

North West Boroughs Healthcare NHS Foundation Trust

Inspection report

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

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

This report is a summary of our inspection findings. You can find more detailed information about the service and what we found during our inspection in the related Evidence appendix (see www.cqc.org.uk/provider/RTV/reports)

Ratings

Overall rating for this trust

Good 

Are services safe?

Good 

Are services effective?

Good 

Are services caring?

Good 

Are services responsive?

Requires improvement 

Are services well-led?

Good 

Summary of findings

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

Background to the trust

North West Boroughs Healthcare NHS Foundation Trust delivers community and inpatient mental health services as well as community-based physical health services. The trust also provides specialist services for people with learning disabilities and services for people with mental health needs in the criminal justice system in Greater Manchester, Halton and Warrington.

Formerly known as 5 Boroughs Partnership NHS Foundation Trust, the trust changed its name in April 2017 when it expanded its geographic footprint to deliver community health services with St Helens and Knowsley Teaching Hospitals NHS Trust. Working across a varied population of more than 3.5 million people the trust employs around 3,800 staff members and delivers services in the following areas:

- Bolton
- Greater Manchester
- Halton
- Knowsley
- St Helens
- Warrington
- Wigan

During 2017/18 the annual turnover of the trust was £181 million. The services the trust provides are commissioned by three local authorities and five Clinical Commissioning Groups, including NHS England. The trust also holds sub-contract arrangements with two other local NHS trusts and works in partnership with independent sector partners.

The trust provides the following core mental health services:

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

Summary of findings

The trust provides the following community health services;

- Community health services for adults
- Community health services for children and young people
- Community end of life care.

The trust delivers its services from ten locations made up of 21 wards with a total of 317 beds, 10 of which are children's mental health beds. The trust also delivers services out in the community and runs 251 community clinics a week. The locations the trust provide services from are:

- Wigan Atherleigh Park
- Fairhaven
- Halewood Health Centre
- Halton
- Knowsley
- Litherland Walk-in Centre
- Nutgrove Villa
- St Chads Clinic
- St Helens
- Warrington

In July 2015, we conducted a comprehensive inspection and rated eleven out of the thirteen core services as good. The forensic inpatient/secure wards and community end of life care services were both rated as requires improvement. This resulted in the trust receiving an overall rating of requires improvement.

Following an inspection in July 2016 we re-rated the forensic inpatient/secure wards and community end of life care services from requires improvement to good. This resulted in the overall rating for the trust changing from requires improvement to good. In wards for older people with mental health problems, the safe key question remained rated as requires improvement.

Overall summary

Our rating of this trust stayed the same . We rated it as Good ● → ←

What this trust does

North West Boroughs Healthcare NHS Foundation Trust delivers a range of mental and physical health care services across Bolton, Halton, Sefton, St Helens, Greater Manchester, Warrington, Knowsley and Wigan.

Key questions and ratings

We inspect and regulate healthcare service providers in England.

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

Summary of findings

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

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

What we inspected and why

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

As part of our continual checks on the safety and quality of healthcare services we inspected the following services between 30 May and 11 July 2018 at this trust:

- Wards for older people with mental health problems
- Wards for people with learning disabilities or autism
- Acute wards for adults of working age and psychiatric intensive care units
- Child and adolescent mental health wards
- Community based mental health services for adults of working age
- Community health services for adults.

The trust also provides the following additional services that we did not inspect:

- Community health services for children, young people and families
- Community mental health services for people with learning disabilities or autism
- Community mental health services for older people
- Specialist community mental health services for children and young people
- Forensic inpatient/secure wards
- Mental health crisis services and health-based places of safety
- Community end of life care.

Our comprehensive inspections of NHS trusts have shown a strong link between the quality of overall management of a trust and the quality of its services. For that reason, all trust inspections now include inspection of the well-led key question for the trust overall. What we found is summarised in the section headed: Is this organisation well-led?

What we found

Overall trust

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

- We rated and safe, caring, effective and well led as good and responsive as requires improvement. In reaching an overall rating for the trust, we took into account the previous ratings of the services we did not inspect this time.
- The trust had a strategy for engagement and involvement and worked with stakeholders, patients and the public.
- The trust had a programme of innovation and new initiatives that they engaged with and celebrated at staff events.

Summary of findings

- The trust had a cost improvement plan that was reviewed and managed with quality impact assessments undertaken to ensure quality of care was not compromised.
- The trust leadership team had established a vision and set of values which was well embedded within the organisation. Staff were able to talk about the vision and values in their work and senior leaders described the vision and values as a golden thread which ran through the organisation.
- There was a person-centred culture across the trust with patients at the centre. Staff recognised this was a top priority which was reflected in the staff survey results.
- Staff at all levels knew how to report incidents and had access to systems that allowed them to do this. The trust had systems in place to identify learning from incidents and to ensure the learning was disseminated across the trust.
- We saw evidence of good physical health monitoring in the mental health core services.

However:

- The trust had introduced new structures and lines of accountability to deliver its strategy and services but these had not been fully embedded at the time of the inspection. Our inspection found that, in some instances, the governance system had not provided the necessary assurance of safety and quality.
- There was a lack of senior leadership oversight regarding systemic issues affecting patient safety in two of the core services that we inspected on this occasion. These were wards for older people with mental health problems and wards for people with learning disabilities or autism. We rated wards for older people as inadequate for safe because the wards were poorly maintained and staff did not take the steps necessary to separate the accommodation for men and women. The trust managers had failed to provide staff with guidance on how to eliminate mixed sex accommodation. The ward for people with learning disabilities was not functioning as an assessment and treatment ward. Staff did not have positive behaviour support training, however, the trust management had a plan in place to train staff.
- Staff on some wards imposed blanket restrictions on patients that were not based on an assessment of the patients' individual risks or needs. On the wards for older people with mental health problems, these included placing restrictions on patients' access to the ward gardens and the female only lounges. On wards for people with learning disabilities or autism, staff did not allow patients to have free access to drinks when they wished and patients bedroom doors were routinely locked during the day. On the child and adolescent mental health ward young people had restrictions placed on their mobile phone and internet access.
- Waiting times in three of the community based mental health services for adults of working age were of an unacceptable length. The wait was up to two years for the attention deficit hyperactivity disorder service, six weeks in the Wigan assessment team and 100 days for psychological interventions in the recovery teams.
- Feedback from stakeholders who worked with the trust was mixed. Some described a picture of developing services with a reactive rather than proactive response to identifying and addressing issues in an open and transparent way.

Are services safe?

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

- Taking account of the previous ratings of those we did not inspect on this occasion, we have rated 11 of the 13 core services managed by the trust as good for safe. For the acute wards for adults of working age and psychiatric intensive care units, we have improved the rating from requires improvement to good.
- In most services staff assessed and monitored risks associated with patients' mental and physical health well.

Summary of findings

- The acute mental health wards for adults of working age and the psychiatric intensive care units and the ward for people with a learning disability complied with the Department of Health guidance on same sex accommodation.
- The rate of compliance with mandatory training was good in most core services.
- The trust had an effective system in place for reporting and learning from incidents. There was a positive staff culture of reporting and learning from incidents. Staff were aware of how to report, lessons learnt were shared across the service by managers. Staff gave examples of changes in practice as a result.
- The trust had safeguarding processes in place and staff knew what action to take to protect vulnerable patients.

However:

- We rated wards for older people with mental health problems as inadequate for safe and rated wards for people with learning disabilities or autism as requires improvement. Both of these ratings were worse than at the last inspection.
- On two of the wards for older people with mental health problems, staff did not follow national guidance on eliminating mixed sex accommodation. We observed patients entering other patients' rooms on corridors that had both men's and women's bedrooms. Staff were not always present to observe the corridors. On two of the wards, staff had locked the female-only lounge and sometimes used the lounges for other purposes. The trust did not have guidance for staff on the action required to maintain patient safety and dignity on wards that admitted both men and women.
- The older people's wards were poorly maintained. Also, there were ligature risks that environmental audits had not identified. The risk that these posed was compounded on one of the wards where staffing levels were not sufficient to meet the needs of the patients. Also, patients could not easily access the staff call alarm buttons.
- On the acute mental health wards for adults of working age, older people's wards, child and adolescent mental health ward and the adult community health service we found deficits with the labelling, dating, storing, reviewing and monitoring of medicines. We also raised two patient related medicines concerns to the ward manager on one of the older peoples' wards.
- We found maintenance issues with equipment and accommodation in four of the core services we inspected. These included; broken equipment, out of date servicing, poor decor, a damaged door panel with sharp edges in a bedroom door, out of date consumables and out of date environmental risk assessments.
- There were blanket restrictions on the learning disability ward, the older people's wards and on the child and adolescent ward. These were not based on individual patient's risks and compromised patient's dignity, choice and independence.
- We found there was not a clear strategy to reduce restrictive practices or physical restraint in evidence on the learning disability ward. On the child and adolescent mental health ward interventions resulting in physical restraint were not documented fully in records.

Are services effective?

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

- Following this inspection, and taking account of the previous ratings of those core services that we did not inspect on this occasion, we have rated 12 of the 13 core services managed by the trust as good for effective.
- Staff provided good physical healthcare in all of the core services that we inspected on this occasion.
- In the community health service, older people's wards, and community mental health services, staff maintained up to date care records that were recovery orientated, person centred and assessments and treatment plans were in place.

Summary of findings

- In most services, we found evidence that staff took account of best practice guidance when providing care and treatment.
- Staff in the community mental health services for adults of working age, acute wards for adults of working age and psychiatric intensive care units, community health service for adults and older people's wards worked in an effective multidisciplinary way, with regular team meetings.
- Staff had good understanding of the Mental Health Act and Code of Practice and the Mental Capacity Act and had received training in their application. Staff could demonstrate good practice in this area.

However:

- We rated the ward for people with a learning disability as requires improvement for effective. The ward was not operating as a treatment and assessment ward. The ward did not deliver recovery focussed interventions and was not aligned to the transforming care agenda (the national programme to move the locus of care from a hospital-setting to a community-setting). Staff did not always use proactive strategies to de-escalate challenging behaviour. Staff were not trained in positive behaviour support strategies and there was not a framework in place to facilitate the delivery of this intervention – which is the approach recommended to support people with learning disability and challenging behaviour.
- Clinical supervision was not fully embedded across the services. In the learning disability ward and the child and adolescent mental health ward, there was no effective recording of clinical supervision taking place.
- Care plans in the acute wards for adults of working age and psychiatric intensive care units and the learning disability ward were not always comprehensive, individualised and not in an accessible format.

Are services caring?

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

- Taking account of the previous ratings of those we did not inspect on this occasion, we have rated 11 of the 13 core services managed by the trust as good and one outstanding for caring.
- We observed patients being supported in a caring, compassionate and kind manner by staff in the majority of interactions.
- On the acute wards for adults of working age and psychiatric intensive care units, we observed patient involvement in the running of the ward through community meetings. Patients and carers on the older people's wards, the child and adolescent mental health ward and both community adult's services were involved in care planning.
- Feedback from patients and carers was generally positive about the care they or the person they cared for received from staff. Many patients described staff as supportive, caring and compassionate towards them.
- Patients were involved in decisions about their care in the older people's wards, community mental health teams, acute wards for adults of working age and psychiatric intensive care and community health services for adults.

However:

- We rated the learning disability ward as requires improvement for caring, which was down one rating from our last inspection. We observed some staff interactions that did not promote dignity and respect of the patients. Also, the care records on the ward did not indicate that patients had been actively involved in decisions regarding their care and treatment or that they had been offered a copy of their care plans.
- On the older people's wards, two patients gave mixed feedback about staff approaches and not knocking before entering their rooms.

Summary of findings

Are services responsive?

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

- We rated three of the six core services that we inspected on this occasion as requires improvement for responsive.
- Some patients referred to the community mental health services waited a long time for assessment or treatment. There was a two-year wait for the adult attention deficit hyperactivity disorder service. In the Wigan assessment team, patients waited six weeks for a face to face appointment. In the recovery teams, patients waited over 100 days for access to psychological therapy.
- There were delayed discharges on a number of the wards that we inspected. On the learning disability ward, staff did not initiate discharge planning at the point of admission. This reflected the fact that the ward was not operating to an assessment and treatment model. On the older people's wards, nearly 50% of patient discharges were delayed. On the acute wards for working age adults and psychiatric intensive care units, discharge plans were not up-dated during admission to reflect discussions in ward rounds.
- The older people's mental health wards and the child and adolescent mental health ward did not always cater for patient food choices. This could mean that there was not always sufficient food available, of the preferred type, to meet patients' nutritional needs or food choices.
- The facilities on some of the older people's wards did not always promote care and treatment for example; unsuitable bedroom furniture and missing shower curtains from some bathrooms. Some of the gardens and not well maintained.
- Information was not always provided in accessible formats for people in the community health adult service and the learning disability ward.

However:

- Patients had access to a range of activities in the older people's wards, acute wards for adults of working age and psychiatric intensive care and learning disabilities ward. Pets as therapy was offered on some wards and was well regarded. On the learning disability ward patients had engagement within community settings.
- There was a process to manage and learn from complaints across the services, lessons learned and changes to practice were shared with staff.
- Services had been planned to meet the needs of different people and were accessible. The community mental health services facilities were soundproofed and had a variety of rooms available.
- The trust had a complaints procedure and in most services we inspected and patients told us they knew how to complain.

Are services well-led?

We rated well-led at the trust as good. For more information, see the section headed Is this organisation well-led?

Ratings tables

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

Summary of findings

Areas for improvement

We found areas for improvement, including 20 breaches of legal requirements across three core services that the trust must put right. We found a number of things that the trust should improve to comply with a breach that did not justify regulatory action, to prevent breaching a legal requirement, or to improve service quality. See the Areas for improvement section below for details.

Action we have taken

We have issued the trust with eight requirement notices across three core services.

What happens next

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

Areas for improvement

Action the trust **MUST** take is necessary to comply with its legal obligations. Action a trust **SHOULD** take is to comply with a breach that did not justify regulatory action, to prevent it failing to comply with legal requirements in future, or to improve services.

Action the trust **MUST** take to improve

In the Community based mental health services for adults

- The trust must ensure that patients are able to access the attention deficit hyperactivity disorder service, psychology at the resource teams and the Wigan assessment team in a timely manner in line with national guidance and best practice.

In the wards for older people with mental health problems

- The trust must ensure that mixed sex accommodation is managed safely and that there is guidance to staff in recognising mixed sex accommodation breaches.
- The trust must ensure that ligature audits capture all ligature risks on all wards.
- The trust must ensure that wards are cleaned thoroughly and promptly in response to incidents.
- The trust must ensure that moving and handling equipment is cleaned, maintained and used correctly.
- The trust must ensure staff have sufficient guidance and training to enable them to complete moving and handling assessments and that these are completed for all patients who need them.
- The trust must ensure environmental audits are completed regularly and actions taken.
- The trust must ensure that maintenance issues are identified and addressed promptly.
- The trust must ensure sufficient staff on Kingsley ward and sufficient provision in relation to domestic and housekeeping staff across all wards.
- The trust must review restrictive practices in relation to lounges and gardens.
- The trust must ensure there is sufficient food available to meet patient's nutritional needs.

Summary of findings

- The trust must ensure patient alarms are accessible.

In the wards for people with a learning disability or autism

- The trust must ensure that restrictive practices on the ward are based upon individual patient risks.
- The trust must ensure that the ward implements a robust framework for the delivery of positive behavioural support.
- The trust must ensure that staff are trained in positive behavioural support.
- The trust must ensure there is a coherent policy and approach to promote a reduction in the use of restrictive interventions.
- The trust must ensure that patients are assessed for the need for a personal emergency evacuation plan and that these are in place where required.
- The trust must ensure that all equipment is tested and within date.
- The trust must ensure that all staff interactions with patients maintain the patients' dignity.
- The trust must ensure it delivers an appropriate assessment and treatment model of care which reflects the transforming care agenda.

Action we have told the trust it SHOULD take:

Trust wide

- The trust should ensure the governance system provides the necessary assurance of safety and quality.
- The trust should provide staff with up to date guidance, policies and procedures to carry out their roles effectively.
- The trust should ensure that there are systems in place to record and review restrictive practices and blanket restrictions across services and ensure that they are removed as soon as practicable.
- The trust should ensure that an effective system of clinical supervision and recording for all staff is initiated.
- The trust should ensure that services for patients are delivered in a timely, safe and effective way to meet patients needs.
- The trust should ensure that their duty of candour paperwork includes a final letter.

In the Community based mental health services for adults

- The trust should dispose of the out of date clinic supplies at the Wigan and Leigh early intervention team and St Helens and Knowsley early intervention team.
- The trust should ensure the medicine fridge temperatures are read, recorded and acted upon at St Helens and Knowsley early intervention team.
- The trust should ensure the Warrington recovery team resolves the faulty lock on the medicine fridge.
- The trust should review their policy "Assessing mental capacity" reviewed June 2018 to ensure it complies with the Mental Capacity Act and ensure appendices are included in the community treatment order procedure.
- The trust should ensure that patients are aware of how to complain about the service.

In the wards for older people with mental health problems

- The trust should ensure the gardens at Atherleigh Park are maintained.

Summary of findings

- The trust should consider mandatory updating of moving and handling level two training in this service.
- The trust should ensure that deprivation of liberty safeguard authorisations are notified to CQC.
- The trust should ensure the fixed bed provision is reviewed on Parsonage ward.
- The trust should consider how it can develop its estate so that each patient has a single room with an en-suite bathroom.

In the wards for people with a learning disability or autism

- The trust should ensure that care plans around epilepsy incorporate the use of bathrooms and taking of medication.
- The trust should ensure patient and carer involvement is evidenced within care records.
- The trust should ensure that easy read copies of care plans are available for patients. When a patient declines a copy of a care plan this should be clearly recorded.
- The trust should record and monitor compliance with clinical supervision for nursing staff
- The trust should ensure there is input from psychologists especially in relation to patient formulations.
- The trust should ensure that information is available in easy read formats.
- The trust should ensure staff attend to patients needs in a timely manner.

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

- The trust should ensure that it continues to manage and mitigate the risks relating to a number of staff vacancies, higher numbers of preceptorship nurses, high use of bank staff and managing patient flow so that patient care is not adversely impacted.
- The trust should ensure that regular bank staff can access prevention and management of violence and aggression training.
- The trust should ensure that staff are reminded that they should label all opened medicine bottle and creams to state when they were opened.
- The trust should ensure that written care plans are individualised and updated to reflect discussions in ward rounds where discharge planning is discussed.
- The trust should continue to roll out initiatives to further reduce restraint on patients across all wards and locations.
- The trust should continue to ensure that staff at Atherleigh Park feel fully supported and supported with the challenges of high acuity of patients and high numbers of admissions and discharges.
- The trust should monitor any delays in doctors responding to seclusion episodes and continue to improve the seclusion room environments.
- The trust should ensure that the wards display the correct CQC ratings poster.

In the child and adolescent mental health ward

- The trust should ensure it has the appropriate facilities and provision available to ensure young people have a full and varied compliment of activities available each day to promote their recovery and independence.
- The trust should review the use of restrictive practices such as mobile phone and internet access to ensure any such restrictions are based on individual risk assessments.

Summary of findings

- The trust should record and monitor compliance with clinical supervision for nursing staff.
- The trust should consider patient choice when menu planning for the ward.
- The trust should ensure the provision of age appropriate patient information.
- The trust should review as required medicines in line with trust policy.

In the community health adults service

- The trust should ensure all staff have completed mandatory training.
- The trust should ensure robust processes are in place and staff are aware of their responsibilities to make sure medicines, equipment and consumables are maintained, monitored and safe to use.
- The trust should ensure they continue to monitor and take actions to meet referral to treatment targets.
- The service should ensure that processes are in place for patient treatment goals to be identified and recorded, along with the ongoing monitoring of patient risk.
- The trust should ensure all handwashing and infection control audits are performed at all community locations with action plans in place to address areas requiring improvement.
- The trust should consider facilitating staff to engage and share good practice across all localities and boroughs.
- The trust should ensure staff have access to all patient information is available in languages other than English and different formats including pictorial aids to assist when providing care to patients with additional needs.
- The trust should ensure all staff, patients and their carers have access to support in relation to dementia care.
- The trust should ensure all staff receive their annual appraisal.
- The trust should ensure that staff are aware of and have a clear strategy to follow.

Is this organisation well-led?

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

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

- The trust had a strategy for engagement and involvement and worked with stakeholders, patients and the public.
- The trust had a programme of innovation and new initiatives that they engaged with and celebrated at staff events.
- The trust had a cost improvement plan that was reviewed and managed with quality impact assessments undertaken to ensure quality of care was not compromised.
- The trust leadership team had established a vision and set of values and staff were aware of what these were. Senior leaders told us that the vision and values were the golden thread that ran through the organisation.
- There was a person-centred culture across the trust with patients at the centre. Staff recognised this was a top priority which was reflected in the staff survey results.

Summary of findings

- Staff at all levels knew how to report incidents and had access to systems that allowed them to do this. The trust had systems in place to identify learning from incidents and to ensure the learning was disseminated across the trust.

However:

- The trust had introduced new structures and lines of accountability to deliver its strategy and services but these had not been fully embedded at the time of the inspection. Our inspection found that, in some instances, the governance system had not provided the necessary assurance of safety and quality.
- There was a lack of senior leadership oversight regarding systemic issues affecting patient safety in two of the core services that we inspected on this occasion. These were wards for older people with mental health problems and wards for people with learning disabilities or autism. We rated wards for older people as inadequate for safe because the wards were poorly maintained and staff did not take the steps necessary to separate the accommodation for men and women. The trust managers had failed to provide staff with guidance on how to eliminate mixed sex accommodation. The learning disability ward was not operating as a treatment and assessment ward. Staff did not have positive behaviour support training, however, the trust management had a plan in place to train staff.
- We found other examples of where the trust managers had not provided staff with up to date guidance, policies and procedures to carry out their role effectively. For example, the trusts procedure for incidents reaching the Duty of Candour threshold did not include a final letter with the findings. In the core services; staff on the wards for older people with mental health problems had not been issued with guidance on moving and handling. In the community based services for adults of working age the trust did not provide staff with effective policy and guidance on the Mental Capacity Act and had an incomplete community treatment procedure.
- The trust managers had not ensured that nursing staff received regular clinical supervision. Managers in some services that we inspected did not record if this had been done.
- Feedback from stakeholders who worked with the trust was mixed. Some described a picture of developing services with a reactive rather than proactive response to identifying and addressing issues in an open and transparent way.

Ratings tables

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

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

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

Ratings for the whole trust

Safe	Effective	Caring	Responsive	Well-led	Overall
Good →← Oct 2018	Good →← Oct 2018	Good →← Oct 2018	Requires improvement ↓ Oct 2018	Good →← Oct 2018	Good →← Oct 2018

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

Ratings for a combined trust

	Safe	Effective	Caring	Responsive	Well-led	Overall
Community	Good →← Oct 2018	Good →← Oct 2018	Good →← Oct 2018	Good →← Oct 2018	Good →← Oct 2018	Good →← Oct 2018
Mental health	Good →← Oct 2018	Good →← Oct 2018	Good →← Oct 2018	Requires improvement ↓ Oct 2018	Good →← Oct 2018	Good →← Oct 2018
Overall trust	Good →← Oct 2018	Good →← Oct 2018	Good →← Oct 2018	Requires improvement ↓ Oct 2018	Good →← Oct 2018	Good →← Oct 2018

The rating for the well-led key question is based on our inspection at trust level, taking into account what we found in individual services. Ratings for other key questions take into account the ratings for different types of service. Our decisions on overall ratings take into account the relative size of services. We use our professional judgement to reach fair and balanced ratings.

Ratings for community health services

	Safe	Effective	Caring	Responsive	Well-led	Overall
Community health services for adults	Good →← Oct 2018	Good →← Oct 2018	Good →← Oct 2018	Good →← Oct 2018	Good →← Oct 2018	Good →← Oct 2018
Community health services for children and young people	Good Feb 2016	Good Feb 2016	Good Feb 2016	Good Feb 2016	Good Feb 2016	Good Feb 2016
Community end of life care	Good Nov 2016	Good Nov 2016	Outstanding Nov 2016	Good Nov 2016	Good Nov 2016	Good Nov 2016
Overall*	Good →← Oct 2018	Good →← Oct 2018	Good →← Oct 2018	Good →← Oct 2018	Good →← Oct 2018	Good →← Oct 2018

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

Ratings for mental health services

	Safe	Effective	Caring	Responsive	Well-led	Overall
Acute wards for adults of working age and psychiatric intensive care units	Good ↑ Oct 2018	Good →← Oct 2018	Good →← Oct 2018	Good →← Oct 2018	Good →← Oct 2018	Good →← Oct 2018
Forensic inpatient or secure wards	Good Nov 2016	Good Nov 2016	Good Nov 2016	Good Nov 2016	Good Nov 2016	Good Nov 2016
Child and adolescent mental health wards	Good →← Oct 2018	Good →← Oct 2018	Good →← Oct 2018	Good →← Oct 2018	Good →← Oct 2018	Good →← Oct 2018
Wards for older people with mental health problems	Inadequate ↓ Oct 2018	Good →← Oct 2018	Good →← Oct 2018	Requires improvement ↓ Oct 2018	Inadequate ↓↓ Oct 2018	Inadequate ↓↓ Oct 2018
Wards for people with a learning disability or autism	Requires improvement ↓ Oct 2018	Requires improvement ↓ Oct 2018	Requires improvement ↓ Oct 2018	Requires improvement ↓ Oct 2018	Requires improvement ↓ Oct 2018	Requires improvement ↓ Oct 2018
Community-based mental health services for adults of working age	Good →← Oct 2018	Good →← Oct 2018	Good →← Oct 2018	Requires improvement ↓ Oct 2018	Good →← Oct 2018	Good →← Oct 2018
Mental health crisis services and health-based places of safety	Good Nov 2016	Good Nov 2016	Not rated	Good Nov 2016	Good Nov 2016	Good Nov 2016
Specialist community mental health services for children and young people	Good Feb 2016	Good Feb 2016	Good Feb 2016	Good Feb 2016	Good Feb 2016	Good Feb 2016
Community-based mental health services for older people	Good Feb 2016	Good Feb 2016	Good Feb 2016	Good Feb 2016	Good Feb 2016	Good Feb 2016
Community mental health services for people with a learning disability or autism	Good Feb 2016	Good Feb 2016	Good Feb 2016	Good Feb 2016	Good Feb 2016	Good Feb 2016
Overall	Good →← Oct 2018	Good →← Oct 2018	Good →← Oct 2018	Requires improvement ↓ Oct 2018	Good →← Oct 2018	Good →← Oct 2018

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

Community health services

Background to community health services

The trust provides community health services for adults and for children and families, and community end of life care. See Background to the trust section above for more information.

Summary of community health services

Good   

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

- We inspected only community health services for adults and rated them good overall.
- We took into account ratings for the services we did not inspect this time, both of which were rated good overall in 2016.

Community health services for adults

Good   

Key facts and figures

North West Boroughs NHS Foundation Trust provides community-based health services for adults who live in the Knowsley and St Helens area. Teams within Knowsley and St Helens areas were overseen and managed by a separate management team.

There were four community district nursing teams within the Knowsley borough and five across St Helens in addition to an out of hour's service from 8 pm to 8 am.

Community matrons for quality were based with the community nurses and worked closely with the GP's and community teams in managing and monitoring patients with long term complex conditions.

Adult community services include district nursing, matrons for quality, treatment room's, speech and language team, physiotherapy, podiatry and phlebotomy, continence, weight management, falls and well-being, and orthotics, dietetics and tissue viability. The community nursing teams provide care and treatment such as wound care, pressure area care, continence care and palliative care to patients who are housebound or have complex conditions.

The service also provided treatment clinics for mobile patients to access care such as injections, ear syringing and wound care. The appointments were available seven days a week across five locations in Knowsley and at ten locations across St Helens.

Staff received a short period of notice of our inspection between 30 May to 1 June 2018.

During our inspection we visited nine locations; St Chads clinic, Bluebell Centre, Puma Court, Halewood Primary Resource Centre, Nutgrove Villa Surgery, Garswood Health centre, Finger post health centre, Whiston primary care centre and the Centre for Independent Living.

We spoke with 15 patients, three relatives and sixty members of staff including nursing, therapy and admin staff, team leaders, managers and senior managers. We reviewed 23 patient records and four prescription sheets.

Summary of this service

Our overall rating of this service stayed the same.

We rated it as good because:

- Staffing levels within the community nursing service were sufficient and staff had the right qualifications, skills and training.
- The service prioritised patient protection and there were defined systems, processes and standard operating procedures to keep people safe and safeguarded from abuse.
- There was good compliance with mandatory training in most services however a few services were significantly below trust target in some areas of training.
- We saw evidence of an open and transparent culture in relation to incident reporting. Staff were able to learn from the feedback received from managers and were comfortable reporting their concerns or any near misses.

Community health services for adults

- Staff treated patients in compassionate, dignified, and respectful ways. Staff were hard-working, caring and committed to delivering a good quality service. They spoke with passion about their work and were proud of what they did.
- Staff reported that managers were available, visible, and approachable. They also told us that leadership of the service and staff morale were good, and staff across the services felt supported and valued by their peers and managers.
- There was an effective governance structure for formal escalation of risk where appropriate.
- Staff were competent, knowledgeable and responded to the needs of patients and of their patients carers.
- Staff understood their roles and responsibilities under the Mental Capacity Act. They could describe when to use it for patients who appeared to lack capacity to make decisions about their care.

However:

- Although the trust monitored and had taken action to address delays in referral to treatment, some services were not achieving the referral to treatment targets.
- The servicing of equipment was not always performed and consumables were not always within date.
- Staff were not supported by the systems and processes in place to consistently monitor and mitigate patient's risks.

Is the service safe?

Good   

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

- Staff understood how to protect patients from abuse and the service worked well with other agencies to do so. The service prioritised patient protection and there were defined systems, processes and standard operating procedures to keep people safe and safeguarded from abuse.
- Equipment and clinical areas were clean and the majority of staff followed infection control policies.
- Although there was good compliance with mandatory training in most services, some areas were significantly below the trust target.
- The service had enough staff with the right qualifications, skills, training and experience to keep people safe from avoidable harm and abuse and to provide the right care and treatment.
- Staffing levels within the community nursing service were adequate and capacity and demand was monitored daily.
- The service managed patient safety incidents well. Staff recognised incidents and reported them appropriately. Team managers investigated incidents and shared lessons learned with the whole team and the wider service. When things went wrong, staff apologised and gave patients honest information and suitable support.

However:

- Although staff had access to equipment and consumables to provide care and treatment, the servicing of equipment was not always performed and consumables were not always within date.
- There were inconsistencies in the monitoring and storage of medication.
- Staff were not supported by the systems and processes in place to consistently monitor and mitigate patient's risks.

Community health services for adults

Is the service effective?

Good ● ➡ ➡

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

- Staff were qualified and had the skills they needed to carry out their roles effectively and in line with best practice. The service had processes for identifying staff learning and training needs.
- Staff of different disciplines worked together as a team to benefit patients. Nurses and allied healthcare professionals supported each other to provide good care.
- Current evidence-based guidance, standards, best practice and legislation were applied to patients treatment and care.
- Staff assessed patients needs well, including consideration of clinical, and physical needs as well as nutrition and hydration needs.
- The service monitored the effectiveness of care and treatment. Patient outcome measure results were mainly positive.
- Staff across the service encouraged patients to make healthy lifestyle changes and choices where appropriate.
- Staff understood their roles and responsibilities under the Mental Capacity Act. They could describe when to use it for patients who appeared to lack capacity to make decisions about their care.

Is the service caring?

Good ● ➡ ➡

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

- We observed 15 interactions between staff and patients and saw patients were treated in a compassionate, dignified and respectful way
- Staff were hard working, caring and committed to delivering a good quality service. They spoke with passion about their work and were proud of what they did.
- Patients told us that staff included them in decision-making and listened to their wishes. We observed staff listen to patients and discuss care options and treatments, and provide choice to patients.

Is the service responsive?

Good ● ➡ ➡

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

- The trust worked closely with commissioners and other external bodies to make sure it planned and delivered services according to the needs of local people.
- Services had been introduced to ensure people could access the service when they needed it.

Community health services for adults

- The trust treated concerns and complaints seriously and investigated them. Where they learned lessons, or changed practices as a result, these were shared with staff.
- The needs of different people were taken into account when planning and delivering services. However not all patients or services had access to dementia support or advice.

However:

- Although the service monitored referral to initial assessment/treatment waiting times and took action to address delays in referral to treatment, some services were not achieving the referral to treatment targets.
- Patient information was not always available for people whose first language was not English, or in an alternative format for example pictorial aids to support in the care provided to those with additional needs.

Is the service well-led?

Good   

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

- Staff understood and could describe the trust vision and values.
- The service had a management structure and the managers knew about the quality issues, priorities and challenges within the service. Staff could explain the risks to the department and the plans to deal with them.
- Managers supported their staff and encouraged them to undertake training. Staff said they felt supported, respected and valued by colleagues at all levels.
- The trust engaged with patients, staff, the public and local organisations to plan and manage appropriate services, and collaborated with partner organisations effectively.
- The service was committed to improving services by learning from when things go well and when they go wrong, promoting training, research and innovation.

However:

- The service did not have a strategy in place and only managers were aware of the recently implemented trust strategy.
- There was little evidence of staff engaging, sharing best practice or working together across Boroughs. Lessons learned and good practice were shared within teams but not always across the localities.

Areas for improvement

The trust should:

- The trust should ensure all staff have completed mandatory training.
- The trust should ensure robust processes are in place and staff are aware of their responsibilities to make sure medicines, equipment and consumables are maintained, monitored and safe to use.
- The trust should ensure they continue to monitor and take actions to meet referral to treatment targets.
- The service should ensure that processes are in place for patient treatment goals to be identified and recorded, along with the ongoing monitoring of patient risk.

Community health services for adults

- The trust should ensure all handwashing and infection control audits are performed at all community locations with action plans in place to address areas requiring improvement.
- The trust should consider facilitating staff to engage and share good practice across all localities and boroughs.
- The trust should ensure staff have access to all patient information available in languages other than English and different formats including pictorial aids to assist when providing care to patients with additional needs.
- The trust should ensure all staff; patients and their carers have access to support in relation to dementia care.
- The trust should ensure all staff receive their annual appraisal.
- The trust should ensure that staff are aware of and have a clear strategy to follow.

Mental health services

Background to mental health services

The trust provides community and inpatient mental health services. It also provides specialist services for people with learning disabilities and services for people with mental health needs in the criminal justice system in Greater Manchester, Halton and Warrington.

Summary of mental health services

Good   

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

- Our overall rating of three of the five services we inspected was good and stayed the same. We took into account ratings for services not inspected this time. This made the overall rating for mental health services good. See individual service sections below and the ratings tables above for more details.

Wards for older people with mental health problems

Inadequate   

Key facts and figures

North West Boroughs NHS Foundation Trust provides inpatient services for older adults with mental health problems. The trust had four inpatient wards for older adults.

At Knowsley resource and recovery centre there was one ward

- Rydal ward, a 12 bed mixed sex urgent response ward for people with a diagnosis of a functional or organic mental health problem.

At Atherleigh Park, Leigh, there were two wards

- Golborne ward, an 18 bed mixed sex ward for people with an organic mental health problem.
- Parsonage ward, a 16 bed mixed sex ward for people with an organic or functional mental health problem who had co-existing physical health problems.

At Hollins Park, Warrington, there was one ward

- Kingsley ward, an 18 bed mixed sex ward for people with an organic mental health problem.

We visited all four wards in this core service.

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

The service had previously been inspected in June 2015. At that inspection, there had been concerns about the provision of female lounges. We rated the service as good overall. We rated safe as requires improvement and effective, caring, responsive and well led as good. An action plan was developed by the provider to address these issues.

A requirement notice was served for a breach of regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. At this inspection we found this had been met.

A focused inspection was undertaken in July 2016. This inspection looked only at the safe domain. There were issues raised in relation to observation windows in bedroom doors being left locked in an open position and a requirement notice was served for a breach of regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. At this inspection we found this had been met.

Two of the wards, Parsonage and Golborne wards, opened in 2017 and have not been inspected before.

Before the inspection visit, we reviewed information that we held about the service and asked a range of other organisations for information.

During the inspection visit, the inspection team:

- visited all four wards, looked at the quality of the ward environment and observed how staff were caring for patients;
- spoke with seven patients who were using the service;
- spoke with eight carers;
- spoke with the ward managers at each ward;

Wards for older people with mental health problems

- spoke with 28 other staff members; including support workers, doctors, nurses, occupational therapy staff, pharmacists and domestic staff;
- spoke with one advocate;
- attended and observed one planning meeting;
- attended and observed one multidisciplinary review meeting;
- attended and observed one handover meeting;
- looked at 16 care and treatment records of patients;
- undertook observations including observations using the short observation framework for inspection tool;
- attended and observed ward based activities, including breakfast groups, exercise groups, art groups and a karaoke session;
- carried out a specific check of the medication management on two wards;
- reviewed 45 prescription charts and
- looked at a range of policies, procedures and other documents relating to the running of the service.

Summary of this service

Our overall rating of this service went down. We rated it as inadequate because:

- There were considerable issues with safety of this service. Patients were at risk because mixed sex accommodation was not managed safely. There were infection and contamination risks when incidents were not promptly managed and equipment was not maintained. Moving and handling plans were not in place for those patients who needed them. Staff did not have all information needed to manage risks because ligature risk audits did not capture all risks and environmental risk assessments were out of date. Staffing levels on one ward were too low.
- Bed occupancy rates were high and patients were moved between wards. Beds were not always available in the nearest service to patients' homes. There were high levels of delayed discharge from wards and high levels of readmission shortly after discharge.
- On all wards, there were issues with food choices and the availability of sufficient food to enable patients to choose meals that they wanted.
- There was a lack of senior management oversight of these wards in terms of identifying and addressing systemic risks. This included addressing the ongoing staffing shortages on Kingsley ward. Whilst audits were completed, the frequency of these was too far apart, for example, mattress audits every six months where not all mattresses were examined. When issues were identified, these were not checked more quickly (for example, infection control audits on Rydal ward were carried out annually, despite there being issues at audit and the same issues still present at the re-audit). Issues were escalated to the risk register for prolonged periods with no action taken, for example, a garden which patients could not use without staff present had been on the risk register for 18 months.

However:

- Nursing staff completed thorough risk assessments and care plans. There was adequate medical cover and good physical healthcare. There was innovative practice in relation to falls prevention.

Wards for older people with mental health problems

- Staff were kind and caring, and carers gave positive feedback about care of loved ones. There was excellent provision for activities on all wards, with occupational therapy staff and activity co-ordinators providing a varied range of activities and exercise.
- Ward managers were described as supportive and valued, and staff described a good morale within their teams.

Is the service safe?

Inadequate ● ↓

Our rating of safe went down. We rated it as inadequate because:

- Staff did not ensure the safety by separating the accommodation for men and women on Kingsley and Parsonage wards. Both wards admitted men and women to bedrooms on the same corridors. On Parsonage and Kingsley wards, we observed patients entering other patients' bedrooms along these corridors. Staff were not always present in the corridors. This meant that they might fail to see and intervene in incidents that took place in these areas of the wards.
- There were female only lounges on each ward. These were locked on Golborne and Parsonage ward and on Rydal and Kingsley wards they were used for other purposes, including family visits.
- Despite what we found, the trust had reported no breaches of the national guidance on eliminating mixed sex accommodation within this core service in the last 12 months. The trust had not provided staff with guidance as to what would constitute a breach.
- On Kingsley ward, there was a shared bedroom for two patients and the trust had no plans to eliminate this shared accommodation.
- Environmental risk assessments were over 12 months old on three of the four wards. Two had been completed for wards prior to opening. On all wards, there were ligature risks that had not been identified on ligature audits.
- There were maintenance issues including a number of bedrooms where paint was peeling and a radiator cover was rusty on Kingsley ward. On Golborne ward, there were sharp edges protruding from a damaged visibility window on a bedroom door.
- On Parsonage ward and on Kingsley ward, staff did not ensure that the ward was cleaned when required. This could result in contamination and raised risk of infection.
- Staff on Parsonage ward, were not using moving and handling equipment correctly. Also, not all of the equipment was fit for purpose and some items had not been cleaned. On Rydal ward, a hoist was in a poor state of repair including flaking paint and rusted. Disposable slings were being re-used. This posed a risk to patients.
- There was no standardisation of documentation across the trust for moving and handling assessment and the trust policy did not provide practical guidance to staff. Moving and handling assessments and plans were not in place for all patients who needed these.
- Staffing levels were too low on Kingsley ward with impacts on patients including delays promptly attending to personal care, cancelled activities and delays in receiving prescribed medicines.
- The wards had blanket restrictions in place which were not based on risk. These included restricting patients' access to lounges and gardens which were locked by staff.
- On Parsonage ward, we raised two patient related medicines concerns with the ward manager.

Wards for older people with mental health problems

- Patient bedroom alarm buttons were not easily accessible on Parsonage and Kingsley wards. On Kingsley ward, these were not near beds and were unreachable with bed rails in situ. On Parsonage ward, these were behind the head of the beds. This meant that patients may not be able to summon assistance if needed.

However:

- Clinic rooms in all four wards were kept clean and tidy.
- There was adequate medical cover and a doctor could attend the ward in an emergency.
- Nursing staff regularly reviewed and updated risk assessments.
- Staff used de-escalation techniques frequently and the least restrictive interventions.
- Lessons learned and feedback from investigations was shared in staff team meetings.

Is the service effective?

Good  → ←

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

- Medical and nursing staff completed thorough admission assessments, including mental state and physical health.
- Patients received good physical healthcare
- Staff had implemented innovative practice in relation to falls prevention, including comprehensive multifactorial falls assessments and regular multidisciplinary falls clinics.
- Staff completed induction and mandatory training when they commenced employment
- Regular and effective multidisciplinary team meetings took place.
- Staff demonstrated good practice in relation to the Mental Capacity Act.

Is the service caring?

Good  → ←

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

- Staff were kind, respectful and caring towards patients.
- Staff engaged patients in several activities which were varied and well planned.
- Carers gave positive feedback about the care that staff provided to their loved ones.
- Staff involved patients and carers in the care planning process.
- Each of the wards ran a carers group.
- Patients were aware of advocacy services.

However:

- Two patients gave mixed feedback about their care. They told us that staff did not always knock on the bedroom door before entering and that some staff could be impatient and less approachable.

Wards for older people with mental health problems

Is the service responsive?

Requires improvement ● ↓

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

- The service did not cater for patients' individual food choices. This meant that patients' choice of food might not be available and this created a risk that patients might not eat a sufficient amount of food to meet their nutritional needs.
- There were high rates of delayed discharge within this service, with nearly 50% of patient discharges being classed as delayed.
- Parsonage ward had been built with fixed beds. This presented challenges for the patient group, particularly those with mobility problems. Golborne ward had bedroom furniture which was not suitable for this patient group.
- There were no shower curtains in the assisted bathrooms in Kingsley and Golborne wards.

However:

- There was excellent provision for activities on all wards, with occupational therapy staff and activity co-ordinators providing a varied range of activities and exercise.
- Staff visited regularly from a "pets as therapy" service and this was well regarded by patients and staff.
- Patients and carers knew how to raise concerns or complaints.

Is the service well-led?

Inadequate ● ↓↓

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

- There was a lack of higher level oversight of these wards in terms of identifying and addressing systemic issues, including ongoing staffing issues.
- The trust had failed to adhere to NHS guidance in relation to mixed sex accommodation and had no guidance or policies to advise staff. The lack of gender specific bed areas on Kingsley and Parsonage wards had potential impacts for patients in terms of safety as well as privacy and dignity concerns which had not been identified.
- The trust did not have adequate arrangements to audit quality and safety on these wards. Staff did not complete key audits frequently enough of, for example, infection prevention and mattresses. Environmental audits for three of the four wards were over 12 months old and completed as self-assessments by ward managers. Two of these were completed before the wards had opened and had not been re-assessed since.
- Managers had taken a long time to resolve some issues that had been escalated to the risk register.
- The move to borough-based management meant there was no overall management of these services collectively as specialist services for older people. This meant that services were managed by different managers in each borough, who also had responsibility for adult services and community services. This meant issues which were apparent in one ward would not necessarily be known or addressed in identical wards in other boroughs.

Wards for older people with mental health problems

- Some allied health professionals were split across services or wards as a result of the changes and were struggling with a higher workload.

However:

- Nursing staff were positive about their colleagues and managers and felt valued and respected.
- There was a strong sense of working together in ward and multidisciplinary teams.

Areas for improvement

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

Wards for people with a learning disability or autism

Requires improvement  

Key facts and figures

North West Boroughs Healthcare NHS Foundation trust provides inpatient services for individuals with a learning disability or autism to the populations of Halton, Knowsley, St Helens, Warrington and Wigan.

The service consists of one ward, called Byron ward located at Hollins Park hospital in Warrington. Byron ward is a nine bed mixed gender ward. The ward worked closely with community learning disability teams in each of the localities.

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

This core service was last inspected in July 2015. The service was rated as good overall and in each of the five domains. We did not issue any requirement notices.

Before the inspection visit, we reviewed information that we held about the service and asked a range of other organisations for information.

During the inspection visit, the inspection team:

- visited the ward, looked at the quality of the ward environment and observed how staff were caring for patients
- spoke with two patients who were using the service
- spoke with two carers
- spoke with senior management within the specialist service clinical network
- spoke with the ward manager and nine other staff members; including doctors, nurses, healthcare assistants, pharmacists, activity workers and domestic staff
- attended and observed one ward round and one handover
- looked at six care and treatment records of patients
- carried out a check of medication management on the ward and reviewed prescription charts for all patients
- looked at a range of policies, procedures and other documents relating to the running of the service.

Summary of this service

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

- The ward was not delivering care in line with national guidance and best practice. The service was not operating as an assessment and treatment ward. The ward did not have a robust framework to deliver positive behavioural support. However, the trust were aware of this and were rolling out a framework at the time of our inspection.
- There was no coherent and consistent approach to reducing the use of restrictive interventions such as restraint and seclusion. There were restrictive practices on the ward that had not been identified or reviewed.
- We observed inappropriate and aggressive behavior towards a patient. We observed one patient wait 15 minutes for assistance to change their clothing following a period of incontinence.

Wards for people with a learning disability or autism

- Some clinical equipment was overdue trust mandated maintenance checks. Personal emergency evacuation plans were not in place.

However:

- The service had reviewed its staffing establishment and managed staffing levels to ensure patient safety. Staffing levels were reviewed in daily safety huddles. The ward manager was able to access bank and agency staff and staffing levels were adjusted to meet need.
- Staff assessed and monitored the physical healthcare needs of patients. They referred patients to appropriate specialist services when indicated and supported them to attend appointments.
- Patient and carer feedback on staff was generally positive. However, carers we spoke with told us they would like to see improved communication.
- Patients had access to a range of facilities. Activities were provided seven days a week. Patients were encouraged to maintain contact with families and to engage with the community.
- Staff morale was positive. Staff told us they felt valued and supported. Staff worked well together as a team.

Is the service safe?

Requires improvement  

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

- Patients did not have personal emergency evacuation plans in place. This meant there was a risk that vulnerable patients who required assistance to vacate the building in the event of an emergency, would not receive the support they needed.
- Some clinical equipment was overdue trust mandated annual maintenance checks.
- There were blanket restrictions in place on the ward which were not based on patients' individual risks. Some of these restrictions compromised patients' dignity, choice and independence.
- There was no clear strategy to reduce the use of physical interventions or restrictive practices. This was not in line with best practice guidance.
- When staff assessed patient risks, they did not use a specialist learning disability risk assessment tool.

However:

- Risk assessments that were in place had been reviewed and were up to date.
- The ward's seclusion facility was appropriate for use and complied with Mental Health Act Code of Practice requirements.
- There was good medication management. Pharmacists visited the ward each day. Staff prescribed medication was prescribed in line with the stopping over medication of people with a learning disability or autism agenda.
- The staffing establishment had been set following a staffing review. Daily safety huddles were held to ensure appropriate staffing levels. There was access to bank and agency staff where required.
- Compliance with mandatory training was high.
- The service had procedures in place to review, investigate and learn from adverse incidents.

Wards for people with a learning disability or autism

Is the service effective?

Requires improvement ● ↓

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

- The service was not operating as an assessment and treatment ward. The ward was not consistently delivering recovery focused interventions to all patients. The delivery of care was not fully aligned to the transforming care agenda.
- Assessments of patients needs and care plans were not always comprehensive. Staff did not use care plans which were in an accessible format for the patient group despite these being available.
- The ward did not have a robust framework in place to facilitate the delivery of positive behavioural support. Positive behavioural support plans that were in place were of varied quality and did not always follow the principles of positive behavioural support. Staff were not trained in the use or implementation of positive behavioural support plans. Staff did not always effectively use proactive strategies to de-escalate challenging behaviour.

However:

- Staff provided patients with good physical healthcare. Staff referred patients to specialist healthcare professionals when this was required.
- Qualified nursing staff received clinical supervision. However, this was not always clearly recorded.
- Staff received an induction when they started working on the ward. They received regular managerial supervision and annual appraisals.
- The ward did not have a dedicated clinical psychologist but staff could refer patients to a clinical psychologist in one of the community teams. We saw evidence of psychological involvement in care records we reviewed.
- Compliance with the Mental Health Act and Mental Capacity Act was good. Staff had completed training in both Acts.

Is the service caring?

Requires improvement ● ↓

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

- We observed inappropriate and aggressive behavior towards a patient.
- We observed one patient waiting 15 minutes for assistance after being incontinent.
- Patient involvement in decisions about their treatment and care was not always evidenced in care plans. Care plans were not always person centred.
- It was not clear that patients had been offered a copy of their care plan.
- Staff did not routinely offer carers a carers assessment.

However:

- The majority of engagement between staff and patients that we observed was positive. In these instances, staff were caring and respectful.

Wards for people with a learning disability or autism

- Carers we spoke with told us they had been involved in aspects of care planning for their loved one.
- Patient and carer feedback on staff was generally positive. Staff were described as kind and caring.

Is the service responsive?

Requires improvement  

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

- There were delayed discharges which reflected the fact the ward was not operating to an assessment and treatment model. Discharge planning did not always start at the point of admission.
- The average length of stay exceeded the expectation for an assessment and treatment ward. The expected length of stay for an assessment and treatment ward should be between four to 12 weeks. The average length of stay on Byron ward was between 20 to 31 weeks.

However:

- Patients had access to a range of facilities. These included lounges, quiet areas, an activity room and outdoor space.
- Patients had access to a range of activities. There was a dedicated activity worker and a well-equipped activity room. Patients were engaged with the community.
- Patients' spiritual and religious needs were identified and met.
- There was a process to manage and learn from complaints. Information on how to make a complaint was available to patients and carers.
- Patients and carers had access to a range of information. However; information was not always presented in an easy read format.

Is the service well-led?

Requires improvement  

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

- We rated the safe, effective, caring and responsive domains as requires improvement.
- The service was not functioning as an assessment and treatment ward. The service was not following best practice in terms of positive behavioural support. Service management were aware of these issues and had plans in place to address them.
- Managers did not have full oversight of staff compliance with clinical supervision because this was not effectively recorded.

However:

- Staff considered managers to be approachable and supportive.
- Staff had access to a risk register. High level risks could be escalated up to the board framework. This meant that senior managers had oversight of the risks associated with the service.
- Staff morale was generally positive. Overall staff felt supported and respected.

Wards for people with a learning disability or autism

Areas for improvement

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

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

Good   

Key facts and figures

North West Boroughs Healthcare NHS Foundation Trust had ten acute wards for people of working age across five hospital locations for adults who required hospital admission due to their mental health needs. The trust also had one psychiatric intensive care unit for people of working age who required higher staffing levels and more intensive support. The wards provided assessment, treatment and care for adults who had functional mental health problems (such as depression, schizophrenia or bipolar disorder).

The wards consisted of;

- Austen Ward was a ward for men at Hollins Park hospital, Warrington with 17 beds.
- Sheridan Ward was a ward for women at Hollins Park hospital, Warrington with 16 beds.
- Iris Ward was a ward for women at St Helens Hope and Recovery centre, Peasley Cross with 15 beds.
- Taylor Ward was a ward for men at St Helens Hope and Recovery centre, Peasley Cross with 17 beds.
- Bridge Ward was a ward for men at the Brooker centre, Halton hospital with 14 beds.
- Weaver Ward was a ward for women at the Brooker centre, Halton hospital with 14 beds.
- Grasmere Ward was a ward for women at Knowsley resource and recovery centre, Whiston hospital with 15 beds.
- Coniston Ward was a ward for men at Knowsley resource and recovery centre, Whiston hospital with 18 beds.
- Westleigh unit was a ward for women at Atherleigh Park with 20 beds.
- Sovereign unit was a ward for men at Atherleigh Park with 20 beds.
- Priestner's unit was a ward for both men and women at Atherleigh Park providing psychiatric intensive care with eight beds.

We conducted a comprehensive inspection of the trust's acute wards for adults of working age and psychiatric intensive care units in July 2015. We issued one requirement notice against regulation 12 for acute wards. This was for safe care and treatment due to ligature risks and the seclusion room environments on the wards. We returned in July 2016 and found that the trust had improved in these areas.

We carried out a focused inspection of the safe key question at Atherleigh Park in July 2017 following police concerns about how staff were managing patients who went absent without authorised leave. We issued two requirement notices against regulation 12 and regulation 17 for acute wards. These were for safe care and treatment due to staff not always acting fully when a patient went absent without authorised leave and for good governance as the trust did not have a policy to guide staff on what to do when patients went absent without authorised leave and the quality of the recording of such incidents. On this inspection we looked to see if staff had made improvements in these areas and saw that improvements had been made.

The team that inspected the wards for wards for adults of working age and the psychiatric intensive care unit comprised of two CQC inspectors, two CQC assistant inspectors, two CQC pharmacist inspectors, and three specialist advisors which were two mental health nurses and one staff grade mental health doctor and an expert by experience. Experts by Experience are people who have personal experience of using, or caring for someone who use, health or mental health services.

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

We carried out unannounced visits on 18 to 20 June 2018 to all the trust's acute wards for adults of working age and psychiatric intensive care units.

During this inspection we:

- visited all of the wards at five hospital locations
- looked at the quality of the ward environments
- observed how staff were caring for patients
- spoke with 61 patients and 4 carers
- spoke with the managers or senior nurse in charge for each of the wards and two service managers
- spoke with 38 members of staff from a range of disciplines and roles. Staff we spoke with included consultant psychiatrists, nurses, clinical psychologists, occupational therapists and nursing assistants
- looked at 58 care records
- attended five multidisciplinary meetings
- looked at all of the clinic rooms
- looked at the arrangements for the management of medicines including looking at 96 medicine charts
- looked at records about the management of the service including policies, incident records, minutes of meetings and results of audits.

Summary of this service

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

- The wards provided a safe environment. The seclusion room at St Helens had been moved into a quieter area away from reception. Staff carried out ongoing risk assessments on patients. Staff and clinicians were better at recording and managing the risks when patients went on section 17 leave and went absent without leave. Where incidents had occurred, staff took appropriate action to address them, change their practice and learnt lessons.
- Patients received input from a full multidisciplinary team and in line with national standards. Staff provided a range of interventions for patients with specific types of problem, including a self-injury pathway. Staff provided support to ensure that patients received appropriate physical health care. There were good systems in place to support adherence to the Mental Health Act and there had been improvements on areas we raised such as consent to treatment recording. Where staff carried out mental capacity assessments, these were decision specific and followed the principles and stages set out in the Mental Capacity Act.
- Many patients were positive and were happy with the quality of care and support. We observed staff providing support to patients in a caring manner and staff knew patients well. Patients were encouraged to be involved in decisions that affected them and developing their care plans. There were wider patient involvement initiatives such as the secret diner initiative. Patients had access to independent advocacy input.
- Most patients were receiving care close to home and patients could access a bed in their local area. Staff discussed discharge plans with patients routinely throughout their admission. The wards had a range of rooms and facilities for patients with the wards at Atherleigh Park also having an activities hub with many more facilities. There had been low numbers of complaints across the acute wards and patients knew how to complain.

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

- There was good local leadership and most ward staff felt well supported with the exception of some staff at Atherleigh Park. The trust had identified pressures on some wards with staff vacancies and low numbers of experienced qualified staff. This was reflected on the trust risk register. Governance arrangements and audit checks were largely good, with good adherence to requirements relating to staffing, training and mental health legal requirements. There were a number of good practice initiatives such as the self-injury pathway.

However:

- Some seclusion rooms did not have controllable heating, subdued lighting or blinds at the window. There were a small number of reported delays of doctors attending seclusion episodes initially especially at night.
- On some wards there were a number of staff vacancies and higher numbers of preceptorship nurses but patient care was not adversely impacted. Some staff at Atherleigh Park did not feel fully supported and faced challenges of high acuity of patients and high numbers of admissions and discharges but this was reflected on the trust risk register. Bank staff did not routinely have prevention and management of violence and aggression training but there was always enough staff on the wards to manage incidents.
- Some wards were using initiatives to further reduce restraint on patients but this had not been rolled out across all wards and locations.
- While staff were managing most medicines appropriately, on some wards, there were a small number of opened medicine bottle and creams which were not labelled to state when they were opened.
- Although most care plans were of a good standard, some were not always fully personalised and holistic. Written discharge care plans were completed by staff but these were not always updated to reflect discussions in ward rounds where discharge was discussed.
- The wards were not displaying the correct CQC ratings poster but there were difficulties pulling the trust's correct ratings through on our website.

Is the service safe?

Good  

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

- Many of the ligature risks across the wards had been addressed with collapsible curtains and ligature free bathroom fittings.
- The acute wards were single sex and the psychiatric intensive care unit complied with the Department of Health guidance on same sex accommodation.
- The seclusion room at St Helens had been moved into a quieter area away from reception.
- Staff carried out ongoing risk assessments on patients. Staff and clinicians were better at recording and managing the risks when patients went on section 17 leave.
- There had been improvements in how staff responded when patients went absent without leave at Atherleigh Park and had current guidance to support them.
- Staff understood safeguarding procedures and took action to safeguard vulnerable patients.
- Patients were not subject to blanket restrictive practices and staff were working to reduce restrictions further.
- Staff uptake of mandatory training was good.

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

- Where incidents had occurred, staff took appropriate action to address them and learnt lessons.
- Staff were starting to carry out checks on patients prior to and following leave. This was in response to a small number of serious incidents involving patients who were awaiting discharge with extended leave.

However:

- Some seclusion rooms did not have controllable heating, subdued lighting or blinds at the window.
- On some wards there were a number of staff vacancies and higher numbers of preceptorship nurses but through the use of bank staff, patient care was not adversely impacted.
- Some wards were using initiatives to further reduce restraint on patients but this had not been rolled out across all wards and locations.
- Bank staff did not routinely have prevention and management of violence and aggression training but there was always enough staff on the wards to manage incidents.
- While staff were managing most medicines appropriately, on some wards, there were a small number of opened medicine bottle and creams which were not labelled to state when they were opened.
- There were a small number of reported delays of doctors attending seclusion episodes initially especially at night but the trust were unable to clarify the exact numbers.

Is the service effective?

Good   

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

- Patients received medical and clinical interventions in line with national standards.
- Patients received input from a multidisciplinary team which included a consultant psychiatrist, nurses and ward based designated clinical psychologists and occupational therapists.
- Staff provided a range of interventions for patients with specific types of problem. These included a self-injury pathway to provide more effective care and treatment to patients who self-harmed and dialectical behavioural approaches to manage patients with personality disorder in line with best practice.
- Staff undertook ongoing checks and provided support to ensure that patients received appropriate physical health care.
- There were good systems in place to support adherence to the Mental Health Act and there had been improvements on areas we raised on Mental Health Act monitoring visits such as consent to treatment recording.
- Where staff carried out mental capacity assessments, these were decision specific and followed the principles and stages set out in the Mental Capacity Act.

However:

- Although most care plans were of a good standard, some were not always fully personalised and holistic.

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

Is the service caring?

Good   

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

- Many patients were positive about the staff in the hospital stating they were happy with the quality of care and support.
- We observed staff providing support to patients in a caring manner and staff knew patients well.
- Patients were encouraged to be involved in decisions that affected them at ward rounds.
- Patients were involved in identifying their needs and developing their care plans.
- Patients were encouraged to be involved in the running of the wards through community meetings.
- There were wider patient involvement initiatives such as the secret diner initiative.
- Patients had access to independent advocacy input.

However:

- Some patients told us they were not happy but often this was because they were detained and did not want to be in hospital and they would prefer to be at home.

Is the service responsive?

Good   

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

- Patients were admitted through a bed manager in office hours and through home treatment out of office hours.
- Most patients were receiving care close to home and patients could access a bed in their local area.
- Staff discussed discharge plans with patients routinely throughout their admission.
- The wards had a range of rooms and facilities for patients including quiet rooms, gyms, art and activities rooms and relaxation rooms. The wards at Atherleigh Park had an activities hub with many more facilities.
- There had been low numbers of complaints across the acute wards and patients knew how to complain.

However:

- At Atherleigh Park, staff were managing high acuity of patients together with high admission and discharge rates leading to significant pressures and workload for ward staff.
- Although we saw evidence of good discharge planning, some patients had written discharge care plans which were completed by staff on admission with very broad details that were not updated to reflect discussions in ward rounds where discharge was discussed.

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

Is the service well-led?

Good  → ←

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

- There was good local leadership and most ward staff felt well supported with the exception of some staff at Atherleigh Park.
- Managers and senior nurses felt well supported.
- The trust had identified pressures on some wards with staff vacancies and low numbers of experienced qualified staff. This was reflected on the trust risk register.
- Governance arrangements and audit checks in place were largely good.
- There was good adherence to requirements relating to staffing, training and mental health legal requirements.
- One ward at Atherleigh Park was accredited by the Royal College of Psychiatrists and there were a number of other good practice initiatives such as the self-injury pathway.

However:

- Some staff at Atherleigh Park did not feel fully supported and faced challenges of high acuity of patients and high numbers of admissions and discharges but this was reflected on the trust risk register.
- The wards were not displaying the correct CQC ratings poster but there were difficulties pulling the trust's correct ratings through on our website.

Areas for improvement

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

Community-based mental health services for adults of working age

Good   

Key facts and figures

North West Boroughs Healthcare NHS Foundation Trust provides community based mental health support to adults of working age across the following areas:

- Halton
- Knowsley
- Leigh
- St Helens
- Warrington
- Wigan

The trust had three early intervention teams offering assessment, support and treatment for people experiencing their first episode of psychosis.

There were four assessment teams in Knowsley, St Helens, Warrington and Wigan. These teams offered a telephone triage and signposting service and face to face assessments and referrals onto other organisations and teams within the trust. These teams also offered short term intervention for people and provided the gatekeeping service for accessing inpatient beds.

Recovery teams were based in Halton, Knowsley, St Helens, Warrington and Wigan. These teams offered care coordination services and supported people whose care was provided under the Care Programme Approach. They also oversaw patients on a Community Treatment Order, which is part of the Mental Health Act to ensure patients engaged in their treatment. The teams ran the depot clinics too and consultants provided outpatients appointments as part of the recovery teams.

Home treatment teams were based in Knowsley, St Helens, Warrington and Wigan. These teams offered intensive support to people in their own homes from the hours of 8am to 8pm seven days a week. The aim of this service was to support people on discharge from hospital and to avoid hospital admissions.

Trust wide mental health services were:

- Attention Deficit Hyperactivity Disorder service, for diagnosis and ongoing monitoring of adults with attention deficit hyperactivity disorder.
- Secure services outreach offering support to patients discharged from forensic services.
- Criminal justice liaison, offering assessment, support and recommendations regarding whether it is in the public interest for patients to proceed through the criminal justice system.
- Specialist perinatal service, offering assessment and support for pregnant women and information and guidance to care coordinators who have pregnant women on their caseload.
- Skin camouflage service, providing medical creams for patients with self-harm scars to help improve confidence and mental wellbeing.

At this inspection we inspected the following teams:

Community-based mental health services for adults of working age

- Attention Deficit Hyperactivity Disorder service
- Secure Services Outreach
- Wigan Assessment team
- Wigan Recovery Team North
- Wigan and Leigh Early Intervention Team
- Early Intervention team St Helens and Knowsley
- Knowsley Recovery Team
- Early Intervention Team Halton and Warrington
- Recovery Team Warrington
- Warrington Home Treatment Team

Our inspection was short-notice announced (staff did not know we were coming) to enable us to observe routine activity.

We chose to inspect these teams because they were either teams that we had not inspected before or they had actions from the last inspection that we wanted to review if they had achieved.

At the last inspection in July 2015, we did not issue any requirement notices, however we did identify the following areas the trust should improve:

- The trust should ensure that the lone working policy is fully embedded and reviewed throughout the community teams and specifies who is required to check staff safety following visits and to improve the regularity of the checks.
- The trust should review and monitor their community bases where staff work alone and see patients in visiting rooms or within the community against the trust's associated policies and procedures for lone working to ensure staff and patients are safe.
- The trust should continue to review and monitor patients who are subject to the Care Programme Approach to ensure patients receive planned reviews and coordinated care they need.
- The trust should ensure that each team's operational guidance is updated to reflect the services provided by mental health services for adults of working age in the community.
- The trust should ensure staff receive clinical supervision and appraisals.
- The trust should provide the Care Quality Commission's contact details alongside the Mental Health Act (MHA) patient information, so that patients know where to make a complaint regarding the application of the MHA.
- The trust should ensure that the Warrington and Halton home treatment team review the use of their medicines cabinet to ensure their medicine storage facility is fit for purpose.

Before the inspection visit, we reviewed the information that we held about the service and asked a range of other organisations for information. During the inspection we:

- Spoke with 39 patients and four carers.
- Received 59 completed comments cards.

Community-based mental health services for adults of working age

- Spoke with 49 staff including administrators, doctors, nurses, occupational therapists, pharmacist, psychologists, social workers and support time and recovery workers.
- Spoke with 14 managers including team managers, heads of service, matrons, operational managers and assistant directors.
- Reviewed 56 care records.
- Completed a tour of all 10 team environments and clinic rooms.
- Observed two activities; allotment and smoking cessation group.
- Observed six consultations with patients.
- Observed three meetings; a referrals meeting, a multidisciplinary meeting and a team meeting.
- Reviewed a variety of documentation including incident data, meeting minutes and waiting lists.

Summary of this service

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

- Progress had been made following the last inspection in 2015, where we stated the trust should improve in several areas. We reviewed these as part of the inspection and found staff fully understood and followed the lone working policy, staff were reviewing patients on a CPA with the introduction of nurse-led reviews in between consultant reviews, staff received regular supervision and appraisal and the medicine storage concerns at Warrington and Halton home treatment team had been resolved.
- Patients and carers that we spoke with were happy with the service they received. Progress had been made in the involvement of patients in their care, by facilitating service user groups and activities they could participate in. These included anxiety education sessions and the recovery, education and support time group to increase patients understanding of their conditions and treatment options.
- Staff were passionate and positive about their roles. They reported enjoying working for the trust and felt supported by their managers.
- Record keeping was to a good standard, with comprehensive risk assessments, care assessments and care plans in the records we reviewed. Staff had made the transition to working with the new electronic record system successfully.
- The service delivered safe care and treatment to patients, with physical health screening taking place and the treatment provided was in line with best practice and national guidance.
- Innovations were in place with the street triage service in Warrington, trust wide perinatal service and secure outreach service. Teams had changed ways of working to provide efficiency with the introduction of the telephone triage service at the assessment teams and assessment practitioners at the early intervention teams. This reduced the waiting time for patients to access the service.
- Services were well managed with regular team meetings and supervisions taking place. There were a variety of methods of sharing information. Managers were involved in reviewing their team's performance.

However:

Community-based mental health services for adults of working age

- We were concerned about the access and waiting times for three of the services. At the Attention Deficit Hyperactivity Disorder service, patients were waiting for up to two years for an appointment. Wigan assessment team had 319 people on the waiting list. Face to face assessment appointments were being booked in for six weeks away.

Is the service safe?

Good   

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

- Staff had access to the equipment they required to monitor patients physical health. This included portable equipment which enabled them to complete screening in patients own homes.
- Caseloads were well managed with the use of the workforce calculator to agree caseload sizes, managers reviewed caseloads in supervisions and patients referred for care coordination could be allocated within a week of referral to the teams.
- Mandatory training levels were high for this core service, with compliance rates for all courses being above 75%.
- Staff were good at assessing and managing risks to patients. They completed individual risk assessments and used recognised rating scales with patients, where appropriate. Assessment teams were available 24 hours a day, seven days a week.
- Staff we spoke with were aware of the lone working arrangements, the policy and their role in relation to this.
- Staff had received training in safeguarding and staff we spoke with had a good understanding of what constituted a safeguarding concern and how to respond.
- Staff managed medicines well. Where stocks were held, these were all in date and tallied with the records. Equipment and stock for the depot clinics were all within date, tallied with records and was stored in an orderly fashion.
- Staff were aware of the need to report incidents and accidents via the electronic incident reporting system. Lessons learnt were shared across the services via the managers briefing notes and core brief. Staff gave examples of changes in practice following incidents.

However:

- Some equipment was out of date. This included one and a half boxes of blood collection systems and four boxes of plasters at Wigan and Leigh early intervention team and a batch of needles in the St Helens and Knowsley early intervention team. Managers were aware of this but they had not been disposed of.
- There were gaps in the medicine fridge temperature recording at St Helens and Knowsley early intervention team and the medicine fridge lock was faulty at Warrington recovery team.
- At the Attention Deficit Hyperactivity Disorder service, there was no system for reviewing the people on the waiting list regarding any increase in risk.
- We reviewed five incidents meeting the duty of candour threshold and found no evidence of a final letter with the investigation findings as stated in the regulation. The trust was not following the duty of candour regulation. This will be further explored in the trust well led report.

Community-based mental health services for adults of working age

Is the service effective?

Good   

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

- Records were well managed. All records reviewed had assessments in place, including the use of recognised rating scales to assess patients mental state and provide a baseline.
- Teams provided care and treatment in line with best practice in relation to the early intervention teams and the service offered. Annual health checks were provided to all patients in line with best practice.
- We saw examples of teams supporting patients to lead healthier lifestyles, including walking groups, smoking cessation group, an allotment and access to free gym membership.
- Teams were multidisciplinary, with nurses, occupational therapists, psychiatrists, psychologists and support time and recovery workers based within teams. Pharmacists worked into the teams on a weekly basis and were available via phone. Networking with other teams took place and we observed positive multidisciplinary working taking place.
- The teams met the requirements of the Mental Health Act. Staff we spoke with had a good understanding of their role in relation to the Mental Health Act. Mental Health Act documentation was in place and in order. Patients had access to advocacy.
- Staff we spoke with had a good understanding of the Mental Capacity Act. They followed the principles in their practice.

However:

- The trust's policy "Assessing mental capacity" did not follow the Mental Capacity Act as the policy stated, "decisions concerning mental capacity are made by the RMO" which the Mental Capacity Act does not stipulate. The community treatment order procedure did not include the appendices for staff.
- The Attention Deficit Hyperactivity Disorder service was not following best practice in relation to transition between children's and adult's services.

Is the service caring?

Good   

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

- The staff interactions with patients that we observed were caring, compassionate, supportive, respectful and staff involved patients in the decision-making process.
- Patients and carers told us that staff were very respectful, caring, knowledgeable and supportive, they were very complimentary about the care they received.
- Staff were aware of the individual needs of patients, we saw examples of interpreters being booked and written text being translated into the patients first language to aid communication.
- Patients were involved in the development of the services, with the opportunity to be involved in recruitment, training and the creation of pathways.

Community-based mental health services for adults of working age

- Patients had the opportunity to attend service user forums and contribute to the recovery newsletter.
- Support was available for carers. A carers support worker was available to refer into. Carers also reported attending mental health awareness groups and feeling fully involved in their loved one's care.

Is the service responsive?

Requires improvement  

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

- We were concerned about the waiting times for some of the community teams. Patients referred to the Attention Deficit Hyperactivity Disorder service could be waiting up to two years for an appointment. Within this time, patients could go without medicine, an assessment and review of their condition. At Wigan assessment team, patients were waiting up to six weeks for a face to face assessment appointment. Patients were waiting to access psychology for over 100 days at the recovery teams we visited.
- Twenty of the 39 patients we spoke with did not know how to complain.

However:

- The trust demonstrated clear processes for supporting patients and carers in making a complaint. Managers we spoke with knew how to manage complaints. They explained how they responded to low level concerns and recorded these within the electronic records which they showed us. Managers understood the formal complaints process and the trust oversight of this.
- Patients had the opportunity to increase their knowledge of mental health conditions, treatment and self-help skills with the option to attend service user forums, anxiety education sessions and a recovery, education and support time group. The early intervention teams provided support for people to return to employment or education.
- There was innovative practice in place, with the street triage service in Warrington, trust wide perinatal service and secure outreach service. Teams had changed ways of working to provide efficiency with the introduction of the telephone triage service at the assessment teams and assessment practitioners at the early intervention teams. This had reduced the waiting time for patients to access the service.
- All services had a variety of rooms where consultations could take place. Consultation rooms were mainly on a ground floor and were accessible for people with a physical disability. In locations where rooms were upstairs, lifts were available. The rooms had adequate soundproofing for privacy and dignity. Staff had access to weighing scales and height measurers and portable equipment for health screening.
- Services were flexible in meeting different needs of patients, with medicine information available in large font and symbols, access to interpreters and staff translated documents into patient's first language. Waiting areas had a variety of information on display, including the pending CQC inspection, self-help booklets, how to make complaints and compliments, family and friends tests were available for people to complete and return. Comments boxes were available in most of the teams for people to give feedback.

Is the service well-led?

Good   

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

Community-based mental health services for adults of working age

- Teams were well led. Team managers we spoke with were knowledgeable about the team they managed and their local teams and the interface between them.
- The trust provided a coaching opportunity for managers. This entailed pairing the manager with another leader who was more experienced and could offer guidance and support in leadership.
- Managers could access information regarding their services, were aware of the creation of trust documents including core brief and borough story. They knew how their teams were performing in relation to targets set by commissioners and whether they were delivering treatment in line with best practice.
- Team managers reported that senior managers were supportive. Staff knew who the senior managers were and confirmed they were visible within teams.
- Managers described the culture of the trust as supportive and as one that promoted coaching. Staff were respected, valued and were passionate about their roles and the teams they worked in. Staff reported managers were approachable and they could express concerns which would be listened to and acted on.
- Managers were aware of the items relating to their service that were on the risk register and were confident at being able to add additional risks. The risk register was accessible on the electronic system, managers showed us the system and their entries.

Areas for improvement

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

Child and adolescent mental health wards

Good   

Key facts and figures

The trust provides inpatient mental health care, support and treatment for children and young people aged 14 to 18 in a 10-bed ward at Fairhaven young people's unit in Warrington.

We inspected the unit in July 2015. We rated all five key questions as good and the service as good overall. However, in December 2017, we carried out a focused inspection following concerns raised to us about patient safety. We did not rate the service and looked only at specific areas. We found several areas for improvement, including three breaches of regulations relating to person-centred care (regulation 9), safe care and treatment (regulation 12), and staffing (regulation 18).

We found that these breaches had been met at the time of this inspection.

Our latest inspection was unannounced, which meant the ward did not know we were coming in advance. This enabled us to observe routine activity.

Before the inspection visit, we reviewed information we held about the service and asked other organisations for information.

The inspection team:

- visited the inpatient ward
- looked at the quality of the ward environment
- observed how staff interacted with and cared for young people
- spoke with five young people, two carers and a patient advocate
- spoke with the ward manager and eight other staff, including healthcare assistants, a consultant psychiatrist, nurses, a family therapist, a pharmacist and a social worker
- attended and observed one multidisciplinary morning meeting
- looked at care and treatment records of young people including prescription charts, seclusion records, progress notes and care plans
- attended and observed ward educational activities
- reviewed incident reporting processes and records
- looked at shift records and minutes for clinical workshops, community and team meetings
- checked medication management
- looked at policies, procedures and other documents relating to the running of the service.

Summary of this service

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

- Staff were caring and supportive of the young people in their care, showing respect and kindness to patients. The young people told us that they were treated with kindness, dignity and respect.

Child and adolescent mental health wards

- All young people underwent an assessment of need and care planning was holistic, recovery oriented and included their physical health needs.
- Multidisciplinary meetings were held and attendance by outside agencies and carers was encouraged. Good communication between outside agencies was evident and carers told us they were kept up to date with their relative's progress. This included in care planning and review meetings.
- Advocacy services were accessible and available to all young people. The advocate was active in the ward area and supported the young people to have a voice in meetings including community meetings.
- The ward was clean and tidy and staff followed infection control procedures. The ward environment was checked regularly.
- Environmental observational and ligature risks were identified and regular environmental checks were conducted. Action plans were in place to mitigate against these risks.
- The clinic room was equipped to support healthcare needs and emergency equipment was available to staff. Medical equipment was subject to regular maintenance checks.
- Medicines were dispensed and stored securely in line with trust policy. Regular medicines management audits took place.
- Young people were supported by a skilled multidisciplinary team which included nursing, psychiatrist and psychology staff. The ward had recruited to the vacant occupational therapy post. Young people also had the opportunity to continue with their educational development.
- Treatment practices including physical healthcare was based on nationally recognised guidance.
- Care planning was holistic, individual risks were reviewed regularly. Young people and their carers were encouraged to be involved in this process.
- Safeguarding processes were in place and understood by all staff. There was a clear reporting structure and staff had undertaken level 3 safeguarding training. Any concerns relating to child protection were communicated to the relevant protection agencies.
- Young people and carers knew how to complain and were aware of the complaints procedure.
- An admission criteria was in place and referral waiting times, delayed discharges and length of stay was monitored.
- Staff were trained in the Mental Health Act and Mental Capacity Act. Staff had support from a Mental Health Act administrator and young people were given information and support in understanding their rights.
- There were systems in place with clear lines of accountability in the operational delivery of the service with an established governance structure supporting decision making. Performance management and quality reporting and monitoring which included identified risks were discussed in governance forums with action taken to address these.
- Staff were aware of the visions and values of the trust and were committed to improving and developing quality services with the young people in their care.

However:

- The Mental Health Act Code of Practice was not being fully followed, with a number of blanket restrictions present across the service.
- Individual clinical supervision and team meetings were not regularly recorded. This meant it was not possible for the service to monitor if staff had been fully supported.

Child and adolescent mental health wards

- When young people had been restrained, records did not consistently give full information to describe the intervention used.
- There were gaps in cleaning records for the service.
- Required medication was not reviewed every 14 days as stipulated by the trust guidance in order to ensure appropriate medication usage.
- Patient choice at meal times could not always be facilitated.
- Activities had been limited whilst the activities coordinator and occupational therapist posts were being filled. This had impacted upon the young people's satisfaction with finding activities to fill their time on the ward.
- Leaflets and information available to young people were not always available in a child friendly format.

Is the service safe?

Good   

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

- The ward was clean and well maintained. Difficulties in observation of young people were mitigated with the use of mirrors and restricting their access to high risk areas of the ward.
- Staff routinely monitored all areas of the ward to ensure the environment was safe.
- Staff discussed individual risks and how these could be mitigated each morning, to ensure that the safety of the young people was maintained.
- There was a fully equipped clinic room with accessible emergency equipment. Infection prevention and control procedures were in place.
- Weekly medicines management audits were conducted jointly by a pharmacist and a senior member of the ward team to ensure medication was safely managed and used.
- Staffing was reviewed regularly and young people were supported by a sufficiently skilled multidisciplinary team. Mandatory training compliance was above the trust target which was an improvement since our last inspection.
- Staff were encouraged to use approaches which avoided the use of physical restraint. The service had changed its policy as to how staff managed risk and responded to incidents of aggression. Staff used de-escalation and were trained to use restrictive practices only as a last resort to keep patients and staff safe. The incident of restraint had significantly reduced over the past six months.
- Staff understood their role in recognising and preventing potential abuse. Staff received training on safeguarding both adults and children. Staff completed safeguarding records comprehensively and in a timely manner to ensure the safety and wellbeing of vulnerable people.
- Staff knew how to report incidents and managers shared lessons learned from investigations with staff to help improve safety.
- Records were stored electronically and information governance systems were in place to ensure the security of the medical records.

However;

Child and adolescent mental health wards

- When young people had been restrained, records did not consistently give full information to describe the intervention used.
- There were gaps in cleaning records for the service.
- Required medication was not reviewed every 14 days as stipulated by the trust guidance in order to ensure appropriate use of medication.

Is the service effective?

Good ● ➡ ➡

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

- Physical health monitoring was undertaken regularly on a weekly basis and following the administration of rapid tranquilisation.
- The multidisciplinary team members reviewed care goals, potential obstacles and achievements for the week ahead for two patients each day.
- All young people underwent an assessment of need. Care planning risks and reviews were undertaken regularly and young people and their carers were involved in this.
- Treatment practices were based on nationally recognised guidance and standardised outcome measures were used.
- Staff made patient referrals to other services when this was required including physiotherapists and speech and language therapists.
- Group training workshops took place for staff to develop their understanding on different topics.
- The service maintained close working relationship with the independent Mental Health Act advocate and worked in collaboration with the advocate to help young people. Patients had timely access to the advocate as required.
- A range of psychological interventions including family therapy, cognitive behavioural therapy and dialectic behavioural therapy was available to young people.
- Regular multidisciplinary meetings were held and attendance by outside agencies and carers was encouraged.
- Staff were trained and had a good understanding of the Mental Health Act and the Mental Capacity Act. Staff followed local procedures and support was available from Mental Health Act administrators.

However:

- Young people could only access their mobile phones and tablets for two hours during the evening, which was a restrictive practice and not in accordance with the Code of Practice.

Is the service caring?

Good ● ➡ ➡

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

- The young people spoke positively about their experiences of the care and treatment they had received.
- We observed positive, kind and supportive interactions between staff and the young people.

Child and adolescent mental health wards

- Young people were orientated to the ward and given key information when they were admitted.
- Young people were invited to participate in conversations about their care including ward rounds and care and treatment reviews.
- Community meetings were held which the advocate was invited to and young people could engage with the service and share ideas.
- Carers spoke positively about their experiences of the service and felt included in their relative's care, having been invited to carers meetings and events.
- Surveys relating to the young persons and carer experience were regularly undertaken.

Is the service responsive?

Good   

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

- The physical ward environment promoted young people's comfort, dignity and confidentiality.
- The ward was accessible to young people with disabilities including those with a mobility impairment.
- The ward had a clear admission criterion. Referral systems, waiting times, delayed discharges and length of stay were monitored. Strategies were in place to reduce the length of stay.
- Young people's bedrooms were deemed their personal space and were available for them when they returned from leave.
- Patients had access to snacks, cold and warm drinks. Young people were encouraged to eat healthy choices and develop independence by choosing the ingredients of foods to cook.
- Education provision was available for all young people.
- Young people were supported to maintain contact with carers and family members where appropriate.
- Any identified spiritual needs and cultural requirements were supported by staff.
- Young people and carers were aware of the complaints process. Complaints and compliments were regularly reviewed and any learning was acted upon to improve the quality of care.

However:

- Patient choice at meal times could not always be met.
- Activities had been limited whilst the activities coordinator and occupational therapist posts were being filled. This had impacted upon the young people's satisfaction with finding activities to fill their time on the ward.
- Leaflets and information available to young people were not always available in a child friendly format.

Is the service well-led?

Good   

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

Child and adolescent mental health wards

- Staff felt supported and told us that the new ward manager had made a positive impact on the service.
- Staff had an awareness of the values of the organisation and staff regularly reflected on these.
- Daily catch up meetings which involved all members of the multidisciplinary team were improving team working and planning across the service.
- The trust was committed to improving services and governance systems were in place to monitor most aspects of care delivery. Performance management and quality reporting was clearly set out and risks were identified and monitored.
- Performance issues were escalated and discussed at relevant governance forums and action was taken to address emerging issues.
- Staff were involved in the governance processes within the service, their views were sought to support a commitment to quality care.

However:

- Individual clinical supervision and team meetings were not regularly recorded. This meant it was not possible for the service to monitor if staff had been fully supported.

Outstanding practice

Areas for improvement

We found areas for improvement in this service.

Action we have told the trust they SHOULD take:

- The trust should ensure it has the appropriate facilities and provision available to ensure young people have a full and varied compliment of activities available each day to promote their recovery and independence.
- The trust should review the use of restrictive practices such as mobile phones and internet access to ensure any such restrictions are based on individual risk assessments.
- The trust should record and monitor compliance with clinical supervision for nursing staff.
- The trust should consider patient choice when menu planning for the ward.
- The trust should ensure the provision of age appropriate patient information.
- The trust should review as required medicines in line with trust policy.

This section is primarily information for the provider

Requirement notices

Action we have told the provider to take

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

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

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

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

Regulated activity

Nursing care
Treatment of disease, disorder or injury

Regulation

Regulation 9 HSCA (RA) Regulations 2014 Person-centred care

Regulated activity

Diagnostic and screening procedures
Nursing care

Regulation

Regulation 10 HSCA (RA) Regulations 2014 Dignity and respect

Regulated activity

Assessment or medical treatment for persons detained under the Mental Health Act 1983
Treatment of disease, disorder or injury

Regulation

Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment

Regulated activity

Assessment or medical treatment for persons detained under the Mental Health Act 1983
Nursing care
Treatment of disease, disorder or injury

Regulation

Regulation 13 HSCA (RA) Regulations 2014 Safeguarding service users from abuse and improper treatment

Regulated activity

Nursing care
Treatment of disease, disorder or injury

Regulation

Regulation 14 HSCA (RA) Regulations 2014 Meeting nutritional and hydration needs

This section is primarily information for the provider

Requirement notices

Regulated activity

Accommodation for persons who require nursing or personal care

Treatment of disease, disorder or injury

Regulation

Regulation 15 HSCA (RA) Regulations 2014 Premises and equipment

Regulated activity

Nursing care

Treatment of disease, disorder or injury

Regulation

Regulation 18 HSCA (RA) Regulations 2014 Staffing

Our inspection team

The team included a Head of Inspection an Inspection Manager, eight inspectors, two mental health act reviewers, three pharmacy reviewers, two assistant inspectors, 13 specialist advisers and five experts by experience.

Specialist advisers are experts in their field who we do not directly employ. Experts by experience are people who have personal experience of using or caring for people who use health and social care services.