Care Quality Commission

Coventry and Warwickshire Partnership NHS Trust

Quality Report

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Date of publication: 17/04/2014
Date of inspection visit: 21-24 January 2014

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

Summary of findings

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Overall summary

Coventry and Warwickshire Partnership Trust was formed in 2006 and integrated with community services from NHS Coventry in April 2011.

The Trust provides the following services:

Brooklands Solihull (8 Units)
Core service provided: Medium secure forensic unit; Two specialist assessment and treatment units for people aged16 – 25 and 18+ years Three Low secure units; Two Adolescent Specialist Assessment and Treatment units12 – 19 year

Total Bed Capacity: 95

St Michael's Warwick (5 Wards)
Core service provided: Two Acute admission wards, a Psychiatric intensive care ward; health-based place of safety; Long stay/forensic/secure wards, one of which is men only

Total Bed Capacity: 78

Caludon Centre Coventry (8 Wards)
Core service provided: Two older peoples wards; Intensive care unit; Place of safety suite; four acute admission wards (one women only); one ward for people with a learning disability

Total Bed Capacity: 112

Caludon Centre includes the following services:

Community based mental health and community health services
Core service provided: These services are mainly provided in a person's home.

The Aspen Centre Warwick
Core service provided: Specialist treatment for people aged 16 and over with a severe eating disorder.

Total Bed Capacity: 16

Hawkesbury Lodge in Longford, Coventry.
Core service provided: Secure rehabilitation unit for men and women

Total Bed Capacity: 20

Highfield House Nuneaton
Core service provided: Community-based rehabilitation unit for men and women.

Total Bed Capacity: 8

The Manor Hospital Nuneaton
Core service provided: Secure assessment and treatment service for over 65 years

Total Bed Capacity: 12

Woodloes Avenue Warwick
Core service provided: Acute assessment and treatment to people over 65 years

Total Bed Capacity: 25

Lyndon House in Solihull
Core service provided: Respite service for children with learning disabilities, behaviours that can challenge and additional physical health needs.

Total Bed Capacity: 7

Gramer House and Holly House North Warwickshire
Core service provided: Respite service for children with learning disabilities, behaviours that can challenge and additional physical health needs.

Total Bed Capacity: 4 and 3

Bradbury House in Coventry
Core service provided: Respite care for children with learning disabilities and behaviours that may challenge.

Total Bed Capacity: 7

The Birches in Coventry
Core service provided: Respite care for children with learning disabilities and additional physical health needs.

Total Bed Capacity: 7

The provider headquarters is based at Wayside House in Coventry. Coventry and Warwickshire Partnership NHS

Summary of findings

Trust serves a population of 1,053.000, of which 850,000 live within Coventry and Warwickshire, with delivery of very specialist services to a wider geographical area. It provides integrated services such as all age mental health, specialist services, primary care and prevention, integrated children's services and all age community services. The trust has a total of 80 sites spread over 870 square miles. The trust has a budget of £200 million, employing 4000 whole time equivalent staff.

The trust has a bed occupancy rate of 93.3% compared to the England average of 85.2%. We found the high bed occupancy rate sometimes had a negative impact on the use of beds held for people on leave and the ability to properly segregate accommodation for men and women.

The Board was working hard at leading the trust through a transformation agenda supported by core values. However, this was unsettling for staff who expressed these concerns to us during the inspection. Some staff reported feeling well informed; however, others told us they felt unsupported by the trust and were afraid to raise concerns.

We found from the sites we visited that there were inconsistencies across the trust in staff practice and this had an impact on the Board's ability to be aware of the risks within the organisation regarding quality and safety. There was inconsistency in safe storage and administration of medication and practices, and some inconsistency in adhering to the Mental Health and Mental Capacity Acts.

There was not enough overview of the Board's groups and subgroups to bring issues together from the CQC Mental Health Act monitoring visits.

There were examples of very good practice in one service that was not mirrored at another and good practice was not shared even within the same hospital site. Where an experienced ward-based manager offered good leadership, there were positive outcomes for patients and staff; these included access to information, staff supervision and development, following the safeguarding process and addressing concerns promptly.

Staff employed by the trust were caring and committed, made good patient care and safety central to their work,

and interacted well with patients. People told us about individuals who gave excellent care and support. We also saw some examples of good physical healthcare in a mental health setting.

We found where wards were poorly staffed and where they frequently used agency workers or non-permanent staff, the ability of staff to provide consistent and compassionate care was reduced. We found a lack of age appropriate activities and access to facilities. This was partly due to a lack of consistent support.

Some teams were without a manager for long periods. Others reported that where they had a manager, they had not had team meetings and therefore were unaware of changes and other messages from the trust.

We saw some good evidence of multi-disciplinary team working, particularly from inpatient to community teams and in planning people's discharge from hospital. We also saw some very good specialist areas. These included the specialist inpatient eating disorder service, the children's respite services, Electro Convulsive Therapy (ECT) unit, community services and some specialist wards at the Brooklands site.

In children's services there were waiting lists of up to 15 months to access a service.

We saw some positive examples of staff balancing and managing caseloads to ensure that they had the right amount of time to undertake their work well, particularly in the community services. Some good processes were in place to monitor and respond to serious incidents and identify early warnings of issues.

We had some concerns about the safety of patients and staff, particularly the medium secure unit at Brooklands. This was due to difficulties in repairing external gate and the fact that the lone working policy was not being consistently followed throughout the trust. Learning from incidents across the organisation required some improvement to give consistent messages to staff.

Training for some teams was excellent. However in some areas staff had limited knowledge of safeguarding and deprivation of liberty procedures and staff were not always following the trust's procedures in reporting incidents and risks.

Summary of findings

The five questions we ask about services and what we found

We always ask the following five questions of services.

Are services safe?

There were systems to identify and investigate patient safety incidents and there was an emphasis in the organisation to reduce harm to patients. Action plans were monitored by local governance groups. The trust had an active risk register that informed where to make improvements.

There was inconsistency in sharing learning across the organisation to identify and consider serious incidents, near miss incidents and risks and what to do with that information. This meant staff were not always aware of the messages and there were differences in how middle managers shared the lessons learnt across the trust.

There was inconsistency in service areas regarding the use of risk assessments to keep people and the environment safe. These were not always in place to identify people at risk of falls or pressure ulcer development. Permanent staff were aware of risks to people, but records were not always accurate or accessible and often failed to show people's involvement. We saw that there were some environmental ligature points that may place people at risk from harming themselves.

Staffing within permanent roles were very stretched and there was high use of agency staff and a delay in recruiting to permanent posts. This was particularly the case in acute admission wards and older people's inpatient and community services. In the child and adolescent mental health service (CAMHS), children and young people were waiting a long time to receive a service. This was a particular concern for those who were in a crisis or who needed specialist inpatient care that could lead to unsafe care.

Are services effective?

In most services at Coventry and Warwickshire Partnership Trust, we found that the care and treatment provided was effective. This was because people's needs were discussed at the time of referral and decisions were made among professionals following a review. We saw examples of some very good collaborative work and innovative practice.

The bed occupancy rate is 93% in the trust. The Board receives performance reports and monitors readmission rates. On some wards there were daily ward rounds to review patients and delayed from discharge from hospital are reported on a daily basis. Locum doctors were being used across all services, and cover during one period of consultant leave was not appropriately managed.

We found that the lack of qualified school nurses created pressure in the transfer of children's care across services. School nurses demonstrated good partnership working with midwives, police and social services.

Staff access to supervision, appraisal, training and good clinical guidance was inconsistent. In some services the staff had received training to effectively support their responsibilities and roles. However, some staff reported that they did not get regular access to managers, either on a one-to-one basis or as part of a team meeting, and that protected learning time was not available.

Are services caring?

Most people we spoke with before and during the inspection said that they had positive experiences of care. People using the services, their families and carers generally felt well supported and involved with their treatment. They told us that staff were compassionate, kind and respected them at all times.

Summary of findings

We found at most of the services we visited, that staff were hard working and caring. Some staff expressed concerns that a lack of regular and substantive staff had a negative impact on their ability to provide good outcomes for people on wards, and we saw evidence of this. On one ward for older people, staff were failing to effectively assess and plan the delivery of care for people. The care did not always meet people's individual needs and care plans did not identify their preferences or the potential for risk.

Some staff were concerned that the change programme would have a detrimental effect on patient care. The trust acknowledged the cultural change as a major risk. Many people expressed their frustration about the length of time the transformation project was taking and lack of communication about the proposals at a local level.

Are services responsive to people's needs?

Teams worked hard to ensure person-centred care, tailored to best meet the needs of patients, families and carers. Some people could access services, including inpatient and community teams, at the right time and without delay. In CAMHS, children and young people were waiting a long time to receive a service.

Our analysis of data from our intelligence monitoring before the visit, showed that the number of written complaints received by the trust in 2012/13 was less than the previous year. Forty-one per cent of complaints over the two year period were upheld. Executives had undertaken "deep dives" into some complaints to review the lessons learned and challenge if they found some of them should have been upheld.

We found a number of issues in regard to high bed occupancy. On some wards bed occupancy was over 100%, this meant that people had to sleep out on other wards to enable new people to be admitted. Additionally we found designated single sex areas were used inappropriately creating 'mixed sex' accommodation.

Are services well-led?

Monitor deferred the trust's application for foundation trust status in 2013, as the trust had not yet demonstrated that it met the quality governance requirements for authorisation. The trust responded to the feedback from Monitor by reviewing their governance systems. The changes resulted in the establishment of new committees and revisions to existing ones.

We saw that the Board and senior managers had oversight of the reported risks and had measures in place to manage them. However, inconsistency in incident reporting and learning challenged the extent to which the Board were fully aware of risks within the organisation in relation to quality and safety.

Staff at service level said they did not feel involved in the trust as a whole and the trust vision and values were not embedded into the units. The 2012 NHS staff survey did not identify any evidence of risk but there were some areas where the trust was in the worst 20% of mental health trusts nationally. These were for staff ability to contribute towards improvements at work, support from immediate managers, staff motivation at work and for staff feeling pressure to attend work when feeling unwell. Following the inspection visit the 2013 report was published. We saw that the trust had compared most favourably with other mental health/learning disability trusts in receipt of health and safety training, feeling satisfied with the quality of work and patient care they were able to deliver, feeling motivated at work and in regard to work related stress.

There were some areas where staff experiences had deteriorated since the 2012 survey and would be areas the trust could improve as an employer. These were staff stating they experienced bullying and harassment at work and staff working additional hours.

Summary of findings

We found that the non-executive directors were unfamiliar with the Mental Health Act commissioner reports and the emerging themes of quality and safety within these reports. Audits and trends in relation to restraint and seclusion were monitored by other governance subgroups. No one on the Legislative group knew who monitored rapid tranquilisation. This meant that issues and themes may be missed as there was not enough overview to bring issues together.

Summary of findings

What people who use the provider's services say

As part of this inspection we looked at survey results, held groups with people using the services and their relatives, spoke with some individuals who requested to speak with us personally, and used comments cards before and during the inspection.

Community Mental Health Patient Experience Survey 2013

This survey was conducted to find out about the experiences of people who receive care and treatment. Those who were eligible for the survey were receiving specialist care or treatment for a mental health condition aged 18 and above and had been seen by the trust between 1 July 2012 and 30 September 2012. The questionnaire was sent to 850 people, and responses were received from 230 people.

Analysis of data from the Community Mental Health Patients Experience Survey shows that the trust is generally performing the same as other providers nationally in all the nine areas assessed.

The Voluntary Sector Mental Health Providers Forum group held on 13 January 2014

This group provided a varied response from people who use services. Some services were identified as 'caring', 'exceptional' and outstanding. In particular Willow Vale, the obsessive compulsive disorder/ eating disorder service and the Whitestone service (CAMHS) in Nuneaton. Others were identified as 'confrontational' and that comments made by staff, made people feel 'inferior'. People at this group felt there was a training need for staff in speaking to people with respect.

The recent changes brought about in response to the trust's transformational change programme gave some people concern. In particular the Cedarwood day hospital in Warwick was suspended at short notice and changes to people's consultant had occurred without consultation. This was particularly mentioned regarding the outpatients department. People said that this interfered with the therapeutic relationship and they felt they were starting again. There was also a reported delay in access to psychological services with initial assessments taking too long.

Some people using the service said they did not always feel safe in secure units and were not provided with opportunities to debrief after incidents.

There were mixed views about people's involvement: some people said they were not always given information. Some people said they had few opportunities to feed back about services. Others said no notice was taken following feedback and no feedback was given on actions taken.

Comments cards

We left comments cards at 11main hospital sites and community locations before and during the inspection. Thirty five comments were received and were generally very positive about the staff and the care received. However there were some less positive comments with people saying that they had received a varied level of service.

Areas for improvement

Action the provider MUST take to improve

- Ensure that planning and delivery of care meets people's individual needs, safety and welfare.
- Ensure effective arrangements are in place to identify, assess and manage risks consistently across services.
- Ensure that people using services are protected against the risks of potentially unsafe or unsuitable premises.

- Ensure that suitable storage, recording and monitoring systems are in place to ensure medications are handled safely and appropriately.
- Ensure sufficient numbers of suitably qualified, skilled and experienced persons are available at all times.
- Ensure that accurate records are maintained that hold appropriate information about people's care and treatment.

Summary of findings

- Ensure that records are kept securely and located promptly when required.

Action the provider SHOULD take to improve

- Ensure consistency in the learning from incidents across the organisation to give consistent messages.
- Ensure that specialist training (for example dementia, autism training and rapid tranquilisation) is provided to all staff working in specialist areas of the trust.
- Ensure that the lone working policy is used consistently to adequately protect staff.
- Review the results of the 2013 staff survey and consider the actions to be taken in response to staff stating they experienced bullying and harassment at work and staff working additional hours.
- Ensure consistent use and knowledge of safeguarding practices is developed and implemented and information concerning vulnerable adult and children's safeguarding reporting processes are available.
- Ensure all staff are given equal access to supervision and processes are in place to monitor these arrangements.
- Review the use of agency staff and temporary staff to ensure continuity of care.
- Ensure staff are given equal opportunity to 'de-brief' following incidents and that learning is cascaded throughout the trust.
- Confirm plans with timescales as to when and how the environment in some areas of the trust will be improved.
- Ensure access to meaningful activities to prevent boredom.

Action the provider COULD take to improve

- Staff could share ideas of best practice to make the service more effective for people who use it.
- People who use the service could be supported to express their views about the service provided and be given feedback on actions taken.
- More staff support could be given to ensure that ways to measure the quality of care that people experience is effective and that people receiving a service can make changes where possible.
- The Mental Health Act Legislative group would benefit from receiving a holistic picture of the issues relating to detained patients to ensure the least restrictive principle was always applied.

Good practice

- We found the following areas of good practice within the trust:
- The trust had some good and some outstanding services. These included their specialist inpatient eating disorder service, the children's respite services, Electro Convulsive Therapy unit (ECT), and community services including the Olive Tree day service.
- The Lakeview ECT Clinic, Gosford Ward at Caludon Centre and Amber Ward at Brooklands were all AIMS accredited, and rated excellent, with the Royal College of Psychiatrists. AIMS is a standards-based accreditation service designed to improve the quality of care in psychiatric wards. Standards are drawn from authoritative sources and cover all aspects of the inpatient journey. Compliance is measured by self- and peer-review.
- Most staff support people with care are committed to provide a good quality service.
- There were some examples of good multi-disciplinary team working practices that were person centred and planned for an effective discharge from hospital. School nurses demonstrated good partnership working with midwives, police and social services.
- The children's respite services benefitted from long-established staff teams who had a long-term relationship and good rapport and understanding with the children they looked after.

Coventry and Warwickshire Partnership NHS Trust

Detailed findings

Registered locations we looked at:

Trust headquarters,Wayside House, Aspen Centre,Brooklands, Caludon Centre, Children's respite services, Highfield House, Hawkesbury Lodge, St Michael's Hospital, The Manor Hospital, Woodloes Avenue

Our inspection team

Our inspection team was led by:

Chair: Professor Patrick Geoghegan OBE

Team Leader: Jackie Howe, Care Quality Commission

The team included CQC inspectors, Mental Health Act commissioners, a pharmacist inspector, an analyst and a variety of specialists which included doctors, nurses, social workers, psychologists, and senior managers.

We were additionally supported by a team of six Experts by Experience who have personal experience of using or caring for someone who uses the type of service we were inspecting.

Background to Coventry and Warwickshire Partnership NHS Trust

Coventry and Warwickshire Partnership Trust was formed in 2006 and integrated with community services from NHS Coventry in April 2011.

Coventry and Warwickshire Partnership NHS Trust serves a population of 1,053.000. It provides integrated services such as all age mental health, specialist services, primary care and prevention, integrated children's services and all age community services. The trust has a total of 70 sites spread over 870 square miles. The trust has a budget of £200 million, employing 3,530 whole time equivalent staff.

The trust has a total of 472 beds and has a bed occupancy rate of 93.3% compared to the England average of 85.2%.

There are three main hospital sites. Brooklands in Solihull, St Michael's Hospital in Warwick and the Caludon Centre in Coventry providing mental health and learning disability

Detailed findings

services. A few specialist services support people from other parts of the country. These include for people with a learning disability, eating disorder or low and medium secure services for people with a learning disability.

Coventry is a city and metropolitan borough which is largely urban. It is in the region of the West Midlands and is governed by Coventry City Council. It is the 50th most deprived authority in England out of 326 authorities in the Index of Multiple Deprivation and is significantly worse than the England average. Life expectancy is worse than average in Coventry. Of the population of Coventry, 26% belong to non-white minorities. Of these, British Indian constitutes the largest ethnic group with 9% of the population.

Warwickshire is a rural ceremonial and none metropolitan county. Deprivation for Warwickshire is significantly better than Coventry in that it is 182nd out of 326 authorities in the Index of Multiple Deprivation and its levels of deprivation are improving slightly. Census data shows an increasing population and a lower than average proportion of Black, Asian and Minority Ethnic (BAME) residents. In Warwickshire, 7% of the population belong to non-White minorities. Of these, British Indian constitutes the largest ethnic group with 3% of the population.

Previously CQC found Coventry and Warwickshire Partnership Trust to be non-compliant with Regulation 17 'respecting and involving people who use services' and Regulation 9 'care and welfare of people who use services' during our inspection at Brooklands on the 5 August 2013. We followed up on these areas during this inspection and found the trust to be compliant at the Brooklands location.

Between 2012 and 2013 there have been over 22 Mental Health Act monitoring visits have been carried out to wards, as well as visits to look at assessment and admission, seclusion, records and community treatment orders. Commissioners have met with detained patients and carers in private. Reports from these visits have been shared with the trust.

The purpose of this report is to describe our judgement of the leadership of the trust and its ability to deliver safe, effective, caring, responsive and well-led services at each of its locations. Our judgement will refer to key findings at each location. For a more detailed understanding of the findings, please refer to the relevant location report.

Why we carried out this inspection

The trust was selected as one of a range of Trusts to be inspected under CQC's revised inspection approach to mental health and community services. The information we hold and gathered about the provider was used to inform the services we looked at during the inspection and the specific questions we asked. The trust is currently in the process of applying to become a Foundation Trust. Their application has currently been deferred by Monitor.

How we carried out this inspection

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

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

The inspection team always inspects the following core services at each inspection:

- Mental Health Act Monitoring.
- Acute admission wards.
- Psychiatric intensive care units and health-based places of safety.
- Long stay/forensic/secure services.
- Child and adolescent mental health services.
- Services for older people.
- Services for people with learning disabilities or autism.
- Adult and children community-based services.
- Community-based crisis services.
- Specialist eating disorder services.

Before visiting, we reviewed a range of information held about the provider and asked other organisations, including user groups, to share what they knew about the provider. We carried out announced visits on 21 to 24 January 2014.

During the visit we:

Detailed findings

- Held focus groups with a range of staff from across the locations, such as nurses, doctors (consultants, registrars, junior doctors) and other health professionals.
- We held meetings with members of the executive team, the chair of the Board and non-executive directors. We met with key personnel who had responsibility for managing process in the trust, for example incident reporting.
- We held drop in clinics for staff and people using the service.
- We attended multidisciplinary team meetings and ward handovers
- We looked at the personal care and treatment records used in inpatient services and in the community.

- We observed how staff cared for people both on the wards but also by going with staff, for example district nurses, to visit people in their own homes.
- We reviewed information we had asked the trust to provide. We collected feedback using comment cards.
- We also carried out a two unannounced visits. On 21January 2014 to Brooklands Hospital Janet Shaw unit because we wanted to check on the security systems and on 22 January 2014 to the Caludon Centre to see how the hospital was run at night, what staff were available and how people were being cared for.

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

Are services safe?

Summary of findings

Systems were in place to identify and investigate patient safety incidents with an emphasis in the organisation to reduce harm to patients. Action plans were monitored by local governance groups. The trust had a risk register as a working document and informed the trust where to make improvements

We found a lack of consistency in regard to incident reporting practice and cascade of learning across the organisation to identify and consider serious incidents, incidents, near miss incidents and risks and what they would do with that information. Staff were not always aware of the messages and there were differences in how middle managers shared lessons learnt across the trust.

There was inconsistency in service areas in the use of risk assessments to keep people and the environment safe. Risk assessments were not always in place to identify people at risk of falls or pressure ulcer development. Permanent staff were aware of risks to people, but records were not always accurate or accessible and often failed to show people's involvement. There were some environmental ligature points that may place people at risk from harming themselves.

Staffing within permanent roles were very stretched in some acute and older people's inpatient and community services. People using the service in some areas, told us of their concerns about not seeing continuity of staff who knew them. We were concerned about the slow recruitment processes to fill vacancies. There was a particular potential concern in the CAMHs service for those who were in a crisis or who needed access to specialist in-patient care, where delays could lead to a risk of unsafe quality of care.

Our findings

Learning from incidents to improve standards of safety for people who use services

Serious incidents known as 'never events' are events classified as so serious they should never happen. The trust had not reported any such events in the 12 month period of November 2012 and October 2013. There were 254 serious incidents reported; 35 in ward areas.

The trust had systems in place to identify learning from serious incidents, with investigations instigated as a result. We were told that learning alert 'core briefs' were sent to staff to share the learning, as well as messages being transferred from the various governance groups. Action plans were monitored by local governance groups. We were told that the trust aimed to ensure staff were offered an opportunity to debrief following an incident.

We saw where safeguard incidents had been reported on to the Safety and Quality team, these had not always been completed with full details of the incident.

We found a lack of consistency in regard to learning from incidents at the services we inspected. Staff were not always aware of the messages and there were differences in how middle managers shared the lessons learnt across the trust. Some areas were very good but in other areas staff were unfamiliar with the messages and lessons. Not all staff were given an opportunity to debrief following incidents.

Arrangements were in place to ensure medicine incidents were documented and investigated. We were told that reported medicine errors were discussed at a 'Drug Error Reporting' group and the 'Safety and Quality' group. We found when medicine errors were reported they were investigated and discussed in order to change practice and learn from lessons. For example, we were told the medicine management team were assessing the amount of 'missed doses' and teaching staff the importance of obtaining medicines and documenting the administration of medicine on people's medicine administration record charts. The pharmacist inspector found no 'missed doses' which means lessons were learnt and acted upon and improved patient safety.

Are services safe?

However, we found some services had poor governance arrangements around the safe storage and management of medicines. This meant not all incidents were recognised and reported as incidents.

Processes and systems reliable, safe and proportionate for people who use services

We found people did not always receive information that ensured they understood their rights as detained patients under the Mental Health Act. Patients went out on section 17 leave with conditions, but we saw inconsistencies with records or logs to show that either they or their carer had agreed to or understood these. This meant people did not always understand their detention or the conditions of their detention.

Safeguarding

Staff access to safeguarding training was identified as a risk by the trust and measures had been put in place to improve this and embed the safe guarding strategy. Some staff were unaware of adult safeguarding and Deprivation of Liberty procedures. In some services safeguarding alerts were made to the local authority and the appropriate process was followed to safeguard people from harm. However, some staff told us that incidents between people who use the service were not always reported and there were more incidents than were actually reported. This could mean that appropriate action was not taken to ensure the safety of people who used the service or that stringent investigation took place as to the cause of the incident.

We spoke with a variety of staff who told us they were unclear on how to report any potential abuse and what the safeguarding procedure was. Staff we spoke with were not able to identify when a safeguarding referral should be made to ensure people were protected.

In the community teams we found a range of staff were involved in safeguarding processes, some health, and some social services staff. There were some inconsistencies throughout the teams as to how meetings were organised, who chaired them and which agencies were involved in safeguarding meetings.

We looked at incident reports issued by the trust on a monthly basis. These reports did not identify safeguarding incidents. One manager told us that they did not always identify an incident as a safeguarding concern when completing monthly returns using the trust's 'dashboard' system.

Records and documents seen relating to safeguarding concerns, were not consistent and it was hard to track the action that had been taken or what the outcomes had been, including whether or not the risk remained.

At some services there was not always a clear line of responsibility for anyone to have oversight of the progress of safeguarding concerns across the multidisciplinary team. This created a potential for information to get lost and meant that not all professionals who had contact with the person, would be aware and able to take the concerns into consideration.

Safe Environment

The trust acknowledged some sites were not suitable and capital investment in line with an estates strategy was in place. We found concerns about the safety and suitability of premises at some locations. The security systems in place at the Janet Shaw unit at Brooklands were not sufficient to protect the safety of people who used the service and staff. Records showed there had been a fault on the door lock that was first reported in June 2013. Action was taken to repair the fault but in September 2013 the system failed again and had consistently failed since then. It failed again during our inspection.

The response to this system failure by the trust was to provide a manual system that was operated by a security guard. On Mondays to Fridays from 10am to 4pm people had free access to the gardens around the unit. However, outside of these times, which included all the weekend, people were escorted by staff five at a time to use a small fenced area-which staff and people referred to as the 'Cage.'

We asked to look at the fire evacuation plan and saw that there was no evidence to show that this had been reviewed since December 2010. The policy for the management of security within Janet Shaw unit had not been amended to include. We were told that the fire evacuation plan remained unchanged because people could still be evacuated into the garden safely. Following our inspection a representative of the trust informed us that action was taken to ensure the safety of people who used the service and staff.

Are services safe?

On wards at other locations there were some environmental ligature points that could place people at risk from harming themselves and some delays in attending to broken showers and furniture which had a negative impact on safety.

Bedrooms were generally sparsely decorated and furnished. In areas of service where people would have an inpatient admission of several months, more could be done to help them personalise their rooms and create a warmer and more comfortable environment.

In two Community Mental Health teams we saw an excess quantity of sharps waste stored in treatment rooms. There were no regular systems in place to ensure sharps waste was removed and disposed of suitably on a regular basis.

Risk management to understand and manage risk to the person using services and others with whom they may live

There was inconsistency in service areas in the use of risk assessment documents to keep people and the environment safe. We found permanent staff were aware of risks to people, but records were not always accurate or accessible and often failed to show people's involvement in their care and treatment.

Medicines management

There was a set of medication procedures to ensure safety. We found that staff did not always follow the procedures according to the guidelines. Staff we spoke with were sometimes confused and not sure whether the correct forms had been used.

Arrangements were in place to provide guidance to medical and nursing staff for the treatment of severe mental and behavioural disturbance. We were shown a 'Rapid Tranquillisation' policy dated February 2011 agreed by the Safety and Quality Committee. We were told that an updated policy dated February 2014 was about to be circulated. The guidelines helped ensure that medical and nursing staff had access to an agreed set of procedures for the safety of the person.

Nursing staff said they had not had any recent updated training on the administration of medicines using the 'Rapid Tranquillisation' policy. This meant that although there were guidelines available there was a lack of training and discussion with staff to see if they were being followed, thus ensuring the safety of people using the service.

We found in some community teams, the trust did not have suitable storage, recording and monitoring systems in place to ensure medications were handled appropriately. Medicine cabinet keys were not always kept securely with no monitoring of room and fridge temperatures to ensure that medicines were being stored in suitable conditions.

There were some medications in cupboards that belonged to people obtained for them from their local pharmacy. There was no record to state what medications might have been removed or were now being stored. At one service we saw that a supply of prescription pads was stored in a lockable but portable tin, in a medicines cupboard to which all staff members potentially had access.

Staff told us there were no internal audits of medicines completed and no visits from the trust pharmacists had taken place.

Whistleblowing

The trust had a whistleblowing policy and staff could whistleblow through their line management structures or directly to the Board members through email. Staff told us that they did not want to use the Trust's intranet to raise issues with the Chief Executive as they did not feel it was confidential.

Staff on some wards told us they knew how to escalate safety concerns. They told us they were aware of procedures for whistleblowing and had received relevant training. They told us they would feel comfortable raising concerns with their managers, and felt they would take them seriously and appropriate action taken.

We saw a positive example of when appropriate action had been taken as a result of poor care being reported and the person whistleblowing had been well supported. We were told that the situation had been handled well to ensure the safety and wellbeing of the person using the service.

Managing risk to the person

Risk assessment forms to document the management of potential risk were available for staff to use. We found in some services that the risk assessment forms available were not being regularly completed. This undermined their effectiveness in prompting staff to consider potential risks more proactively.

The staff at CAMHS worked hard to provide a service and they prioritised urgent cases, but did not have the capacity to meet increasing demand. Children and young people's

Are services safe?

needs were at risk of deteriorating while waiting for a service, and some were not getting the care they needed because they were waiting a long times on general hospital wards without getting specialist input. People aged over 16 did not always get the right service when they needed inpatient care due to a national shortage of beds We found recent cases where young people had had to stay on a paediatric ward for three or four weeks at a time.

We found that staff at one service, did not know how to manage and safeguard people admitted under the age of 18 to an acute admission unit. We saw there was nothing to demonstrate what, if any, special arrangements had been made as a safeguard. At the time of the inspection, a report to inform CQC of an admission of a minor to an adult ward had not been made although this was completed after the visit.

Our analysis of data from our intelligent monitoring before the visit showed that the percentage of falls with harm fluctuated but was higher throughout 2013 than the national average.

We generally found that risk assessments were in place to meet peoples' physical needs which included falls, tissue viability, nutritional and mobility. We saw some examples of good physical healthcare in mental health settings. However we found evidence in some areas that staff were not following the trust's procedures resulting in a lack of consistent clinical care practice and poor patient care. Staff within mental health settings had access to a one day course on physical health training, however this was optional with poor uptake.

Staff on one ward at St Michael's hospital, told us that more people with complex physical health needs were being admitted and the staff had limited physical health knowledge and skills. They told us they referred people to Warwick Hospital more often.

Of the 254 serious incidents reported, over half were grade 3 or above pressure ulcers. As a result the trust had implemented a quarterly reporting system to the Board. Root cause analysis investigations were undertaken to consider what could have been avoided.

The trust had worked on delivering training to district nursing teams, and built this into their core competencies.

There were tissue viability nurses (TVN) in the community to provide specialist support. The trust worked to organise preventative specialist equipment to be used at the earliest opportunity.

Safe staffing levels and quality of staffing to enable safe practice

Generally the trust had caring and committed staff groups at all levels, who had good patient care and safety central to their work. We witnessed some positive interactions.

There was high usage of agency staff in the trust. Staff to patient ratios varied and were based on professional judgement. The transformation programme was leading to the review of staffing in some areas. The acuity of some wards, where more observation of patients is required, was leading to a trust wide staffing review. We found that staff were not clear about these reviews and the impact it would have for their ward or service. Whilst there is an impact on staff from these proposed changes, people using the service in some areas told us of their concerns about not seeing continuity of staff who knew them. We were concerned about the slow recruitment processes to fill vacancies.

Some services and wards were affected more than others by the high use of temporary or agency staff. During our unannounced visits to some acute and intensive care areas at night we saw that 40 % of the staff were bank or agency staff. We were told that a night the previous week over 50% of the staff were from bank and agency. The trust attempted to use the same staff, to give consistency of care where possible, and we spoke to two staff from an agency who told us they regularly worked there. On one of the older people's wards, staff spoken with told us they did not have time to read the care plans and would rely on substantive staff to verbally handover information. However we found there was not always a robust handover, and one member of staff spoken with did not know the name or details about the treatment of someone they were looking after.

There was movement on some wards to change from a two shift system to a three shift system to ensure better deployment of staff. The trust was introducing a "floating" team concept in some clinical locations to assist in sharing resources.

Are services safe?

Staff told us they felt the trust did not appear to be sufficiently aware of the considerable workload requirements of school nurses as a result of rising child protection issues. They were however recruiting additional district nurses and health visitors.

We were told there was a lack of substantive consultant psychiatrists and consequently the posts were covered by locum consultants. Staff told us that they saw regular changes of doctors which had an effect on continuity and people spoken with told us they had to retell their stories several times.

Are Services Effective?

(for example, treatment is effective)

Summary of findings

In most services at Coventry and Warwickshire Partnership Trust, we found that the care and treatment provided was effective. This was because people's needs were discussed at the time of referral and decisions were made among professionals following a review. We saw examples of some very good collaborative work and innovative practice.

The bed occupancy rate is 93% in the trust. The Board receives performance reports and monitors readmission rates. There are daily ward rounds to review patients and delayed discharges are reported on a daily basis. We found that there were locum doctors being used across all services and cover during consultant leave in one instance was not appropriately managed.

We found that the under resourcing of qualified school nurses presented service pressures in the transference of children's care across services. School nurses demonstrated good partnership working with midwives, police and social services.

Children and young people awaiting some CAMHS interventions were waiting a long time to receive a service. This was a particular concern for those who were in a crisis or who needed specialist in-patient care.

We found that staff access to supervision, appraisal, training and good clinical guidance was inconsistent. In some services the staff had received training to effectively support their responsibilities and roles operationally. However some staff reported they did not get regular access to managers either on a one to one basis or as part of a team meeting and that protected learning time was not available.

Our findings

Monitoring and managing quality of care

Focus groups were held with all grades of staff. Clinical staff told us they were able to discuss and raise issues about clinical quality and felt confident about the medical line management and that issues would be listened to and

acted upon. There were systems in place to escalate concerns if caseloads exceeded acceptable and manageable limits. Some consultants said that they felt the transformation process was standardising models of care.

This trust is a low performer in seeking accreditation with the Royal College of Psychiatry.

We saw some examples of good physical healthcare in mental health settings. However we found evidence in some areas that staff were not following the trust's procedures resulting in a lack of consistent clinical care practice and poor patient care. We were told the trust was a good place to train but identified that there were locum doctors being used across all services. Cover during consultant leave on one occasion we found, was not appropriately managed.

The bed occupancy rate is 93% in the trust. The Board receives performance reports and monitors readmission rates. There are daily ward rounds on some wards to review patients and delayed discharges were reported on a daily basis.

Demonstrate collaborative multi-disciplinary working across all services

We saw examples of good multidisciplinary and collaborative team working. For example there were effective goal setting procedures to meet peoples' aspirations, recovery and discharge from inpatient wards. We found examples of consultant psychiatrists and ward staff working alongside the community crisis resolution/ home treatment teams to provide holistic care and treatment to people.

When people were referred, their needs were considered by multi-disciplinary teams to ensure they were signposted to the right support.

In the community health services we found that district nurses demonstrated robust partnership working with community matrons, occupational therapists, physiotherapists, GP's speech and language therapists, dieticians, tissue viability nurse specialists, palliative care nurse specialists and equipment loans services to ensure people received the best care from the right service/ specialist.

We saw a positive example of working with local acute hospitals where there were concerns over a person's physical health needs.

Are Services Effective?
(for example, treatment is effective)

Suitably qualified and competent staff

The trust's transformational project aims to create integrated practice units and a single point of contact. The trust is reviewing the required competencies for staff. The supervision and appraisal systems have been refreshed and are being monitored.

We found that staffs' access to supervision, appraisal, training and good clinical guidance was inconsistent. We found that in some services the staff had received training to effectively support their responsibilities and roles operationally. However some staff reported that they did not get regular access to managers either on a one to one basis or as part of a team meeting. Staff, both in focus groups and at the leadership event, commented that protected learning time was not available and were unclear how it should be accessed. Specific professional supervision or staff trained in specific therapies for example, Behavioural Family Therapy or Non-Medical Prescribing (NMP) was not provided routinely.

Safeguarding training was identified as a key risk by the trust and measures put in place to improve it. We found there was a lack of knowledge of safeguarding and deprivation of liberty procedures amongst operational staff during our visit.

We found staff in some areas had not been appropriately trained to offer care to specific user groups. This had a negative impact on being able to give good quality care for example to people with a dementia, autism or respond to challenging behaviours.

Adhere with the Mental Health Act (MHA) and have regard to the Code of Practice

We inspected a number of wards at different hospital sites where detained people were being treated. We saw there were Mental Health Act administrators in place to monitor the legality of the detention and treatment paperwork as well as preparing for Mental Health Review Tribunals and Hospital Mangers Hearings.

There were 23 associate hospital managers appointed to carry out 'Hospital Manager Hearings' for detained patients. The trust could not provide figures for the number of patients the hospital managers had discharged from their detention but would see such discharges as a serious incident as it would reflect on the robustness of processes their staff had followed. The trust reported it did not carry out specific patient satisfaction audits about the patient experience of 'Hospital Managers Hearings' but relied on informal feedback and the main trust satisfaction survey.

We found that trust policies had not been followed for the admission of young people. There were two adolescents on one adult ward. One of the patients had been admitted nearly three months earlier. The trust provided a policy which had been due for review in 2013, on the admission of young people to adult wards. The policy had not been reviewed, and staff were working to the original policy. The trust did not follow its own policy in that statutory notifications of the presence of these young people were not provided to the CQC. The trust responded when this was brought to their attention by completing the notifications.

The trust has a transitions policy for the transfer of young people to adult mental health services which had been due for review in 2012. We found in one case the trust did not notify the local authority of the requirement under s85 of the Children's Act that a young person was likely to be in hospital for a period of three months or more. The trust responded when we brought this to their attention.

We saw the coroner had previously issued a Schedule 5 recommendation to the trust with the intention that they should learn from the cause of the death and prevent further deaths. The recommendation was "to consider additional staff training in the treatment and monitoring of patients sectioned under the Mental Health Act 1983". This was specifically in relation to the implementation of the observation policy. Staff informed us the policy was reviewed and updated and staff were provided with training. The implementation of the policy was audited three times to ensure it was embedded with staff and they understood it.

We were informed by the Mental Health Act legislative group there was no structured training on the Mental Health Act for staff and this was in the process of being developed. Staff, including non–executives, received some training on induction and in response to serious incidents. The trust appointed medical staff who hold s12 status and their registration is monitored via a register and personal development plans. They receive training updates to maintain their s12 status.

Are Services Effective?

(for example, treatment is effective)

The trust was in the process of signing service level agreements with the acute trust in Coventry and Warwickshire for them to formally provide specialist advice and treatment to people detained in acute hospitals and those requiring mental health support. Although there has always been a psychiatric liaison provision to the acute trust we found young people were admitted to paediatric inpatient services at University Hospital Coventry and Warwick hospital through the Emergency Departments. These young people were assessed by CAMHs and may access beds outside of the area from there. Feedback from the paediatric wards was that the staff did not feel adequately supported by the provider to meet the mental health needs of young people.

There was partnership working with the local authority in relation to the use of Approved Mental Health Professionals (AMPH) for MHA assessments. There was a clear and comprehensive joint policy; 'A Generic Protocol for the Multi-Agency Management of Places of Safety'. This set out joint working between the police and the trust. Both the 'Generic Protocol for the Multi-Agency Management of Places of Safety' and the 'Place of Safety Operational Policy' reflected the purpose, respect and least restriction principles of the MHA. The operational group met every two months.

Are services caring?

Summary of findings

The majority of people we spoke with before and during the inspection said that they had positive experiences of care. People using the services, their families and carers generally felt well supported and involved with their treatment. They told us staff displayed compassion, kindness and respect to them at all times. Generally people felt involved with their care and informed about their treatment.

Whilst we found most staff to be hard working and caring, some expressed concerns that a lack of consistency in staffing had a negative impact on their ability to do this. We saw some poor outcomes for people on wards that relied heavily on temporary staff. During our inspection we identified a number of concerns for one older people's service where people did not always receive the care they required and people's privacy and dignity was not always respected.

Some staff expressed concerns that the outcome of the change programme would have a detrimental effect on patient care. The trust acknowledged the cultural change as a major risk.

Our findings

The trust had revisited its 'vision and values' in collaboration with staff. The vision and values are discussed at leadership events and leadership courses. The trust is currently reshaping its services; for example introducing Integrated Practice Units as part of its plan to transform services and how people work to deliver them. The trust acknowledged the cultural change as a major risk. We found many people expressed their frustration about the length of time the transformation project was taking and the lack of communication about the transformational proposals at local level.

Choice in decisions and participation in reviews
Some people we spoke with felt that they were involved with their care and informed about their treatment. In the community health services, most people we spoke with

described their care as good to excellent and said that staff were caring, despite being busy. This was corroborated by speaking with people during home visits and also at telephone feedback sessions.

We looked at care plan documents across the trust and found that although some were individualised, others were often generic and we did not always find evidence of people's involvement particularly in attending ward review meetings. We saw examples of advocacy being used throughout the trust. At Brooklands access to advocacy is of particular concern because of people's need for support, the advocate we spoke with said she was the only advocate available for the whole hospital.

We received some positive comments from people receiving a service at the Olive Tree day service. One person said, "I think this place is life changing." People told us that staff worked with them in a way that they felt "equal" and that they had developed positive working relationships with staff. We saw that staff had a person centred approach to care planning and risk assessment with people contributing their views and perspective of people's needs.

At the eating disorder services, people told us that they were able to 'go at my own pace' but with staff encouragement to stretch themselves. Two inpatients told us the centre was 'the best NHS service I have been in' although one added 'even though it is very strict!'

Effective communication with staff
We found some good examples of teams working and communicating effectively. Some community crisis resolution/home treatment teams attended ward reviews to work with the ward team to facilitate discharge from hospital.

Before the inspection on site, we received information from people using the service and relatives who did not feel adequately communicated with and were unsure of whom to approach due to the inconsistency of staff.

On the wards, we saw staff interacted with people in a warm and friendly way. However on some wards where there was high agency or temporary staff, we saw that there was little communication.

People receive the support they need
A survey was conducted in 2012 known as the 'Community Mental Health Survey 2012' to find out about the experiences of people receiving a service from mental

Are services caring?

health trusts. In the report, Coventry and Warwickshire Partnership Trust performed the same as other trusts in all areas. However some areas were worse than the results of the previous year. One question 'do you know who your care coordinator is?' was identified as an elevated risk because the trust scored significantly worse than other trusts. We saw that the trust had responded to this and that a letter would be sent to all patients receiving a community mental health service outlining who their care coordinator was. During the inspection people told us that they usually knew a few of the team members so that if their coordinator was not available, there was someone to contact who they were familiar with.

The trust also made use of the 'Patient Opinion' website where patients and staff can provide feedback on the service. 66 comments were recorded on the trust's section. Areas identified as good were the doctors; the service was described as 'excellent' and 'helpful'. Areas identified as requiring improvement were waiting times, involvement of family and friends and accessibility of services. We saw the trust had responded to concerns raised.

During home visits we saw nurses responded well to people's needs, listened to them and answered questions relating to the care and treatment. Staff we spoke with told us how their time in people's homes during visits was used not only to give medication but to listen to people and answer their questions, about their treatment and care plans.

We spoke with staff at each location and out in the community about the care needs of individual people . We wanted to see if staff supported people adequately. We saw that the interaction between staff and people on the wards was good when staff had time to do so. We saw that staff gave explanations and reassurance to people. Some staff knew people well and they were able to describe individual support that people needed. Other staff expressed the view that they were unable to offer adequate support due to their other daily tasks. Some staff raised concerns about the high use of temporary staff. They told us that this meant that people were looked after by staff who did not know them and with very vulnerable people, it meant the care was not delivered in a personal or compassionate manner.

During our inspection we identified a number of concerns on one ward for older people. We found that regular incidents had taken place, but there was no evidence that learning from these incidents had taken place to prevent them happening again.

We found the ward was regularly short staffed and relied heavily on bank or agency workers. This increased the potential risk level to both staff and people living on the wards and this had a negative impact on staffs' ability to provide continuity of care. We identified that some staff did not know about the person they were caring for and had not an opportunity to read the person's care plan records.

We found that the provider had identified the need for an increased staffing level but no additional substantive staff had been employed since the issue was identified.

We found different examples within the acute admission wards with regard to respecting people's individual privacy and dignity. People had single bedrooms with en-suite facilities where they could go when they wanted to have some time alone. However in some wards there were general rules and we found bedrooms were locked and people were not always able to access their room when they requested to do so. Some communal rooms on wards were inaccessible having been locked by staff or used for a different purpose. This meant that people had to use crowded lounges and were not always able to go somewhere quieter or to remove themselves if people exhibited challenging behaviour.

At Brooklands, both Intensive Care Suites on the ward were being used as bedrooms. No operational procedures were in place to cover operational management of situations without the Intensive Care suites being available.

Use of seclusion

We were concerned not all staff working in intensive care units had fully read or understood the trust's policy on the use of seclusion. Seclusion is the supervised confinement of a patient in a room, which may be locked. Its sole aim is to contain severely disturbed behaviour which is likely to cause harm to others. It is not viewed as a therapeutic intervention, and so should never be pre-planned as part of an individual's package of care.

Are services caring?

We saw on one ward that the seclusion policy had an attached form which required staff to sign to confirm by signing, that they had read and understood the policy. There were 32 staff names on the confirmation sheet but only nine staff had signed.

We reviewed a seclusion log and found that entries of seclusions were not in date order and dates had been changed. This meant a contemporaneous and accurate record of all seclusion had not been kept. We found 14 occasions where a review should have been completed after four hours by a nurse and a doctor but was in fact completed by two nurses. This meant that people were secluded for long periods without an independent review of their seclusion.

At Brooklands there was no attached de-escalation suite to the seclusion room, which would help the person to calm down reducing the need for seclusion. Staff told us that seclusion was not used that often and they could not remember the last time it was used. However records showed one person had been secluded at the beginning of January 2014. A nurse had initiated the person's seclusion but it was not recorded that a senior nurse had been informed of the seclusion as per the trust's seclusion policy. On one ward at Brooklands, the seclusion suite was un-usable owing to the low temperature. There were no procedures in place about operational management of situations without the seclusion suite being available.

Are services responsive to people's needs?
(for example, to feedback?)

Summary of findings

Teams worked hard to ensure individualised and person centred care tailored to best meet the needs of patients, families and carers. Some people could access services, including acute admission wards and community teams, at the right time and without delay. In the CAMHs service children and young people were waiting a long time to receive a service.

Our analysis of data from our intelligence monitoring before the visit showed that the number of written complaints received by the trust in 2013 – 2013 were fewer than the previous year. In each of the past two years 41% of complaints were upheld. Executives have undertaken a process of "deep dives" in to some complaints to review the lessons learnt and challenge if they find some complaints should have been upheld.

We found a number of issues in regard to high bed occupancy. On some wards bed occupancy was over 100%. We saw evidence that people had to sleep out on other wards to enable new people to be admitted. Additionally we found this had a negative impact on 'mixed sex' accommodation and designated single sex areas were used inappropriately. Breaches of single sex accommodation procedures did not appear to be reported within the trust, and some staff we spoke to did not recognise the breaches.

Our findings

Individual needs met, services meeting the needs of the local community
The trust identified that increasing demands and waiting times in some services were a challenge for the future and were working with partner agencies for longer term planning.

We found that people with eating disorders got a good, responsive service and benefited from the link between in-patient and out-patient services. This supported good admission and discharge transition processes. People's needs were well monitored and followed up, which helped ensure that the service could identify and respond to their changing needs quickly. There was a good range of different types of therapeutic support for people and staff ensured they were offered help to meet their emotional and psychological needs even when they were extremely unwell.

In the CAMHS service we found and people told us that children and young people were waiting a long time to receive a service. This was a particular concern for those who were in a crisis or who needed specialist in-patient care.

We found a number of issues in regard to high bed occupancy. On some wards bed occupancy was over 100%. We saw evidence that people had to sleep out on other wards to enable new people to be admitted.

At one service we found when the ward was at full capacity, leave beds remained open for people to return from leave and were not reallocated.

The trust monitored the policy implementation in relation to mixed gender accommodation and executive members reported no breaches. We saw some mixed sex wards had appropriate same gender lounge, washing and toilet facilities. There were a number of issues in regard to high bed occupancy that had a negative impact on mixed sex accommodation. Additionally we found that designated single sex areas were used inappropriately.

People told us they wanted to have better and consistent access to activities. A number of people from across the provider's services reported limited availability of activities in the evenings and at the weekends, people told us they were 'bored' or activities available were unsuitable.

Provider acts on and learns from concerns and complaints
Our analysis of data from our intelligence monitoring before the visit showed that the number of written complaints received by the trust in 2013 – 2013 were less than the previous year. 41% of complaints over the two year period were upheld. Executives have undertaken a process of "deep dives" in to some complaints to review the lessons learnt and challenge if they found some complaints should have been upheld.

A clear system was in place in respect of the complaints process. Managers we spoke with were clear about their role and that of their staff in managing issues at the earliest opportunity before they could develop to a formal complaint. Managers told us they would not directly

Are services responsive to people's needs?

(for example, to feedback?)

investigate complaints that were linked to their team but would undertake investigations for other teams. We saw information displayed in the lobby areas of hospitals, buildings, meeting rooms and other areas accessed by people using services that provided information on how to make a complaint. Information was primarily in English, but we were told other languages and formats could be accessed as required. The PALs service played a good part in ensuring that complaints were locally resolved.

The trust also monitored the number of compliments received.

In the community teams, people could not recall being asked to share their views of the service they received in a structured manner. Service managers told us that they were aware of events held that involved engaging people across the trust but that they were not directly seeking feedback about their own team's performance from people using the services. There were inconsistencies amongst the teams with regard to how people's views were sought. There was no systematic and consistent manner which informed local service planning.

Are services well-led?
(for example, are they well-managed and do senior leaders listen, learn and take appropriate action)

Summary of findings

Monitor deferred the trust's application for foundation trust status in 2013, as the trust had not yet demonstrated that it met the quality governance requirements for authorisation. The trust responded to the feedback from Monitor by reviewing their governance systems. The changes resulted in the establishment of new committees and revisions to existing ones.

We saw that the Board and senior managers had oversight of the reported risks and had measures in place to manage reported risks. However inconsistency in incident reporting practice and learning and cascade of learning across the organisation from incidents, challenge the extent to which the Board are fully aware of risks within the organisation in relation to quality and safety.

Staff at service level said they did not feel involved in the trust as a whole and the trust vision and values were not embedded into the units. The 2012 NHS staff survey did not identify any evidence of risk but there were some areas where the trust was in the worst 20% of mental health trusts nationally, for staff ability to contribute towards improvements at work, support from immediate managers, staff motivation at work and for staff feeling pressure to attend work when feeling unwell. Following the inspection visit the 2013 report was published. We saw that the trust had compared most favourably with other mental health/learning disability trusts in receipt of health and safety training, feeling satisfied with the quality of work and patient care they were able to deliver, feeling motivated at work and in regard to work related stress.

There were some areas where staff experiences had deteriorated since the 2012 survey and would be areas the trust could improve as an employer. These were staff stating they experienced bullying and harassment at work and staff working additional hours.

We found that the Non-Executive Directors were unfamiliar with the themes emerging due to the exception reporting process. Audits and trends in relation to restraint and seclusion was monitored by other governance sub groups. No one on the Legislative group knew who monitored rapid tranquilisation. This meant that issues and themes discussed in the various subgroups may be missed as there was not sufficient overview to bring issues together.

Our findings

Governance framework is coherent, complete, clear, well understood and functioning

Monitor deferred the trust's application for Foundation Trust status in 2013, as the trust had not yet demonstrated that it met the quality governance requirements for authorisation. The trust responded to the feedback from Monitor by reviewing their governance systems. The changes resulted in the establishment of new committees and revisions to existing ones. A full review of the terms of reference was conducted and two new board committees were established; the' Integrated Performance Committee' and a 'Financial Planning and Investment Committee'.

We were told that sub groups reported to the Safety and Quality Operational Committee monthly and that This structure ensured that all of the sub group's work, and risks were brought together and reported.

We found that staff's understanding of the trust's governance framework function was inconsistent in the services we inspected. Some staff told us they regularly received information via email with updates on issues in the service. Some staff reported not knowing all of the systems to give feedback centrally on trust issues.

Some staff reported positive leadership in their service and from direct line managers but that they had limited contact with executive managers.

We were told that regular random audit of the quality of Care Programme Approach (CPA) documentation was undertaken by managers but in some services there was no record of the findings available for us to see. Senior managers told us that gaps in documentation were discussed with the staff in supervision. A more extensive overview of the quality of entries in patient records, for example the content of assessments or care plans were undertaken once a year. However again we were unable to see records of these checks at all the services we inspected.

The Provider told us that in addition to the two audit processes for which we were provided with no evidence,

Are services well-led?

(for example, are they well-managed and do senior leaders listen, learn and take appropriate action)

some themed auditing was undertaken periodically throughout the year. It was not clear that there was a proactive, overarching assessment of how well a service was functioning. Since we were not able to see results from these audits we cannot comment upon how they improved the quality of the service.

Engagement with staff and supporting staff with change and challenges.

At the time of this inspection, a lengthy restructuring process was underway. Some staff posts had been identified as being 'at risk', and there were plans in place to reduce clinical and administrative capacity.

Anxieties about the impact of the restructuring on workloads and capacity were high. Uncertainty about job security and some negative experiences of the process used in the reorganisation had undermined morale, and some staff had experienced it as uncaring and some clinical staff felt they were "not listened to." Some clinicians were not aware of an overarching vision for the service or the rationale for decision making around the restructuring and commented that the service was "manager dominated" rather than clinical staff feeling they had a sense of influence.

We were told that the trust wanted to ensure that staff felt well supported at work and enjoyed working for the trust. Senior managers we spoke with had an understanding of the issues however there was a disconnect between the perception of senior managers, who felt that they were providing clear management and leadership, and that of staff in services, some of who felt unclear and unsupported.

Staff spoken with at services and in the focus groups held, told us about the changes and consultation events taking place in the trust. Some staff at service level said they did not feel involved in the trust as a whole and the provider's vision and values were not embedded into all the services.

The Department of Health conducts an annual survey of NHS organisations to help gauge the views of staff across the country. The 2012 NHS staff survey did not identify any evidence of risk at this trust. Two areas; staff experiencing bullying or abuse in the previous 12 months and experiencing pressure of work were better than other mental health trusts nationally. There were some areas where the trust was in the worst 20% nationally; for staff

ability to contribute towards improvements at work, support from immediate managers, staff motivation at work and for staff feeling pressure to attend work when feeling unwell.

The 2013 survey was conducted from October to December 2013, and covered all groups of staff. At the time of the inspection visits the results were not published from this report however the trust had proactively surveyed a sample of its 4,300 staff, to gauge how staff were feeling at the point the survey was conducted late last year.

Following the inspection visit the 2013 report was published. We saw that the trust had compared most favourably with other mental health/learning disability trusts in receipt of health and safety training, feeling satisfied with the quality of work and patient care they were able to deliver, feeling motivated at work and in regard to work related stress.

There were some areas where staff experiences had deteriorated since the 2012 survey and would be areas the trust could improve as an employer. These were staff stating they experienced bullying and harassment at work and staff working additional hours.

During our visits to clinical areas staff told us they did not know who senior staff were although knew their immediate line managers. Very few staff reported having seen the executive team on the 'back to the floor' days they said had happened.

Some teams had been without a manager for long periods. Others reported that whilst they had a manager they had not had team meetings and therefore were unaware of changes and other cascaded messages. Some staff reported feeling unsupported by the trust and managers especially after incidents and sickness.

The trust integrated performance report of October 2013, to the executive performance committee, reported that staff agency use was routinely monitored across the services and had reduced for a second month in a row, from 7.81% (September 2013) to 6.48% (October 2013) with plans to reduce further to achieve the Trust target of 3.6%. On a number of wards, we found that recruitment to some permanent nursing vacancies had not taken place even though it had been agreed. Bank and agency staff were used instead.

Are services well-led?
(for example, are they well-managed and do senior leaders listen, learn and take appropriate action)

Whistleblowing

The trust has a whistleblowing policy which has been used by staff. Examples were given whereby serious issues were found in clinical areas that resulted in significant change and in disciplinary action against staff.

Some staff reported being able to raise any concerns at a local level such as team meetings and in supervision. We saw examples of where whistleblowing concerns raised had been dealt with effectively.

Despite the availability of focus groups and drop in clinics, CQC received a number of calls from staff during the visit to report concerns about the changes in the trust. Some staff spoke of a 'bullying culture' and were reluctant to raise concerns in fear of reprisal. A number of staff reported concerns about their service's future.

Staff could whistle blow through their line management structures or directly to the Board members through email. The Chief Executive had a 'blog' but some staff told us they did not want to use this. Board members spoken with were unclear as to whether whistleblowing could be undertaken anonymously through email or telephone.

Effective leadership

The trust has had a slightly higher staff sickness and absence rate compared to the national average for similar trusts in the same time period and is above the trust's target in a number of areas.

The staff survey, although identifying improvements from 2011, showed the trust was in the worst 20% of mental health trusts for staff feeling pressure to attend work when feeling unwell. The trust monitored the sickness levels and had taken action to bring sickness rates down.

Staff in focus groups and at the leadership event commented that protected learning time was not available. There was confusion as to how it should be accessed.

Doctors reported that the trust was a good place to train. Focus groups identified that there were too many locum doctors being used across all services, locum access to computers was limited and handovers were not comprehensive. Cover during consultant leave in some instances was not appropriately managed and junior doctors were struggling to cover nights. The Trust was

auditing the medical cover rotas and found them to be compliant. Trainees reported that they had had little information about the transformational project and how it would affect them.

Engagement with people who use services.

Systems were in place for people using the service, staff and others to give feedback such as reviews, suggestions boxes, and NHS and trust surveys.

An 'Annual Complaints Compliments and Pals' (Patient Advice and Liaison Service) report gave feedback on the Trust process and analysis of reported complaints and compliments.

Additionally the trust's website gave access to the patient opinion website, an independent site where people can share their views of UK health services and to NHS choices.

When issues were raised by people across the service, feedback was shown via noticeboards in a 'You said…. we did…' style. We noted that some trust information displayed for people was 20 months old and therefore may not be relevant or up to date to enable staff to track and identify themes actions to be taken.

The trust provided services to an area where there were many people for whom English was not their first language and interpreters were required. Staff we spoke with told us they had good access to interpreters and that written information was available in other languages on request. Additionally the Trust made use of staff who had knowledge of other languages. Some staff told us that family members were used to communicate with people. However this may not have been an effective method of communicating with people as the staff member would not be able to verify the correct information was being conveyed and the views were truly those of the person receiving care.

The trust has an "Equal Partners" strategy that aims to develop a culture of 'equal partnership and empowerment, where everyone has a chance to have their say'. The Equal Partners summary document is displayed on the trust's website.

Family and Friends tests are not yet implemented nationally in mental health trusts, but have to be implemented by the end of December 2014. Coventry and Warwickshire Partnership Trust is taking an incremental approach to implementing it and has extended it to eight

Are services well-led?

(for example, are they well-managed and do senior leaders listen, learn and take appropriate action)

services during the first three quarters of 2013/14: -Planned Care, Speech and Language Therapy, District Nursing Services, Integrated Sexual health Services, Continence Service, Clinical Assessment Services, with the latest to be included from quarter 3 being Tissue Viability and Central Booking Services.

Functioning Governance Framework for Mental Health Act (MHA) duties

We saw that Mental Health Act administrators were appointed to monitor the legality of the detention and treatment paperwork. They also prepared for Mental Health Review Tribunals and Hospital Mangers Hearings. The MHA administrators had recently been awarded an internal quality award for their work. Audits were completed on the wards in relation to consent to treatment and the giving of s132 rights and s17 leave.

The trust had a Mental Health Act Legislative Group which reported to the Safety and Quality Committee. This made exception reports to the trust Board. The groups reviewed themes emerging from the reports made by CQC Mental Health Act monitoring visits and monitored action plans, as well as sharing relevant findings with other governance subgroups.

We found that the non-executive directors were unfamiliar with the themes emerging due to the exception reporting process. Audits and trends in relation to restraint and

seclusion were monitored by other governance sub groups. No one on the Legislative group knew who monitored rapid tranquilisation. This meant that there was a risk that issues and themes may be missed in the various subgroups as there was not sufficient overview to bring issues together.

The Mental Health Act legislative group reported it intended to make greater links with these groups in order to obtain the results of audits and trends. The legislative group would benefit from receiving a holistic picture of the issues relating to detained patients ensuring the least restrictive principle was always applied.

We found that overall detentions appeared to be lawful, however a few medical recommendations in the assessment for detention, could have explained the reasons more explicitly.

In some wards we found a lack of consent to treatment and an inconsistency in records to demonstrate that people detained on Section 3 of the Mental Health Act accepted or understood their detention forms.

Documents were hard to read and did not always contain the signature of the person or carers to demonstrate their agreement of conditions and contingency plans. We did not see evidence that copies had been given to the patient or their carer.

Compliance actions

Action we have told the provider to take

The table below shows the essential standards of quality and safety that were not being met. The provider must send CQC a report that says what action they are going to take to meet these essential standards.

Regulated activity	Regulation
Treatment of disease, disorder or injury	Regulation 13 HCSA 2008 (Regulated Activities)
	The registered provider was failing to protect patients against the risks associated with the unsafe use and management of medicines.
	Regulation 13

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983	Regulation 20 HCSA 2008 (Regulated Activities)
Treatment of disease, disorder or injury	People who use services were at risk of unsafe or inappropriate care and treatment from a lack of proper information about them and the safe keeping of their information.
	Regulation 20(1) (a) (b) (i) (2) (a).

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983	Regulation 17 HCSA 2008 (Regulated Activities)
Treatment of disease, disorder or injury	The registered person had not as reasonably practicable made suitable arrangements to ensure the dignity, privacy and independence of service users.
	Regulation 17(1) (a)

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983	Regulation 23 HCSA 2008 (Regulated Activities)
Diagnostic and screening procedures	The registered person did not have suitable arrangements in place to ensure that people were appropriately supported to enable them to deliver care and treatment to service users and to an appropriate standard, by-
Treatment of disease, disorder or injury	

Compliance actions

(a)   receiving appropriate training, professional development, supervision and appraisal

Regulation 23. (1)(a)

Regulated activity	Regulation
Treatment of disease, disorder or injury	Regulation 15 HCSA 2008 (Regulated Activities) The registered person must ensure that people are protected against the risk of unsafe and unsuitable premises. Appropriate measures must be taken to ensure that facilities are safe and that adequate maintenance is undertaken. Regulation 15(1) (b) (c) HSCA 2008 (Regulated Activities) Regulations 2010

Enforcement actions

Action we have told the provider to take

The table below shows the essential standards of quality and safety that were not being met. The provider must send CQC a report that says what action they are going to take to meet these essential standards.

Regulated activity	Regulation
Treatment of disease, disorder or injury	The registered person must take proper steps to ensure that each service user is protected against the risks of receiving care or treatment that is inappropriate or unsafe, by means of—
	(a) the carrying out of an assessment of the needs of the service user; and
	(b) the planning and delivery of care and, where appropriate, treatment in such a way as to—
	(i) meet the service user's individual needs,
	(ii) ensure the welfare and safety of the service user,
	Regulation 9. (1) (a) (b) (i) (ii) HSCA 2008 (Regulated Activities) Regulations 2010