

5 Boroughs Partnership NHS Foundation Trust

Quality Report

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Core services inspected	CQC registered location	CQC location ID
Acute wards for adults of working age and psychiatric intensive care units	Hollins Park Wigan Knowsley St Helens Halton	RTV06 RTV04 RTV51 RTV02 RTV03
Wards for older people	Hollins Park Wigan Knowsley Halton	RTV06 RTV04 RTV51 RTV03
Forensic inpatient/secure wards	Hollins Park	RTV06
Child and adolescent inpatient wards	Fairhaven	RTVX1
Community-based mental health services for working age adults	5 Boroughs Partnership NHS Foundation Trust	RTV
Community-based mental health services for older people	St Helens Halton	RTV02 RTV03
Community services for children and young people	St Chads Clinic	RTV54
Wards for people with learning disabilities or autism	5 Boroughs Partnership NHS Foundation Trust	RTV

Summary of findings

Community mental health services for people with learning disabilities and autism	Willis House 5 Boroughs Partnership NHS Foundation Trust	RTV59 RTV
Health-based places of safety	Hollins Park Knowsley	RTV06 RTV51
Community health services for adults	Nutgrove villa St Chads clinic 5 Boroughs Partnership NHS Foundation Trust	RTVX2 RTV54 RTV
Community health services for children, young people and families	St Chads clinic	RTV54
Community health services for end of life care	Halewood health centre	RTV30

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

Summary of findings

Ratings

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

Overall rating for services at this Provider

Requires improvement



Are Services safe?

Requires improvement



Are Services effective?

Good



Are Services caring?

Good



Are Services responsive?

Good



Are Services well-led?

Requires improvement



Mental Health Act responsibilities and Mental Capacity Act/Deprivation of Liberty Safeguards

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

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

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

Summary of findings

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Summary of findings

Overall summary

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

We found that the provider was performing at a level which led to a judgement of requires improvement overall. In mental health services, we rated nine of the ten core services we inspected as good, with the forensic service rated as requires improvement. In acute community services which the trust provided in one borough, we rated two of the three services as good with end of life care rated as requires improvement.

The trust had identified that its governance system needed improving and was in the process of strengthening this. The trust had also taken steps to improve clinical input at a senior level with the introduction of new roles.

The areas where improvements were needed were:

- In end of life care there was no formal strategy, policy and framework for the delivery of care.
- Policies and procedures that should have ensured that all staff delivered a similar safe, caring, effective and responsive service were not always ratified or in date.
- In end of life care, medicines were not managed safely. Records were not correctly completed and there were discrepancies in stock levels. Staff were not following trust policies and procedures for handling medicines. Across the trust, only 22% of staff had completed medicines management training.
- Learning from incidents and complaints was not consistent across the trust which meant that the same problem could recur. The trust had taken steps recently to address this but the actions taken were not yet embedded sufficiently to deliver a robust learning culture across all services.
- Governance systems were not always identifying shortfalls or variations in quality of care. There was a

lack of consistency of quality of care across services which meant that patients could have different experiences of care depending on which ward they were admitted to. This was seen in acute wards for people of working age and in the forensic service. Risks were not always identified and acted upon.

The trust took immediate action to reduce risks in response to concerns raised at the time of the inspection. It is our view that the trust needs to take steps to improve the quality of their services and we find that they are currently in breach of regulations.

Areas of positive performance included:

- Staff were committed and passionate about providing good care and were proud to work at the trust.
- There were a number of ways for patients and their carers to be involved in the running of their trust. Governors spoke highly of the way the trust involved in them.
- The trust worked with the community and worked hard to promote positive attitudes towards people living with mental health needs.
- In mental health services, medicines were generally well managed with a culture of high reporting of errors.
- The chief executive was visible and accessible.
- The trust visions were known by most staff working across the trust and they understood how this informed their work
- The leadership team recognised the importance of strong engagement with patients, staff and external stakeholders and were working to develop this further.
- The trust worked hard to reduce the stigma of mental health in the local community.

We will be working with the trust to agree an action plan to assist them in improving the standards of care and treatment and promote a consistent quality of care across services.

Summary of findings

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

We always ask the following five questions of the services.

Are services safe?

We rated safe as **requires improvement** because:

- Some of the mental health wards did not provide a safe environment. The seclusion rooms on Taylor ward and Chesterton wards had 'blind spots' where staff could not observe patients who might be at risk of self-harm. Staff on 10 of the 11 mental health acute wards for adults of working age did not have assessments available which identified risks posed by fixtures and fittings that patients at risk of suicide could use to attach a ligature. There were no women only lounges on Grange and Kingsley wards.
- On some wards and in some community teams, staff did not manage medicines safely. The clinic rooms on Weaver and Grange ward did not store medicines at the correct temperature. In the end of life service, there were discrepancies of stock levels of controlled drugs and other medicines and medication records were not always completed correctly.
- Staff at Chesterton, Auden and Tennyson units did not undertake adequate assessments of risk for individual patients under their care. On acute wards and PICU, five risk assessments in the 58 records had not been reviewed recently and one had not been reviewed since the patient's admission in April 2015 and did not include any risks identified since admission.
- Not all staff had received training required to perform their role. The number of staff who had received training in medicines management was low across the trust.
- Learning from incidents was not consistently demonstrated across all services. The quality of investigations and timeliness of reports varied across the trust. The trust had recently taken action to improve this but consistent improvement was not yet seen.

However, the trust was a high reporter of incidents which demonstrated an open and transparent approach to incidents. Most patients had up to date risk assessments in place. There were sufficient staff to look after people safely. There was an effective system in place to provide assurance from ward to board that risks were being managed safely. The trust had effective safeguarding procedures in place which staff followed. The majority of staff we spoke with understood the underlying principles of the Duty of

Requires improvement



Summary of findings

Candour requirements and the relevance of this in their work. The trust had effective systems in place to ensure that there were enough staff on duty. Where there were vacancies, the trust employed temporary staff to ensure shifts were covered.

Are services effective?

We rated effective as **good** because:

- In 11 of the 13 core services we inspected, people's needs were assessed and care delivered in line with best practice and national guidelines. There were examples where best practice guidance had been integrated into the delivery of care. The exceptions to this were community health end of life care and forensic mental health service.
- There were systems in place to ensure physical health needs were assessed and annual health checks undertaken where required.
- The trust routinely monitored treatment outcomes for people.
- Multi-disciplinary teams worked together well to meet the needs of the patients they were supporting, except on one unit in the forensic service.
- The trust had effective systems in place for the recruitment of staff. Staff were supported with induction and mandatory training programmes, with most staff up to date with training. Staff received annual appraisals.
- The trust had a research strategy and participated in studies.

However, care plans did not always reflect patient centred care. For example, in six of the 11 acute wards we visited, care plans contained standardised information. There was no evidence that the views of patients had been sought and reflected in their care plans. Some patients had to wait to access psychological therapies. Patients were detained lawfully, with paperwork generally good. However, in forensic services, MHA documents were not always completed fully or correctly. In acute wards, there were no risk assessments in place for patients going on Section 17 leave. The trust was not always following best practice and national guidance. For example, in community end of life services, care was not always personalised, dying patients were not always identified and care coordinated appropriately. In acute wards, the trust was not always completing a post seclusion review with patients in line with National Institute for Health and Care Excellence guidance for violence and aggression: short-term management in mental health, health and community settings.

Good



Are services caring?

We rated caring as **good** because:

Good



Summary of findings

- We rated caring as good in 11 of the 12 services we inspected. We did not rate caring in health based places of safety as there was insufficient evidence to make a judgement.
- Staff were passionate about delivering good care to patients.
- Across all of the community health services, and the mental health services (inpatient and community) we inspected, we saw most staff being responsive, respectful, caring and kind when interacting with patients.
- Staff in most services involved patients and carers in the planning and delivery of the care they received.
- Results from the CQC community health patient experience survey were positive, with patients reporting they were treated with dignity and respect.
- The results from the friends and family test were positive in mental health and acute community services, with 89% and 97% of patients respectively recommending the trust as a place to receive care.
- The trust had supported a parent governor to provide an education programme to support carers when their loved one was discharged from hospital.
- There were good examples where patients and carers had been involved in service developments, most recently with the proposed new build hospital in Leigh.
- On Chesterton unit, a patient was running a self-harm support groups and patients were involved in setting up workshops to promote the recovery model.

However, on one unit of the forensic service we observed care records which were not written in a respectful manner. There was mixed feedback on staff attitude from patients and carers. Whilst most interactions were positive, we observed two occasions where staff were dismissive of patients.

Are services responsive to people's needs?

We rated responsive as **good** because:

- We rated responsive as good in 11 of the 13 services we inspected.
- The trust was meeting the target for seeing patients discharged on the care programme approach within seven days.
- The trust was performing consistently better than the England average for discharging people once they were ready to go home or transfer to other services. Routine referrals in the later life and memory service were being seen within target. In community specialist children's services, people were seen for assessment within the target time of 10 days.

Good



Summary of findings

- Readmission rates and outcome measures were within trust targets.
- Teams were seeing people at times that were suitable for the people using the service.

However, facilities did not always promote recovery and dignity. In the forensic service, staff, patients and carers told us that the wards were not a suitable environment for the patient mix. Chesterton and Auden unit were loud and busy. Bed occupancy was high and above the trust target. On occasion, beds from patients on leave were being used for new admissions. Stakeholders and patients were not involved in the development of the end of life service and feedback from patients was not routinely sought in the end of life service.

Are services well-led?

We rated well led as **requires improvement** because:

- The governance structure from senior manager level to ward level had been reviewed. Although there were risk registers in place in services not all issues that we found had been identified by internal processes.
- Feedback from incidents and complaints was not happening consistently across the trust. This meant that learning was not fully embedded across all services.
- There were inconsistencies in the quality of care within services which meant that patients could have different experiences depending on which ward they were admitted to.
- There were a number of policies which were out of date or had not been ratified.
- In end of life care there was no formal strategy, policy and framework for the delivery of care.

However, the board had a clear five-year plan that set out the vision and strategic objectives for the trust, which most staff were aware of and understood. The trust had developed a good governance structure at board level to senior manager level, with established committees that monitored quality, financial performance and operational issues relating to the trust. The trust had action plans to drive service improvements and risk registers to monitor progress. There was good leadership at board level with a visible executive team. The leadership team recognised the importance of strong engagement with patients, staff and external stakeholders and were working to develop this further.

Requires improvement



Summary of findings

Our inspection team

Our inspection team was led by:

Chair: Kevin Cleary, Medical Director and Director for Quality and Performance, East London NHS Foundation Trust

Head of Inspection – Nicholas Smith, Head of Hospital Inspection, Care Quality Commission

Team leaders: Sarah Dunnett, Inspection Manager, Care Quality Commission

Patti Boden, Inspection Manager, Care Quality Commission

Lorraine Bolam, Inspection Manager, Care Quality Commission

The team included CQC inspectors and a variety of specialists: consultant psychiatrists, a dietitian, a district nurse, experts by experience who had personal experience of using or caring for someone who uses the type of services we were inspecting, health visitors, Mental Health Act reviewers, nurses (registered general nurses, registered mental nurses and registered nurses for learning disabilities), occupational therapists, pharmacy inspectors, a physiotherapist, a podiatrist, psychologists, a school nurse, a paediatric nurse, senior managers and a social worker.

Why we carried out this inspection

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

How we carried out this inspection

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

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

Before visiting, we reviewed a range of information we hold about the trust and asked other organisations to share what they knew. We carried out announced visits to all core services on 21, 22 and 23 July 2015. During the visit we held focus groups with a range of staff who worked within the service, such as nurses, doctors, therapists. We talked with people who use services. We observed how people were being cared for and talked with carers and/or family members and reviewed care or treatment records of people who use services. We met with people who use services and carers, who shared their views and experiences of the core service. We carried out unannounced visits on 30 July and 3 and 6 August 2015.

During the visit we:

- met with 388 trust employees
- met with representatives from other organisations including commissioners of health services and local authority personnel
- met with 205 patients who use services who shared their views and experiences of the core services we visited
- observed how patients were being cared for
- reviewed 232 care or treatment records of patients who use services and 190 medication administration charts
- spoke with 57 carers or relatives of people who use the service
- looked at a range of records including clinical and management records
- observed multi-disciplinary team meetings
- held focus groups with a range of staff who worked in the service. This included nurses, doctors, psychologists, allied health professionals, and administrative staff.

Summary of findings

- reviewed 194 comment cards completed by service users or carers.

Information about the provider

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

It provides the following core mental health services:

- acute wards for adults of working age and psychiatric intensive care units
- forensic inpatient/secure wards
- child and adolescent mental health wards
- wards for older people with mental health problems
- wards for people with learning disabilities or autism
- community-based mental health services for adults of working age
- mental health crisis services and health-based places of safety
- specialist community mental health services for children and young people
- community-based mental health services for older people
- community mental health services for people with learning disabilities or autism.

The trust also provides the following acute services:

- community health services for adults
- community health services for children, young people and families

- community end of life care

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

- Hollins Park hospital
- Knowsley resource and recovery centre at Whiston hospital
- Leigh infirmary
- St Helens hope and recovery centre at Peasley Cross hospital
- Brooker centre at Halton hospital
- Fairhaven.

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

5 Boroughs Partnership NHS Foundation Trust was authorised as a foundation trust in March 2010. The organisation provides services from more than nine locations with an income of about £152 million, and employs more than 3223 staff.

5 Boroughs Partnership NHS Foundation Trust has been inspected seven times since registration. There have been seven inspections covering six locations which are registered for mental health conditions. CQC had not previously inspected community services. The trust was meeting the required standards when we last inspected.

What people who use the provider's services say

A review of comments placed on the 'patient opinion' and 'NHS choices' websites was conducted ahead of the inspection.

Patient Opinion

The trust scored 4.7 stars out of 5 for 'respect' based on 300 ratings.

The trust scored 4.6 out of 5 stars for 'listening' based on 296 ratings.

The trust scored 4.6 out of 5 stars for 'involved' based on 289 ratings.

The trust scored 3.6 out of 5 stars for 'social support' based on 50 ratings.

The trust scored 4.6 out of 5 stars for 'information' based on 291 ratings.

On the patient opinion website positive comments included:

Summary of findings

- Staff professionalism/attitude/skills (especially podiatrist and physiotherapist)
- kindness/helpfulness/listening/attention
- care/service/treatment
- information/explanation/advice provided
- appointment times/waiting times.

Areas of concern that were identified included:

- staff attitude
- waiting times
- food and environment
- communication.

Service user views

Before the inspection, we spoke with the local Healthwatch groups who told us that people had reported mixed experiences of the trust. There had been 56 responses about the trust, with 47 from people who use services. The responses were 15 mixed comments, 14 negative comments and 27 positive comments. Of the positive comments, 75% were about the quality of care people received. Access to appointments was the most negative aspect commented.

Concerns were raised about the time people had to wait for psychological therapies.

Local Healthwatch groups had visited wards and community teams and been impressed with the passion and professionalism of staff. Where issues had been identified such as activities on wards, the trust had responded effectively and improved access to them.

Inspection

During our inspection we received 194 comment cards completed by service users or carers. Of those 151 gave positive comments about the way staff behaved and cared for them. Twenty eight comment cards gave negative comments that related to a wide range of issues that we were unable to follow up on individually during the inspection. We received 15 comment cards that provided mixed feedback about the trust and the care and treatment received.

Throughout the inspection we spoke with 262 patients and carers who had used inpatient services or were receiving community treatment. Comments about care were overwhelmingly positive.

NHS Choices

There was only one review of the trust on NHS Choices which was positive.

Good practice

The trust had a 'stamp out stigma' campaign whose aim was to educate people to not stigmatise people with mental illness and learning disabilities by calling them names that are hurtful and offensive. The trust worked to increase knowledge of mental health issues and reduce stigma in the community by a number of methods including social media, events, resource packs for employers and schools and partnerships with professional sports teams.

In health-based places of safety

- In 2014/15, Merseyside police reported that no-one had been taken into police custody on a section 136 detention.
- Street triage initiatives had reduced the number of section 136 detentions in health-based places of safety by 62%.

- The trust's policy for a joint assessment of the patient to be completed by the duty doctor and AMHP within two hours of their being admitted was under the three hours' time set out in the MHA Code of Practice.
- There was an established mental health law strategy steering group attended by representatives from the trust, police, ambulance service and the local authorities. This included a development day held in June 2015, looking to progress the street triage by extending the hours covered during the night and further improve partnership working.

Community based services for older people

- The community mental health services showed us good examples of work designed to meet people's diverse needs, such as a spirituality conference and work with gender diversity, homeless people and the traveller community.

Summary of findings

Acute wards and PICU

- The “my recovery story”, a person centred document was being used on Lakeside unit, Coniston and Iris wards. The document was aimed at patients for their completion. It included sections on mental health confidence scale, my story and this admission, my recovery journey and action plan.
- We saw examples of local initiatives such as the advancing quality alliance which was an NHS health and care quality improvement organisation. Work funded by a grant from the health foundation was ongoing in some ward areas to reduce the use of physical restraint over a two year period.
- A local initiative to support patients who self-harm was led by a ward manager. He had introduced a self-harm pathway on one ward area, which resulted in reduced incidents; he had recently moved wards and was planning to introduce this in another ward area.

Child and adolescent mental health wards

- The teaching staff had developed a “dragons den” forum at which patients could bid for money for projects. The initial amount of money allocated was £50. Projects included making cakes, cards, candles, and chocolate. The patients were involved in planning, making and selling the produce and they had successfully turned the initial investment of £50 into £250. The patients were planning to use the profit for additional social activities over the summer holidays.

- Each week a senior manager attended the unit to run a reading group. This meant that the ward team and patients were connected to the senior management team.

Forensic/secure wards

- The service developed and delivered positive communication and empowerment sessions to patients following concerns about the level of hate-related incidents on the wards. The programme had been developed with the trust’s equality and diversity lead and patients and aimed to raise awareness of diversity and inclusion.

Community services for learning disability and autism

- There was evidence of research taking place to help inform best practice and care pathways.
- There were good levels of support with communication and communication aids to help assess people’s understanding of their rights under the Mental Health Act and people’s capacity to make decisions about their care.

Community health services for adults

- The Centre for Independent Living provided equipment for patients in the community. There were areas for people to try equipment before ordering as well as designated cleaning areas. There were systems in place to ensure equipment was delivered to people and training and support in place to help them use it.

Areas for improvement

Action the provider MUST take to improve

In acute and PICU wards

- The trust must ensure that the blind spot in the seclusion room in Taylor ward is mitigated and there is access to toilet and washing facilities for patients that are secluded.
- The trust must ensure that medicines are administered safely. It must resolve the unsafe storage of medicines on Weaver ward. The ambient room temperature in the clinic room was regularly in excess of 25 C. It must also ensure that staff attend the medicines management training.

- The trust must ensure that there are facilities on Lakeside ward for patients to make a private phone call.
- The trust must resolve the identified ligature risks on Sheridan ward.

In forensic/low secure service

- The trust must ensure that staff complete seclusion and MHA records accurately.
- The trust must ensure that patient records, are complete and accurate and supporting management plans are in place where required. This includes risk assessments, care plans and discharge plans.

Summary of findings

- The trust must ensure staff report serious incidents according to trust policy and that learning from incidents is shared with staff.
- The trust must ensure that staff receive appropriate training to perform their role and are up to date with mandatory training.
- The trust must ensure that patients are involved in the planning of their care. Patients must be able to discuss care and treatment choices continually and have support to make any changes to those choices if they wish.
- The trust must ensure that patients are prescribed medicines in accordance with the forms of authorisation.

In wards for older people

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

In health based places of safety

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

In community services for end of life care

- Develop and implement a formal strategy, policy and framework for the delivery of end of life care ensuring executive scrutiny.
- Ensure that the management of medicines is safe within the end of life care service, particularly in relation to controlled drugs management.
- Address the low training levels for mandatory medicines management training, end of life care and use of their internal reporting system.
- Implement a standardised approach to care planning for end of life care.
- Improve governance within the end of life care service including monitoring and risk management at all levels.
- Ensure patients receive medication in a timely way when they require it.

- Address the workload of senior managers involved with the delivery of end of life care to ensure this is manageable and safe.
- Ensure that records made by their staff are comprehensive, accurate and contemporaneous.
- Improve their engagement with the public in relation to end of life care services.

Action the provider **SHOULD** take to improve

- The trust should ensure that policies in use are ratified so that there is assurance that staff are working to the correct version and practice is consistent across the trust.

In acute wards and PICU

- The trust should complete a comprehensive ligature risk audit for each ward and address the findings.
- The trust should ensure that patients are involved in the creation of their care plans and that care plans reflect their preferences.
- The trust should ensure that the seclusion room at Taylor, Grasmere and Coniston wards meet the requirements of the Mental Health Act code of practice.
- The trust should ensure that staff attend mandatory training courses at the trusts target level of 85% attendance.
- The trust should ensure that there is a system in place to share the learning and actions from serious incidents with ward managers and their teams.
- The trust should follow the National Institute for Health and Care Excellence (NICE) guidance 10 by completing the post seclusion review with patients. The review will discuss reasons and possible triggers for the behaviour presented from a patient, which resulted in seclusion.
- The trust should ratify the Mental Capacity Act policy and procedure, which is currently in draft, and disseminate to all staff.

In wards for older people with mental health problems

- The trust should review the practice of leaving open door observation windows into patients' bedrooms.
- The trust should ensure that female only lounge areas should be clearly identified on all of the wards.
- The trust should continue the work addressing the temperature of the clinic room on Grange ward.

Summary of findings

- The trust should ensure the use of the Careflex Smart seat is recognised as a potential mechanical restraint and is included in an associated policy.
- The trust should ensure that it maintains the recent improvement in staff receiving line management supervision.

In forensic/low secure service

- The trust should adopt a model of care in line with good practice for distinct service areas and relevant to the patient cohort.
- The trust should ensure that informal complaints are recorded and themes identified so that lessons can be learnt.
- The trust should ensure multidisciplinary teams (MDTs) are effective.

In health-based places of safety

- The trust should ensure that blinds are fitted to the health-based place of safety at Knowsley resource and recovery centre to protect the privacy and dignity of patients.
- The trust should review the training needs of staff in the use of health - based place of safety and control and restraint training as requested by staff.
- The trust should ensure that staff have received mandatory training in line with trust targets.

In specialist community services for children and young people

- The provider should review the plan to improve the décor at the St Helens and Knowsley office as it had been recognised that the décor needed updating.

In wards for people with learning disability or autism

- The trust should implement the plan for bringing supervision up to date for all staff.
- The trust should ensure the plan for ensuring that all staff are up to date with their mandatory training is met.
- The trust should ensure the “time” field is recorded on section 17 leave forms in line with the Mental Health Act Code of Practice.

- The trust should ensure there are regular team meetings which are effectively and accurately recorded.

In community services for people with learning disability or autism

- The trust should improve compliance with mandatory training in the areas that fall below the trust target levels.
- The trust should ensure that assessments of people’s capacity to make decisions about their care are recorded consistently.

In community health services for adults

The provider should:

- Improve the uptake of mandatory training where there are pockets of low compliance.
- Ensure outcomes of patient surveys and internal audit results are fed to staff within teams and used to monitor and improve services.
- Ensure all staff who may be required to offer support during major incidents are aware of their roles.
- Continue to review the incidents relating to missed insulin doses to ensure that action plans to address this are effective in reducing the risk of recurrence.

In community services for children, young people and families

- The trust should improve compliance with the lone working policy so risk assessments are completed appropriately.
- The trust should improve compliance with consent policies so Gillick competency and Fraser guidelines are used effectively.
- The trust should improve performance against the 18 week referral to treatment standards for therapy services.
- The trust should reduce the number of patients that ‘did not attend’ scheduled appointments or sessions.

5 Boroughs Partnership NHS Foundation Trust

Detailed findings

Mental Health Act responsibilities

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

Where the Mental Health Act 1983 was used, people were detained with a full set of corresponding legal paperwork. In almost all the care records reviewed relating to the detention, care and treatment of detained patients the principles of the Act had been followed and the Code of Practice adhered to. The exception to this was in forensic services where we found seclusion records had not always been completed fully and wards for people with learning disability or autism where section 17 leave forms were not always fully completed.

Treatment was given under the appropriate legal authority. Prescription charts had the relevant forms of authority attached, which were completed fully and monitored regularly by the pharmacist. In two instances on the forensic service, patients were prescribed medicines above the limit written on the form of authority.

There was evidence that patients were advised of their rights in accordance with section 132.

There was an independent mental health advocacy (IMHA) service available to all patients. Information about the advocacy service was displayed on all the wards.

Mental Health Act training was available. Training records showed that staff uptake varied across the trust. The lowest

rate of staff trained in the MHA was 52% on Fairhaven unit, with the highest being 100% of staff on Tennyson. However, most of the staff we talked to appeared to be knowledgeable about the application of the Act.

Mental Capacity Act and Deprivation of Liberty Safeguards

There was an up to date policy for implementing the Mental Capacity Act (MCA) and obtaining authorisation for deprivation of liberty safeguards (DoLS).

The trust had submitted DoLS notifications to CQC in line with the trust's regulatory duty.

(Deprivation of liberty safeguards are rules on how someone's freedom may be restricted in their best interests to enable essential care or treatment to be provided to them. The safeguards ensure that the least restrictive option that can be identified to meet a specific need is applied.)

The number of staff trained in the MCA varied across the trust. Weaver ward had the lowest rate staff trained (57%) and Tennyson ward had the highest rate (100%). Staff demonstrated a good understanding of the Mental Capacity Act. Records showed, and staff and patient and carers confirmed, that patients were supported to make their own decisions wherever possible. Decisions about capacity to consent to decisions were recorded. Where patients were assessed to lack capacity to make a decision, best interest meetings were held. These meetings included

Detailed findings

members of the multi-disciplinary team and relevant carers where appropriate. However, in community services for people with a learning disability or autism, decisions about capacity were not always being recorded.

In the community health services for children, young people and family's service, there was guidance for staff on how to obtain consent and how to apply the Gillick competency and Fraser guidelines. However, this was not always being applied. Staff in the immunisation team were routinely seeking consent from parents/carers instead of identifying whether the young person had the capacity to consent.

(Gillick competency involves deciding whether a child of 16 years or younger is able to consent to medical treatment without the need for parental permission or knowledge. The Fraser Guidelines were set out by Lord Fraser in his judgement of the Gillick case in the House of Lords in 1985 and apply specifically to contraception. They are used to decide whether a girl of 16 or under can be given contraceptive advice or treatment without the consent or knowledge of her parents.)

Requires improvement



Are services safe?

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

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

Summary of findings

- Some of the mental health wards did not provide a safe environment. The seclusion rooms on Taylor ward and Chesterton wards had 'blind spots' where staff could not observe patients who might be at risk of self-harm. Staff on 10 of the 11 mental health acute wards for adults of working age did not have assessments available which identified risks posed by fixtures and fittings that patients at risk of suicide could use to attach a ligature. There were no women only lounges on Grange and Kingsley wards.
- On some wards and in some community teams, staff did not manage medicines safely. The clinic rooms on Weaver and Grange ward did not store medicines at the correct temperature. In the end of life service, there were discrepancies of stock levels of controlled drugs and other medicines and medication records were not always completed correctly.

- Staff at Chesterton, Auden and Tennyson units did not undertake adequate assessments of risk for individual patients under their care. On acute wards and PICU, five risk assessments in the 58 records had not been reviewed recently and one had not been reviewed since the patient's admission in April 2015 and did not include any risks identified since admission.
- Not all staff had received training required to perform their role. The number of staff who had received training in medicines management was low across the trust.
- Learning from incidents was not consistently demonstrated across all services. The quality of investigations and timeliness of reports varied across the trust. The trust had recently taken action to improve this but consistent improvement was not yet seen.

Detailed findings

However, the trust was a high reporter of incidents which demonstrated an open and transparent approach to incidents. Most patients had up to date risk assessments in place. There were sufficient staff to look after people safely. There was an effective system in place to provide assurance from ward to board that risks were being managed safely. The trust had effective safeguarding procedures in place which staff followed. The majority of staff we spoke with understood the underlying principles of the Duty of Candour requirements and the relevance of this in their work. The trust had effective systems in place to ensure that there were enough staff on duty. Where there were vacancies, the trust employed temporary staff to ensure shifts were covered.

Our findings

Track record on safety

The strategic executive information system (STEIS) records serious incidents and 'never events'.

('Never events' are serious incidents that are wholly preventable as guidance or safety recommendations that provide strong systemic protective barriers are available at a national level and should have been implemented by all healthcare providers so any 'never event' reported could indicate unsafe care.) Trusts have been required to report any 'never events' through STEIS since April 2011. Between 1 May 2014 and 30 April 2015 the trust reported no never events.

Serious incidents are those that require an investigation. The trust reported 106 serious incidents between 1 May 2014 and 30 April 2015. There were 75 deaths reported in that time through STEIS.

The majority of incidents related to the 'unexpected death of community patient in the community in receipt of services' (31), followed by 'suspected suicide' (25). Seven of the deaths were 'unexpected death of in-patient (in receipt of care and treatment)', six 'unexpected death of community patient (not in receipt)', three 'unexpected death of outpatient (in receipt)', one unexpected death of outpatient (not in receipt), and one 'unexpected death (general)'.

The average time it took for incidents to be closed was 121 days. A quarter of the serious incidents occurring between

1 May 2014 and 30 April 2015 were closed on STEIS. There were 63 incidents which had not been closed within the expected time as of 15 May 2015. Of the incidents regarding 'unexpected death of community patient and suspected suicide' (in receipt) 59% were overdue.

Coroners have the legal power and duty to write reports to a person, organisation, local authority or government department or agency where the coroner believes that action should be taken to prevent future deaths. The trust had received four reports to prevent future death, since December 2013.

Since 2004 trusts have been encouraged to report all patient safety incidents to the National Reporting and Learning System (NRLS) and since 2010 it has been mandatory for them to report all death or severe harm incidents to the Care Quality Commission (CQC) via the NRLS.

A total of 4229 incidents were reported to NRLS between 1 May 2014 and 30 April 2015. The majority of incidents reported during the 12 month period, resulted in no harm (76%) or low harm (20%) to the patient. The trust took an average of 34 days to report incidents to the NRLS.

The highest category of all incidents reported via NRLS was self-harming behaviour which accounted for a quarter of all incidents (1082). Of these, 600 were rated as resulting in no harm to the patient, 398 rated as low harm, 59 rated as moderate harm, four as severe harm and 21 deaths. The next highest category was medication incidents which accounted for nearly a quarter of all incidents reported via NRLS (1026). One thousand of these were rated as resulting in no harm to the patient, 22 low harm and 4 rated as resulting in moderate harm to the patient.

CQC's intelligent monitoring (IM) report identified the trust as an outlier for consistency of reporting to NRLS.

Learning from incidents

The trust had recognised that it needed to improve its performance in investigating and learning from incidents. It had taken a number of actions to improve.

Actions included:

- training more staff to investigate incidents and improve the quality of investigations.
- the appointment of assistant director clinical leads to further strengthen clinical leadership within the sectors.
- the establishment of a forum for learning from incidents

Detailed findings

These actions had only recently been completed and so it was too early to comment on the effect they had in driving service improvements. However, commissioners of the service reported that they were seeing improvements in the quality of investigation reports. There remained variation in the quality of the report and time taken to complete the investigation.

We held a focus group with matrons who told us about the training they had received into investigating incidents and how they were seeking to embed learning in their services.

Most staff knew how to report incidents and the trust had a high reporting culture. However there were exceptions to this. In community health services, local managers felt that incident reporting was low in some areas. Actions to address this were not clear. In forensic services, there were inconsistencies in how incidents were reported.

There was variation across the trust in whether staff heard back following incidents. Some teams had learning from incidents and complaints as a standard agenda item for staff meetings, but this was not the case across all services.

Medicines management

The trust provided training in medicines management. However, only 22% of staff identified as needing it had received training at the time of our inspection. Medication incidents were the second highest category of incidents reported to the NRLS. The trust reported 1026 medication incidents. One thousand of these were rated as resulting in no harm to the patient, 22 low harm and 4 rated as resulting in moderate harm to the patient. Being a high reporter reflected the trust's open and transparent approach to medicines management.

The pharmacy team were highly visible and encouraged staff to report errors and near misses.

Medicines were generally well managed in mental health services at the trust, with the exception of two wards where the temperature was too high in the room where medicines were stored. However, in the community services for end of life there were significant issues with the quality of medication records. In a number of records we found discrepancies in the stock levels of controlled drugs and other medications. These discrepancies had not been identified by the relevant teams and therefore not reported appropriately.

Safe staffing

Since April 2014 all hospitals are required to publish information about staffing levels on wards, including the percentage of shifts meeting their agreed staffing levels. This initiative is part of the NHS response to the Francis report which called for greater openness and transparency in the health service. Since February 2015, figures for the trust showed that the average fill rate was over 80% for all wards except Rydal Ward at Whiston in February with a rate of 79% for daytime registered nursing staff. In March 2015, Sheridan Ward at Hollins Park recorded 78% for daytime registered nursing staff and Rydal at Whiston Hospital recorded 78% for daytime registered nursing staff. In April 2015, all wards recorded staff fill rates of over 80% except for Marlowe ward at Hollins Park, which recorded 79% for daytime registered nursing staff. In May 2015, all wards achieved staff fills rates of over 80% except Auden Ward at Hollins Park which recorded 73% for daytime registered nursing staff.

Chesterton ward had the highest number of vacancies with 4.8 whole time equivalent (WTE) registered nurse vacancies, followed by Byron ward with 4.4 (WTE) registered nurses vacancies. Chesterton also had the highest number of vacancies for nursing assistants which stood at 4 WTE.

Trust board papers showed that staffing and recruitment were monitored and discussed. For example, the high number of vacancies on Chesterton unit was on the risk register and approval had been given to over spend on temporary staff to help improve care.

The trust had a training strategy in place. This identified statutory training which all staff at the trust had to undertake. There was also core training which was broken down to clinical and non-clinical groups. The trust target was for 85% of staff to have received training which had been identified as necessary for them to perform their role. The trust monitored this via a training matrix which broke down rates according to where staff worked.

Of the 29 areas of training identified, the trust had achieved or exceeded its target of 85% in 13.

The training with the highest rates of staff attendance were:

- health and safety 97%
- bullying and harassment 95%
- customer care 94%
- risk management 94%

Detailed findings

- equality and diversity 93%
- safeguarding children level 3 93%

Not all staff had completed their mandatory training which could put patients and staff at risk.

The training with the lowest rates of staff attendance were :

- clinical supervision 3%
- dual diagnosis 14%
- CPA training 19%
- moving and handling patient 22%
- rapid tranquilisation 18%

Nursing and quality groups had attained this standard in all areas with the exception of fire safety 83%, infection control 77% and breakaway techniques level two at 39%.

Pharmacy achieved this target in all areas with the exception of breakaway techniques level two at 70%.

Estates and facilities were below target in fire safety 50%, information governance 54% and conflict resolution 75%.

Human resources and organisational development were below target in fire safety 73% and conflict resolution 81%.

Finance, information and business development were below target in fire safety at 71% and information governance at 78%. The trust board were below target in fire safety 64%, infection control 79%, safeguarding children 79%, information governance 29%, equality diversity and human rights 72%, conflict resolution 50%, bullying and harassment 50%, customer services 43% and risk management 43%.

There was an action plan in place to improve compliance across all areas and ensure that training had been uploaded to the electronic recording system as this had been identified as a problem.

The trust's managing violence and aggression policy was ratified in May 2015 and was in line with the changes to management of violence and aggression policy and guidance produced by NHS England, the Department of Health, and NHS Protect.

Safe and clean environment

The trust participated in annual patient led assessment of the care environment (PLACE) visits. The trust scored above the national average for three of the four scores ('cleanliness', 'food', 'privacy and dignity'). For 'condition, appearance and maintenance' the trust scored below the national average.

There was not a consistent way of managing environmental risks for patients across the trust. On wards for acutely ill adults of working age there was only one (Sheridan Ward) of the 11 wards visited where there was an available up to date ligature risk assessment.

Women-only lounge areas were not available on Grange or Kingsley wards.

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

There were clear protocols in place for infection prevention and these were well-communicated across the staff teams. The housekeeping staff on the wards were informed of the clinical indications of bacterial infections, such as MRSA, and were able to undertake appropriate cleaning and safe disposal. The housekeeping staff had effective systems in place for communicating and maintaining a safe environment within the wards.

Wards were generally clean. There were dispensers at the entrance to all wards with hand sanitizer. Staff were observed using hand sanitizers. All staff observed during the inspection were bare below the elbows as is trust policy.

Seclusion

Out of the 21 wards who reported seclusion, there were 220 uses of seclusion and no uses of segregation in the period 1 October 2014 – 31 March 2015. Auden, Chesterton and Lakeside units reported the highest numbers of uses of seclusion in this time period. Auden unit was also one of the highest reporting units for restraint and restraint in the prone position. Grange and Rydal wards had no instances of seclusion.

There were no episodes of segregation reported for this period.

Restraint

The trust had ensured that staff training had been amended to reflect changes in national guidance to ensure that staff knew that restraint in a prone position (face down) put patients at high risk of injury. The prone position

Detailed findings

was only to be used for the safe administration of rapid tranquillisation. Rapid tranquillisation is when medicines are given to a person who is very agitated or displaying aggressive behaviour to help quickly calm them. This is to reduce any risk to themselves or others, and allow them to receive the medical care that they need. The trust protocol was that once the medicines had been given the patient must be rolled back over immediately.

Between 1 October 2014 and 31 March 2015 restraint was used on 814 occasions. These restraints occurred within 22 patient wards, units or teams. In 71 of these incidents patients were restrained in the prone position and 27 of these prone restraints resulted in the use of rapid tranquilisation. This meant that on 44 occasions, prone restraint had been used outside of the trust's own protocol.

Three areas reported the highest use of restraint:

- Kingsley Unit reported 191 episodes of restraint, of which one was in the prone position and did not result in the use of rapid tranquillisation.
- Fairhaven Young Persons Unit reported 128 episodes of restraint, of which 15 were in the prone position and 14 resulted in rapid tranquillisation.
- Auden Unit reported 113 episodes of restraint, of which 12 were in the prone position and none of which resulted in rapid tranquillisation.

Safeguarding

The trust had identified safeguarding leads for adults and for children. In each clinical area, there were named nurses and specialist safeguarding practitioners. The trust had an up to date safeguarding policy for children and adults.

There were governance systems in place to provide assurance to the board that safeguarding was being managed appropriately. There was a safeguarding governance meeting in place which aimed to assure the delivery of the strategic plan which reflected national guidance. There was also a safeguarding assurance group to provide assurance to the respective designated nurses on behalf of the CCGs.

The trust reported to five local authorities in relation to safeguarding incidents. We met with the trust's safeguarding lead who felt supported in their role.

The training rates for staff required to do safeguarding training on 22 June 2015 were as follows:

- Safeguarding children level 1, 87%

- Safeguarding children level 2, 83%
- Safeguarding children level 3, 93%
- Safeguarding adults 90%

Since 1 May 2013, CQC had received 2 safeguarding alerts and 11 safeguarding concerns which is a low number for a trust of this size. Staff across the trust were able to identify and knew how to raise safeguarding incidents.

Whistleblowing

CQC had received no whistle-blowing enquiries between 1 May 2013 and May 2015. The trust had a policy in place, ratified in April 2015, for staff to raise concerns internally. The policy reflected the trust commitment to courage as one of the 6Cs essential for safe patient care. The policy identified a designated director as the trust board lead. Staff in all areas told us they were able to raise concerns and felt listened to.

We held a focus group with the board of governors who told us they felt able to raise concerns and were confident that they would be listened to and any action taken.

Assessing and monitoring safety and risk

The trust had reviewed how it managed risk and developed a board assurance framework (BAF) which included recommendations from an external review of the trust's risk management processes from March 2014. The board assurance framework (BAF) was a live, dynamic document which focused on all risks with a current score of 12 and above with fair or limited controls.

Risks were to be reviewed and updated at least every quarter. The BAF included a review date and action plan for each identified risk. It was reviewed by the trust board at alternate meetings, where risks from the corporate risk register were also presented. We reviewed the corporate risk register and found that it was not consistently completed. For example, none of the risks assigned to the medical director had target dates, dates of opening or dates for review been updated within the target dates.

Risk was also monitored at the quality and safety meeting where the risk owner had to present a report and plans in place to address it.

In community health services, there were arrangements for identifying, recording and managing risks. However, not all the issues that the inspection team were present.

Across most services, we found that comprehensive risk assessments were in place for patients to assess and

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manage risks. In learning disability services, risk assessments were carried out for patients and risk management plans developed in line with national guidance. However, in forensic services and acute wards, risk assessments were not always completed fully or updated following incidents.

Potential risks

Within forensic services, the service had identified concerns on one of the units and alerted commissioners promptly. The commissioners had produced a report which had identified issues with staffing, training and low reporting of serious incidents. The trust had taken action in response to this. The level of temporary staff used in forensic services remained high, however the trust tried to use the same staff to improve consistency for patients and staff. In end of life services, the management of medicines was not being carried out in line with trust policy. The trust took immediate action at the time of the inspection. The trust did not have an overarching framework or strategy for end of life care. The trust had appointed a board member as a lead for end of life care but there was no non-executive director lead identified.

There were a number of different electronic information systems being used within the trust. The trust had recognised the risks and was in the process of

implementing a single system. However, in some services, such as community, paper and electronic records were held. This meant there was a risk of important information not being shared or visible to all people involved in care.

Duty of Candour

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

The trust had a strategy in place to ensure that it was meeting the regulation. The trust had a “Being Open Policy” clearly meeting the duty of candour requirement. There was a designated operational lead. The trust had informed staff of the requirements and evidence of the trust being open when things had gone wrong were seen in reviews of serious incidents.

The majority of staff we spoke with understood the underlying principles and how it applied in their workplace.

Are services effective?

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

Summary of findings

We rated effective as **good** because:

- In 11 of the 13 core services we inspected, people's needs were assessed and care delivered in line with best practice and national guidelines. There were examples where best practice guidance had been integrated into the delivery of care. The exceptions to this were community health end of life care and forensic mental health service.
- There were systems in place to ensure physical health needs were assessed and annual health checks undertaken where required.
- The trust routinely monitored treatment outcomes for people.
- Multi-disciplinary teams worked together well to meet the needs of the patients they were supporting, except on one unit in the forensic service.
- The trust had effective systems in place for the recruitment of staff. Staff were supported with induction and mandatory training programmes, with most staff up to date with training. Staff received annual appraisals.
- The trust had a research strategy and participated in studies.

However, care plans did not always reflect patient centred care. For example, in six of the 11 acute wards we visited, care plans contained standardised information. There was no evidence that the views of patients had been sought and reflected in their care plans. Some patients had to wait to access psychological therapies. Patients were detained lawfully, with paperwork generally good. However, in forensic services, MHA documents were not always completed fully or correctly. In acute wards, there were no risk assessments in place for patients going on Section 17 leave. The trust was not always following best practice and national guidance. For example, in

community end of life services, care was not always personalised, dying patients were not always identified and care coordinated appropriately. In acute wards, the trust was not always completing a post seclusion review with patients in line with National Institute for Health and Care Excellence guidance for violence and aggression: short-term management in mental health, health and community settings.

Our findings

Assessment of needs and planning of care

In most services, staff completed comprehensive assessments of the needs of patients. Care plans were reviewed regularly with patients and their carers, where appropriate. Patient involvement in care planning was not always seen in the forensic service or the acute wards.

In most mental health services, staff had completed risk assessments which led to detailed management plans to help care for people safely. This was not always done for patients in forensic services or acute wards.

In end of life services, care was not always delivered in line with national guidance. There was a comprehensive advance care plan, based on best practice guidance from National Institute for Health and Care Excellence (NICE) and other documents, to replace the Liverpool care pathway which was withdrawn in July 2014. However this plan was not yet in use and had led to inconsistent care being provided and we observed examples of how this had negatively impacted on patient's care.

The provision of cognitive behavioural therapy was identified as a risk on CQC intelligent monitoring system. The trust was also identified as an elevated risk for the offer of family intervention.

The proportion of admissions to acute wards that were gate-kept in 2014/15 was above the national average for three out of four quarters of the time period. This means that patients were being assessed appropriately and alternatives to inpatient admission were considered.

Are services effective?

The Care Quality Commission Community Mental Health Patient Experience Survey scored the trust as about the same as other trusts for all areas we asked people to comment on.

In health-based places of safety, the trust policy was for patients to be seen and assessed within two hours, which was an hour quicker than the time expected within the MHA Code of Practice para 16.47.

Outcomes for people using services

The trust participated in all national audits for which it was eligible in 2014/15.

These included:

- prescribing for people with personality disorder
- antipsychotic prescribing in people with learning disabilities
- cardio metabolic assessment for patients with schizophrenia 2014/15
- national audit of intermediate care 2015
- sentinel stroke national audit programme
- memory clinics audit 2014
- national chronic obstructive pulmonary disease rehabilitation audit
- national confidential inquiry into suicide and homicide by people with mental illness.

There was also a local audit programme, which comprised 313 audits during 2014/15. which included, for example, audits of discharge summaries, the care programme approach and medicines audits. In order to ensure audits resulted in improvements in quality of health care, the trust had committed to produce action plans which were agreed at the appropriate local group. Each action had an appointed lead with a time scale for completion. Action plans were monitored locally and through the trust's quality committees.

The introduction of the street triage service had reduced the number of section 136 detentions in health-based places of safety by 62%.

The teams were using a range of assessment tools to identify patients health and treatment needs which included

- The Historical Clinical Risk Management - 20
- Health of the Nation Outcome Scales
- Malnutrition Universal Screening Tool
- Falls risk assessment

The trust had a research strategy which set out objectives for 2015/16. It aimed to ensure the trust met national research performance targets, ensured robust and efficient research governance arrangements, in order for the trust to reach its full research potential across the whole organisation.

In 2014/15 the trust was involved in two successful submissions to the National Institute for Health Research for patient benefit funding programme. One was a piece of research on the use of medical skin camouflage for the women who self-harm. The second was the award of a doctoral research fellowship for research into understanding long standing emotional difficulties in primary care.

Staff skill

The trust employed a full range of mental health disciplines and workers to provide input into patient care. However, in forensic services there was a shortage of psychology staff.

There were effective systems in place to recruit staff with suitable skills. We reviewed 20 files and found that trust policies and procedures had been followed with all necessary checks completed.

The trust had a target that 85% staff completed mandatory training. There was also training specific to roles. Staff were also able to access funding for external training.

There was an induction for staff when they joined the trust. Some areas had also devised local induction programmes to ensure that staff were orientated to the area they were working.

For the year ending March 2015, 67% of non-medical staff had received an appraisal. All medical staff who were required to in this period had completed revalidation.

In the NHS staff survey 2014, 38% rated their appraisal as being well structured against the national average of 41%.

There was a clinical supervision policy in place and we found that most staff were receiving supervision. However, staff on Chesterton unit in the forensic service, on Coniston Ward in the acute service were not receiving supervision regularly.

The trust also ran coaching workshops. The aim was for 350 of trust managers to attend the programme to enhance their ability to facilitate and open coaching conversations and to come up with innovative ways of working.

Are services effective?

Multi-disciplinary working

Regular and effective multidisciplinary team meetings (MDT) and handovers of care were in place at the trust. We observed MDT meetings and saw that they were well run and disciplines listened to each other.

There were effective systems to handover care between teams and services.

On the forensic services, there was a weekly clinic run by a local GP who provided care for people's physical health needs.

We held a focus group with commissioners who reported good working relationships with the trust.

Information and Records Systems

The trust was rated as satisfactory in the information governance toolkit in both 2013/14 (76% overall) and 2014/15 (87% overall). The trust was also rated as satisfactory in all sub categories.

The trust operated a number of systems for managing patient records which were both electronic and paper based. In some areas, such as specialist community mental health services for children and young people, this worked well. However in other services, staff could not always access all the information held about patients. For example, in health based places of safety, records for section 136 episodes were in paper format which the trust could not easily access. In community health services for children, young people and families, staff sometimes experienced connectivity issues which meant they could not access electronic records.

The trust was in the process of standardising the electronic information system, with an implementation programme underway. There were local implementation groups in place to facilitate the change to the new system and a programme of training for staff. Key risks associated with the implementation had been assessed, documented and were being monitored.

Adherence to the MHA and the MHA Code of Practice

Section 120B of the MHA allows CQC to require providers to produce a statement of the actions that they will take as a result of a monitoring visit. During the course of the 20 monitoring visits that CQC had undertaken in the previous 12 months, the most frequent types of issues were

- lack of evidence of a discussion about capacity to consent by the responsible clinician, or any recording of an assessment of a patient's capacity to consent to treatment on first admission (on 16 occasions)
- issues with section 17 leave documentation and risk assessment (11 locations)
- lack of evidence of involvement of service users/carers in care plans (8 locations)

The following locations had the most issues:

- Taylor
- Sephton
- Cavendish
- Austen

During the inspection, we saw that where patients were detained under the MHA, the correct legal paperwork was generally in place. Treatment was given under the appropriate legal authority,. In almost all the care records reviewed relating to the detention, care and treatment of detained patients the principles of the Act had been followed and the Code of Practice adhered to. The exceptions to this were in forensic services where we found seclusion records had not always been completed fully and wards for people with learning disability or autism where section 17 leave forms were not always fully completed. In two instances on the forensic service, authorisation certificates for medicines did not include all the medicines prescribed. We saw evidence that patients were advised of their rights in accordance with section 132.

Patients and carers told us that they had been involved in the development of care plans, except for three of the forensic wards. There was not always evidence on the acute wards to show that patients had been offered a copy.

Good practice in applying the Mental Capacity Act 2005

The trust's policy and procedure for the MCA was only in draft and had not yet been ratified. There were 27 deprivation of liberty applications made by the trust during between May 2013 and May 2015. Of these, 16 were for patients on Sephton ward in Wigan, nine on Grange ward and one on Weaver ward and one on Kingsley ward.

Staff had received training on the MCA .The trust had identified the MCA as a quality priority and were working with the Advancing Quality Alliance, an NHS and care quality improvement organisation, to implement shared decision making in outpatient clinics.

Are services effective?

Across the trust we saw that capacity to make decisions was assessed and documented. However, in community services for people with a learning disability or autism, decisions about capacity were not always being recorded. In the community health services for children, young people and families' service, there was guidance for staff on

how to obtain consent and how to apply the Gillick competency and Fraser guidelines. However, this was not always being applied. Staff in the immunisation team were routinely seeking consent from parents/carers instead of identifying whether the young person had the capacity to consent.

Are services caring?

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

Summary of findings

We rated caring as **good** because:

- We rated caring as good in 11 of the 12 services we inspected. We did not rate caring in health based places of safety as there was insufficient evidence to make a judgement.
- Staff were passionate about delivering good care to patients.
- Across all of the community health services, and the mental health services (inpatient and community) we inspected, we saw most staff being responsive, respectful, caring and kind when interacting with patients.
- Staff in most services involved patients and carers in the planning and delivery of the care they received.
- Results from the CQC community health patient experience survey were positive, with patients reporting they were treated with dignity and respect.
- The results from the friends and family test were positive in mental health and acute community services, with 89% and 97% of patients respectively recommending the trust as a place to receive care.
- The trust had supported a parent governor to provide an education programme to support carers when their loved one was discharged from hospital.
- There were good examples where patients and carers had been involved in service developments, most recently with the proposed new build hospital in Leigh.
- On Chesterton unit, a patient was running a self-harm support groups and patients were involved in setting up workshops to promote the recovery model.

However, on the forensic service we observed care records which were not written in a respectful manner. There was mixed feedback on staff attitude from patients and carers. Whilst most interactions were positive, we observed two occasions where staff were dismissive of patients.

Our findings

Dignity, respect and compassion

The patient led assessment of the care environment (PLACE), England 2014 identified that the trust scored 93% for the privacy, dignity and well-being element of the assessment against an England average of 90% for mental health and learning disability services. There was PLACE information available for six locations which all scored above the England average.

CQC community mental health patient experience survey finds out about the experiences of people who receive care and treatment in the community. A questionnaire was sent to 850 people who received community mental health services from the trust. Responses were received from 209 people. The trust scored 8.3 out of 10 for privacy, dignity and respect which was about the same as most other trusts that took part in the survey.

On the patient opinion website, the trust scored 4.7 stars out of 5 for 'respect' based on 300 ratings and 4.6 out of 5 stars for 'listening' based on 296 ratings. Between June 2014 and May 2015 there was one comment about the trust on NHS Choices. There were five 'share your experience' comments between 1 May 2014 and 20 April 2015.

Patients were overwhelmingly positive about the care they received and reported that staff treated them with compassion and care. Staff spoke about patients with respect and demonstrated a good understanding of their individual needs.

Involvement of people using services

In the 2014 CQC community mental health patient experience survey the trust performed similar to other trusts in 'being informed' (6.7 out of 10), 'involvement in planning care' (7.4 out of 10), 'agreeing care' (5.6 out of 10), 'involvement in care review' (7.5 out of 10 and 'shared decisions' (7.9 out of 10).

In one question the trust had a score that was worse than most other trusts: 'The last time you had a new medicine prescribed, were you given information about it in a way that you were able to understand?' with a score of 6 out of 10.

Are services caring?

On the Patient Opinion website, the trust scored 4.6 out of 5 stars for 'involved' based on 289 ratings, and 4.6 out of 5 stars for 'information' based on 291 ratings.

Between June 2014 and May 2015 there was one comment about the trust on NHS Choices. There were five 'share your experience' comments between 1 May 2014 and 20 April 2015.

Across all of the community health services and mental health services (inpatient and community) we inspected, we saw staff being responsive, respectful, caring and kind when caring for patients.

On the Patient Opinion website, the trust scored 3.6 out of 5 stars for 'social support' based on 50 ratings.

The Friends and Family Test (FFT) is a single question survey which asks patients whether they would recommend the NHS service they have received to friends and family who need similar treatment or care. In the mental health FFT for May 2015 89% of patients recommended the trust compared to the England average of 88%. In acute community services, 97% of patients recommended the trust compared with the England average of 95%.

From April 2014 the staff FFT was introduced to allow staff feedback on NHS Services based on recent experience. Staff are asked to respond to two questions. The 'care' question asks how likely staff are to recommend the NHS services they work in to friends and family who need similar treatment or care. The 'work' question asks how likely staff would be to recommend the NHS service they work in to

friends and family as a place to work. The results for July - September 2014 showed that 50% of staff would recommend the trust as a place to work which was below the England average of 60%. The percentage of staff who would recommend the trust as a place to receive care was 73%, which was slightly below the England average of 76%.

Patients were shown around the ward when they were admitted and given information about the ward.

In learning disability services, patients received a survey from the trust every year to provide feedback. We also evidence of 'you said, we did' across the trust.

Emotional support for people

In community health services, patients were very positive about the level of emotional support they received. We observed good levels of support being offered during visits and when staff spoke with patients on the telephone. Patient's relatives were satisfied with the level of communication and the support they received.

Patients were allocated a named nurse to oversee their care to ensure continuity of care.

Staff, patients and their relatives had access to bereavement and counselling services provided by the trust to ensure they received appropriate support following a traumatic event.

Advocacy services were available and promoted within services. All the wards we visited had information about the advocacy services available.

Are services responsive to people's needs?

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

Summary of findings

We rated responsive as **good** because:

- We rated responsive as good in 11 of the 13 services we inspected.
- The trust was meeting the target for seeing patients discharged on the care programme approach within seven days.
- The trust was performing consistently better than the England average for discharging people once they were ready to go home or transfer to other services. Routine referrals in the late life and memory services were being seen within target. In community specialist children's services, people were seen for assessment within the target time of 10 days.
- Readmission rates and outcome measures were within trust targets.
- Teams were seeing people at times that were suitable for the people using the service.

However, facilities did not always promote recovery and dignity. In the forensic service, staff, patients and carers told us that the wards were not a suitable environment for the patient mix. Chesterton and Auden unit were loud and busy. Bed occupancy was high and above the trust target. On occasion, beds from patients on leave were being used for new admissions. Stakeholders and patients were not involved in the development of the end of life service and feedback from patients was not routinely sought in the end of life service.

were on leave were on occasion being used for new admissions. This led to occupancy rates of over 100% and the risk that a patient would return from leave and not have a bed.

There were effective systems in place to monitor bed occupancy, length of stay and unplanned readmissions. A monthly operational performance report was prepared at business stream level which was then sent to the trust board.

The trust was planning to move inpatient services at the Leigh site to a new build hospital at Atherleigh. There was good evidence of how patients, carers and governors had been involved in the development of the new build.

The trust was also remodelling how services were delivered to a borough based model. There was evidence that the proposed model had been shared with staff, patients, carers and governors. Staff side representatives confirmed that staff had been actively encouraged by the trust to be involved in consultations regarding the changes

Diversity of needs

The trust had an equality strategy and action plan to ensure that staff and people using the service had access to personal, fair and diverse services. There was an identified executive lead for equality. There was a trust equality, diversity and inclusion team.

The trust had a governance structure in place with three committees to implement the trust's strategy and action plan. There was an equality human rights and inclusion strategy group which was attended by executive directors and assistant directors. Beneath this sat a trust equality and human rights working group which was attended by managers, staff and included service user and carer representatives. Finally there was a trust external equality and human rights reference group which had a membership of service users, carers, Healthwatch and other third sector diversity organisations.

We saw evidence of the implementation of this strategy. The forensic service had developed and delivered positive communication and empowerment sessions to patients in

Our findings

Planning and delivery of services

The assessment service was the single point of access to services for patients of working age. This operated 24 hours a day, 365 days a year. The home treatment team acted as gatekeepers for admission to acute inpatient services.

In common with many mental health trusts there were issues related to bed availability and patient flow for adults of working age. In the acute service, beds of patients who

Are services responsive to people's needs?

response to hate-related incidents. The trust's equality and diversity lead and patients had been involved in the development of the programme which aimed to raise awareness of diversity and inclusion.

The equality delivery system 2 (EDS2) was developed by NHS England to help NHS organisations, in discussion with local people and partners, review and improve their performance for people with characteristics protected by the Equality Act 2010. The trust's annual Equality Act 2010 statutory information report of January 2015 identified that the trust was achieving three of the four areas of the EDS2: better health outcomes for all, a represented and supported workforce and inclusive leadership. It was rated as developing for improved patient access and experience.

The trust supported the international disability awareness day by holding an annual 'ignite your life, mental health and wellbeing' event. The event consisted of exhibitions and workshops aimed at promoting healthy lifestyles.

The trust provided training for staff in equality, diversity and human rights and 93% had attended the training. Service users, patients and carers were regularly involved in the development and delivery of staff training sessions.

In mental health services and community health services, patients' diversity and human rights were respected. Staff understood, promoted and supported patients and their differences. Staff were aware of patient's individual needs and tried to ensure these were met. This included cultural, language and religious needs. Staff had access to translation services. However, in community health services for adults there was a lack of information in languages other than English.

Right care at the right time

The trust had set a target rate of 85% for bed occupancy. The Royal College of Psychiatrists identified 85% occupancy as optimal as this means people can be admitted in a timely way to a local bed, which helps people maintain links with their community and support network. Delays in admission, which result from higher rates of bed occupancy, may cause a person's illness to worsen and may be detrimental to their long-term health.

The bed occupancy rates for mental health beds at 5 Boroughs Partnership Trust had been consistently higher than the England average for the last 12 months. CQC intelligent monitoring had identified this as a risk.

For the period October 2014 - March 2015, 18 out of 21 wards had occupancy levels above the trust's target of 85%.

The wards with the highest bed occupancy were:

- Bridge ward 103%
- Sheridan ward 101%
- Iris ward 100%
- Grasmere unit 100%

The wards with the lowest bed occupancy were:

- Grange ward 85%
- Tennyson unit 71%
- Byron ward 66%

All patients who are discharged and on the care programme approach (CPA) must be followed up within seven days of discharge. The trust's performance against this target was consistently better than the England average for three out of four quarters in 2014/15 and the same as the England average for the remaining quarter.

Data for times patients were waiting to be seen by community mental health services showed that the trust was meeting its targets for assessment for working age adults and CAMHS, for urgent, emergency and routine cases. The trust was not meeting its targets for urgent assessments for the later life and memory service (LLAMS). The trust had set a target of seeing urgent cases within 24 hours and none of the five LLAMS teams was meeting the target. Routine referrals were being seen within the target time of 10 days. However, the target of 12 weeks for referral to diagnosis was being met by three of the five teams.

The trust performed well at ensuring patients were discharged in a timely fashion. The trust consistently had fewer patients delayed at the point of discharge than the England national average.

CQC's intelligent monitoring system had identified as a risk the proportion of people who had waited more than 28 days for access to psychological therapies. The local Healthwatch had raised this as an issue before our inspection.

Learning from concerns and complaints

The trust had policies and procedures in place for the management of complaints. Staff received training on complaints during induction, which included what staff were expected to do and who to contact in the event of a complaint or query being raised directly with them.

Are services responsive to people's needs?

Monthly reports of complaints were monitored via the trust's governance systems. Complaints were analysed for themes. The trust shared analysis of complaints in the reports it provided to commissioners.

An evaluation of the trust's complaints handling in November 2014 had made the following recommendations:

- evaluate accessibility of content : complaints contact literature and internet contact details to be circulated to partners from Healthwatch and the equality, diversity and inclusion team for comment
- send communication to all operational services to promote knowledge of complaints team contact details
- ensure local resolution of complaints is highlighted within complaints training for trust staff
- revise information sent on acknowledgment of complaint to include information on the complaint handling process.

We found that across the trust staff and patients knew about the complaints process. In all the services we visited

information on how to complain was visible. In the forensic service, on Chesterton unit, informal complaints were not always being recorded to enable themes to be identified locally.

During 2013/14, the trust received 244 complaints about the services it provided. Following investigation by the trust, 104 of these complaints had been upheld which means they were based on solid evidence or good reasons.

Of the complaints aligned to a specific profession, nursing, midwifery and health visiting had the most complaints with 127 reported and 55 upheld. The next highest staff group to be complained about was doctors who received 53 complaints with 20 upheld.

The issue most likely to be complained about was 'all aspects of clinical treatment' which had 88 complaints with 36 upheld, followed by staff attitude which accounted for 56 complaints with 24 upheld. Overall, the number of complaints received had increased slightly from the previous year as had the number of complaints upheld.

Are services well-led?

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

Summary of findings

We rated well led as **requires improvement** because:

- The governance structure from senior manager level to ward level had been reviewed. Although there were risk registers in place in services not all issues that we found had been identified by internal processes.
- Feedback from incidents and complaints was not happening consistently across the trust. This meant that learning was not fully embedded across all services.
- There were inconsistencies in the quality of care within services which meant that patients could have different experiences depending on which ward they were admitted to.
- There were a number of policies which were out of date or had not been ratified.
- In end of life care there was no formal strategy, policy and framework for the delivery of care.

However, the board had a clear five-year plan that set out the vision and strategic objectives for the trust, which most staff were aware of and understood. The trust had developed a good governance structure at board level to senior manager level, with established committees that monitored quality, financial performance and operational issues relating to the trust. The trust had action plans to drive service improvements and risk registers to monitor progress. There was good leadership at board level with a visible executive team. The leadership team recognised the importance of strong engagement with patients, staff and external stakeholders and were working to develop this further.

“We will always do our very best to make the right decision for the health and wellbeing of our patients and staff”.

The trust overall purpose was defined as:

“We will take a lead in improving the wellbeing of our communities in order to make a positive difference throughout peoples’ lives”.

The trust had identified six strategic action areas in which projects were being undertaken to support delivery of the overall purpose:

- long-term conditions and learning lessons from our community health services
- partnering
- pathways (understanding and being able to describe these)
- reputation
- research
- innovation.

In 2010 the trust held a series of events to gain the views and opinions of staff, following this consultation period a set of values were developed and delivered in 2012:

- delivering commitments
- dignity and respect
- quality and excellence
- feedback and communication
- listening and learning

To support the delivery of the overall purpose and underpin the values, the trust had developed a quality statement to help describe how this would be achieved.

“The users of our services are the first priority in everything we do ensuring that they receive effective care from caring, compassionate and committed people working within a common culture and protected from harm.”

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

- care
- compassion
- commitment

Our findings

Vision, values and strategy

The trust operated a purpose and values model. The trust board purpose was defined as:

Are services well-led?

- courage
- communication
- competence

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

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

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

Quality priorities for 2014/15 had been identified in the quality strategy.

- patient safety
- patient experience
- effectiveness of services

The implementation of the quality strategy was monitored by the quality committee which was supported by the quality strategy improvement plan.

There was clear vision and strategy across mental health services and community adult and children's services however this was not found in the end of life service. There was no end of life strategy. The lack of an end of life framework and monitoring of performance against it meant the service lacked clarity of role and the executive team could not receive assurance of the quality of the service.

Good governance

The trust board were accountable for the running of the trust. They provided the strategic leadership for the trust.

There was a council of governors who held the trust's board to account for their performance.

There was a clear governance structure in place to provide assurance of how the trust was performing. There were a number of committees which fed into the board:

- executive quality and performance meeting
- strategic committee
- clinical leadership group
- audit committee
- quality committee
- quality and safety committee

- council of governors

The quality committee provided leadership and assurance to the board on the effectiveness and consistency of the trust's arrangements for quality. The primary focus was on safety, effectiveness and patient experience. Assurance was delivered through the business stream quality and safety meetings. The reporting framework was further strengthened by the use of 'deep dives' where areas of concern were looked at in greater detail. The minutes of the quality committee for June 2015 showed that a carer had attended which demonstrated a commitment by the trust to increase carer involvement.

The trust had pledged to be part of the Sign up to Safety campaign in December 2014 and submitted a safety improvement plan to NHS England in January 2015.

The trust had a safety improvement strategy 2015 - 2018 which aimed to:

- reduce the overall incidence of avoidable harm in the Trust by 50% in three years
- identify, support and manage the risk of avoidable harm to service users
- bring together established strategies for harm reduction into one over-arching safety improvement strategy
- demonstrate implementation of related policies and procedures in practice.

There was a designated executive lead for safety who was supported by the safety improvement leads from established strategic groups which were working on already identified areas of suicide and self-harm, prevention and management of violence and aggression, falls and physical health. The trust also had safety champions and ambassadors across the trust to support specific initiatives and training.

The trust target for mandatory training was 85%. This was not always being achieved across the trust with rates below target for staff in community health services for adults, community services for end of life care, wards for people with learning disability or autism, community services for people with learning disability or autism, and health based places of safety. The significantly low uptake of training around medicines management (22%) was identified by the trust as a contributing factor to the poor medicines management we found in the community services for end of life care.

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The trust had an action plan in place to improve compliance across all areas and ensure that training had been uploaded to the electronic recording system.

Staff appraisal rate for the trust was 67% for the past 12 months. Staff across the trust were receiving supervision. However, on Chesterton unit, not all staff were receiving supervision in line with trust policy.

There was a process and system for managing risk at a corporate level that was robust. Risks were escalated to the appropriate level and serious incident were scrutinised and countersigned by the director of nursing and the medical director.

We took feedback from commissioners prior to the inspection and held a focus group during the inspection. Feedback on communication with the trust was mainly favourable and commissioners acknowledged the need for this to be a two way process. Some of the areas of concern were: high bed occupancy rates, staff sickness, multi disciplinary team participation, delivery of 25 hours meaningful activity and training of staff in control and restraint techniques. Commissioners made comment that the trust can sometimes be more reactive rather than proactive in addressing issues to prevent incidents. The trust was working with commissioners to set up a lessons learned group to improve on this. We also saw lessons learned into practice was reported in the transformation board minutes. Commissioners spoke highly of the quality event held each November and involvement in the street triage scheme.

The provider was aware of its performance in its various service areas although there was a lack of performance monitoring in the end of life service and in one of the three district nursing teams. This meant the local leaders in these areas did not have assurance as to the safety or quality of the service being delivered.

CQC's intelligent monitoring system had identified sickness levels for nursing and non-clinical staff sickness overall as a risk. Chesterton unit, in the forensic service had high sickness rated

In community health services, staffing levels and caseloads were within acceptable ranges and there were low levels of turnover and sickness.

Leadership and culture

In the 2014 staff survey, the trust had a response rate of 41%. In relation to the overall indicator of staff engagement, the trust scored 3.6 which were worse than other trusts of a similar type.

The score for support from immediate managers was the same as the national average at 3.8. The score for job satisfaction was 3.6, slightly below the national average of 3.7.

The result for staff recommending the trust for a place to work or receive treatment was 3.5, compared to the national average of 3.9.

The percentage of staff experiencing bullying or harassment from other staff in the last 12 months was 18%, which was better than the national average of 21% and placed the trust in the top 20% nationally.

The percentage of staff feeling satisfied with the quality of work and patient care they were able to deliver was 75% in line with the national average.

The staff survey showed that front line staff wanted executives and senior managers to be more visible and in keeping with the requirements within the trust high level trust objective of being well led. As a result of this a framework for monthly visits to clinical areas by members of the board and senior managers to hear directly from staff the concerns and issues they dealt with every day that compromise patient safety. Visits started in May 2015 and reports listed the concerns, local and strategic accountability for action

Between 1 April 2014 and 31 March 2015 the sickness absence rate for the trust was 5.4%, which was above the national average for mental health trusts of 4.8%.

There were policies in place to address all aspects of staff performance. A review of staff files showed that policy was followed and issues dealt with promptly. Staff side representatives reported good working relationships with the trust.

We held a focus group with governors who were very positive about the openness and accessibility of the trust board. Where they had identified issues, they felt able to raise them and confident that action would be taken. They provided examples of where their feedback to the board had been listened to and action taken. They were particularly proud of how they had been involved in the

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development of the new build. Governors felt supported to perform their role and received appropriate training. Some governors had recently participated in root cause analysis training so they could be involved in the investigation of serious incidents.

The duty of candour regulation ensures that providers are open and transparent with people who use services. The trust had a strategy in place to ensure that it was meeting the regulation. There was a designated operational lead. The trust had informed staff of the requirements and evidence of the trust being open when things had gone wrong were seen in reviews of serious incidents. The trust had a “Being Open Policy” clearly demonstrating the duty of candour requirement.

There was evidence from data and from the assessment of core services of a ‘healthy’ culture within the organisation as it promoted the safety and wellbeing of staff. The trust encouraged appreciative, supportive relationships among staff as well as candour, openness and honesty. It was centred on the needs and experience of people who use services.

However, end of life services lacked executive leadership and scrutiny. There was not an identified non-executive director with a lead role on end of life although there was a named executive lead.

Fit and Proper Person Requirement

The Fit and Proper Person Requirement (FPPR) is one of the new regulations that applied to all NHS trusts, NHS foundation trusts and special health authorities from 27 November 2014. Regulation 5 says that individuals, who have authority in organisations that deliver care, including providers’ board directors or equivalents, are responsible for the overall quality and safety of that care. This regulation is about ensuring that those individuals are fit and proper to carry out this important role and providers must take proper steps to ensure that their directors (both executive and non-executive), or equivalent, are fit and proper for the role.

Directors, or equivalent, must be of good character, physically and mentally fit, have the necessary qualifications, skills and experience for the role, and be able to supply certain information (including a Disclosure and Barring Service check (DBS) and a full employment history).

There was a policy in place to ensure that the trust was meeting the fit and proper person requirement. A paper went to board in January 2015 which outlined actions that the trust needed to take. This required all directors to self declare fitness which had been completed by February 2015.

The trust provided the information that they had relied on to be assured they had met the requirement. Disclosure and barring checks had been completed by 20 July 2015. On first review of the documents, references were not available for eight of the 12 directors. The non-compliance with the requirement had not been identified or placed on the risk register. The missing references were provided by the last day of the inspection. This meant that the trust had not been compliant with the requirement when it had come into place on 27 November. The trust took immediate action to address this and put a system in place to ensure continuing compliance with the regulation.

Engaging with the public and with people who use services

The trust engaged with the public and people using services in a number of ways:

- an active involvement scheme with over 500 patients and carer volunteers
- social media presence
- service user and carer forums
- director walk arounds
- ‘you said, we did’
- via a service user and carer magazine ‘Outlook’.

Examples of the involvement scheme contribution included:

- being on recruitment panels
- presenting on induction and doctor training
- ‘mystery’ food tasting on wards
- being part of internal inspection teams
- supporting ward staff to provide activities
- participating in task and finish groups and committees.

Examples which demonstrated meaningful engagement in the planning and delivery of care included an education programme developed by a carer governor to help support carers. This was an eight month training course delivered by a carer aimed at reducing readmissions and keeping

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people using services and carers well. Engagement was seen in both mental health and acute community services. However, in acute community services, the trust did not always gather the views of people using the service.

The trust was building a new hospital at Atherleigh Park. There had been wide engagement with service users, carers and the community in the development of the project. Volunteers were used in recruitment of staff from band 8A upwards. Governors had been trained to contribute to serious incident reviews.

The trust had a 'stamp out stigma' campaign whose aim was to educate people to not stigmatise people with mental illness and learning disabilities by calling them names that are hurtful and offensive. The trust worked to increase knowledge of mental health issues and reduce stigma. There was a website, resource packs for schools and employers and an events programme to promote the campaign. The trust had strong working relationships with local sports clubs to promote the anti-stigma message.

Quality improvement, innovation and sustainability

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

- Austen ward, Hollins Park Hospital
- Bridge ward, Halton General Hospital
- Cavendish ward, Leigh Infirmary
- Coniston unit, Whiston Hospital
- Grasmere unit, Whiston Hospital
- Iris ward, St. Helens

- Lakeside ward, Leigh Infirmary
- Sheridan ward, Hollins Park Hospital

The trust transformation board met monthly and was chaired by the chief finance officer. It provided a forum to share, discuss and develop the transformation programmes of the trust, explore opportunities and provided space for innovative and creative discussion to achieve trust strategy. Minutes of the transformation board identified progress and evaluation through a dashboard report. Each project was reviewed and a scoring criteria was applied either red, amber or green and actions to be taken where projects were not on target.

The trust was in the process of changing the model used to deliver services from a service based model to a borough based model. The trust's "Future Fit Transformation Programme" aimed to deliver a borough based operational model with enhanced clinical leadership and redesigned patient pathways. It was aligned with the trust's overall purpose. In November 2014 a series of information events were held to outline the vision and a range of external discussions took place with partners including commissioners who were positive about the changes this would bring. A programme board was established in April 2015 and a full project plan was approved at the projects board first meeting. Some staff told us they were still uncertain about how the changed might affect them. The core brief was used to formerly brief all staff on the programme in May 2015. An intranet page had been developed to allow staff to view the proposals and raise questions via email.

This section is primarily information for the provider

Requirement notices

Action we have told the provider to take

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

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Treatment of disease, disorder or injury	<p>Regulation 9 HSCA (RA) Regulations 2014 Person-centred care In forensic/low secure services</p> <p>Patients were not always involved in the planning of their care. Involvement was not clear in some care plans and some patients told us they did not feel involved.</p> <p>Two patients were prescribed medicines which were not included on the forms of authorisation (T2/T3).</p> <p>This was a breach of Regulation 9(3)(b)(c)(d)(6)</p> <p>In community end of life services</p> <p>The trust did not have a standardised approach to care planning for end of life care. We found that there were occasions where there were delays in patients receiving medications they required they required because the Macmillan nursing team did not routinely administer medications.</p> <p>This was a breach of Regulation 9 (1)(a)(b)(c) (3)(a)(b)(c)(d)(e)(f)(g)</p>
Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Nursing care Treatment of disease, disorder or injury	<p>Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment In forensic/low secure service</p> <p>Risk assessments were not always undertaken, complete or updated on Chesterton, Auden and Tennyson units.</p> <p>This was a breach of Regulation 12(2)(a)</p> <p>In forensic/low secure</p>

This section is primarily information for the provider

Requirement notices

Learning from incidents was not embedded across the service to ensure that all staff received feedback.

Environmental risks were not always managed effectively. There were blindspots on wards and in a seclusion room.

This was a breach of Regulation 12(2)(b)(d)

In acute wards and PICU

The seclusion facilities for Taylor, Grasmere and Coniston wards do not meet the Mental Health Act code of practice and there was a blind spot in the seclusion room at Taylor Ward. There were ligature risks which had not been identified by an audit and had no plans in place to manage them.

The medicines were not being administered safely as they was unsafe storage of medicines on Weaver ward as the ambient room temperature in the clinic room was regularly in excess of 25 C.

This was a breach of Regulation 12(2)(d)(g)

In community end of life services

We found a number of incidents where medicines were not accounted for and managed appropriately. We were not assured that medicines were being managed safely within the end of life care service, particularly in relation to controlled drugs management.

Training uptake for mandatory medicines management was poor in all teams involved in the delivery of end of life care.

Staff who were required to use the trusts internal reporting system had not received appropriate training in how to use the system.

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

This section is primarily information for the provider

Requirement notices

Regulated activity

Assessment or medical treatment for persons detained under the Mental Health Act 1983

Nursing care

Treatment of disease, disorder or injury

Regulation

Regulation 17 HSCA (RA) Regulations 2014 Good governance

Trust wide

There were a number of policies which were out of date or had not been ratified. This meant there was a lack of assurance that staff were working consistently across the trust.

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

Health-based places of safety

The trust was unable to provide data to give assurance that the health-based places of safety were being used in line with national guidance and the MHA Code of Practice para 16.64, 16.63 and 16.71.

This was a breach of Regulation 17 (2)(a)

In forensic/low secure service

The systems in place to monitor the quality of care being delivered were not effective or were not being used. Audits were not identifying shortfalls in quality, for example the care plan audit. The recording of patient activities was not accurate.

There were separate records of staff working on the unit which meant that local records did not always reflect the names of staff who were working. Patient records were not always complete. This included seclusion records and MHA records. There were duplicate copies of MHA records on Chesterton unit.

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

In community services for end of life

The trust did not have a formal strategy, policy and framework for the delivery of end of life care.

No evidence was found that governance was being monitored within the end of life care service and being used to inform risk management.

This section is primarily information for the provider

Requirement notices

We found that some patient records were not comprehensive and accurate. The service had not identified and reported all risks in line with their own procedures.

Senior managers within the trust told us they did not routinely seek patient or public engagement when planning and delivering end of life care services.

Senior managers within the service told us that the workload of senior managers involved with the delivery of end of life care was unmanageable. Documents we reviewed showed that the operational manager for end of life care services had responsibility for three teams.

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

Regulated activity

Regulation

Assessment or medical treatment for persons detained under the Mental Health Act 1983

Nursing care

Regulation 18 HSCA (RA) Regulations 2014 Staffing
In forensic/low secure service

Not all staff had received the training needed to perform their role. Bank health care assistants did not have breakaway training.

This was a breach of regulation 18(2)(a)

Regulated activity

Regulation

Assessment or medical treatment for persons detained under the Mental Health Act 1983

Treatment of disease, disorder or injury

Regulation 10 HSCA (RA) Regulations 2014 Dignity and respect

In two wards there were no identified female only lounges which is not in line with best practice.

This was a breach of regulation 10(2) (a)