North Staffordshire Combined Healthcare NHS Trust

Quality Report

Trust Headquarters
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Date of inspection visit: To Be Confirmed
Date of publication: 22/03/2016

Core services inspected	CQC registered location	CQC location ID
Acute wards for adults of working age and psychiatric intensive care units (PICUs)	Harpland's Hospital Hilton Road Stoke-on-Trent Staffordshire ST4 6TH	RLY88
Long stay/rehabilitation mental health wards for working age adults	Summers View Furlong Road Stoke On Trent Staffordshire ST6 5UD	RLY87
Wards for older people with mental health problems	Harpland's Hospital Hilton Road Stoke-on-Trent Staffordshire ST4 6TH	RLY88
Wards for people with a learning disability or autism	A&T and Telford Harpland's hospital Hilton road Stoke-on-Trent ST4 6TH	RLY82

Summary of findings

Mental health crisis services and health-based places of safety	Harpland's Hospital Hilton Road Stoke-on-Trent Staffordshire ST4 6TH	RLY88
Community mental health services for people with learning disabilities or autism	Dragon Square Community Unit Chesterton Newcastle-under-Lyme Staffordshire ST5 7HL	RLY36
Community-based mental health services for older people	Harpland's Hospital Hilton Road Stoke-on-Trent Staffordshire ST4 6TH	RLY88
Wards for child and adolescent mental health (CAMHS)	Darwin Centre 167 Queens Road Penkhull Stoke-on-Trent Staffordshire ST4 7LF	RLY86
Community mental health services for child and adolescent mental health (CAMHS)	Darwin Centre 167 Queens Road Penkhull Stoke-on-Trent Staffordshire ST4 7LF	RLY86
Substance misuse service	Harpland's Hospital Hilton Road Stoke-on-Trent Staffordshire ST4 6TH	RLY88
Community mental health service for adults of working age	Harpland's 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	Requires improvement 
Are Mental Health Services safe?	**Requires improvement** 
Are Mental Health Services effective?	**Requires improvement** 
Are Mental Health Services caring?	**Good** 
Are Mental Health Services responsive?	**Requires improvement** 
Are Mental Health Services well-led?	**Requires improvement** 

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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Overall summary

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

We found that the North Staffordshire Combined Healthcare NHS Trust was performing at a level which led to a judgement of Requires Improvement.

We found inconsistencies in the leadership at board and executive team level. The Chief Executive had been in post for 18 months; we were impressed by her leadership skills. A strategy to improve safety, quality of care and patient experience has been developed, however, this process is in it's infancy and as such not fully embedded trust wide. Key positions in the leadership team remain interim and we were concerned by the turnover in relation to the Director of Nursing role. However, **the Director of Nursing and the Director of Strategy and Development had been appointed but not yet commenced in post**

Governance & data systems within the Trust were not robust and did not ensure that systems to enable the effective monitoring of safety, quality & risk are in place. However, we saw evidence that the Trust is developing systems for learning from incidents and complaints.

The provider failed to ensure that all people receiving a service were protected from potential harm due to ligature risks and poor quality of risk assessments. We have issued an Enforcement Action in relation to specialist community mental health services for children and adolescents which gives a strict timescale for them to improve.

The provider scored below the national average with regards to staff recommending the Trust as a place to work. Some of the staff that we spoke with felt disengaged from improvements that the leadership team are trying to embed. However, we saw evidence that the Trust is attempting to engage with staff and service users be developing initiatives such as 'listening into action' and the newly formed service user and carer council.

The Trust can be proud of the caring culture within the staff group. We saw consistent evidence of people who use Trust services being treated with dignity, kindness and respect.

We will be working with them to agree an action plan to assist them in improving the standards of care and treatment.

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 requires improvement for safe because:

- There was an absence of risk assessments completed for patients referred to the home treatment team
- The risk management plans across the home treatment, Crisis and Access teams were not detailed enough to identify how staff were to safely manage patients. We found there were no clear guidelines on how staff should respond and address the risks identified. These management plans were not regularly reviewed.
- Staff were not protected against the risk of carrying out home visits because risk assessments were not completed neither were they given devices to ensure they were kept safe.
- There were not appropriate arrangements for safe storage and management of medication in the home treatment team. Medicines were stored in a cupboard next to a radiator. Temperatures were not recorded. There were no drug charts for medicines administered by nurses to sign that medicines had been given.
- The storage of controlled drugs were not in accordance with guidance for controlled drug storage and controlled drug records were not accurately completed
- Staffing levels in the community CAMHS services were not safe because there were not enough multi-disciplinary staff.
- Risk assessments for young people using the services were not always completed. When young people did have a risk assessment and identified risks, they did not always have a risk management or safety plan.
- There was not an effective system in place to assess the risks to young people whilst they were waiting for assessment or treatment.
- There was evidence of some physical health checks not been completed i.e. monthly height checks for an eating disorder patient and recommended ECG after weight loss on leave. This could have potential to cause harm or distress to them.
- There were two filing errors in care notes on Darwin ward which could lead to inaccurate information been used or vital information not available to guide care.

Summary of findings

- The female only bathroom and toilet area on Darwin ward was accessed via the mixed gender games room which meant that male patients would be unable to use the games area when female patients needed access to bathroom facilities. The trust had a protocol to manage this issue.
- We found that all of the bedrooms in rehabilitation wards were situated on one corridor.

However

- Most ward areas were clean and tidy. Patients and staff reported that the trust's cleaning services were good.
- Clinic rooms were appropriately equipped with emergency equipment and they were checked regularly to ensure they could be used in an emergency.
- Staff were able to describe the electronic system to report incidents and their role in the reporting process. Each core service had access to an online electronic system to report and record incidents and near misses.
- Managers were able to adjust staffing levels daily to take into account increased clinical needs. This included, for example, increased level of observation or patient escort.
- There were systems in place to learn from incidents.
- The learning from incidents was discussed across teams in their meetings.

Are services effective?

Requires improvement

We rated North Staffordshire Combined healthcare NHS Trust as requires improvement for effective because:

- Care plans were frequently not personalised and did not include patients' views. They did not cover the full range of patients' problems and needs.
- Children's services were not following the MARSIPAN guidelines for young people admitted for treatment of low weight eating disorder. Treatment should include regular monitoring of weight and other physical indices. We did not find this was happening.
- In the six months between October 2014 and March 2015 there were 80 delayed discharges across the trust in eight locations.
- Between October 2014 and March 2015 there were 91 re-admissions within 90 days on 6 wards.
- Nurses expressed the perception that they are not valued by the trust; especially amongst learning disability nursing staff.
- There has been a reduction of allied health professional focus because several staff from these professional backgrounds are working in generic/non-professional specific roles.

Summary of findings

- The prolonged interim nature and inconsistency in the nursing director role has negatively impacted on the AHP voice and influence within the Trust.
- The trust did not achieve its target for staff mandatory training of 95%.
- The trust came within the bottom 20% of mental health trust in England for staff recommending the trust as a place to work.
- The trust did not tell their patients who they shared their information with.

However:

- Patients had a physical healthcare check completed on admission and their physical healthcare needs were regularly been met. Physical health examinations and assessments were documented by medical staff following the patient's admission to the ward.
- A range of psychological interventions available and some psychologists were imbedded within some teams.
- Community teams were using the '5 W's (who, what, when where and why) as a focus on measuring outcome and recovery for people in the community team mental health services.
- All persons involved in the care and treatment of patients were invited to their care programme approach (CPA) meetings.
- Independent advocacy through ASIST was provided for patients throughout the trust. We saw contact information for on display across for patients to contact them if they wanted assistance. Patients rights were on display on notice boards.

Are services caring?

Good

We rated North Staffordshire Combined healthcare NHS Trust Good for caring because:

- The trust scored 100% in their PLACE assessments which was better than the England average of 87%.
- The trust scored the same as other mental health trusts in the CQC's Community Mental Health Patient Experience Survey.
- We observed examples of staff treating patients with kindness, compassion and communicating effectively.
- The majority of young people said they were able to trust staff and that staff listened to them.
- Welcome pack for patients was available in most wards that contained information to help patients orientate and provide them with information they might need whilst in hospital.

However

Summary of findings

- We received mixed feedback from patients about their involvement in the care they receive. Documented evidence of patients having input to their care plans was inconsistent.
- The trust was below the national average for similar mental health trusts in the audit results of the trusts Friends and Family test at 69.3%.
- Patients told us that they did not receive appropriate one to one time with their named nurse because they were sometimes too busy to spend time with them.

Are services responsive to people's needs?

Requires improvement

We rated North Staffordshire Combined healthcare NHS Trust requires improvement for responsive because:

- We found bed occupancy in the three acute wards or adults were consistently more than 100% in the last five months.
- There were five cases of patients admitted out of area when the wards were full. High bed occupancy also meant that on occasions, some patients were required to 'board' on older people's mental health wards until a bed became available on the acute wards.
- On Ward 2, there were 23 patients on the 22-bedded ward with one patient on overnight section 17 leave. This meant If the patient returned early from leave there may not be a bed available.
- The trust had a lower number of delayed discharges than the England national average. Waiting for non-acute care and housing were the main reasons for patients having their discharge delayed.
- The trust achieved referral to assessment and assessment to treatment targets in all areas other than CAMHS Community Services and CAMHS ASD, which were 136 days and 148 days respectively compared to the target of 126 days for both referral to assessment and assessment to treatment.
- We found excessively long waits in community CAMHS services. Following assessments young people had to wait up to a year for psychological therapy. Children assessed as needing school observation by a staff member were placed on a waiting list for school observation that was up to one year. Following school observation, most young people then had an appointment with a psychiatrist. The wait for a non-urgent appointment with the psychiatrist was two or three months. Many young people first received treatment well over a year after the initial referral.
- Summers View did not promote recovery because the ward was small with no quiet areas for patients to use. Male and female bedrooms are all on the same corridor.

Summary of findings

- Patients told us they found the rehabilitation wards unsettling because other patients were sometimes loud or aggressive.

However

- The trust was above the national average in regard to percentage of patients on CPA who were followed up within seven days after discharge over all 4 quarters of 2014/15, and was at 100% for quarters 1, 3 and 4.
- Some patients told us they felt they would be able to raise a complaint should they have one and were confident that staff would listen to them.
- Learning lessons information was shared with staff through emails and team managers used their team meetings to discuss the learning with their teams. Information was sent out in the trusts newsletter.
- The trusts community learning disability services was outstanding.

Are services well-led?

Requires improvement

We rated North Staffordshire Combined healthcare NHS Trust requires improvement for Well-Led because:

- The trust had risk registers in place and held at different levels of the organisation.We found the review of risks was subjective and not evidence based which meant governace arrangements were not always successfully identifying risks.
- We found that issues that had been raised in previous MHAR visits regarding risk assessments following a sucide 18 months ago had not been addressed.
- We found that morale was variable in the trust. Some staff told us this was because of the changes that had taken place.
- Average sickness rates at the trust were consistently higher than the England average for the past year.
- The trusts staff turnover rate in the past twelve months was 13.74%. Learning disability services had the trust's highest turnover area with over 27%, this related to a time when learning disability services were been decommissioned.
- Over the past three years there has been eight changes of nursing director. This has had an effect on stability and the trusts ability to effectively monitor quality & safety.
- The trust reported that through the Friends and Family Test 69.3% of staff said they would recommend the Trust as a place to receive care. This was below the England average.

However

Summary of findings

- Some staff felt engaged by the trust and had participated in the listening into action process. There had also been a number of staff engagement events and the launch of the Aston leadership programme to improve leadership within the trust. The trust board held senior leadership team meeting every two weeks, alternating with Executive Team meetings.
- The trust had a clear governace framework that tried to drive the quality agenda throughout the trust. Most staff demonstrated to us during the inspection that they understood the governance process and their responsibilities within the process.
- Risk registers were held at board, directorate and team level. Staff were able to raise concerns and those could be added to the relevant risk register.
- Once per month the trust has an engagement day when team brief is delivered and themed meetings are held. Staff at ward manager level and above are invited to the plenary session where the chief executive and chairman both speak.

Summary of findings

Our inspection team

Our inspection team was led by:

Chair: Paul Lelliott, Deputy Chief Inspector of Hospitals (Mental Health)

Team Leader: James Mullins, Head of Hospital Inspection, mental health hospitals, CQC

Inspection Manager: Kenrick Jackson, mental health hospitals, CQCThe team included CQC managers, inspection managers, inspectors, Mental Health Act reviewers, support staff and a variety of specialists and experts by experience that had personal experience of using or caring for someone who uses the type of services we were inspecting.

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

Why we carried out this inspection

We inspected this core service as part of our ongoing comprehensive mental health inspection programme.

How we carried out this inspection

To get to the heart of people who use services' experience of care, 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 visiting, we reviewed a range of information we hold about North Staffordshire Combined Trust and asked other organisations to share what they knew.

We carried out an announced visit between 7th and 11th September 2015. We also carried out an unnanouced visit to the learning disability childrens respite service.

During the visit:

- We held focus groups with a range of staff who worked within the service, such as nurses, doctors, therapists.
- We talked with over 260 staff
- We talked with over 160 people who used services.
- Attended community treatment appointments
- We observed how people were being cared for and talked with over 30 carers and/or family members.
- Reviewed care or treatment records of people who use services.
- We met with people who use services and carers, who shared their their views and experiences of the core service.

We visited most of the trusts hospital locations and sampled a large number of community healthcare and community mental health services.

We inspected all mental health inpatient services across the trust including adult acute services, The older people's wards and specialist wards for people with learning disabilities and children and adolescents. We inspected the trust's place of safety under section 136 of the mental health act and the crisis services.

Information about the provider

North Staffordshire Combined Healthcare Trust provides mental health and learning disability care to people predominantly living in the city of Stoke on Trent and in North Staffordshire. The trust has a staff compliment of

Summary of findings

around 1,250 whole time equivalent (WTE), 1,450 (headcount). They serve a population of approximately 464,000 people from a variety of diverse communities across Northern Staffordshire. The Trust's closing income for 2013-2014 was £87.5m.

The trust services are provided from both hospital and community based premises, operating from approximately 30 sites. The main site is Harplands Hospital, which opened in 2001 and provides the setting for most of the trusts inpatient units. All corporate staff work from Lawton House,the current Trust Headquarters building since December 2012.

The Trust provides the following core services:

- Child and Adolescent Mental Health wards (CAMHS)
- Child and Adolescents community service
- Substance misuse services
- Adult inpatient acute mental health wards
- Adult community mental health services
- Older adult inpatient mental health services
- Older adult community mental health services
- Crisis and health based places of safety
- Long stay rehabilitation wards
- Learning disability wards
- Learning disability community service

What people who use the provider's services say

The majority of patients we spoke with very positive about the staff, and their experience of care on the wards. Patients and their families or carers told us they had the opportunity to be involved in discussions about their care. One person told us that care was 'second to none'.

Most patients receiving a community service were very complimentary about their care and treatment. Patients using the community mental health service told us how happy they were with the treatment they received from staff. Young people in the CAMHS said that staff made them feel listened to.

People receiving care from crisis and home treatment teams told us home visits were usually carried out on time and they had been given good information about the service. They also said they knew how to contact the service when they needed to.

Most people knew how to raise concerns and make a complaint. They felt they would be able to raise a concern should they have one and believed that staff would listen to them.

However:

Carers in the community CAMHS service told us they had concerns about the length of time young people had to wait to be seen once referred.

Good practice

- The trust had piloted ZOKENS. A scheme to monitor staff stress levels during each individual shift. Staff placed a red or green token in a box at the end of a shift to indicate how stressful it had been. Staff are then contacted individually to follow up and offered support as needed. Staff said that it was useful way to reflect upon how individual shifts impacted on stress levels.
- At Dragon square we reviewed some excellent examples of risk assessment and management plans incare records. All were up to date, detailed and fully individualised to the specific needs of each child, such as swallowing, transportation, lifting and handling, self-injurious behaviour and sleeping.
- The community CAMHS waiting list for the specialist paediatric psychology services was short. Young people were seen within two weeks. Sometimes young people were seen the same day. Staff had undertaken evening and weekend work to reduce waiting lists. They were not required to do this.
- Ward 4 operated as a shared care ward and was a good example of how joint working between acute and mental health services could bring benefits and improve outcomes for patients.
- The learning disability intensive support team had developed an electronic clinical pathway that gave

Summary of findings

staff a chronological pathway to follow which contained all the documentation they would need. This allowed staff to plan holistic and patient centered care with access to a wide variety of tools.

- The hearing loss specialist nurse had developed a service to ensure patients with hearing loss had their needs met. They had secured ipads and online apps which provided instant access to signers. Patients experiencing hearing loss would then have access to this service on admission throughout the trust.
- Florence House have adopted a dog with the Dogs' Trust and have regular visits from a therapy dog. This was in response to patient requests.

Areas for improvement

Action the provider MUST take to improve

- The trust must ensure that all relevant care records contain risk assessments that are informed by historical risks of the patient.
- The trust must ensure that the care plans are recovery oriented with the patients strengths and goals evident within them.
- The trust must ensure that a persons relatives or carer's are involvement in the care planning/ management planning.
- The trust must ensure that consent to treatment and information sharing is consistently recorded within the care records.
- The Trust must ensure that staff are appraised on an annual basis and that this is recorded.
- The trust must ensure that individual caseloads within the ICMHT's remain within the guidance of the mental health policy implementation guide for community mental health teams and that teams have adequate staffing provision.
- The trust must adhere to the requirements of the Mental Health Act (1983) Code of Practice (2015) with regards to seclusion. Across the three acute wards, seclusion took place in patients' bedrooms or the annexe in Ward 1. None of these rooms fitted the criteria for a seclusion room according to the Code of Practice. The review logs did not indicate when reviews should take place, nor highlight which professionals were required at each stage of the review. This was not in line with the Code of Practice. The paperwork did not include the setting where the seclusion was being managed.
- The trust must ensure all ligature risks are undertaken and there is action to reduce those identified ligature risks 1.
- The trust must ensure informal patients are aware of their right to leave the ward and that there is appropriate legal authority in place if staff prevent informal patients from leaving.
- The trust must ensure all staff adhere to current legislation and guidance on Control of Substances Hazardous to Health Regulations (COSHH) when cleaning up bodily fluids.
- The trust must ensure that there are sufficient numbers of staff in CAMHS community services.
- The trust must ensure that equipment are calibrated regularly.
- The trust must ensure that all children and young people have a risk assessment with an appropriate risk management or safety plan.
- The trust must ensure that all staff receive the appropriate safeguarding training to the required level.
- The trust must ensure that all young people have a care plan that is specific, detailed and personalised. The plans must address all of the young person's needs and record their views.
- The trust must ensure that clinical records are complete, comprehensive and are available to staff who need them.
- The Trust must ensure that outcome measures are used consistently so that the effectiveness of services can be assessed.
- The trust must ensure that all young people are able to have an assessment and access to diagnostic or treatment interventions, in a timely manner.

Summary of findings

- The trust must ensure that all buildings operating CAMHS services are suitable for their use.
- The trust must ensure that all staff have a good understanding of the Mental Capacity Act and how it is used for patients in their care.
- The trust must ensure that there are robust physical risk assessments and physical health management plans in place for all patients.
- The trust must ensure that all incidents are recorded correctly and when errors in care are made they follow the trusts Being Open policy.

Action the provider SHOULD take to improve

- The trust should ensure that all staff who undertake home visits do so in line with the trusts lone worker policy.
- The trust should reviews staff mix on wards, especially male only and female only wards to ensure dignity and privacy at all times.
- The trust should make information available to detained patients about to contact CQC in order to complain.
- All staff have a good understanding of the MCA and consent when treating patients.
- All nursing staff should undergo medicines management training.
- The trust should ensure that there is an effective system in place to assess the risks to young people whilst they are waiting for assessment or treatment.
- The trust should ensure that a record of supervision is maintained.
- The trust should ensure that all appraisals record staff members' progress, development and performance.

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.

The trust had systems and processes in place that was monitored and audited by the mental health act office to ensure good application of the mental health act and the MHA code of practice. We found that most patients had received their rights under section 132 of the mental health act and that staff regularly repeated this information.

MHA paperwork was regularly monitored and we found most of the paperwork we looked at was correctly completed. Patients had been given copies of their section 17 leave authority and were clear about the type of leave that was being authorised with the number of the escorts required.

Information was displayed throughout the trust informing patients of how to contact the independent mental health advocate (IMHA).

Most staff had received training in the MHA and those staff we talked to had a good understanding of the mental health act and how to apply it in their work with patients.

Mental Capacity Act and Deprivation of Liberty Safeguards

Most staff we met and spoke to had a clear understanding of their responsibilities under the MCA and DoL safeguards. However we found that staff in the CAMHS wards did not demonstrate good knowledge and understanding of the MCA.

Most wards had when needed had made appropriate DoLS applications. We saw that best interest assessments had taken place for patients who lacked capacity.

Requires improvement

Are services safe?

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

Detailed findings

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

Summary of findings

Our findings

Track record on safety

- The trust reported a total of 2,715 incidents to National Reporting and Learning Systems (NRLS) between 1 April 2014 and 11 May 2015.
- The majority of incidents resulted in no harm (66.2%) or low harm (27.3%) to the patient. A total of 5.1% of incidents resulted in moderate harm and 0.5% resulted in severe harm.
- There were 26 National Reportiing and Learning Systems incidents categorised as deaths during the period which accounted for 1.0% of all the incidents reported.
- 61 incidents were reported to STEIS (Strategic Executive Information System) between 1 April 2014 – 11 May 2015. 33 of these involved the death of a patient. The trust reported there were no never events. The top three incident types reported were the 18 unexpected death of community patient in receipt of care. 13 suspected suicides and six falls.
- 41 Serious Incidents Requiring Investigation (SIRI) were reported by the trust. 36 concerned unexpected deaths and five involved ward closures.
- All unexpected deaths took place in the community apart from one who died of natural causes on Ward 6, Harplands.
- Inpatient services had systems in place to ensure equipment was serviced and electrically tested. Equipment was labelled with testing dates which were current. Generally we found necessary equipment to carry out physical examinations.

Learning from incidents

- The trust had a system in place to capture incidents and accidents and to learn from them when things went wrong. Staff were able to explain the process they used to report incidents through the trust's reporting systems.
- Staff were aware of how to complete incident forms and their responsibilities in relation to reporting incidents. Some staff told us that where they were not confident in using the online system but they could get support to report incidents.
- An on-line incident form was completed on the trusts incident reporting system following any incident. Managers and governance leads reviewed incidents weekly. All incidents were reported to the Clinical Safety Improvement Group led by the medical director.
- A Clinical Quality Review meeting chaired by the medical director reported to the trusts Quality Committee on all serious incidents and complaints. All serious incidents were reported to the trust board with themes considered quarterly.
- Monthly updates via email from the trust safety lead called 'learning lessons' were sent to all staff. Lesssons learned were discussed weekly in the team meetings and monthly governance meetings.
- Following incidents de-brief sessions were offered to all staff. Some wards had appointed de-brief leads to take the lead in organising the de-brief sessions.

Safeguarding

- The trust had policies in place relating to safeguarding and raising concerns, (whistleblowing procedures). Additional guidance was available to staff via the trust's intranet. We were told that the trust's internal and the local authorities' safeguarding teams were also accessible and available to staff for additional advice.
- Managers and staff told us of occasions where they had raised urgent issues of concern. We heard about a number of positive actions as a result of this.
- Safeguarding training requirements were set out in line with the specific role undertaken by staff. 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. Most staff were able to describe situations that would constitute abuse and could demonstrate how to report concerns.
- A governance process was in place that looked at safeguarding issues at both a trust and at directorate levels on a regular basis.

Assessing and monitoring safety and risk

- The trust had an assurance framework to provide the Trust Board with a tool for the management of the risks that threaten the delivery of their Principal Objectives.
- The trust maintained a corporate risk register which takes risks that are scored above 12 each risk has an identified executive lead with timescales for completion of identified actions.
- Risk registers were also in place at service and clinical directorate level. Risks with a score of 8 to 12 are maintained by the directorate. These were monitored through the clinical directorate meeting. Scores below 8 are managed a team level. The mitigation for risks and the process for reviewing scores is subjective and not evidence based.
- Ligature risks are scored at 10 and so is held at clinical directorate level therefore there is no corporate level ligature risk assessment.
- The new Associate Director of Governance has already carried out a root and branch review of risk management processes and training was ongoing.
- Board meeting and assurance committee minutes confirmed that corporate and high level or emerging risks were discussed on an ongoing basis.
- We looked at the quality of individual risk assessments across all the services we inspected. Risk assessments were undertaken on admission and updated regularly. In the substance misuse service risk assessments were not always completed. Risk assessments in the health based place of safety were not fully completed.
- The home treatment team did not complete any risk assessments when patients were referred to them from other teams. The risk assessments received from other teams were not updated even when patients needs had changed.
- In the older people's community teams we found 80% of patients had a risk assessment but 50% if those assessments were not up to date.
- In the CAMHS risk assessments for young people using the services were not always completed. At CONNECT and First Steps (Stoke) 51% of young people did not have a risk assessment.
- In the in-patient CAMHS we found that one patient with low body weight had not had appropriate monitoring or their physical health.
- Staff in the community mental health teams undertook risk assessments of patients on the teams caseload but that these were not always regularly updated.
- On the older adults wards risk assesments were completed for every patient on admission and updated regularly after every incident**.**
- The trust undertook an annual programme of environmental health and safety checks that included ligature risk assessments as part of this programme.
- We found that there were minimal ligature points on most wards and where necessary measures were in place to minimise the risk to patients, including the use of nursing observations. Generally staff were aware of the risks to patients' safety caused by the environment and had increased patients observation levels as needed.
- However, in acute wards there were some ligature risks which we highlighted on the visit that had not been previously noted. At the time the trust took the appropriate action and added these to their risk register.
- In learning disability services ligature risks were mitigated by staff observation, risk assessment and care planning. However, staff told us that the increased observation levels affected the time they had to spend with patients.
- The trust had an observation policy in place. Generally staff were aware of the procedures for observing patients. Ward managers confirmed that they were able to request additional staff to undertake observations.

Potential risks

- Systems were in place to maintain staff safety in the community.
- The trust had lone working policies and arrangements.
- Most staff in community teams told us that they felt safe in the delivery of their role. However, for staff in the home treatment and crisis team risk assessments were not completed for home visits and they did not have equipment to ensure their safety.

Duty of Candour

- There was recognition from most staff members that further work was required in relation to the Duty of Candour. Duty of candour information was available at hospital sites, but there was no evidence of policy.
- Incidents are reviewed at the Weekly Incident Review meeting to explore whether action is required in relation to Duty of Candour.

- Staff in the acute wards for working age and psychiatric intensive care units had a good knowledge of the Duty of Candour and were able to give examples when it had been applied.
- Where a mistake had been made in the recording of a patients body mass index (BMI) there was no evidence that the trust had informed the patient or their family.

Safe and clean environments

- 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.
- On the majority of 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. However in the CAMHS the female only bathroom was accessed via the mixed gender games room. Staff mitigated this by allocation of the en-suite rooms and closing the rooms at times. The staff were using a draft protocol to manage the female bathroom issue.
- Fire procedures and equipment were in place at all services. Staff had received fire safety training, and were aware of what to do in an emergency.
- Infection control is overseen by the risk review group within the trust. Staff received infection control practice as part of mandatory training. We found good levels of completion for this training. Regular trust-wide cleanliness audits were undertaken.
- Infection control procedures were being followed by most staff. Hand gels and other equipment was readily available and in use. There was information available to patients and families around good practice and advice to prevent the spread of infection. Most inpatient services were found to have hand-washing facilities readily available and we observed staff adhering to the trust's policy.
- The trust had performed better than the national average with regard to its overall score for cleanliness (99%) and condition, appearance and maintenance of the environment (95%) in the patient-led assessment of the care environment (PLACE) programme. Services were clean and most were well maintained. Patients were happy with the standards of cleanliness.
- All clinic rooms we visited appeared clean and most were fit for purpose. Equipment was checked regularly to ensure it was in good working order so that it could be used in an emergency.

Safe staffing

- The trust reviewed staffing levels for all inpatient areas. The trust's monitors and reports on shift fill rates for the wards. In the open trust board minutes for March 2015 the shift fill rate was 93.8 % for registered nurses. A total of 284 shifts between 1st to 28th February were not filled as planned however It was noted that ward managers had been able to maintain safe staffing levels.
- At the time of our inspection in September 2015 we found that staffing was generally sufficient on the wards. However, we found that some wards, particularly in CAMHS, were using very high levels of bank and agency staff to minimise the risk to patients.
- Staff and patients on the wards for people with learning disabilities reported that there was not always sufficient staff and this had a direct impact on activities and patient's leave.
- The trust acknowledged challenges regarding recruitment and retention and told us that they are working hard to address this issue. We saw detailed action plans and positive information about recruitment initiatives. We found that staffing levels had improved for a number of teams.
- In relevant services the trust used specific dependency tools to evaluate the number of staff required to ensure the service was safely staffed. Ward and team managers confirmed that processes were in place to request additional staff where required.
- Medical cover was generally acceptable across most inpatient and community services. However in CAMHS services were not safely staffed. There were not enough consultant psychiatrists, nurses, psychologists, or therapists. We found that staff on maternity or long term sick leave were not replaced by temporay staff. The number of psychiatrists did not match the levels recommended by the royal college of psychiatrists for the size population covered by the CAMHS service.
- The trust required staff to attend a variety of mandatory training courses. These included courses in basic life support, medical emergency response, observation of service users, fire safety, safeguarding, Mental Capacity

Act, physical intervention and people moving and handling. Training records showed that 87% of staff had attended their mandatory training. It was noted that the trust did not offer mandatory training in the MHA.

Medicines management

- The trust had a well-established pharmacy team that provided good clinical services to ensure people's medicines were handled safely. The pharmacy team were actively involved in all aspects of a person's individual medicine requirements from the point of admission through to discharge. Pharmacists visited wards to check people's medicine records and were also involved in multidisciplinary team meetings to discuss people's medicine requirements. Any concerns or advice about medicines were written directly onto the person's medicine records. Nursing staff told us that the pharmacy service was essential for medicine safety and if they had any medicine queries they had access to pharmacist advice at all times.
- In response to the NHS England and MHRA patient safety alert: Improving medication error incident reporting and learning (March 2014) the trust had appointed a Medicine Safety Officer (MSO). Arrangements were in place to ensure that medicine incidents were documented and investigated. The learning from medicine related incidents was shared with staff via staff team meetings. The pharmacy team also undertook monitoring of any changes to ensure safe practice continued. In particular the pharmacy team had recently undertaken an audit of missed doses where people had not been given their medicine. This identified the need for nursing staff to be careful to document the reason why a medicine was not given.
- Arrangements were in place to check that medicines were stored securely and within safe temperature ranges (except for Acute Home Treatment Team).
- Medicine management training was provided by the pharmacy team for junior doctors and nurses. However, the medicine management training for nurses was not mandatory and was not always well attended.
- When people were detained under the Mental Health Act (1983) we saw that sometimes all the correct legal documentation for treatment for mental disorder was not completed accurately. We further found that the necessary checks/scrutiny of the treatment documentation to ensure safe and legal prescribing were not always being undertaken. (except on Learning Disability where they were checked)

Requires improvement

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 and delivery of care and treatment

- The trust proportion of admissions to acute wards gate kept by the CRHT Team was 100% for the first three quarters for 2014/2015 but fell in the last quarter. However, they were above the England average for the entire year.
- The trust's National Audit of Prescribing for people with personality disorder results demonstrated:-
  - Availability and uptake of psychological therapies was below average for the trust from case record data. Service user report of receipt of such therapies was around average.
  - Monitoring of most Physical Health risk factors, intervention for Physical Health Problems and prescribing practice was around average for the Trust.
- The majority of care plans were not personalised and did not include patients' views. They did not cover the full range of patients' problems and needs. For example, In the learning disabilities service one set of care plans were not dated or signed by either staff or patient. The information in the plan was vague and there was no evidence that it had been reviewed. Most patients had not been given a copy of their care plan.
- Some information was missing in many of the S136 records we reviewed. This included patients social and family history. Physical health checks were completed and where needed ongoing healthcare was provided.
- In-patients had a physical healthcare check completed on admission and their physical healthcare needs were being met. Physical health examinations and assessments were documented by medical staff following the patient's admission to the ward. Ongoing monitoring of physical health problems was taking place. Most patients had a care plan that showed staff how to meet these physical healthcare needs.
- Children admitted for treatment of low weight/eating disorder should receive regular monitoring of weight and other physical indices in accordance with Management of really sick Patients under 18 with Anorexia Nervosa (MARSIPAN) guidelines. We did not find this to be the case.
- There was a variety of information systems in use across the trust. Some information was duplicated between paper and computerised health records. In the LD community services, the consultant psychiatrists kept a separate set of notes to those used by the rest of the team.

Outcomes for people using services

- Between October 2014 and March 2015 there were 80 delayed discharges across the trust in eight locations. Ward 1(10) Ward 2 (11) Ward 3 (16) Ward 4 (03) Ward 5 (02) Ward 6 (21) Ward 7 (16) and Assessment and Treatment (01)
- Between October 2014 and March 2015 there were 91 re-admissions within 90 days on 6 wards. Ward 2 (43), Ward 3 (25) and Ward 1 (15) had the highest number.
- Outcomes for patients using the services were monitored and audited by the trust. This included the monitoring of key performance indicators such as length of stay, the use of control and restraint, and rapid tranquilisation. However, it was not clear what actions had been taken by the trust as a result of these audits.
- There was a range of psychological interventions available. For example, we saw that psychologists were an integeral part of the learning disability in patient ward teams but when they were absent due to illness they were not replaced.
- Community based staff were using the '5 W's (who, what, when where and why) methodology as a focus on measuring outcome and recovery for people who used the community team mental health services.
- Regular audits were carried out across the trust. An example saw band 6 nurses rotating across wards to audit casenotes.
- The Learning disability teams helped patients to access the education systems and to find work opportunities using their skills and knowlege.

Requires improvement

Are services effective?

Staff skill

- From May 2014 to April 2015 the trust achieved a compliance rate of 87% with staff mandatory training against their target of 95%.
- There was a variety of mandatory training available for staff. This included courses in managing acutual and potential aggression (MAPA), safeguarding adults, health and safety and information governance.
- New permanent staff underwent a formal induction period. This involved attending a corporate induction, learning about the trust and trust policies followed by a period of shadowing existing staff before working alone. A number of student nurses told us of a well-structured and in-depth mentorship programme. Mentorship is a personal developmental relationship in which a more experienced or more knowledgeable person helps to guide a less experienced or less knowledgeable person. Most of them wanted to work in the trust post qualifying.
- Staff described receiving support and debriefing from within their team following serious incidents.

Multi-disciplinary working

- Professional leadership has been weakened by the redesign of directorates, reducing professional leadership within the directorate and limiting the professional influence at senor executive level.
- There is no nursing or allied health professional (AHP) voice in clinical directorates as these are medically led.
- There was a perception among nurses that they are not valued, especially amongst learning disability nursing staff.
- The redesign has also reduced the allied health professional focus. Several who are from these professional backgrounds are working in generic/non-professional specific roles.
- We found through focus groups and interviews that the prolonged interim nature and inconsistency in the nursing director role has impeded and negatively impacted on the AHP voice and influence within the Trust, with respect to redesign/change/planning.
- We found that care programme approach (CPA) meetings were scheduled for patients and all involved in the patients care were invited to attend.
- Handover meetings took place throughout the trust which enabled staff to share information about patients and review their progress. We saw good example of handover in the acute wards. They were structured and with handover forms completed with good information for staff coming onto the ward to use.
- Team meetings took place which were attended by a range of qualified and unqualified nursing staff, managers and activities co-ordinators. A range of issues were discussed that included staffing levels, patient concerns, debriefs from incidents and health and safety audits.
- Minutes were produced for those meetings and they provided a record of the meetings but allowed staff not present to read up on the issues discussed.
- In the teams that had a range of professionals we found they worked together effectively to assess and plan patients' care and treatment. There was appropriate sharing of information to ensure continuity and safety of care across the trust.
- The NHS staff survey showed us that the trust came within the bottom 20% of mental health trust in England for recommending the trust as a place to work.

Information and Records Systems

- The trust had a information govenance policy but we found that the content was out of date and had not received an annual qualitative review. Some documentation reviewed during the inspection did not contain the trust header. Senior managers did not know when the policy was going to be reviewed and did not show any urgency despite the vulnerabilities of not having a live policy. This was not on the trust's risk register.
- The trust did not tell their patients who they shared info with and how their information was held. However, in inpatient areas they have a confidentiality statement built into the pathway but they were not always completed.
- The trust shares information with social services and that information is entered onto social care systems. This presents a risk for the Trust because patient do not know their information is shared with social services.
- Standard record-keeping structures exist but is followed to varying levels. There is a section in the structure for incidents to be recorded, but no incidents were seen in this section. The litigation authority has asked that incidents are not put in records, so this section should be removed.

Requires improvement

Are services effective?

- Primary patient information was a paper-based system, but the risk is mitigated by the scanning of records and the use of a patient tracking system. Information governance managers were not aware of the need to have standards in place for scanning and therefore records may not be legally admissible.

Consent to care and treatment

- Mental health act training was provided to clinical staff. This training was combined with the mental capacity act and deprivation of liberty guidelines. Training was based on the trusts policy for mental capacity act and deprivation of liberty safeguards.
- There was evidence that patients had been given information about their rights under section 132. However we found in the rehabilitation service that patients had the information given every two months without any explanation why that time period rather than monthly.
- Independent advocacy was provided for patients throughout the trust. We saw contact information for the advocacy service on display across the trust for patients to contact them if they wanted assistance. Patients rights were on display on notice boards.
- The trust had made 41 Deprivation of Liberty Safeguards application between October 2014 and March 2015. The highest level of application was from the older adults Harplands hospital, with the highest application from Ward 6 (14) Ward 4 (17).
- The mental health act team monitored the use of the mental health act and the application of the mental capacity act across the trust.

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

Dignity, respect and compassion

- The trust's overall score during their patient led assessment of the care environment assessments for dignity, privacy and respect was 100%, which was better than the England average of 87%.
- The trust scored 100% for ward food; except at Harplands hospital.
- Results of the Friends and Family test showed 69.3% of staff would recommend the trust as a place to receive care (Quarter 4 2014/2015). This score was below the national average for similar mental health trusts.
- The CQC's Community Mental Health Patient Experience Survey showed the trust scored the same as other mental health trusts.
- We observed examples of staff treating patients with kindness, compassion and communicating effectively. We saw staff engaging with patients in a kind and respectful manner throughout the trust. For example, on the acute wards and PICU staff managed patients in a calm and responsive way and supported them with the issues affecting them. Staff demonstrated good personalised care that was not always reflected in their care plans.
- We saw patients felt comfortable approaching the ward office and we saw positive interactions between the staff and patients. We observed staff knocked before entering patients' rooms, and speaking positively with patients.
- In the CAMHS community service the majority of young people said they were able to trust staff and that staff listenened to them.
- Some patients felt that they did not receive appropriate one to one time with their named nurse because they were sometimes too busy to spend time with them.
- Individual feedback from the completed comment cards during the inspection was mixed.

Involvement of people using services

- Most patients and their carers told us that they were orientated to their ward on admission. and were shown around by staff. They had received information leaflets relating to the trust. Welcome pack for patients was available in most wards that contained information to help patients orientate and provide them with information they might need whilst in hospital. The learning disability services provided their information pack in an easy read format to help explain about the ward and the facilities it provided. It also contained information about advocacy and how to make a complaint.
- We received mixed feedback from patients about their involvement in the care they receive. Documented evidence of patients having input to their care plans was inconsistent. However some patients told us they were consulted about their care plans and felt involved in their care. Patients in the rehabilitation service told us they were always offered a copy of their care plan.
- Information was displayed on the wards about advocacy services and specifically the Independent Mental Health Advocacy (IMHA) service for patients detained under the MHA. Staff were familiar with the role of advocates and they knew how to contact them on behalf of patients. Some patients we spoke to had accessed the advocacy services.
- Patients told us they had opportunities to keep in contact with their family where appropriate. Visiting areas were in place. Special arrangements were in place for child visitors.

Requires improvement

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

Planning and delivery of services

- Information received from the trust showed that nine out of 13 wards at the trust had bed occupancy above 85% for the year. However beds, in learning disability and mental health, occupancy had consistently been below the national average for the last 12 months. But occupancy levels for both increased in Quarter 4 of 2014/15, according to NHS England figures.
- We found evidence that bed occupancy was consistently more than 100% in the last five months in the three adult acute wards. From July 2015 Ward 1 had five cases of patients admitted out of area when the ward was full. High bed occupancy also meant that on occasions, some patients were required to 'board' on older people's mental health wards until a bed became available on the acute wards.
- On Ward 2, there were 23 patients on the 22-bedded ward with one patient on overnight section 17 leave. If the patients returned early from leave there may not be a bed available, staff told us in these instances patients would have to sleep on other wards.
- The trust was above the national average in regard to percentage of patients on CPA who were followed up within seven days after discharge over all 4 quarters of 2014/15, and was at 100% for quarters 1, 3 and 4.
- The trust has consistently had a lower number of delayed days than the England national average. The number of delays peaked in March 2015 but began to rise again in May 2015.The main reasons for both patient delays and days delayed over the past 12 months were waiting for non-acute care and housing.
- The trust achieved referral to assessment and assessment to treatment targets in all areas other than CAMHS Community Services and CAMHS ASD, which were 136 days and 148 days respectively compared to the target of 126 days for both referral to assessment and assessment to treatment.
- We found excessively long waits in community CAMHS services. Following assessments young people had to wait up to a year for psychological therapy. Children assessed as needing school observation by a staff member were placed on a waiting list for school observation that was up to one year. Following school observation, most young people then had an appointment with a psychiatrist. The wait for a non-urgent appointment with the psychiatrist was two or three months. Many young people first received treatment well over a year after the initial referral.

The service environment optimises recovery, comfort and dignity

- The trust's overall score during their patient led assessment of the care environment assessments was better than the England average for other similar trusts for cleanliness and condition and appearance and maintenance.
- The trust score for food was above the England average for similar trusts.
- Activity coordinators were available across wards. In the learning disability service activity coordinators organised activities during the working week whilst activities were provided by nursing staff at weekends.
- The environment on Summers View did not promote recovery. The ward was small with limited space with no quiet areas for patients to use. We found the ward that male and female bedrooms are all on the same corridor. The ward was noisy and unsettled much of the time. Patients told us they found the ward unsettling because other patients were sometimes loud or aggressive. Patients had keys to their bedrooms and were able to personalise them.
- In the older adults wards there was a good range of communal rooms that enabled patients to interact and to participate in a variety of activities, or spend time in quiet areas. Corridors and rooms were light, airy and spacious.

Learning from concerns and complaints

Requires improvement

Are services responsive to people's needs?

- There were leaflets on notice boards advertising the Patients Advisory and Liaison service, (PALS) and the Independent Mental Health Advocates (IMHA) service with contact details.
- 55 complaints were received by the trust In 2012/13. In 2013/14 there was slight increase to 57 but the number that was upheld remained the same. All aspects of clinical treatment was the most common complaint category in both 2012/13 and 2013/14, although this reduced in the second year compared to the first.
- 65 formal complaints were made in the 12 months to 31st March 2015. 16 of these were upheld. The hightest number of complaints concerned home treatment Team (Moorlands) and Integtated Community Mental HealthTeam (City) Sutherland Centre.
- Most patients and carers knew how to raise concerns and make a complaint. Some patients told us they felt they would be able to raise concerns should they have one and were confident that staff would listen to them.
- We saw staff receiving a complaint from a patient in the learning disability service. They took details of the complaint and reported the concerns in line with trust policy. At the Darwin centre patients told us they knew how to complain and would if they need to. We saw that some complaints were dealt with in community meetings or by the modern matron.
- The majority of carers in the community CAMHS said that they did not know the complaints procedure. They said they would approach staff with their concerns if they had them. Many of these concerns held by carers involved waiting times for assessment or treatment. We saw concerns were dealt with informally by the service managers. There was no system for monitoring concerns of young people or carers. This meant possible themes or trends were not always identified. The CYP directorate was planning to monitor concerns from young people and carers.
- Learning lessons information was sent out by emails to staff, they were shared and discussed by ward and team managers in local meetings and shared within the trusts newsletter.

Requires improvement

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 a high quality health and social care provider that continuously improved patient experience and deployed its resources intelligently and efficiently.
- The trust's values were 'Valuing people as individuals, providing high quality innovative care, working together for better lives, openness and honesty and exceeding expectations'
- The trust had four quality goals. Services will be consistently safe. Care will be personalised to the individual needs of service users. Processes and structures will guarantee access to services for service users and their carers and focus will be on the recovery needs of those with mental illness.
- The trust's vision and values were on display in the trust and were available on the trust's intranet. However, there was an inconsistent level of front line staff's knowledge and awareness of the trust's vision and strategy.
- In Spring 2014 Listening into Action was launched, as well as staff engagement events and the launch of the Aston leadership programme. There were senior leadership team meeting every two weeks, alternating with Executive Team meetings, which had a focus on strategy.
- Senior staff within the trust had visited some wards and community services. These included the chief executive and non-executive directors. Staff in the community CAMHS told us the chief executive had recently visited their services.
- Whilst, trust board members interviewed were clear about the trust's vision and strategy. Some senior clinicians were unclear about their role in influencing the trusts direction. They felt supported but were unsure of the direction the trust was heading in.

Good governance

- The trust had a board of directors who were accountable for the delivery of its services and assuarance through its governance systems for the quality and safety of the trust. There were a number of committee that reported to the board. These were audit, finance and performance, quality, remunerations, risk management, charitable funds and people and culture. These committees all had terms of reference and a clear membership with decision making authority.
- The trust managed quality governance through the quality committee. The committee monitored all quality, safety, safeguarding, mental health law and patient experience / complaint issues. The committee drove the quality agenda informing progress against quality metrics and assurance on risk treatment plans, CQC compliance, reports and action plans. The lead for quality at board level is the medical and nursing director.
- The trust had an integraged board assurance framework and risk register that it reviewed regularly. Risk registers were also in place and held at different levels of the organisation which were reviewed at directorate meetings. The review of risks was subjective and not evidence based which meant governace arrangements were not always successfully identifying risks.
- At the inspection we found that most of the board members had a good understanding of the issues faced by the trust in delivering services. The board held staff to account whilst allowing the executive team to manage the delivery of services.
- The Clinical Quality Review meeting reports regularly to the Quality Committee on complaints and incidents. All serious incidents are considered by the Board, with themes considered quarterly. The Clinical Safety Improvement Group led by the Medical Director looks at serious complaints. Incidents are monitored weekly and evaluated if necessary. Themes go into learning lessons bulletins, or weekly briefing. Quarterly learning lessons events are held.
- Most staff demonstrated they were aware of the governace process and their responsibilities. Some staff

told us they had access to performance information and meeting minutes. Staff said they were able to escalate risks through the team and directorate structures and they would be placed onto the directorates risk register.
- We found that issues that had been raised in previous MHAR visits regarding risk assessments following a sucide 18 months ago had not been addressed. The trust had agreed to look at the risk assessment tools used by staff to reduce the risk of suicide. At this inspection we found the management of risk training for staff is focused on environmental risks and not on assessing suicidal intent.

Leadership and culture

- Morale was found to be variable in the trust and some staff told us this was because of the changes that had taken place. Some staff felt engaged by the trust and had participated in the listening into action process. Staff told us that the chief executive and senior directorate managers were visible. Staff in Darwin ward told us about the senior managers responding to their request for attendace to discuss concerns that they had had.
- Average sickness rates at the trust have been consistently higher than the England average for the past year. Most core services finished the financial year with a staff sickness of 3-5% except adult in-patients which was has the highest staff sickness. There was an increase in staff sickness for learning disabilities between June 2014 and February 2015 to over 9%. There was a staff turnover rate in the trust of 13.74%, this was highest in the learning disability service of over 27%. Over the past three years there has been changes of nursing director five times.
- In the 2014 NHS staff survey, the trust scored better tha the average for two key measures. These were receiving job related training/development in the past 12 months and receiving health and safety training in the past 12 months.
- The trust scored worse than the national average and were in the worse 20% of trusts nationally in nine areas. These included feeling satisfied with the quality of work and patient care they are able to deliver and reporting good communication between senior management and staff.
- The trust used the Friends and Family Test to consider staff's vews. 69.3% of staff would recommend the Trust as a place to receive care (Q4 2014/2015). This was a decrease of 1.7% and below the national average.
- Most staff told us they knew their immediate senior managers and most felt they had a good working relationship with them. Most staff was aware of the directorate management structure and felt supported by them.
- During the inspection we saw that three of the executive director posts were interim appointments. The trust has now recruited to the director of nursing, Director of finance and director of strategy posts substantially.
- Staff were aware of ther role in monitoring concerns and assessing risks. They were aware of how to report concerns to their line manager and said they would be supported.
- The trust had embarked on the Aston leadership programme. The feedback from staff was positive and that they had seen an improvement in team cohesion as a result of the training.
- Each Executive Team member shadows monthly at Directorate level. The chief executive also makes random visits weekly and publishes a weekly blog.
- The first Wednesday of the month is engagement day. In the morning there is a general team brief, then in the afternoon a team brief to corporate areas, followed by a plenary based around a theme and subsequent discussion. All Trust staff at ward manager level and above are invited to the plenary. Both the chair and chief executive speak.
- The chief executve also runs a "Dear Caroline" system which staff can email anonomously with concerns.

Fit and Proper Person Requirement

- In November 2014 a CQC regulation was introduced requiring NHS trust to ensure that all directors were fit and proper persons. The trust had checked that all senior staff met the requirements and had set up procedures and polices to ensure that future senior staff have had the relevant checks.

Engaging with the public and with people who use services

- The trust has engaged with service users and carers in the clinical pathways. As a result a service user and carer council developed. By the time of our inspection there

had been two meetings of the user and carer council. We heard from service users that it was early days but they are aware that the chair of the council will sit as part of the trust board.

- Each directorate managment team now had a carer and user representative as part of the core managemen group.
- Service users told us they had been part of the listening into action initiative. Some of the ideas they had put forward through listening into action had happened such as 'softer toilet paper' and an activities coordinator had been appointed resulting in service user now having a choice of activities.
- We saw that the trust had commenced involving service users in the interview panel for new staff.
- The trust has appointed a patient engagement lead to develop patient engagement strategy and ensure patients and carers are at the heart of the trusts values.
- The feedback received from focus groups held with patients and was mixed. Some people were happy with the support offered by staff whilst others felt that care delivery was unsatisfactory and communication with was poor.
- Most inpatient services held ward meetings to engage patients in the planning, delivery of the service and to receive feedback. Patients were able to raise concerns in these and told us that they felt involved.

Quality improvement, innovation and sustainability

- The trust had participated in some national mechanisms for quality improvement. Accreditation for Inpatient Mental Health Services (AIMS) identifies and acknowledges wards that have high standards of organisation and patient care and supports and enables others to achieve these. Wards 1, 2 and 3 at Harplands Hospital, have been re-accredited for a further four years, with Ward 2 being accredited as 'excellent'.
- The two rehabilitation wards had achieved AIMS accreditation for the quality of standard of care delivered by the service.
- Darwin centre participates in the quality network inpatient CAMHS (QNIC) review cycle. They have not met the required standards because there was no provisionfor occupational therapy and limited access to psychology.
- The learning disability service had developed Intensive Support Team (IST) as a specialist multi-professional health and social care team focused on providing assessment, support and treatment to adults who had a learning disability and complex needs. This included people with severe challenging behavior, autism and mental health needs. The team supports people who are approaching crisis and may require an admission to learning disability bed based services. They also support people during the transition from the Trust's assessment and treatment service to home.
- The acute wards had introduced non-medical nurse prescriber roles to support the medical staff and this had improved patient care by reducing waiting time for treatment or review by doctors.
- Development of a psychiatric intensive care unit (PICU) has been approved by the business case and the trust have the capital to provide this facility.

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 9 HSCA (RA) Regulations 2014 Person-centred care Regulation 9: HSCA (RA) Regulations 2014 Person-centred care · North Staffordshire Combined Healthcare Trust must ensure that the care and treatment of patients must be appropriate to meet their needs and reflect their preferences. Patients did not have care plans that were up to date, personalised, holistic or recovery orientated. Patients did not actively participate in care planning, care reviews and did not have copies of their care plans. Health checks were not carried out and physical health needs were not monitored. the trust did not have regular and effective multi-disciplinary team meetings taking place. Regulation 9 (1) (a,b,c) (3) (a, b,c,d,e,f)

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 10 HSCA (RA) Regulations 2014 Dignity and respect Regulation 10: HSCA (RA) Regulations 2014 Dignity and respect · The assessment details did not address areas of disability or sexual orientation needs of individuals. · The management of potential risk from ligature points in the 136 suite did not respect patients privacy and dignity.

This section is primarily information for the provider

Requirement notices

· All sleeping and bathroom areas should be segregated and patients should not have to walk through an area occupied by another sex to reach toilets or bathrooms. Separate male and female toilets and bathrooms should be provided

Regulation 10 (10) (2) (a) (c)

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 11 HSCA (RA) Regulations 2014 Need for consent Regulation 11 HSCA (RA) Regulations 2014 Need for consent · The trust must ensure that capacity to consent has been assessed prior to treatment being given · Staff had limited understanding of the principles of the mental capacity act and how they apply to young people above the age of 16. Regulation 11 (1) (3)

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 Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment · Patients did not always have robust risk assessments and management plans that were updated as their needs changed to mitigate risks. · Staff did not receive appropriate training , supervision and support to enable them to carry out their duties · The trust had not taken proper steps to ensure that each person using the service was protected against the risks of receiving care or treatment in premises that was unsafe

This section is primarily information for the provider

Requirement notices

· The trust did not have appropriate arrangements for the safe management of medicines. Controlled drugs were not stored in accordance with guidance for controlled drug storage.

Regulation 12 (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 13 HSCA (RA) Regulations 2014 Safeguarding service users from abuse and improper treatment Regulation 13 HSCA (RA) Regulations 2014 Safeguarding service users from abuse and improper treatment · Service users were not protected from abuse and improper treatment, and systems and processes were not operated effectively to prevent abuse of service users. All staff were not trained to level three safeguarding children. · The trust must ensure there is appropriate legal authority in place if they prevent informal patients from leaving the ward Regulated 13 (1) (2) (5

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 15 HSCA (RA) Regulations 2014 Premises and equipment Regulation 15 HSCA (RA) Regulations 2014 Premises and equipment · The trust must ensure that appropriate warning notices are displayed where oxygen cylinders are stored · Equipment provided in the community for the storage of medication must be properly maintained · Premises used by the trust must be suitable for the purpose for which they are being used. Regulation 15 (1) (e)

Regulated activity	Regulation

This section is primarily information for the provider

Requirement notices

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 Regulation 17 HSCA (RA) Regulations 2014 Good governance · The trust must ensure that patient records are organised and easily accessible and that risk management plans and care plans are regularly reviewed and updated · The trust must ensure that they assess, monitor and mitigate risks relating to health, safety and welfare of service users and others who may be at risk from ligatures in its buildings · The trust did not have robust systems and methods to effectively assess and monitor that the service is performing well around quality and safety Regulation17 (1) (2) (a,b,c)
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 Regulation 18 HSCA (RA) Regulations 2014 Staffing · The trust must provide sufficient and suitably qualified competent skilled and experienced person in order to meet the needs of patients and the trusts regulatory obligations. · The trust must ensure that staff receive appropriate supervision and appraisal as necessary to carry out their duties. Regulation 18 (1) (2) (a,)

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.

Regulated activity	Regulation
Treatment of disease, disorder or injury	Regulation 9 HSCA (RA) Regulations 2014 Person-centred care Regulation 9 HSCA 2008 (Regulated Activities) Regulations 2014 Person-centred care · The care and treatment of service users was not · appropriate, did not meet their needs, or reflect their · preferences. Care and treatment was not designed with a view to achieving service users' preferences and ensuring their needs are met. · Not all young people using the services had a care plan. When they did have a care plan, this was not always appropriate. Care plans described interventions, were not specific, detailed or personalised. · Not all of the young persons' needs were recorded. Young people, or their carers', views and preferences were not recorded. This was a breach of Regulation 9(1)(a)(b)(c)(3)(b)

Regulated activity	Regulation
Treatment of disease, disorder or injury	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment Regulation 12 HSCA 2008 (Regulated Activities) Regulations 2014: Safe care and treatment Care and treatment was not provided in a safe way for service users.

This section is primarily information for the provider

Enforcement actions

· Risks to the health and safety of service users of receiving the care and treatment were not always assessed. Services did not do all that was reasonably practical to mitigate such risks.

· Some people providing care or treatment to service users did not have the skills and experience to do so safely.

· The equipment used for providing care or treatment to a service user was not safe for such use.

· Services were not assessing the risk of preventing, detecting and controlling the spread of, infections.

· Young people did not always have a risk assessment. This included young people with multiple or serious risks. When young people did have a risk assessment, with risks identified, they did not always have a risk management or safety plan.

· A specialty doctor and two nurse prescribers did not have suitable experience, or specialist training. They did not have the skills or experience for their roles.

· Weighing scales in the services had not been calibrated regularly. This was particularly important for young people with eating disorders.

· Infection control audits were not undertaken. Plastic toys in waiting areas and interview rooms were not disinfected regularly.

This was a breach of Regulation 12(1)(2)(a)(b)(c)(e)(h)

Regulated activity	Regulation
Treatment of disease, disorder or injury	Regulation 17 HSCA (RA) Regulations 2014 Good governance Regulation 17 HSCA 2008 (Regulated Activities) Regulations 2014 Good governance

This section is primarily information for the provider

Enforcement actions

· Systems or processes were not established or operated effectively.

· Systems or processes did not effectively assess, monitor and improve the quality and safety of the services provided (including the quality of the experience of service users in receiving those services).

· They did not effectively assess, monitor and mitigate the risks relating to the health, safety and welfare of service users and others who may be at risk.

· There was not an accurate, complete and contemporaneous record in respect of each service user, including a record of the care and treatment provided to the service user and of decisions taken in relation to the care and treatment provided.

· Concerns from, and the experience of, people using the service, or their carers, were not effectively monitored to identify themes and trends.

· The duty worker system was not operated effectively.

· There was no reliable system for accessing a psychiatrist.

· In most services, there was an absence of an operational policy to ensure the quality and safety of the services.

· Environmental risks, in the locations carrying on the regulated activity, were not assessed.

· Risks involving the operation of each service were not assessed.

· Outcome measures were not used consistently so that the quality of services could be monitored and improved

· People using the service may have more than one clinical record regarding their care and treatment, and decisions taken in relation to their care and treatment.

· Clinical records for people using the service were not always complete.

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

This section is primarily information for the provider

Enforcement actions

Regulated activity	Regulation
Treatment of disease, disorder or injury	Regulation 18 HSCA (RA) Regulations 2014 Staffing Regulation 18 HSCA 2008 (Regulated Activities) Regulations 2014 Staffing · There were not sufficient numbers of suitably qualified, competent, skilled and experienced persons deployed in the CAMHS community services. · There was a lack of staff deployed in services to meet the demands on services. · There was a wait of three or four months for a non urgent assessment. Following this the · wait for further diagnostic assessment, or for treatment, was often over one year. This was a breach of Regulation 18(1)