and carers and user representative groups. We also met with Health watch and local authority representatives.

The service users' and carers council highlighted several areas of positive activity and improvement, which included recognising the organisation's efforts to recruit to their workforce, changes to the provision of psychology within teams and the significant improvement in the involvement of service users' and carer council members in all aspects of the trust including staff recruitment and board meetings. The council members reported that the environment at Harplands hospital had improved significantly and all inpatient wards had robust leadership in place. However, several areas of concern were raised which included the pending funding cuts to substance misuse services and the affect this may have on other mental health services. There was also a concern of a lack of service provision for service users' with dual diagnosis and challenges to accessing services for travellers and homeless persons and the need for the trust to be better at succession planning for the retirement of staff.

Health watch representatives told us that they continue to work closely with the trust, having been involved in the review of the trust's complaints policy and process and contributing to staff investigatory training for staff. Health watch shared concerns that the crisis team was not as responsive to people's needs as the public would like, with people experiencing difficulties contacting their care co-ordinators when in crisis. The public had also fedback to Health watch that they found the community provision, including the access team and home treatment teams, to have insufficient provision for the degree of need, resulting in excessive caseloads for staff. Health watch also highlighted funding cuts to substance misuse services as a concern going forward into the future and child and adolescent mental health services (CAMHS) as an area for future investment due to the excessive waiting lists.

During the inspection, we spoke with 192 people using services or their relatives and carers, either in person or by phone. Patients' who were engaged with community services for older people spoke exceptionally highly of the staff stating they could not have managed without the support of these staff. Feedback from 17 questionnaires completed by parents of children at Dragon Square specialist children's short break service gave the centre ten out of ten on rating forms for how happy their children were to be at the centre.

Patients' on adult acute wards told us that their community meetings gave them the opportunity to contribute to what happens on the wards. The majority of patients' also told us that they felt staff involved them in their care planning and they received copies of their care plans.

Young people and their families were very positive about their experiences of community CAMHS once they were receiving treatment. However, all of the 24 young people and/or parents that we spoke with said there had been long waits for treatment and felt this could have had a negative impact on their mental health. The families that we spoke with, who were on the waiting lists, felt forgotten and unsupported.

We received 199 completed comment cards; of which 185 (93%) were positive, six negative and seven of mixed views. Themes of feedback received included staff being good listeners, were supportive and caring. They said that environments were clean and that staff treated all patients' with respect. However, respondents also shared that there was a lack of activities in some community teams; that there were some communication difficulties for those for who English was not their first language or they experienced hearing difficulties; a lack of transport for appointments; staffing issues resulted in cancellation of some appointments at short notice and long waiting lists for some services.

Summary of findings

Good practice

- The trust had done impressive work around deaf and hard of hearing patient groups; particularly the deaf café, British sign language (BSL) training for staff and effectively addressing communication needs.
- The organisation had implemented the accessible information standard and ensured that this was owned at directorate level where clinical staff seemed to be well aware of requirements.
- The vascular wellbeing team manager had published a paper on the use of a camera for people with short-term memory problems. They have since worked with the local clinical commissioning group (CCG) to incorporate the use of text messaging service with the camera and were working on an 'app' for patients' with early onset dementia and mild cognitive impairment.
- The care home liaison team held multi-disciplinary patients' meetings at five care homes that included GPs and families where appropriate. GPs and families reported that this worked well. The input of physiotherapy into care homes with patients' at risks of falls had reduced hospital admissions.
- The mild-cognitive impairment (MCI) practitioner pilot had delayed the onset of dementia in patients' with MCI, giving them an improved lifestyle and wellbeing.
- The intensive support team had developed an electronic pathway tool. This gave staff a chronological pathway to follow which contained all the documentation that they would need to plan and implement patient care. This initiative was shared within the organisation.
- The community child and adolescent mental health services (CAMHS) had run a 'CAMHS in schools' project with special schools for the past 11 years. They had developed a pilot to introduce the model into mainstream schools. At the time of inspection, work was taking place in one primary school, three special schools and with an independent provider funded by the local authority. The schools contributed financially for this service. The model was designed to ensure that the project was responsive to the needs of the school, staff and children and the intensity of support could vary as need increased and decreased. Community CAMHS delivered a range of services to pupils, parents and staff in school. This included consultation, teaching, training, group and individual work. CAMHS found that being located in the school and working as part of the staff team, enabled them to work more effectively with the whole school to promote good mental health and provide support for pupils having trouble at the earliest opportunity. The art therapist developed a child and adolescent tool kit to aide communication when talking about difficulties and concerns. This service had also photographed and displayed young people's artwork on the walls within the North Staffordshire base.
- Staff on ward 3 had offered patients' complimentary therapies, which patients' liked. These had positive outcomes, including a reduction in PRN (as needed) medication for those patients' who took part. As a result, the ward planned to increase the frequency of sessions.
- The trust's crisis service had developed a position for an in-reach worker who visited patients' and worked with inpatient services from around the trust to manage transitions between inpatient and crisis services.
- A military veterans' drop-in service was also developed. Managers allocated one member of staff two days a week to develop this. It grew quickly and, at the time of our inspection, had a caseload of 42 patients'.

Areas for improvement

Action the provider MUST take to improve

- The provider must ensure that its' Rapid tranquilisation policy accurately reflects current prescribing guidance from national institute for health and care excellence (NICE) guidelines [NG10] on-Violence and aggression: short-term management in mental health, health and community settings.

Summary of findings

- The provider must ensure that clinical staff have a consistent approach to the use of rapid tranquillisation, understand its' risks and record its' use.
- The provider must ensure that prescribing, administration and monitoring of vital signs of patients' is completed as detailed in the NICE guidelines [NG10] on-Violence and aggression: short-term management in mental health, health and community settings.
- The provider must address breaches of the public sector equality duty including the effective interpretation of "due regard" to the three aims of the general duty, as defined in the Brown case.
- The provider must ensure the organisation's equality delivery system 2 (EDS2) has adopted the methodology as suggested by NHS England to clearly identify what difference the EDS2 implementation has made; especially in relation to the patient focused areas.
- The provider must ensure governance and board-level ownership of workforce race equality standard (WRES) at an early stage, ensure that the board is aware of its responsibilities and ensure that the data is calculated and analysed in line with the NHS England WRES guidance and appropriately triangulated. It is particularly important that the Trust seeks qualitative feedback from BME staff prior to making conclusions.
- The provider must ensure that their community CAMHS waiting list targets from referral to treatment continue to improve.
- The provider must ensure that their process of sending out monthly letters to the young people on the waiting list from initial assessment to treatment is followed and the letter copied to the referrer.
- The provider must continue to work towards seeing young people within 18 weeks from the point of referral.
- The provider must ensure that it protects confidential patient information and ensure it is not visible to other people.
- The provider must ensure that there is enough input from psychiatrists to provide appropriate care to patients' using the access and home treatment teams.
- The provider must ensure that staff always record any prescribed medication that is given, omitted or refused on patients' prescription charts.
- The provider must consistently maintain and monitor medication at their correct temperatures and action any issues.

Action the provider SHOULD take to improve

- The provider should ensure that privacy impact assessments are undertaken to identify the perspectives of staff and patients' at the commencement of projects / programmes and not following decisions that had been made.
- The provider should ensure that staff follow appropriate procedures for Mental Capacity Act and national institute for health and care excellence (NICE) guidance on managing medicines in care homes where nurses administer covert medication for physical health issues.
- The provider should offer formal clinical supervision to all staff and record this appropriately. This should include a plan of action to address the current deficit in supervision rates across the access and RAID teams.
- The provider should ensure all staff complete an annual appraisal.
- The provider should ensure appropriate signage at the memory clinics to enable all patients' to access.
- The provider should ensure that young people and their families are aware of the complaints procedure and that there are leaflets in the waiting areas explaining the complaints process.
- The provider should ensure that care plans for the learning disability service are written clearly in a way that the family will understand and available in an easy read format for the young person dependent on their level of learning disability.
- The provider should continue to take steps to ensure that staff from the learning disability teams feel engaged with trust initiatives and are encouraged to feel a valued part of the organisation.
- The provider should ensure that all wards are fitted with nurse call systems.
- The provider should ensure that wards have an area with a couch to examine patients.
- The provider should ensure that decision-specific capacity assessments and outcomes are recorded fully and accurately in patients'' files and are easy to access.
- The provider should ensure that staff can fully observe all areas of the seclusion rooms.

Summary of findings

- The provider should review how the open viewing panels in bedroom doors affect patients' privacy and dignity.
- The provider should ensure that recording systems are fit for purpose and that there is a system in place to ensure that information is accessible. This includes access by the wider trust team when patients' move between services.
- The provider should ensure that when the multi-disciplinary team transfers patients' between wards, they clearly document clinical reasons for doing so.
- The provider should ensure that staff work in partnership with patients' and carers to develop advanced decisions where applicable.
- The provider should ensure the use of outcome measurement tools (where applicable) in order to gauge deterioration or progress being made by those using services.
- The provider should ensure that all people who use services are able to become involved in decisions about the service for which they receive.
- The provider should ensure that a pharmacist is regularly involved clinical multi-disciplinary team meetings to review patients'' medication.
- The provider should ensure that the patient's allergy status is completed on all administration charts.
- The provider should ensure that all staff receive training in resuscitation, safer handling of people and dementia.
- The provider should ensure all staff know where emergency medication is located.
- The provider should ensure daily cleaning records are completed and that staff use clean stickers to indicate clinical equipment has been cleaned.
- The provider should ensure staff carry out daily checks to ensure clinical equipment is working across all services.
- The provider should ensure staff complete their statutory and mandatory training to meet the local targets set.
- The provider should ensure that all Mental Health Act paperwork is up to date and stored correctly.
- The provider should ensure all care plans and risk assessments are recorded on their electronic system.
- The provider should ensure waiting lists are reduced so that patients' can access assessment and treatment in a timely manner.

North Staffordshire Combined Healthcare NHS 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.

North Staffordshire has had 12 MHA review visits since May 2015, the latest in August 2016 (all unannounced). The acute inpatient wards showed the highest number of issues, ward three being the highest with eight issues found. The most common issues highlighted were regarding case records, recording errors or non-existence of MHA forms. The number of issues had decreased on each visit since July 2015 suggesting that the trust had put improvements into place locally.

Most staff (84% in August 2016) had received mandatory combined Mental Health Act (MHA) and Mental Capacity Act and deprivation of liberty training. However, this compliance level was below the trust target of 90%. The trust's team of MHA managers received training on the revised code of practice, regular refresher training for in-depth issues and three managers' forums held each year for development and support.

The trust had a current Mental Health Act policy and staff told us that they were aware of this. Staff we spoke to had a good understanding of the Mental Health Act and explained how to apply it to their work with patients'. All staff reported they were aware that support and legal advice was available from the trust's Mental Health Act office. We found that most patients' had their rights under the MHA explained to them on admission and regularly thereafter.

Access to independent mental health advocates (IMHA) was available and provided by the local authority in accordance with the MHA code of practice. Patients' we spoke with said that they were aware of these services, able to use advocacy services and staff supported them to do so when required. Mental health advocates we spoke to during inspection told us that staff were generally confused about the appropriateness to refer to an IMHA or independent mental capacity advocate (IMCA) possible due to not fully understanding how roles differ.

The majority of MHA paperwork was completed and stored correctly. However, nursing staff on the wards for older people with mental health problems carried out capacity to consent to medication assessments rather than the patient's responsible clinician. The community mental health teams Community Treatment Order documentation was, for the most part, up to date, competed properly and stored correctly. However, we found two files that did not contain capacity to consent documentation during our inspection.

We noted during inspection that the acute inpatient wards had effective MHA administration systems in place that ensured patient files contained accurately completed and up to date documents. Staff followed consent to treatment

and capacity requirements and attached copies of consent to treatment forms to medication charts where applicable. Regular audits ensured that staff applied the MHA correctly and there was evidence of learning from these audits.

The Mental Health Act (MHA) and Mental Capacity Act (MCA) forums met jointly on a bi-monthly basis to share MHA audit results, review all incidents relating to the MHA and fed into lessons learnt within the organisation as well as MHA documentation preparation for the new electronic system.

Mental Capacity Act and Deprivation of Liberty Safeguards

The trust had a current policy on Mental Capacity Act (MCA) including deprivation of liberty safeguards (DoLS) that staff were aware of and could refer to it. Staff were trained in and had a good understanding of MCA 2005, in particular the five statutory principles. Mental Capacity Act training at the trust was mandatory and had a 90% target compliance level. Of the 11 cores services, eight had compliance over 90%. However, the overall trust compliance was 87.7% in June 2016.

The MCA is not applicable to children under the age of 16. Trust staff working in child and adolescent mental health services (CAMHS) used Gillick competence, which balances children's rights with the responsibility to keep children under 16 safe from harm. All staff we spoke to within CAMHS demonstrated knowledge of Gillick competence.

Advice regarding MCA, including DoLS, within the trust was available from the trust's Mental Health Act and Mental Capacity Act team.

There was a policy on the deprivation of liberty safeguards (DoLS) which staff were aware of and could refer. Staff made appropriate deprivation of liberty safeguards (DoLS) applications when needed. Staff across services assessed mental capacity on a decision specific basis. Patients' were generally involved in decision-making when appropriate and families were involved for those who lacked capacity when making best interest decisions to assist in recognising individual wishes, feelings and culture. Some staff were also trained as best interest assessors and were available to support colleagues.

However, we found that the recording of capacity to consent assessments and decisions lacked detail and were difficult to locate in patient files on the adult acute inpatient wards at the time of inspection. As stated above, mental health advocates we spoke to during inspection told us that staff were generally confused about the appropriateness to refer to an independent mental health advocate (IMHA) or independent mental capacity advocate (IMCA) possible due to not fully understanding how roles differ.

Requires improvement

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

Our findings

Safe and clean care environments

- The physical environment around the trust was generally clean, well maintained and decorated appropriately for the patient groups that it catered for.
- The trust-wide ligature risk policy was in date. Management had undertaken an annual ligature risk assessment in all inpatient areas and patient areas within community team bases. (A ligature point is any feature in the environment that could support a strangulation device). We saw several examples of improvements in a variety of trust environments, including the adult acute wards, where the trust had replaced all beds across the wards with anti-ligature beds. All wards also had updated ligature risk assessments that identified how staff mitigated risks where there were ligature risks. Child and adolescent wards had building improvements underway to remove all ligature risks and fit anti-ligature fixtures and fittings. The trust expected contractors to complete this work by October 2016. The staff on the older people's inpatient wards stated that regular environmental risk assessments, both internal and external, had led to the replacement of all door handles that could support a ligature and managers of the inpatient ward for learning difficulties or autism shared with us the plans to renew the ward and fit with anti-ligature fittings.
- The trust had yet to fully implement a non-smoking policy throughout the organisation.
- PLACE assessments are self-assessments undertaken by NHS and private/ independent health care providers, and include at least 50% members of the public (known as patient assessors). They focus on different aspects of the environment in which care was provided, as well as supporting non-clinical services. In relation to cleanliness, PLACE data for North Staffordshire Combined Healthcare NHS Trust was 99.7% at the time of inspection. This was just over 2% above the national average of 97%. All trust sites were above the national average for cleanliness.
- We found that the layout of the wards generally allowed clear lines of sight for staff to observe patients. Where this was not the case, the trust had installed observation mirrors or used staff observation to mitigate this risk.
- Since the last inspection in September 2015, the trust had built a seclusion suite on ward 1 that had become operational in September 2016. On inspection, this suite met the standards required by the MHA Code of Practice. However, staff noted that the height of the observation window in the door restricted some staffs observations. Staff recognised this and stated they would look into this further.
- On inpatient wards, there were clear arrangements for ensuring that there was single-sex accommodation in adherence to guidance from the Department of Health and the MHA Code of Practice. Female and male patients' did not share any bathroom or toilet facilities and there were separate lounges available on mixed wards.
- Staff on all wards we visited followed infection control principles including handwashing. Wards displayed information on how to follow infection control principles in all key areas. We saw staff using alcohol gel and practising good infection control procedures through hand washing hygiene and food hygiene. All services had regular infection control and prevention audits in place and staff addressed all actions.
- All clinic rooms that we visited appeared clean and most were fit for purpose. Staff checked equipment regularly to ensure that it was in good working order so that equipment was safe for use in an emergency. Not all community team bases had specific clinic rooms but had height and weight measuring devices and equipment for carrying out monitoring of vital signs.
- The trust had a programme in place to carry out portable appliance tests consistently for all equipment used. This included stickers to indicate that staff had checked equipment and displayed next test dates to ensure that it was safe for use.

Requires improvement

Are services safe?

- There was access to appropriate alarms and nurse-call systems in the majority of services. There were not alarms available to staff working in the rapid assessment interface discharge (RAID) team and home treatment teams. However, staff completed interviews in pairs and worked in pairs until risk assessments were completed. The inpatient ward for learning disabilities or autism did not have alarms fitted in the ward itself. However, all staff carried personal safety alarms attached to them, which were regularly tested. Staff accessed community team bases through locked intercom systems and premises fitted with alarm systems. Portable alarms were available to all staff. Staff in some teams wore alarms when seeing all patients' and others carried alarm triggers when required for first assessments or when indicated following a risk assessment.

Safe staffing

- The trust had a recruitment strategy in place and recognised its workforce recruitment challenges. Over the 12 months prior to inspection, the trust had been proactive and focused on improving recruitment through several initiatives including a focus on local community advertising for healthcare assistant roles, one stop recruitment appointment to complete all human resources requirements, radio advertising and recruitment fairs as well as improving links with further education.
- The establishment for nursing staff as of 31 July 2016 was 488 whole time equivalent (WTE) for qualified nursing staff and 233 WTE for nursing assistants.
- Trust data from April 2016 and July 2016 showed a decrease in vacancy rates from 15% to 10% for qualified nursing and from 7.9% to 0.9% for assistant nursing staff. As of 31 July 2016, there were 50 vacancies for qualified nurses and 2 vacancies for nursing assistants. Trust data showed that a high proportion of vacancies for qualified nurses were for the acute inpatient wards, child and adolescent community mental health services (CAMHS), crisis services and older people's inpatient wards. At the time of inspection, the acute wards had significantly reduced their vacancy rates from 22.5% in July 2016 to 4% and were expecting 14 new staff to commence work in late September / October 2016. However, we noted that for CAMHS community services and older people's wards, the high vacancy rates reflected an increase in the staffing establishment.
- As of 31 July 2016, the average staff turnover rate across core services was 11.7% at the 30 April 2016. CAHMS community services had the highest turnover rate at 13% while substance misuse services had the lowest rate of 0.11%.
- The trust's overall sickness rate for all staff for the 12 months to 30 April 2016 was 7.6%. In the 12 months to 31 July 2016, the sickness level for permanent staff in core services was 5.2% %, which was just above the national average sickness rate of 4.6% for mental health and learning disability trusts. The rehabilitation wards had the highest sickness rate of 10.7%. The organisation recognised the positive impact of staff engagement and welfare had on staff sickness, with a particular focus on how the trust can improve staff physical health by offering support, advice and training.
- At the time of our inspection in September 2016, we concluded that the number of nurse staffing was generally sufficient on the inpatient wards to provide safe care. In the three months period from May to July 2016, there were 1099 shifts filled by bank staff and 177 shifts left unfilled to cover sickness, absence or vacancies. The greatest demand for bank or agency staff to fill shifts came from the acute inpatient wards. We reviewed the trust data for staff fill rates for a three-month period from May to July 2016. This data indicated how many shifts were staffed at any given point in time. It showed that the average fill rate for qualified nursing was 88% on day shifts and 91% on night shifts. The acute inpatient wards had staff fill rates that fell consistently below 90% for most day shifts and some night shifts. The acute wards had a high reliance on bank and agency staff to cover vacancies and fill shifts especially at night. Managers requested bank and agency staff who were familiar with the wards, and where possible booked staff for long periods to ensure continuity of care for patients'.
- Staff and patients that we spoke with told us that staffing numbers were sufficient to carry out physical examinations, facilitate 1:1 sessions and leave when required. Most inpatient wards had sufficient staffing to enable one regular member of staff to be present in the communal areas at all times.

Requires improvement

Are services safe?

- Most community teams had benchmarked against similar services around the country to assure appropriate levels and disciplines of staff. There was variance between community staff caseloads ranging between 40 patients' for clinicians in the community services for learning disabilities or autism teams to 19 patients' for community services for older people with mental health problems. However, qualified nurses in the home treatment team held caseloads of between 35-50 patients' whilst healthcare support workers held caseloads of 15-20 patients. Some substance misuse staff held the highest caseload of between 30-70 patients' at the time of inspection. Managers within substance misuse teams told us that caseloads were manageable and regularly reviewed to ensure safety and quality of care. The community child and adolescent mental health services (CAMHS) teams had caseloads of between 25-30 young people. There was no recognised caseload management tool used to determine safe caseloads but clinicians' reviewed caseloads monthly. CAMHS were experiencing a vacancy rate of 6.3% at the time of inspection and staff turnover of 13.8% for the 12 months prior to inspection that affected caseload management of team members. However, following intensive recruitment, the services projected that they would meet their full establishment by the end of October 2016.
- We noted at the time of inspection that the substance misuse services were undergoing a service redesign, and as such, there was change and movement of staff. Most services were experiencing a high level of staff leaving. There were regular change management meetings within effected teams and consistency plans in place to adapt to meet the needs of the services and patients'.
- Nursing staff told us that they felt safe working alone in the community. There was a good lone worker policy and practice in place, involving a buddy system, personal alarms, mobile phones, safe words, and a risk marker indicator on the electronic record.
- Medical cover was acceptable across inpatient and community services during working hours and included rapid access to a psychiatrist when required. There was an out of hours on call system in place to provide generic psychiatric medical cover to all services and teams. This meant that specialisms including CAMHS and older people psychiatry did not always have access to medical cover with experience in these areas.
- Medical staff, both consultant and trainees, that we spoke to during inspection, expressed concerns regarding co-ordination of rotas and gave examples of where senior staff had to 'act down' to cover junior medical staff rotas at short notice. Medical trainees generally felt demoralised about the national circumstances around trainee contracts and strikes, but also expressed concerns of uncertainty as to the trust's strategy/contingency plan to ensure patient safety during any future strike. Junior medical staff highlighted outpatient clinics as very stressful due to the limited time spent with patients and the increasing time spent documenting and letter writing. Staff had raised this with managers with no change or effect to date.
- The trust detailed twelve mandatory training areas for all trust staff including health and safety, infection control, manual handling- theory, MAPA, conflict resolution, safeguarding children, CPR, in hospital resus, safeguarding adults, safe people handling, fire and information governance. For the twelve months to 31 August 2016, the trust's overall compliance was 89% against its own target of 90%. Seven core services achieved the target of 90% and four of the core services fell just below the trust's target with rates of 89%. Four of the twelve training courses fell below the trust's target compliance rate of 90%. The health and safety training course had the highest compliance rate of 97%. Safe people handling training had the lowest compliance rate of 62% associated with the acute inpatient wards (wards 2 and 3) and substance misuse services (Edward Myers Unit).
- All staff received a matrix of training that was due and all heads of directorates received monthly performance reports to support the monitoring and timeliness of training completion. In addition, the trust had piloted different ways to facilitate the required mandatory training for staff by means of block mandatory training weeks and block core service training. This was in an effort to maximise time efficiencies as well as increase compliance. The trust board did not receive an enhanced level of training in equality and diversity and received the same level as all staff within the organisation. It was unclear what the equality training offered to staff and whether this was sufficient to be

aware of their equality obligations and responsibilities. For the trust to meet its legal equality requirements, staff needed to complete this training as a statutory and mandatory requirement.

Assessing and managing risk to patients' and staff

- The trust had policies in place relating to safeguarding and raising concerns (whistleblowing procedures). We found that all but a few staff had received their mandatory safeguarding training and knew about the relevant trust wide policies relating to safeguarding. For the twelve months to 31 August 2016, safeguarding training was 85.2% across all core services. Most staff described situations that would constitute abuse and could demonstrate how to report concerns and liaise with relevant social care agencies. Staff on the ward for learning disability or autism shared and explained safeguarding procedures in easy read format with patients and relatives.
- The trust did not use a nationally recognised risk assessment; instead, they used a bespoke version that had been developed to suit the needs of the patient groups. The tools used by staff appeared to be fit for purpose and collected the same information as nationally recognised formats. We looked at the quality of individual risk assessments across all the services we inspected. In total, we viewed 243 treatments records including risk assessments during our inspection. Staff completed the trust's risk assessment at the point of admission and updated these regular intervals or following any identified change. The exception to this was young people on the community CAMHS waiting list who had initial risk assessments completed but regular reviews thereafter were sporadic. CAMHS staff were unable to tell us if there was a single process for proactive monitoring of risk and mental health while young people were on the waiting list. Staff in teams discussed risk presentations at multi-disciplinary meetings. We saw, where applicable, treatment records containing crisis or personal safety plans developed from concerns identified in risk assessments. In the community teams, there was a waiting list for the approved mental health professionals and best interests' assessment teams. However, staff managed and triaged this by using a red, amber, green standardised assessment. The Edward Myers Unit had a risk co-ordinator role and a handover file to share risks. This was viewed as important by all staff given the variation in shift patterns of staff and a method of ensuring that all staff were up-to-date with current risks.
- The trust had a restraint policy, which contained guidance and best practice for restrictive and physical interventions including guidance for children. It also included actions that staff were required to take after an incident; including where to report it and post incident learning. The overall restrictive interventions reduction strategy demonstrated that the trust had made significant progress in the reduction of assaults on staff as part of the wider restrictive intervention and violence reduction programme. The strategy also highlighted that progress had been made in developing person-centred care and a positive behavioural support culture to proactively improve the patient experience and the response to potential aggressive incidents.
- The organisation's seclusion policy was in date at the time of inspection. The policy contained criteria for secluding a service user, the seclusion environment, long-term segregation, monitoring and evaluating seclusion. In June 2015, the trust reported zero incidents of seclusion and 481 incidents of restraint prior to our last inspection. However, for the period of 01 March 2016 to 31 August 2016, data showed an increase in seclusion rates; reporting 51 uses of seclusion in this period and a reduction in restraint used by 131 incidents to a figure of 350 incidents compared to June 2015. Figures reported seven prone restraints that resulted in rapid tranquillisation in this six-month period compared to nine in the previous submission. Figures reported 33 incidents of long-term segregation in this period. Of note, the adult mental health services showed the highest number of incidents of seclusion, long-term segregation and restraints of service users.
- The trust acknowledged that restrictive interventions were not analysed according to all characteristics of patients' i.e. disability, black and minority ethnic groups; instead by age and gender.
- The trust had personal safety and lone working procedures in place for all teams. Community staff operated a buddy system that recorded the location for all community visits and staff were provided with a mobile phones and personal alarms by the organisation for use when working in the community. Staff

completed risk assessments of all patients' before undertaking community visits. All services operated a system where staff were accounted for at the end of each working day.

Medicines Management

- The trust had a small pharmacy team that provided a dispensing and clinical service and had oversight of medicines use in the trust. Staff undertook a medicine reconciliation of patients' medicines on admission; checking what current medicines were prescribed and any concerns or advice about medicines was written directly onto the person's medication records.
- There was an audit programme in place to check that medicines were stored securely and they were within safe temperature range. However, these were not always monitored and actioned when there was an issue. Community mental health teams (CMHT) staff told us the medicines audit was last completed 18 months prior to our inspection. City CMHT fridge temperature monitoring and room temperature monitoring was poor, which meant that medication, might not be safe to use. Of the medication cards we examined when visiting CMHTs, over half had no documented allergy status for patients. We found that wards 2 and 6 had raised fridge temperatures that might affect the medicines stored within them. We found no evidence at the Greenfields Centre to evidence the monitoring of medicines fridge temperatures.
- Due to the capacity of the small team, we saw limited involvement of clinical pharmacists in the inpatient multi-disciplinary meetings. In addition, the community-based mental health teams did not have any regular medicines management support to ensure safe and effective administration of medicines.
- A multidisciplinary medicines optimisation group monitored and investigated medication incidents at the Trust. The trust shared learning from medicine-related incidents with staff through emails and team meetings.
- The trust policy covering rapid tranquilisation, based on the previous national institute for care excellence (NICE) guidance dated February 2005, was available during the inspection week. After the inspection, the trust provided a new rapid tranquilisation policy document based on the current NICE guidance dated May 2015. It advised on how to treat patients in order to manage episodes of agitation, when other calming or distraction techniques had failed to work. We found the body of the new policy to be in line with the current NICE guidelines. However, the appendices and references of the new policy did not accurately reflect the current guidelines, and may result in confusion.
- We found that staff did not always document the monitoring of patients vital signs following rapid tranquilisation in the patient records, as recommended by NICE guidelines and the trust's new policy. When inspecting ward 7, we found on four occasions that staff had not reported the use of rapid tranquilisation using the incident reporting system, as stated in the trust's policy. The trust used this data to monitor its use of rapid tranquilisation as it did not carry out a specific audit, so this would result in an under reporting of its use. Similarly, on ward 6, we found two incidents of rapid tranquilisation usage with no evidence of physical health monitoring post administration. However, these were recorded as incidents.

Track record on safety

- NHS trusts are required to submit notifications of incidents to the National Reporting and Learning System (NRLS). In total 2,582 incidents were reported to the NRLS between 01 April 2015 and 31 March 2016. The majority, 74% of these resulted in no harm or low harm, 22%. Moderate harm incidents accounted for 0.2% of incidents and severe harm incidents accounted for 0%. There were 37 incidents categorised as deaths during the period that accounted for 0.14% of all the incidents reported. Adult mental health accounted for 61.6% (1,591) of incidents reported to NRLS, older adult mental health followed with 21.5% (556) incidents. Adult mental health accounted for 19 of the deaths reported.

- Between 15 January 2015 and 12 March 2016, the trust reported 51 serious incidents requiring investigation (SIRIs). None of these were recorded as 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). Of the 51 incidents, 46 were unexpected deaths. This compared with a figure of 41 serious incidents reported in the six months before the previous inspection in September 2015, of which 36 were unexpected deaths. Nine of the

SIRIs reported by the trust in 2014/15 concerned substance misuse services. Substance misuse had the highest number of SIRIs with 18 (36% of the trust total) and adult community services had 15 SIRIs (29%).

- Root cause analysis investigations were carried out for serious incidents and subsequent learning shared with staff, including feedback to staff documented within team meeting minutes for older peoples ward teams. We also saw evidence of changes in practice, for example, staff prompts displayed to ensure that staff regularly updated and recorded patients' contact details to avoid a repeat occurrence of the previous incident. When visiting the crisis team, staff also shared a recent review and increased robustness of protocols for maintaining contact with patients' receiving treatment and methods of managing patient that did not attend appointments.
- NHS staff survey results indicate increases in the number of staff experiencing physical violence, harassment, bullying or abuse from staff, patients', relatives or the public in the past 12 months, and an increase in the number of staff witnessing potentially harmful errors, near misses or incidents.
- An increase of 1% was reported in the number of staff experiencing physical violence from staff in the previous 12 months compared with the survey of 2014. The trust's score was 1% higher than the national average for mental health trusts.
- Survey results indicated a 3% increase in the number of staff experiencing violence from patients', relatives or the public. This was 4% higher than the national average.
- Results report a 2% increase in the number of staff experiencing harassment, bullying or abuse from staff, patients', and relatives or the public in the previous 12 months. This was lower than the national average for mental health trusts.
- The number of staff witnessing potentially harmful errors, near misses or incidents in the past month increased by 2% which was equal to the national average.
- Compared to the findings that indicated a decrease by 2% in the number of staff reporting errors, near misses or incidents witnessed in the past month, which was also equal to the national average.
- Lastly, staff confidence and security in reporting unsafe clinical practice had decreased by 0.03% and was lower than the national average.
- The NHS safety thermometer measures a monthly snapshot of areas of harm including falls and pressure ulcers. Services can used this as an improvement tool for measuring, monitoring and analysing trends over time. During the period between November 2015 and January 2016, the trust reported two new pressure ulcers, six catheter and new urinary tract infections and 12 falls resulting in harm. The trust reported zero falls in five of the 12 months with the highest monthly number of three being reported in both September 2015 and April 2016.

Reporting incidents and learning from when things go wrong

- The trust reported 56 incidents to the Strategic Executive Information System (STEIS) that had taken place between 1 April 2015 and 31 March 2016. None were 'Never Events', 53 were closed, and three ongoing. Forty-two incidents out of the 56 related to 'unexpected or potentially avoidable deaths' (of these six were awaiting review). Substance misuse had the highest proportion of incidents reported to STEIS; accounting for 32.1% of the trusts total, while CAMHS inpatient services reported the lowest number of incidents, with one (1.8%). Twenty-nine out of 56 incidents (50.1%) were reported as 'apparent, actual, or suspected self-inflicted harm'. The trust took an average of 4.8 days to report incidents to STEIS over this period.
- Staff reported they were aware of how to complete incident forms and their responsibilities in relation to reporting incidents. They were able to explain the process they used to report incidents through the trust electronic reporting systems.
- The trust had a clear policies and processes for the responding to and reporting of serious incidents. This involved weekly incident reviews at a senior level and monthly discussions at the safety improvement group. All key findings of incidents across the organisation, themes and learning points, were shared through bulletins and learning lessons, and discussed within staff supervisions.
- Band 7 nursing staff we spoke with told us that the learning lessons process now involved monthly sessions, electronic and paper bulletins to staff to help to give all staff an idea of learning across the organisation. Patient and carer feedback was also included and influenced learning and change.

Requires improvement

Are services safe?

- A group of trained investigation officers, and staff trained in root cause analysis (RCA) investigation to National Patient Safety Agency (NPSA) standards undertook all investigations within the organisation. Of the serious incident investigations we examined, all were comprehensively investigated and contained outcomes, actions plans and lessons learnt.
- Staff received both formal and informal de brief and support following serious incidents as individuals or in groups. The trust had trained a number of staff specifically to facilitate debrief sessions.

Duty of Candour

- The trust had a duty of candour policy, which the board agreed on 4 June 2015. The policy stated that its requirements under the duty of candour include a requirement to tell the patient what has happened if a mistake is made and apologise as soon as is reasonably possible. Providing the patient with a full and true account of all the known facts; advising what else the organisation will need to do; providing reasonable support to the patient and follow-up with a written letter which confirms the information already provided, results of further enquiries and an apology. The trust endorsed recommendation 173 of the Francis Report and aimed to promote a culture of openness.
- All staff we spoke to during our inspection described a transparent culture of explaining to patients' either face to face or in writing if there had been an error. Staff were able to share examples of this. Inspectors also saw evidence of letters written to patients' and notes in patient files of discussions.

Anticipation and planning of risk

- The trust had a major incident response and recovery plan in place. The plan was detailed and contained information on trust emergency and major incident responses as well as processes for debriefing and learning lessons. The plan was available to all staff via the trust intranet.
- Although the trust evacuation policy robustly addressed disability, it lacked consideration of equality considerations. The business continuity documentation included reference to evacuation but no specific reference to how the trust should treat disabled patients' or staff in such a situation.

Good

Are services effective?

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

Our findings

Assessment of needs and planning of care

- The trust had undertaken extensive work to improve the standard of both risk assessments and care plans since the last CQC inspection in September 2015 and involved fortnightly audits to monitor improvement. Staff we spoke to reported having coaching sessions, supervision, training and away days to focus on areas of development.
- We examined 243 treatment records across the services inspected. Treatment records contained the trust's initial comprehensive assessment completed on patient's first appointment. In some specialist services including learning difficulties, the trust had made some improvements to the assessment form to reflect the diverse treatment needs of referrals received for this patient group. The assessments were holistic and considered the needs of carers.
- Care records showed in most trust services that staff completed care-planning processes in a timely manner following patients'' admission. Care plans were personalised, written in patients' own words, demonstrated choice and were recovery orientated. We saw crisis plans in some teams that described how staff would need to support a patient when in crisis and staff routinely gave communication passports and contingency plans to patients' in easy read format on the ward for people with learning difficulties or autism.
- At the time of inspection, the information needed to deliver patient care was stored on both electronic care notes and in paper treatment records. There was an index that clearly demonstrated to staff where they could find the information they needed. All paper records were stored securely and transported in locked bags between locations. Staff accessed the electronic system on computers with individual passwords.
- The trust had invested significantly into the planning and implementation of a new electronic record system, due to be completed in early 2017. Overall, staff were positive about this development and felt engaged in the implementation.

Best practice in treatment and care

- Staff followed national institute of clinical excellence (NICE) guidelines such as challenging behaviour and learning disabilities (NICE guideline 11), mental health problems in people with learning disabilities (NICE guideline 54), medicines adherence (clinical guidance 76) when prescribing medicines, depression in children and young people: identification and management (CG28); Autism Spectrum Disorder in under 19s: support and management (CG170); Anti-social behaviour and conduct disorders in children and young people (QS59) and Attention Deficit Hyperactivity Disorder: diagnosis and management (CG72).
- Staff monitored physical health needs of patients' and ensured physical health care plans were current. The wards carried out annual health checks and regular physical health checks to enable earlier detection of any illnesses and monitored patients' weight, blood pressure, lifestyle choices such as diet and exercise and side effects from medication. Patients' had access to specialists when required.
- Trust services offered patients' a wide range of psychological therapies including cognitive behaviour therapy, dialectical behavioural therapy, cognitive analytic therapy, anxiety management, methods of assessing behavioural functions, coping skills, emotion management and solution focussed therapy. Psychologists also offered support to staff around positive behavioural support.
- Staff across the trust's services used a range of outcome measures such as health of the nation outcome scales (HoNOS), model of human occupation screening tool (MoHOST) and health equalities framework (HEF) to ensure that staff closely monitored patient progress and recovery. The community mental health services for people with learning difficulties and autism also used a range of mood monitoring tools and the revised autism

diagnostic interview, a structured interview completed with the parents / carers of people who may be on the spectrum. Staff at the memory clinic and community mental health team at Maple House told us that they were devising their own outcome measures that were tailored to patients' needs as they had found that the STAR assessment for older adults and HONOS65+ had not given them much information about the outcomes experienced by patients'. The trust research and development team were involved in this.

- Staff were involved in a range of clinical audits to monitor the effectiveness of the service provided. The records reviewed included care records, medicines, infection control and prevention, health and safety and physical health audits. Where staff identified areas of improvement, action plans were completed and followed up. Staff used the findings to identify and address changes needed to improve outcomes for patients. The trust complied with best practice in treatment and care. There was participation in national audits such as prescribing for attention-deficit hyperactivity disorder in children, adolescents and adults and antipsychotic prescribing for people with learning difficulties and the national survey of community mental health services. The trust monitored and audited the outcomes for patients' using services. This included the monitoring of key performance indicators such as mental health outcomes, physical health, preventing suicide, health records, medicines management, and consent to treatment process, 18-week waiting times and care plans.
- The trust had measures in place agreed with commissioners, other stakeholders such as NHS England and in partnerships with social care with the aim of improving the outcomes of people who use their services. However, some commissioners reported receiving internal trust reports and documentation not specifically tailored to the requirements for commissioning.

Skilled staff to deliver care

- The trust had the right staff with the right skills in most services to deliver good and safe treatment and care. All teams were multidisciplinary and where they did not have a particular profession there were links made with appropriate other teams and agencies.
- All new permanent staff completed a formal trust induction. This involved attending a corporate induction, learning about the trust and trust policies, followed by a period of shadowing existing staff before working independently. Most services also offered new staff local inductions in which they shadowed all disciplines of the team to support and familiarise them with the team functions. Newly qualified nursing staff received a two weeks preceptorship when starting in roles followed by action learning sets, peer support groups and buddying staff with experienced colleagues for support. The majority of students we spoke to wanted to work in the trust post qualifying and a number told us of a well-structured and in-depth mentorship programme.
- Across the organisation, the trust had invested in recruiting the right staff for the right roles to deliver care. Although senior management acknowledged that there were still some areas that required further recruitment, strategies were in place to address these areas. The trust was planning for the implementation of apprentice, associate nurses and assistant practitioners in March 2017 with the introduction of the apprentices levy. They were keen to maximise the impact of this within the organisation and implement effectively.
- All staff had opportunities to receive the training they required to undertake their roles. Band one to four received a certificate in mental health for which had service users' involved in the delivery of training. Staff also received development through undertaking care certificates, dementia awareness linked to the national scheme and deaf awareness training.
- Most staff in the organisation received management and clinical / caseload supervision regularly and had access to regular team meetings. Meeting minutes were documented to enable those who did not attend to be informed of discussions and information shared. Some team could access group supervision in addition to individual supervision. However, not all teams' recorded formal supervision therefore it was difficult to assess the effectiveness of this. We also noted during our inspection that the trust's team of Mental Health Act associate managers received no formal appraisal; rather there was a reliance on performance monitoring by peers.
- The average appraisal rate for non-medical staff across the trust was 88.5% at the 30 April 2016. Crisis and Health based place of safety had the highest appraisal rate of 97.7%. Older Adults Inpatients' had the lowest appraised rate of 75.6%. In the NHS Staff Survey 2015,

the trust was in the average range for the quality of its appraisals (3%) and the percentage of staff appraised in the previous 12 months (88%). From the NHS Staff Survey the percentage of staff appraised in the previous 12 months had increased by 4% from 2014 to 2015 survey findings. The 2015 score was 1% lower than the national average for mental health trusts and was marked as being in average range.

- For the period 01 May 2015 to 30 April 2016, the trust reported that all 78 doctors in its 27 teams had been revalidated.
- Student nurses at the trust at the time of inspection told us that they felt well supported through inductions, mentoring, shadowing opportunities and involvement in multi-disciplinary team meetings and regular reflective practice groups. This group of staff told us that they had experienced and observed evidence based practice, patient and carer engagement in care planning and very good activity co-ordination on the inpatient wards.
- Administrative and clerical staff recognised improvements in supervision and the improved effectiveness of team meetings; reception staff and support services now received supervision where they had not previously.
- The organisation addressed poor staff performance promptly and effectively. Team leaders and managers in services across the organisation demonstrated when and how to escalate concerns and knew how to access support from human resources or occupational health teams.

Multidisciplinary and inter-agency team work

- The trust's NHS Staff Survey score for 2015 was 3.86%, which was slightly higher than the National average for mental health trusts for questions relating to effective team working.
- All teams that we visited evidenced regular and effective handovers and multi-disciplinary team (MDT) meetings. We attended several MDT meetings in which we observed in depth discussions that addressed the identified needs of the patients' such as risk, discharge planning, changes to care plans, new referrals, waiting lists, safeguarding issues and some teams also had individual patient case study discussions. Staff took into account patient wishes and considered a holistic approach to patient care. Handover that we observed discussed feedback from MDT meetings, changes in care plans, patients' physical health, mental state, risk, observations, community activities and incidents.
- Teams worked well internally within the trust and established effective networks and relationships with relevant agencies externally. The community mental health services for people with learning disabilities or autism met regularly with the inpatient ward team and the intensive support team to discuss referrals, handover patient care and discuss operational issues. The community mental health services for children and young people had good links with schools, local support groups and organisations including the police, safeguarding boards and the local authority. The ward for people with learning difficulties or autism worked closely with GPs, hospitals, local community facilities, local authorities and health commissioners. All external health and social care providers attended MDT meetings when relevant and beneficial to patient care.
- The trust had modernised its psychological services to address the need for broader evidence-based physiological treatments. This ensured compliance with the National Institute of Clinical Excellence (NICE). The programme embedded psychologists and therapists as specialist members of multidisciplinary teams to strengthen assessment and treatment of patients' complex needs. The service user and carers' council members said the change in psychology provision had improved patient care. The services improved communication by locating psychology and the home treatment and access team together. It developed clear professional leadership to ensure governance and quality services, and consistently involved patients' and carers to help shape services and their delivery. Psychologists we spoke with during our inspection agreed changes had been positive and said they felt valued and empowered to make decisions. They said they were actively involved in developing care pathways and standardising evidence-based practice.
- Medical trainees told us that they felt supported by the medical consultants and teaching was 'brilliant' with good access to supervision. They were generally happy with their core and specialist training, rotations and specialist endorsement training. They reported positive college tutor relationships with the organisation. However, they also raised concern at the challenges of

receiving psychotherapy training and supervision due to the withdrawal of clinical psychology involvement, with no positive change after 18 months of raising the issue with senior managers.

- Allied health professional (AHP) staff reported a mixed experience of multidisciplinary team working, with staff experiencing the most inclusive and positive working relationships in both older adult teams and learning disability (LD) teams compared with the experiences of staff within acute wards and community mental health teams.
- The trust had recruited occupational therapy (OT) staff on the three adult acute wards. However, a lack of therapeutic space on the wards made it difficult for these staff to hold individual or group sessions. The trust had a dedicated therapies facility comprising individual rooms for therapy and goup work, an OT kitchen, physio treatment room, sportshall and gymn available as therapeutic space.
- We saw limited evidence of the involvement of clinical pharmacists in the inpatient multidisciplinary meetings due to the limited capacity of the small team.
- Advocacy services based at Harplands Hospital, had long-standing involvement within the organisation. However the advocacy representative we spoke to in a focus groups prior to the inspection told us that they felt there was a general lack of professional respect for the role they play in offering independent support to service users'. Advocacy staff described staff often forgetting them within patient care and related meeting forums, often receiving poor communication from services and teams. There was a drop in referral rates over the months before our inspection. Advocacy staff offered awareness sessions to staff groups to help them understand their role better. At the time of our inspection, no staff had taken up this offer. Advocacy also described not having clarity on who they should contact if they needed to escalate concerns that they could not resolve locally.
- The trust established a service user and carers' council in August 2015. Over the 12 months before inspection, the trust had progressed the involvement of the service user and carers' council and embedded this into trust processes. The council also highlighted the trust's developments in relation to service users' involvement within the recruitment process, which was now mandatory for all recruitment undertaken within the organisation.
- We saw evidence that the trust had undertaken partnership working within the local health economy, in particular, with the local GPs. However, there was acknowledgement that such partnership working with other key stakeholders including acute services and local councils was not as advanced. A strategic area of development and focus going forward for the provider was working with primary care and improving pathways for service users'.
- During the inspection, we spoke with several external agencies who worked with the trust services. Staffordshire County Council shared an experience of strong and collaborative working arrangements regarding section 75 and communications. These agencies felt that the director of nursing had sight of social care needs and engaged the relevant people in forums and developments.

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

- Staff were trained in and had a good understanding of the Mental Health Act (MHA), the Code of Practice and the guiding principles. Mental Health Act training and the mental capacity act and deprivation of liberty training was combined and mandatory with a 90% target compliance level. Of the 11 core services, seven had compliance rates of 90% or more, leaving four services below the trust target. We found the lowest compliance in substance misuse services that scored 80% compliance with MHA training. The trust's overall compliance had dropped from 94.3% in June 2015 to 84% in August 2016.
- Staff across the trust reported they were aware that administrative support and legal advice on the implementation of the MHA and its code of practice was available for staff from the Mental Health Act office and Mental Health Act managers. The MHA team carried out audits twice a year across services to check that staff applied the MHA correctly.
- Staff adhered to consent to treatment and capacity requirements and attached copies of consent to treatment forms to medication charts where applicable.
- Patients' throughout the trust had their rights under the MHA explained to them on admission and regularly thereafter and staff audited this regularly.
- Access to independent mental health advocacy services was available. We saw posters with information of how staff could support patients' to engage with the

independent mental health advocate when needed. This was also available in easy read format where required. Patients' we spoke with said they were aware of these services, able to use advocacy services and staff supported them to do so when required.

- The trust's Mental Health Act (MHA) and Mental Capacity Act (MCA) forums met jointly every two months following a review of governance arrangements. Within this forum, MHA audit results were shared; all incidents relating to the MHA were reviewed and fed into lessons learning within the organisation. Additional information was also cascaded via a monthly newsletter. This role of this forum also included auditing the use of MHA sections in the organisation, the recruitment of MHA managers, workforce planning to meet managers hearing timeliness requirements, MHA documentation preparation for the new electronic system, monitoring the three-month rule letters sent by responsible clinicians and the facilitation of various training for staff.
- The trust's team of MHA managers received training on the revised code of practice, regular refresher training for in-depth issues and three managers' forums held each year for development and support.
- Mental Health Act associate managers spoken with detailed knowledge and awareness of the legislation, systems and processes associated with the exercise of their powers of discharge under section 23 of the MHA. The managers told us that they received specific training in respect of the Code of Practice and were provider with regular legal update training and support. Managers reported to us that there was no formal appraisal process rather a reliance on performance monitoring by peers. They focused on appeals and renewal panels and were unaware of their wider responsibilities when interviewed during inspection and we found no formal scheme of delegation for these in place. They did not have formal oversight of MHA policies, were not engaged in the monitoring of CQC MHA review reports and action plans and they did not monitor independent mental health advisor (IMHA) activity and not aware of their wider responsibilities in respect of the victims of crime and children and young people. They were aware of the issue of renewals and reviews taking place after the end of the original date of detention but had not taken action to address this at the time of inspection.

Good practice in applying the Mental Capacity Act

- Staff were trained in and had a good understanding of MCA 2005, in particular the five statutory principles. Mental Capacity Act training at the trust was mandatory and had a 90% target compliance level. Of the 11 cores services, seven had compliance above the 90% target, leaving four services below the trust target. The lowest compliance was found at the rehabilitation inpatient services that scored 75% compliance with raining. The trusts compliance rates for MCA and DoLS have decreased from 94.1% in June 2015 to 87.7% in June 2016.
- Advice regarding MCA, including DoLS, within the trust was available from a number of sources including managers, best interest assessors, the intranet and the MHA administration team. The community mental health services for people with learning disabilities or autism and community based mental health services for older people had several staff trained as best interest assessors and were available to support other staff and teams when required.
- There was a policy on the deprivation of liberty safeguards (DoLS) which staff were aware of and could refer. This outlined how the DoLS would operate within the trust and included a statement of the principles, an overview of the process and a definition of the responsibilities of all partners.
- The majority of staff reported a good understanding of the Mental Capacity Act (MCA) 2005, in particular the five statutory principles. Staff were able to demonstrate knowledge of how to access support and advice in connection with the MCA. They could give examples of steps that they had taken to assist a patient in making a decision and described occurrences where staff had made decision specific capacity assessments. The community mental health services for people with learning disabilities or autism staff used communication passports and easy read formats to support patients' in this process.
- Deprivation of Liberty Safeguards (DoLS) applications were made when required. Between 1 December 2015 and 27 May 2016, the trust made 83 DoLS applications, 22 of which (27%) were granted. Older people inpatients' had the highest number of DoLS applications made with 68. Fifteen (22%) of these were granted. Teams categorised in the other core services accounted for 12 DoLS applications, seven (58%) of which were granted. Three DoLS applications in the adult inpatient core service were made, none of which were granted.

Good

Are services effective?

- The trust made 57 Deprivation of Liberty Safeguards applications between 1 March 206 and 31 August 2016.The highest level of application was from the older adults' wards in Harplands Hospital, with the highest application from Ward 4 (22) and Ward 6 (21).
- The MCA is not applicable to children under the age of 16. Staff used the Gillick competence, which balances children's rights with the responsibility to keep children safe from harm, for those under 16. All staff we spoke to within child and adolescent mental health services (CAMHS) demonstrated knowledge of Gillick competence. However, this information was difficult to find in the electronic care records. The service planned to include a capacity section in its electronic assessment form that all staff would have access to. The hub was the only CAMHS service using the electronic form at the time of inspection.
- Staff across services assessed capacity to consent to treatment on a decision specific basis. We saw detailed information on how capacity to consent or refuse treatment had been sought.

Good

Are services caring?

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

Summary of findings

Our findings

Kindness, dignity, respect and support

- The trust's overall score for privacy, dignity and wellbeing in the patient led assessments of the care environment (PLACE) 2015 was 96.4%, which was around 6.5% higher than the England average of 86%. All sites scored above the national average.
- The staff Friends and Family Test (FFT) was launched in April 2014 in all NHS trusts providing acute, community, ambulance and mental health services in England. It asks staff whether they would recommend their service as a place to receive care, and whether they would recommend their service as a place of work. Forty five per cent of staff responding to the trust's Friends and Family Test between April 2015 and March 2016 were either 'likely' or 'extremely likely' to recommend the trust as a place to work, compared to the national average of 61%. Ten per cent of staff were 'extremely unlikely' to recommend the trust as a place to work and is nearly seventeen percentage points higher than the England average.
- Between April 2015 and March 2016, 63.5% of staff responding to the trust's Friends and Family Test said they were either 'likely' or 'extremely likely' to recommend the trust as a place to receive care, compared with the national average of 78%. Ten per cent of staff were 'extremely unlikely' to recommend the trust as a place to receive care. This was eight percentage points higher than the national average. The trust achieved a 25% response rate to this survey, which was slightly more than double the average response rate nationally.
- The trust performed 'about the same' as other trusts in the care quality commission (CQC) Community Mental Health Patient Experience Survey for all questions. With the exception of the section relating to treatment, the trust scored better than other similar trusts.
- Throughout our visit, we saw staff interacting with patients' in a positive, friendly and respectful manner and most patients' we spoke to were positive in their views of staff. We also observed staff speaking about patients' positively in referral and multidisciplinary meetings. Most patients' said that staff addressed their individual needs in care planning and care.
- All staff were found to be caring and respectful during inspection. Staff we spoke to told us about new compassionate care training initiatives that service users' contributed to in order to share their experiences and expectations of compassionate caring. The trust also shared plans to implement Schwartz Rounds as a means to provide structured forums where all staff, clinical and non-clinical, came together regularly to discuss the emotional and social aspects of working in healthcare. The underlying premise was that the compassion shown by staff could make all the difference to a patient's experience of care, but in order to provide compassionate care staff must, in turn, feel supported in their work.
- All teams had mechanisms in place to welcome and orientate new admissions to their wards and services.
- We saw that staff maintained patient confidentiality by using only trust approved electronic communication systems, storing records correctly and not discussing patient information in public areas.

The involvement of people in the care they receive

- All teams we visited during inspection had a variety of mechanisms to promote the inclusion of patients' views in service change and development including annual patient surveys, local community meeting forums or involving patients' or the parents of young people in staff recruitment and team away days. Most inpatient wards facilitated regular community meetings where staff took notes and displayed these on the wards. There were also "you said we did" posters to demonstrate action taken because of patients'' views and feedback.
- The trust had completed a number of service evaluations and audits, which provide evidence and monitor the involvement of people in the care they receive. Service evaluations included patient experience discharge questionnaires in adult mental health,

Good

Are services caring?

substance misuse and older people's services, patient experiences within child and adolescent mental health services (CAMHS) and client satisfaction surveys in substance misuse services. Staff undertook various audits including patient experience and patient engagement audit completed in April 2016.

- The trust had developed several service user and carer forums within service to enable and promote involvement in service changes, recruitment and practice developments. The trust had developed several patient and carer councils and provided a patient experience team to act as a central point of contact for people to provide feedback or raise concerns.
- The children's and young person's council (CYP) was established in 2014 and has since been involved in a wide range of activities influencing child and adolescent mental health services (CAMHS) and reduce stigma. At the time of inspection, there were five active CYP council members and a total of nine belonging to the Facebook group. We had the opportunity to meet and speak with the CYP council during the inspection to gain an understanding of their current projects and achievements. The CYP council told us that staff supported and enabled them to have an influence in a range of ways. These included an inspiration calendar; development of a checklist for young people attending interviews or services for the first time; TVs in CAMHS 54 waiting rooms to show the recording of patient journeys; and proof reading leaflets and information to improve young people's understanding and engagement. The CYP council also contributed to staff recruitment at all levels and was involved in reviewing the summaries of incidents and complaints within CAMHS services. Future projects and areas of influence included youth council leaflets to recruit more members, hosting a celebration event, reviewing the letters sent within CAMHS and interest in being involved in staff inductions. There were also plans to develop a parent group in order to offer support to parents and contribute to the development of the service.
- During our inspection, we saw active involvement of patients', their carers and relatives in care planning in most services. Patients' signed their own care plans and wrote these in their own words. Staff recorded care plans in easy read or pictorial format when required.

Good

Are services responsive to people's needs?

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

Summary of findings

Our findings

Service planning

- Trust services were planned to meet the needs of the local population of Stoke-on-Trent and countywide in North Staffordshire. The trust delivered services within a health economy that contained the diversity, degree of deprivation and health inequalities of the city of Stoke-on-Trent balanced with the needs of rural communities and smaller towns in the wider county.
- We found variation in the level of external stakeholder involvement in the planning and delivery of services. The trust had embarked upon the assistance of the local health watch in order to develop engagement with service users, to review the trust complaints policy, and to facilitate investigatory training for staff. However, feedback from the local clinical commissioning groups (CCG's) was that the trust could improve upon engagement and involvement of the CCG's; particularly in relation to addressing waiting lists in the specialist community mental health teams for children and adolescents.

Access and discharge

- The trust had established an access team to support and enable timely admission to services when required. However, we heard from external agencies and service users' and their relatives who shared concerns that some service users' in crisis struggle to access the access team potentially due to insufficient community provision for the populations' needs. All 24 young people and/or parent we spoke to from the Child and Adolescent Mental Health (CAMHs) community services with said there were long waits for treatment and felt this could have had a negative impact on their mental health. The families we spoke with who were on the waiting lists felt forgotten and unsupported.
- The trust met all its national 'days from referral to initial assessment' targets across adult community and crisis service provision. The trust's national target of '126 days from initial assessment to onset of treatment' was met by all services. Newcastle community mental health team (CMHT) and autistic spectrum disorder (ASD) team had the highest assessment to treatment time of 68 days. Dementia Primary Care Liaison Team had the lowest at zero days.
- The community teams for older people memory services were the top performing service in the West Midlands for diagnostic rates for dementia and the eighth overall in England. The time from referral to appointment at the time of the inspection was four weeks at Marrow House memory clinic, slightly longer than the targeted three weeks.
- The trust provided details of bed occupancy rates for 13 Wards from 01 March 2016 to 31 August 2016. Ten out of 13 wards had bed occupancy rates of 85% and above, this compared to nine out of 13 wards which had bed occupancy rates of 85% and above in the 2014/15 data pack ahead of the previous inspection in September 2015. In the current data, the core services with the highest average bed occupancy were the long stay/ rehabilitation ward at Summers View (104%) and the adult acute inpatient wards (103%). The wards with the lowest average bed occupancies were the older adults ward four (67%) and Dragon Square, a child and adolescent mental health inpatient ward (71%).
- The assessment and treatment (A&T) Unit (a learning difficulties ward) had the longest length of stay at an average of 1,052 days from December 2015 to May 2016. This was partly due to changes in services and transfer of patients' from previous long-stay inpatient wards. Staff had successfully discharged most transferred patients' to community placements with the exception of one patient. Since the introduction of transforming care in the community teams in January 2015, the average length of stay for all patients' admitted from January 2015 to December 2015 was reduced to 96 days. Dragon Square (CAMHS ward) had the shortest average length of stay at three days, followed by the

Good

Are services responsive to people's needs?

Edwards Myers Centre (Substance Misuse) at seven days. There were 79 delayed discharged for adult inpatient, older adult inpatient and neuropsychiatry for the period between November 2015 and May 2016.

- Staff and patients' we spoke to on the adult acute wards reported no issues with bed availability on return from leave and confirmed that there had been no patient transfers between wards unless clinically indicated.
- Readmission figures for the period 01 March 2016 to 31 August 2016 show readmission of 106 patients' (Acute ward 1 = 37, acute ward 2 = 34, acute ward 3 = 35) of which 20 patients' for the adult acute wards were readmitted within 90 days from discharge and 10 readmissions within 90 days of discharge for older adult inpatient wards. The trust did not provide figures for learning disability, child and adolescent inpatient services or the rehabilitation wards at the trust. This is comparable with 77 delayed discharges recorded over the six months before the previous CQC inspection in September 2015 (October 2014 to March 2015). The trust provided data on the number of delayed discharges in each month from 1 March 2016 to 31 August 2016. The total number for the six months was 75, across adults and older adults wards.
- One hundred and thirty seven patients' experienced a delayed transfer of care from June 2015 to May 2016. Over this period, the number that was the responsibility of the trust was higher than the number that was the responsibility of the social care in every month. The highest monthly figure for delayed transfer of care was March 2016, with twelve. 'Public funding' was the main reason for delayed patients' (44 patient delayed for this reason which equates to 32.2%). 38 patients' were delayed due to 'housing- patients' not covered by NHS and Community Care Act (27.7%) and 20 (14.6%) were due to patient or family choice. The number of patients' delayed increased from three in July 2015 to 21 in March 2016 and finally to 19 in May 2016.
- There were 4,098 delayed days between June 2015 and May 2016. The reasons with the highest number were as follows: 1350 (32.9%) were due to public funding, 1104 (26.9%) were due to housing (patients' not covered by NHS and Community Care Act) and 576 (14.1%) were due to patient or family choice. The number delayed by public funding increased from 47 in June 2015 to 216 in May 2016, while the number delayed by assessment increased from zero in June 2015 to 98 in May 2016. The total number of days delayed increased from 182 in June 2015 to 551 in May 2016.
- Out of area placements in the last six months prior to 20 June 2016, showed 11 adult inpatients' placed out of area for care and treatment in this period. As of 07 June 2016, staff had discharged five of these 11 patients' (including one self-discharge), staff had transferred three to ward beds in the trust area and three are still on out of area placements. Only patients' referred to the ward for people with learning disability or autism placed out of area required low or medium secure admissions, which the trust could not source locally. The service had regular meetings with commissioners to monitor these patients' to ensure transfer back to community teams as soon as possible.
- The community learning disability teams described steps taken to engage patients' who found it difficult, or were reluctant to work with community services and had processes in place to re-engage with patients' who did not attend their appointments. All teams monitored missed appointments and discussed them at team meetings.
- There was a concern expressed by the Service user and Carers Council of a lack of service provision for service users' with dual diagnosis and challenges to accessing services for travellers and homeless persons.
- Between January and March 2016, services follow up 97.5% of patients' on the Care Programme Approach (CPA) within seven days of discharge from psychiatric inpatient care from this trust. This was slightly above the national average of 97.2%. Historically, the trust had often been 2.5% above the national average yet figures have declined since July 2015 as the number of patients' discharged has risen.

The facilities promote recovery, comfort, dignity and confidentiality

- The majority of the trust's services had the quantity and range of rooms and equipment needed to support treatment and care.
- In relation to food, PLACE data (self-assessments undertaken by NHS and private/ independent health care providers) for North Staffordshire Combined

Good

Are services responsive to people's needs?

Healthcare NHS trust was 93%. This was 6% more than the national average. All sites scored were higher than the national average. Dragon Square community unit was not scored.

- All services were effective in displaying information in different languages and easy read at main receptions and notice boards around buildings. Information included details of patient rights, how to complain and support services available. There was also information feeding back how the trust had responded to the concerns of previous patients' and details of the improvement that staff had made as a result.

Meeting the needs of all people who use the service

- The trust had patient information leaflets in various formats and languages for those who use services. All services had access to interpreters and staff could describe how to access these when required. Staff in some teams were trained in British sign language (BSL) to enable effective communication with some patients.
- The trust provided a choice of food to meet dietary requirements of religious and ethnic groups. Catering staff told us of pictorial menus being used on some wards, a four-week menu of hot and cold food to cater for individual's needs and Harplands hospital having 24 hour catering for all diet categories.
- All inpatient wards and community team environments were fully accessible to people with physical disabilities. The inpatient ward for people with learning disability or autism had signs, symbols and photographs to show areas of the ward ensuring patients' were aware of their ward environment.
- All patients' had access to faith rooms, though not always on the ward they were on. Staff told us that they proactively supported patients' to access faith centre on hospital site or in the community to meet their spiritual needs.
- The older people's community teams demonstrated agile and innovative ways of working to better meet the needs of service users'. The vascular wellbeing team visited memory clinics, set up sessions in sheltered housing complexes and had direct contact with GPs. They held clinics at a neighbourhood centre and a shared care centre on five mornings each week and at another primary care centre one day a week. This helped them to identify the patients' who needed the service. The manager of the care home liaison and dementia primary care teams did some work through 'listening into action' as to why people did not attend appointments (DNA). They identified significant numbers of nonattendance was because there were not enough staff to bring people to appointments, care home often sent agency staff who did not know the person and families were not aware of appointments. In response to this staff from the memory clinics visited patients' who could not get to the clinic at home or arranged transport to support them to attend their appointment. The dementia primary care liaison, GP liaison teams and the physiotherapists also now go into care homes for appointments and have helped to reduce hospital admissions.

Listening to and learning from concerns and complaints

- The trust's approach to managing and investigating complaints was effective and confidential involving a patient experience team, complaints and patient advice and liaison service (PALS) and patient and organisational change team all working from a holistic patient experience approach to investigate and resolve complaints. A team of staff trained in root cause analysis to undertake investigations underpinned this approach. The organisation learnt lessons from complaints through a process that included the circulation of a learning lessons newsletter to all staff and through team meeting discussions.
- Before our inspection, the trust received 151 compliments in the 12 months from April 2015 to March 2016. Community adult teams received the highest number of compliments with 33 (22%) followed by older adult inpatient wards with 27 (18%).
- We undertook an audit of four completed complaints during our inspection. Our findings showed the trust followed robust processes with the exception that staff did not complete a risk assessment on receipt of the compliant. It was also possible that the complaints manager would visit the complainant at their home, which was responsive. However, there was no evidence of this member of staff completing a lone worker assessment before these visits.
- Between April 2015 and March 2016, the trust received 65 complaints of which the majority related to clinical issues (19) and the attitude of staff (14). July 2015 showed the highest number received with ten complaints (15%), between December 2015 and March 2016 the trust received seven each month. Adult

community mental health teams received the highest number with 29 (45%) and the main reason for complaints related to the attitude of staff within these teams.

- Of the 65 complaints received, 23 (35.4%) complaints were not upheld and 23 (35.4%) complaints were upheld with six resolved and 6 partially upheld. Eleven (17%) complaints are ongoing, the oldest from May 2015. The trust referred one complaint to the ombudsman that was under ongoing investigation at the time of inspection
- In addition to the trust's complaints data we received information from other external bodies and organisations prior to our inspection in September 2016.
- The Trust had 65 written complaints from NHS England in 2014/15 (compared with 57 in the previous year). Twenty-nine percent (19) of them were regarding communication / information to patients' and 20% (13) regarding the attitude of staff. Although the number of complaints was lower in 2013/14 compared 2014/15, the number upheld was 30 in 2013/14 compared to 15 in 2014/15. "All aspects of clinical treatment" had the highest number of complaints in 2013/14 with 18 of which nine were upheld. In 2014/15 showed seven complaints in this category with two upheld, showing an overall improvement.
- Nursing, Midwifery and Health Visiting received the highest number with 31 (48%) complaints.
- Dental (including surgical); Scientific; Technical and Professional; Ambulance crews (including paramedics); Maintenance / Ancillary and CCG Administrative staff received zero complaints across the two year period prior to inspection.
- Nursing, Midwifery and Health visiting complaints had increased however; the number of these that were upheld (5) was the same as recorded in 2013/14.
- The trust listened to and learnt from complaints. Patients' generally said they knew how to complain formally and said they were happy to raise issues at community meetings or directly with individual staff. Inpatient wards had various information leaflets readily available on how to make a complaint or compliment, and advocacy details. Patients' we spoke with in various services shared examples of historical complaints or concerns, which the trust had listened to and acted on, resulting in refurbished waiting areas and revised practices. The feedback from parents we spoke with who had children on the waiting list for community mental health services for young people told us they would be reluctant to make complaints as they knew how stretched the services were and they empathised with the staff.
- Staff we spoke with across all services were knowledgeable and confident when discussing the complaints procedure. The majority of staff told us that they would first try and resolve complaints locally and informally in the first instance before escalating then within the organisation. All staff were aware of the trust's policy.

Good

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's vision was "To be an outstanding organisation providing safe, personalised, accessible and recovery-focussed support/services every time." The Values for how the trust wanted their staff to behave are CARE: compassionate, approachable, responsible and excellent and demonstrate equality and diversity embedded within them. All teams and services we visited staff were aware and shared the trust's vision and values. Most teams had team objectives that reflected trust values and those who did not had team away days planned to agree team objectives in line with the trust vision.
- The trust had four quality priorities for which four key areas evidenced that the trust was delivering high quality care and treatment to service users' in a way that was person centred; SPAR:
- Services would be consistently **safe**
- Care would be **personalised** to the individual needs of service users'
- Processes and structures would guarantee **access** to services for service users' and their carers
- Focus would be on the **Recovery** needs of those with mental illness
- Sound methodology of the Monitor toolkit underpinned the trust strategy. This document included key elements of local and national policy drivers embedded such as the needs to meet local community need, improvements based on the previous CQC inspection and the five-year forward view. It was evident that the trust had worked hard to develop a bottom up approach with staff and directorates contributing to policy development and local GPs had been involved.
- The trust has an equality strategy that clearly outlined the trust's vision and includes related actions and the recent appointment of an equality and diversity lead and patient engagement lead had clearly strengthened the trust's ability to address equality and diversity requirements across the organisation. However, not all of these actions evidence development in partnership with staff and service users', are not specific, measureable, and have a defined period. The equality delivery system (EDS2) assessment had informed the trust four-yearly equality strategy but lacked robust methodology for implementation including sufficient depth, focus, and involvement of the senior leadership. This included Board-level ownership of EDS2 at an early stage.

Good governance

- The trust provided its board assurance framework, which also acted as its risk register. This document highlighted seven risks and their progress against these. The system of reporting and monitoring risk covered all levels depending on the risk rating. Risks rated less than eight sat on the teams risk register, risks rated between eight to 12 were highlighted on the directorates risk registers and all risks rated over 12 (the highest possible risk) were included at an executive / board level. This system enabled close monitoring at all levels and accountability and responsibility.
- The majority of staff across trust services had received their mandatory training. For the twelve months to 31 August 2016, the trust's overall compliance was 89% against its own target of 90% compliance. Safe people handling training had the lowest compliance rate of 62% associated with the acute inpatient wards (wards 2 and 3) and substance misuse services (Edward Myers Unit). It was noted the trust board did not receive an enhanced level of training in equality and diversity. Staff generally reported being able to access specialised training when required.
- We found at the time of inspection that the staffing was generally sufficient to provide safe care. We noted that adult mental health psychiatrists provided the child and adolescent mental health services out-of-hours rota. Community team caseloads generally ranged between 19 and 40 patients' and staff reviewed caseloads regularly. However, there was no recognised caseload

tool used within community CAMHS. The highest proportion of vacancies for qualified nurses was for the acute inpatient wards, community CAMHS, crisis services, and older people's inpatient wards. However, for community CAMHS and older people's wards, the high vacancy rates reflected an increase in the staffing establishment. Staff within the trust's community teams told us that there was increased generic working that limited the profession specific expertise required by some patients.

- The proportion of non-medical staff who received regular supervision or who had had an appraisal varied across services that we inspected with the acute inpatient wards being the lowest compliance. Most staff in the organisation also received regular management and clinical / caseload supervision. However, not all teams recorded formal supervision, so it was difficult to assess the effectiveness of this. We noted that not all staff working in the community services for older people received clinical supervision at the time of inspection.
- The majority of MHA paperwork was completed and stored correctly. Regular audits ensured that staff applied the Mental Health Act (MHA) correctly and there was evidence of learning from these audits. However, the Mental Health Act associate managers were unaware of their wider responsibilities when interviewed during inspection and we found no formal scheme of delegation for these in place. They did not have formal oversight of MHA policies, were not engaged in the monitoring of CQC MHA review reports and action plans and they did not monitor independent mental health advisor (IMHA) activity and not aware of their wider responsibilities in respect of the victims of crime and children and young people. They were aware of the issue of renewals and reviews taking place after the end of the original date of detention but had not taken action to address this at the time of inspection.
- The trust had an objective following the previous CQC inspection in September 2015 to strengthen governance. This had been achieved through bringing together several documents together to strengthen the board assurance framework to give assurance for all seven strategic objectives of the organization. The trust was aiming to have clear executive ownership of objectives, identified sub committees to provide assurances, the ability to describe risks and gain both internal and external assurance. During inspection we saw evidence of developing good governance systems where further streamlining of committees and sub groups, frequency of meetings would underpin greater continued effectiveness. At the time of inspection the trust had a semi manual system for performance reporting. The need for accurate and timely data was recognised and initiatives were being developed that included scorecards for teams to monitor performance. It was believed that the introduction of a new electronic system would enable full integration of performance data.
- The trust's board assurance framework was used as a risk register to monitor the trust's objectives and any risks to achieving them. The trust board assurance framework dated May 2015 contained seven objectives:
- To provide the highest quality services
- Encourage, inspire and implement research and innovation at all levels
- Create a leaning culture to continually improve
- Attract and inspire the best people to work here
- Maximize and use our resources intelligently and effectively
- Continually improve our partnership working
- Enhance service users' and career involvement
- Performance data and an escalation and de-escalation system of reporting and monitoring risk informed the trusts risk register. Risks rated less than eight sat on the teams risk register, risks rated between eight to 12 were highlighted on the directorates risk registers and all risks rated over 12 (the highest possible risk) were included at an executive / board level. This system enabled close monitoring at all levels and accountability and responsibility. Directorate risks scoring 12 or above are reported to each sub-committee of the Board (chaired by a NED) and scrutinised in terms of risk score and mitigation. Following this, a summary of each sub committee is presented to the Trust Board containing a discussion outlining the risks and action taken..
- The trust audited and monitored outcomes for patients' using services. This included the monitoring of key performance indicators such as mental health outcomes, physical health, preventing suicide, health records, medicines management, and consent to treatment process, 18-week waiting times and care plans. The trust piloted an inpatient safety audit successfully and planned to implement as part of a

monthly dashboard to demonstrate assurance and improvement across all services. This tool collected data on staffing levels, length of stay, discharges, bed occupancy, incidents, safeguarding and training.

- During inspection, there was a degree of inconsistency found in the performance data held at local service level by the performance team, and at senior level in the organisation, specifically with the community child and adolescent mental health services (CAMHS). Community CAMHS was experiencing excessive waiting lists at the time of inspection for which locally management and staff described mechanisms for monitoring and reviewing all young people waiting. However, we found no evidence in the files we inspected. Through a recent 'listening into action' event, CAMHS managers highlighted inaccuracies in performance data and a lack of reported data regarding referrals, did not attend (DNA) figures, discharges, number of sessions available from the teams, number of initial assessments both routine and urgent. At the time of inspection, this remained unresolved.
- We also noted that the associate director of governance reported performance data directly to the chief executive. Therefore, it was not clear how the organisation gained assurance at a board level from performance, as this role did not sit at director level.
- The trust had a clear policies and processes for the responding to and reporting of serious incidents. This involved weekly incident reviews at a senior level and monthly discussions at the safety improvement group. The trust shared all key findings of incidents across the organisation, themes and learning points through bulletins and learning lessons, and discussed within staff supervisions. Several external stakeholders felt that the organisation's review of serious incidents and learning lessons was very robust and involved service users'.
- The trust appointed a diversity and inclusion lead role which had been in place since October 2015. The purpose of this role was to lead the trust's work on developing a more diverse and inclusive organisation. Key work undertaken in the period December 2015 to May 2016 included:
- A 20-week 'Listening into Action' programme (a bottom up way of working that focuses on priorities important to service users' and staff) to review diversity and inclusion within clinical services
- Diversity and Inclusion Annual Review for 2015
- Equality Delivery System (EDS2) assessment and action planning
- Trust Diversity and Inclusion Strategy
- To progress Equality Objectives 2015-2018
- Deliver programme of engagement and communications around different aspects of diversity and inclusion
- The trust's policies, overall, included appropriate degrees of consideration of disability and equality and diversity issues. The trust had an equality of opportunity policy. The staff sickness policy included a brief reference to disability and the maternity policy included a reference to paternity. In addition, the business continuity paperwork available on the intranet included very little reference to evacuation and no reference to how the organisation should treat disabled patients' and staff in such a situation.
- Equality developments and updates fed into several committees within the organisation's structures however, the equality delivery system report and workforce race equality standards report (WRES) March 2016 had not been shared at a trust board level. There was also a lack of evidence to demonstrate that equality analyses were routinely undertaken for all major decisions in the trust and this was not captured in the trust's risk register indicating the board's awareness of this as a risk to the organisation. The majority of papers going to the board inspected suggested that there were no equality related implications, despite clear equality related risks resulting from the decisions agreed and recorded. Without adequate training for managers and for the board about their duty to undertake equality, the leads may not have been aware of their equality responsibilities.
- The workforce race equality standards report (WRES) March 2016 did not clearly identify all of the relevant data limitations (as required) including the staff survey being undertaken by a total of 28 black and minority ethnic (BME) staff, and training figures not collected as recommended by national guidance but staff survey results used.
- WRES Standard 1: The report did not include an ethnic breakdown of the workforce across all agenda for change pay bands. Instead, it broke the data down across medical/non-clinical staff groups.
- WRES Standard 2: The gap of adverse effect on BME staff had significantly widened since 2015.

Good

Are services well-led?

- WRES Standard 3: The trust had not set itself actions to reduce the adverse effect on BME staff. The only action was to continue improving the culture in the organisation.
- WRES Standard 4: The trust had not used the appropriate data set to report on this standard (training data). There was no recorded action in place to start collecting this data.
- WRES Standard 5: The percentage of BME staff experiencing harassment, bullying or abuse from patients', relatives or the public in previous 12 months had increased from 17.4% to 35.7% since 2015.
- WRES Standard 6: The percentage of BME staff experiencing harassment, bullying or abuse from staff in previous 12 months had increased from 4.5% to 14.8% since 2015.
- WRES Standard 7: The 2016 BME staff results were slightly better than in 2015 but the gap of disparity between white and BME had widened.
- WRES Standard 8: There was a higher percentage of BME staff that had experienced discrimination at work from their manager/team leader or other colleagues than in 2015 (11.1% as compared to 8.3%).
- WRES Standard 9: While the trust had good results in terms of board representation, the action set to improve this further was not specific.
- From the inspection of policies and interviews undertaken during the week of inspection, the organisation had sound systems, processes and controls in place concerning information governance and records. There had been no information governance incidents since March 2014, which for an organisation this size would indicate a concern regarding the current monitoring criteria.
- We found good policies for mitigation and reporting of suicides. However, we did not find evidence to give assurance that the board led on these issues or to show how the organisation managed potential reputational risk.
- Restrictive practices were in line with the Mental Health Act and followed national guidance. We found that staff imposed reasonable restrictions on the adult acute wards to manage identified risks. Staff used restraint as a last resort, after de-escalation techniques had failed. The wards had implemented the safe wards model of care to promote de-escalation.
- The organisation operated a hybrid record system at the time of inspection including paper-based records, the trust's current electronic system (CHIPS) and local authority systems, with plans to implementation a new trust electronic patient record (Rose) in 2017. The trust trained all on-call consultants to access all systems to reduce possible risks of not being able to access information when needed at the point of admission or crisis. There was recognition by the trust of this hybrid system presenting a potential information governance risk. The trust demonstrated this by a general risk relating to IT records being on the trust risk register.
- At the time of the new electronic system, being in place the trust will review its information governance committees and groups to ensure there are no anomalies or information governance gaps regarding responsibilities and the management of risks.
- The trust was starting to use privacy impact assessments (PIA) within the trust however not routinely across all services. All new projects undertaken within the organisation should have had a PIA completed to demonstrate privacy issues had been considered. There were plans to include a PIA in the new electronic patient record system. However, there was no evidence that the trust had completed this even though the system had been purchased by the organisation at the time of inspection.
- During our inspection, we met with a variety of partner organisations working with the trust including Brighter Futures, Changes, ADS and Health Education England. All spoke positively about partnerships with the trust and found the trust to be open minded, supportive and recovery focused. The trust had provided support through human resources and recruitment assistance, joint training, employment of service users' within the organisation and sharing student placements. Partner organisations that we spoke to highlighted a negative around the pace of change due to the organisation's governance structures, which the organisations partners generally accepted.
- The trust took a tiered approach to its programme of audit that incorporated national, mandatory and trust priorities for audit activity. Staff were involved in a range of clinical audits to monitor the effectiveness of the service provided. The trust had undertaken extensive auditing and monitoring of care plans and risk assessments since the previous inspection in September 2015 to assure them of improvement in

quality. However audits of medication storage were not always monitored and actioned and there was no evidence of auditing the organisation's use of rapid tranquilisation.

- The trust had established a chief clinical information officer (CCIO) role on a 0.2 whole time equivalent basis (WTE) with support from the existing chief information officer and informatics team. Both these roles reported to the Executive Director of Strategy who is the SRO for the digital programme on the board. The risk register for the programme is held by the Digital Programme Board chaired the CEO. During inspection, we found a lack of awareness of the value of privacy impact assessments that could have consequences when the General Data Protection Regulations become mandatory in 2018. A live example of this was involvement in a privacy impact assessment at the commencement of the new electronic records project to identify patient and staff perspectives. We were told that this had not been undertaken to date however was an intension in the future implementation of the new electronic system being rolled our across the organisation.

Fit and proper persons test

- Healthcare providers are required to ensure that all directors are fit and proper persons for their senior roles within healthcare organisations. The CQC requires trusts to check that all senior staff met the stated requirements on appointment and set up procedures and policies to give continuous assurance that senior remained fit for role throughout their employment.
- The trust had an appropriate fit and proper person policy (dated May 2015), which the trust reviewed in November 2015. It outlined a robust process for recruitment, appointment and continually evidencing the fitness of Directors in trust employment.
- We reviewed six board members personnel files. All six of these files evidenced consistent processes undertaken to evidence fitness with external agencies, annual self-declarations regarding fitness for a board level role within the organisation and annual appraisals. Four of the six files had evidence of current disclosure and barring service (DBS) checks and two held evidence of references. Shortfalls in the personnel files were highlighted at the time of inspection and an explanation was given of evidence pertaining to declarations of conflicts of interest, supervision records and mandatory training being held in alternative files and systems. The trust addressed these and undertook work to better document and signpost this within executive and broad level personnel files.

Leadership and culture

- North Staffordshire Combined Healthcare NHS Trust saw a response rate of 60% in the 2015 NHS staff survey, when 788 staff took part. This was above average for mental health / learning disability trusts in England, and an increase from 40% in 2014.
- The trust had four key findings that exceeded the average for mental health trusts: effective team working; percentage of staff experiencing discrimination at work in the previous 12 months; percentage of staff believing the organisation provides equal opportunities for career progression/promotion, percentage of staff experiencing harassment, bullying or abuse from staff in the previous 12 months. The percentage of staff suffering work related stress was on par with the national average.
- The trust had six key findings that were below the average for mental health trusts: staff recommendation of the trust as a place to work or receive treatment; percentage of staff feeling pressure in the previous three months to attend work when feeling unwell; organisation and management interest in and action on health/wellbeing; percentage of staff experiencing physical violence from patients', relatives or the public in the previous 12 months; percentage of staff experiencing physical violence from staff in the previous 12 months; and staff confidence and security in reporting unsafe medical practice. The percentage of staff reporting good communication between senior management and staff had improved from the previous NHS staff survey but was still fractionally lower than the national average.
- Staff morale was mostly good across the services in the trust. However, some groups of staff felt less visible and less valued than other staff groups since changes in workforce and concerned about their professional voice and influence at a senior level. The trusts staff sickness rates were just above the national average for mental health and learning disability trusts. However, staff experiencing bullying or harassment in the past twelve

months prior to inspection had increased slightly but still below the national average. Of note, black and minority ethnic (BME) staff reporting experiencing bullying and harassment had almost doubled.

- We found through focus groups and interviews with allied health professional (AHP) staff echoed the concerns related to increased generic working, specifically in community teams, lessening the impact of allied health professionals' impact on patients' recovery journeys.
- All allied health professional staff we spoke with were positive about the director of nursing and their inclusive views. However, all shared concerns that the AHP workforce structure remained flat, with a celling of band 6. They felt this negatively affected staff recruitment and retention. Staff felt that if the wanted to progress further they would need to take management positions that did not support the retention of clinical expertise and maturity to benefit the quality of care patients' received. Staff also said there had been a lack of investment in supporting student occupational therapy placements. The trust recognised this as an issue and was discussing plans to make it possible for staff to support students. Staff highlighted the current AHP Lead (0.2 wte) capacity as insufficient for the role and viewed the announced retirement of the AHP lead as presenting an opportunity to review the workforce structures, professional voice and influence in the organisation.
- The organisation had strengthened the leadership within the trust since the previous inspection in September 2015 by recruiting to several existing senior roles externally as well as developing new roles including the head of nursing to support the director of nursing, a new patient engagement lead and equality and diversity leads. The head of nursing had a key focus on safer staffing and the enhancement of clinical practices through nurse training and development to raise the standard and effectiveness of patient care. New initiatives for this post included values based clinical supervision models and e-rostering systems to bring efficiencies to rosters of staff. The trust had also undertaken significant change in leadership at a middle managers level, recruiting many individuals from external organisations, which had brought new views, experiences and ideas. There was mixed staff views about the leadership within the organisation, some staff groups including nurses felt well represented and increasingly able to influence where others including medical staff, felt there was room for improvement in consultation involvement and development of allied health professionals workforce structure and empowerment. Many improvements had come from key roles and the organisation were aware that all leadership and improvements needed to be system and practice based to be sustainable and consistent.
- Senior nurses spoke highly of the new director of nursing and felling empowered and valued. These staff stated that the focus was now more on clinical contributions than management with views to explore nurse consultant posts in the future to support quality care and career progression. However, they as a group recognise the need for investment going forward as most senior nurses currently in post will be retiring in the next five years that highlighted a workforce planning need.
- Staff in general, and all levels of nursing staff, spoke very highly of the new substantive director of nursing. Staff told us that they now felt they had strong nursing leadership at a senior level in the organisation that was committed to clinical and leadership development. Senior nurses felt empowered and valued. The estates team also described the director of nursing to be actively involved in joint visits to premises to identify where action and investment is required.
- The trust culture encouraged candour, openness and honesty (staff knew how to use the whistle-blowing process and felt able to raise concerns without fear of victimisation).
- Psychologists we spoke to during the inspection told us that recent changes in structure had resulted in positive changes in supervision of psychological staff, dual responsibility for appraisals by the operational and clinical managers. Stabilisation of the executive team and changes to senior management had supported a positive cultural change focusing on growing and retaining staff, providing evidence based treatments and greater patient involvement. Areas of challenge recognised by this group of staff highlighted further improvements in communications and the need to publish more research.
- All staff felt valued through the compassion awards and reach awards designed to support and recognise staff. Nursing staff valued the recent conference and ward managers felt they had benefitted from the leaders in care programme and ongoing support for

developments. The trust had invested in leadership development opportunities for staff including the Aston programme of leadership and enabling staff to attend the Health Education West Midlands directors' programme.

- Black and minority ethnic (BME) staff interviewed during inspection were positive about the trust changes, about their managers and about the leadership. Staff were particularly appreciative of the listening into actions programme, about the dear Caroline initiative and other work the trust had undertaken. These findings were confirmed by the staff survey results (improved staff satisfaction and generally positive results).
- The trust had embedded equality into their revised recruitment policy and procedures. Recruitment introduced equality related questions into the recruitment process, as well as a part of the managers' recruitment training. However, on inspection of the organisation's equality analysis for the recruitment and selection policy, this showed that equality impacts had not been robustly analysed.
- The trust was aware of the equality issues related to effective use of equality monitoring data to improve patient access, experience and outcomes and had started addressing these.
- The organisation promptly and effectively addressed poor staff performance across the organisation. Team leaders and managers in services across the organisation demonstrated when and how to escalate concerns and knew how to access support from human resources or occupational health teams. Since 22 April 2015, there had been 12 instances of staff being suspended or placed under supervised practice: two suspensions and ten staff placed under supervision. The most common grade of staff for this action was Band 5 staff; four instances of managers placing staff under supervision and one suspension. All five of these staff were registered mental health nurses, four of which worked at Harplands Hospital. Staff side representatives told us that in their view, that the trust addressed poor staff performance in a clear, fair and well-considered manner yet, at times, these could be timelier. Staff side representatives described the trust's sickness management procedures as robust however could benefit greatly by a greater focus on preventative measures and a better understanding of the impact of disabilities.
- Staff were actively engaged in developments primarily enabled through the trust's listening into action (LIA) initiative. Staff told us that LIA had enabled all staff to highlight good ideas and gave permission to clinicians and staff to act with positive outcomes for services; they now received team briefs from the trust and the board was more visible. Nursing staff recognised positive changes had come from LIA projects including laptops in community services, a nursing conference, and that the trust had addressed parking issues as much as possible within existing environments. Administrative and clerical (A&C) staff reported a current LIA big conversation to look at what this staff group does well and what can be shared and how to best move forward and improve. Staff shared feeling less invested in than previous times; previously had an internal conference, a training group, steering group and an A&C champion.

Engagement with the public and with people who use services

- The organisation had been proactive in developing new ways for staff and service users' to influence care and engage in developments. These included listening into action, a newly established service user and carer council, the young person's council, service users'' involvement in recruitment and management of actual or potential physical aggression (MAPA) training to share their experiences, and a revised recruitment strategy that highlighted service users'' involvement. Service users' also contributed to staff education about compassionate care. However, the trust did not ensure the involvement of individuals within the all of the different protected characteristics. Significant work had been completed in respect of deaf & hard of hearing people and lesbian, gay, bisexual, transgender (LGBT) people but there was a lack of robust initiatives relating to other protected characteristics.
- The trust had not undertaken an engagement exercise to explore the findings of the workforce race equality standards report (WRES) due to previous experience of poor attendance. Similarly, the equality delivery system (EDS2) report was not of as high of a standard as required.
- The trust had no staff networks in place to give staff with protected characteristics a voice and engage them in a meaningful way. The patient experience lead had also identified engagement with service users' across the protected characteristics as an area for development.

Good

Are services well-led?

Quality improvement, innovation and sustainability

- The Trust had done impressive work around deaf & hard of hearing patient groups, particularly the Deaf café, British sign language (BSL) training for staff and effectively addressing communication needs. Good practice also included the implementation of the accessible information standard, which services owned at directorate levels where clinical staff seemed to be well aware of requirements.
- The trust had examples of having effectively used collected equality information, for instance around recruitment of black and minority ethnic (BME) staff through their new horizons initiative. However, this seemed to be more focused on human resources procedures for recruitment than on patients. All equality service user data was analysed and addressed at a directorate / clinical team level, yet staff interviews indicated that further work is required in this area.
- Wards for people with learning disability or autism had conducted research in September 2015 on antipsychotic prescribing for people with a learning disability in order to improve compliance with the standards as set by the prescribing observatory for mental health (POMH). The results showed that all patients' prescribed antipsychotics for more than 12 months had a general assessment of side effects and all relevant physical health checks. The team had put an action plan in place to improve practice, for example, staff revised a standardised recording sheet in care notes to include the reason for medical staff prescribing an antipsychotic and recording of any side effects.
- Several teams and individual staff within the community services for older people had recently received awards. For example, the outreach team had won the 'Rising Star team of the year' award and the manager had been highly commended for leading with compassion. Two band 6 nurses from the memory clinic at Maple House had won 'leading with compassion' awards and the team was nominated for the trust award. The band 6 nurse who was the mild cognitive impairment practitioner won the 'reach award for excellence' for their work in this programme. The physiotherapist had won a 'Spotlight on Excellence' award.
- The memory service at Maple House had applied to take part in the Memory Services National Accreditation Programme (MSNAP) following the clinics refurbishment, as they were aware, this had previously not met the standard required.
- The manager of the vascular wellbeing team had worked with the clinical commissioning group (CCG) and Keele University on the use of camera and text messaging system to help people with short-term memory problems to remember what to do during the day so enabling the person to have more control over their life. Text messages would remind the person to put the camera on. An evaluation report of the project showed how people's memory of events had improved. For example, one person had taken pictures on their camera of a visit to their son. They were able to play this back and remember the visit and the emotions associated with it. Another person had forgotten they had their car serviced so rebooked it with the garage. When they looked at the images from their camera, the patient saw that they had already completed and so cancelled the second service.
- The community services for people with learning disabilities or autism intensive support team had developed an electronic pathway tool. This gave staff a chronological pathway to follow which contained all the documentation that they would need to plan and implement patient care. The team manager told us the trust had seconded the member of staff responsible to another area of the trust to implement a similar pathway tool.
- Seven of the trust's inpatient wards had achieved accreditation under relevant accreditation schemes; Harplands Hospital was accredited as excellent by the electroconvulsive therapy accreditation service (ECTAS) in May 2011, Wards one, two and three, Florence House and Summers View were all accredited by the acute inpatient mental health services (AIMS) until January 2017. (AIMS) This is an initiative from the Royal College of Psychiatrists' Centre for Quality Improvement that identifies and acknowledges wards that have high standards of organisation and patient care, and supports and enables others to achieve these. The Darwin Centre an inpatient child and adolescent mental health service (CAMHS) also gained quality network for inpatient CAMHS (QNIC) accreditation in November 2015.

Good

Are services well-led?

- The trust is also developing a research partnership with Keele University to underpin quality services and attract clinical expertise to the organisation. This was a shared ambition of the psychology staff group.

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 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 Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment How the regulation was not met: • The provider had not consistently maintained and monitored medication at the correct temperatures and actioned any issues. • The provider had not ensured that the monitoring of vital signs of patients' was completed as detailed in the NICE guidelines. • The provider had not ensured the rapid tranquilisation policy accurately reflected the NICE guidelines and staff did not record effectively in line with the Mental Health Act Code of Practice when they administered rapid tranquilisation. • Staff did not carry out physical observations to monitor closely the effects of rapid tranquilisation. • Staff on ward 6 did not record whether they gave or omitted prescribed medicines on 39 occasions. There was nothing recorded on medicines charts to show whether medicines were given, refused or omitted. One patient was administered medicines covertly outside of the authority of the Mental Health Act. • Staff were not checking fridge and room temperatures where medication was stored across all services. This was a breach of Regulation 12(2)(g)

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 17 HSCA (RA) Regulations 2014 Good governance How the regulation was not met:

This section is primarily information for the provider

Requirement notices

- Patients' and visitors could see confidential patient information on the patient information boards in the staff offices.
- Young people's mental health and risk were not being regularly reviewed and monitored on the waiting lists from initial assessment to treatment for North Stoke CAMHS, South Stoke CAMHS, North Staffordshire CAMHS, Autistic Spectrum Disorder assessment team and the CAMHS Learning Disability team.
- We did not see evidence to support the service statement that since February 2016 all young people on the waiting lists have a monthly letter asking them to contact the service if there are concerns.
- We did not see evidence that showed a plan how the service aims to reduce the waiting lists from initial assessment to treatment.

This was a breach of Regulation 17 (1) (2) (a) (b) (c) (d)

Regulated activity	Regulation
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 How the regulation was not met: • Sufficient numbers of suitable qualified, competent, skilled and experienced persons were not deployed in order to meet the requirements of this part. • In the case of the access and home treatment teams, there were limitations in the amount of input provided to the service by psychiatrist. This was because of the amount of time a psychiatrist was allocated to the service. This was in breach of regulation 18 (1).

This section is primarily information for the provider

Enforcement actions

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.