

North West Boroughs Healthcare NHS Foundation Trust

Inspection report

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

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

This report is a summary of our inspection findings. You can find more detailed information about the service and what we found during our inspection in the related Evidence appendix.

Ratings

Overall trust quality rating

Good 

Are services safe?

Good 

Are services effective?

Good 

Are services caring?

Good 

Are services responsive?

Good 

Are services well-led?

Good 

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

Summary of findings

Background to the trust

North West Boroughs Healthcare NHS Foundation Trust delivers a range of health services across a population of more than 3.5 million people within Cheshire, Merseyside and Greater Manchester. These include community-based physical health services, as well as mental health and learning disability services.

They are part of two health and social care systems – Cheshire and Merseyside Health and Care Partnership for services delivered across Halton, Knowsley, Sefton, St Helens and Warrington; and the devolved Greater Manchester Health and Social Care Partnership for services delivered in Wigan, Bolton and across Greater Manchester. The trust also provides specialist services for people with learning disabilities and services for people with mental health needs in the criminal justice system in Greater Manchester, Halton and Warrington.

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

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

During 2018/19 the annual turnover of the trust was £186 million. The services the trust provides are commissioned by three local authorities and five Clinical Commissioning Groups, including NHS England. The trust also holds subcontract arrangements with two other local NHS trusts and works in partnership with independent sector partners.

The trust provides the following core mental health services:

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

The trust provides the following community health services;

Summary of findings

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

The trust delivers its services from nine locations made up of 19 wards with a total of 297 beds. The trust also delivers services in the community and runs 242 mental health clinics and 414 community physical health clinics a week. The locations the trust provide services from are:

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

Between May and July 2018, we carried out a well-led inspection and unannounced inspections of six core services. The results were published in October 2018, when the trust was rated 'Good' overall. The trust was rated good in safe, effective, caring and well led with requires improvement in responsive. We rated the following core services as good; community health services for adults, acute wards and psychiatric intensive care units, child and adolescent mental health wards and community based mental health services for adults. At the time of this inspection, the Trust no longer provided child and adolescent mental health wards as a core service; Fairhaven ward had closed in March 2019. We rated wards for people with a learning disability or autism as requires improvement and wards for older people with mental health problems as inadequate. We re-inspected both of these core services at this inspection.

Overall summary

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

What this trust does

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

Key questions and ratings

We inspect and regulate healthcare service providers in England.

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

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

Summary of findings

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

What we inspected and why

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

We inspected this trust under CQC's planned checks on the safety and quality of healthcare services. At this inspection we inspected the following between 21 October and 26 November 2019;

- Wards for older people with mental health problems
- Wards for people with learning disabilities or autism
- Forensic inpatient/secure wards
- Mental health crisis services and health-based places of safety
- Specialist community mental health services for children and young people.

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

- Acute wards for adults of working age and psychiatric intensive care units
- Community based mental health services for adults of working age
- Community health services for adults.
- Community health services for children, young people and families
- Community mental health services for people with learning disabilities or autism
- Community mental health services for older people
- Community end of life care.

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

What we found

Overall trust

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

- We rated three of the five services we inspected as good overall. Of the 12 core services provided by this trust, 10 were rated good overall following this inspection. We rated well led for the trust overall as good.
- There was effective leadership across the organisation. The trust had an experienced leadership team with appropriate skills and abilities. The board and senior leadership team had set a clear vision, values and behaviours that were at the heart of all the work within the organisation. The newly developed trust strategy was linked to the vision and values. Staff in most services knew and understood the provider's vision and values and how they were applied in the work of their team. There was a clear five year plan to provide high quality care and financial stability. This included a plan of the trust being acquired by another health and social care provider.

Summary of findings

- Staff provided care that was personalised, holistic and recovery-oriented. Staff treated patients with compassion and kindness. Staff in most services supported and involved patients, families and carers.
- The services had enough nursing staff, who knew patients and received statutory and mandatory training to keep patients safe from avoidable harm. In most services, staff regularly assessed and managed risks to patients and themselves and achieved the right balance between maintaining safety and providing the least restrictive environment possible in order to facilitate patients' recovery.
- The trust made sure that it included and communicated with patients, staff, the public, and local organisations. The trust was focused on improving engagement with a new engagement strategy. Patients and carers were able to give feedback and contribute to improvements. The trust was committed to improving services by learning from when things go well and when they go wrong.
- There was a values-based culture which was positive and open. Work on equality and diversity had progressed and workforce race equality was monitored. Staff were able to speak up and were supported with their well-being. Staff felt respected, supported and valued.
- The trust had effective governance structures, systems and processes. Committees worked well with set agendas and had the ability to be responsive if additional items needed to be reviewed. The board had oversight of risk. Teams had access to the information they needed to provide safe and effective care and used that information to good effect.
- The trust had systems in place to identify learning from incidents, complaints and safeguarding alerts and make improvements. There had been recent improvements in investigating serious incidents. Staff understood how to protect patients from abuse and the services worked well with other agencies to do so.
- The trust had appropriate arrangements in place in relation to Mental Health Act administration and compliance. Staff understood their roles and responsibilities under the Mental Health Act 1983 and the Mental Health Act Code of Practice and discharged these well.
- Information on service quality and sustainability was used and reviewed. Staff could access the data they needed and had the information technology to undertake their roles. The trust had invested in information technology through being part of the Global Digital Exemplar programme.

However,

- On the ward for people with a learning disability or autism, there was not the sufficient range of staff with the required skills to provide safe care and treatment in line with best practice or national guidance. The service did not involve patients and their families in their care and staff did not always review risk in line with trust policy. There were occasions where the inspection team observed staff did not give patients help, emotional support and advice when they needed it or maintain patients' confidentiality.
- In the mental health crisis services and health based places of safety, there was a lack of clear and consistent policies and procedures to support safe care and treatment. The environment at Atherleigh Park did not maintain the privacy and dignity of patients when caring for two patients at the same time. Staff did not always complete patient records in line with trust policy. There was a lack of specialist training for staff and learning was not shared across the service.
- In the specialist community services for children and young people, waiting times from referral to treatment were too long and not meeting trust targets.
- Vacancies for medical staff had improved but remained high and were having an impact on some services. Not all staff had access to clinical supervision. Some teams had not met the trust target for non-medical staff appraisals. Complaints were not always responded to in a timely way.

Summary of findings

Are services safe?

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

- At this inspection we rated three of the five core services that we inspected as good for safe. When these ratings were combined with other existing ratings from previous inspections, 10 trust services were rated good for safe and two were rated requires improvement.
- Wards were safe, clean, well equipped, well furnished, well maintained and fit for purpose. Clinic rooms were fully equipped, with accessible resuscitation equipment and emergency drugs that staff checked regularly.
- The services had enough nursing staff, who knew patients and received statutory and mandatory training to keep patients safe from avoidable harm.
- In most services, staff regularly assessed and managed risks to patients and themselves and achieved the right balance between maintaining safety and providing the least restrictive environment possible in order to facilitate patients' recovery.
- Staff understood how to protect patients from abuse and the services worked well with other agencies to do so. Staff had training on how to recognise and report abuse, and they knew how to apply it.
- Staff had access to the clinical information they needed, and it was easy for them to maintain high quality clinical records, whether paper-based or electronic.
- Services used systems and processes to safely prescribe, administer, record and store medicines. Staff regularly reviewed the effects of medicines on patients' physical health.
- The trust had a good track record on safety. Services managed patient safety incidents well. Staff recognised incidents and reported them appropriately. Managers investigated incidents and shared lessons learned with individuals, teams and the wider service. When things went wrong, staff apologised and gave patients honest information and suitable support.

However,

- The trust did not have a specific observation policy for the use of the health-based places of safety. Staff managing the places of safety did not receive specific training to safely support patients when medication had been used or restraint was required. The environment at the health-based place of safety at Atherleigh Park was not in line with the Mental Health Act code of practice guidance when used for two patients at the same time. The trust had identified issues with magnetic locks on the doors at Atherleigh Park and Hollins Park health-based places of safety following incidents. Staff did not always complete crisis plans for patients.
- On Byron ward, which provided care for patients with a learning disability or autism, the environmental risk assessment and location of the ligature cutters was not included in the ward induction. Three of the five risk assessments we looked at had not been reviewed in line with trust policy. There was one seclusion episode where the seclusion documentation did not reflect the trust policy.
- Within the forensic inpatient service, a ligature risk assessment had not been completed on Tennyson ward in the last 12 months. There was no timescale for work to be completed on Marlowe ward to reduce the risks identified in their ligature risk assessment. Patients within the step-down service were not able to self-medicate as there was no provider policy or procedure for this.
- Despite the fact the trust had worked hard to ensure that mixed sex accommodation breaches were reported, there remained high numbers of incidences within the wards for older people with mental health problems.

Summary of findings

Are services effective?

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

- At this inspection we rated four of the five core services that we inspected as good for effective and one as inadequate. When these ratings were combined with other existing ratings from previous inspections, 11 trust services were rated good for effective and one was rated inadequate.
- Staff assessed the physical and mental health of all patients. Staff in most services developed individual care plans, which they reviewed regularly through multidisciplinary discussion and updated as needed. Care plans reflected the patients' assessed needs, were personalised, holistic and recovery-oriented.
- Staff from different disciplines worked together to benefit patients. They supported each other to make sure patients had no gaps in their care. The wards and teams had effective working relationships within the organisation and with relevant services outside the organisation.
- In most services, staff provided a range of care and treatment interventions consistent with national guidance on best practice. They ensured that patients had good access to physical healthcare and supported patients to live healthier lives.
- The trust had appropriate arrangements in place in relation to Mental Health Act administration and compliance. Staff understood their roles and responsibilities under the Mental Health Act 1983 and the Mental Health Act Code of Practice and discharged these well.
- Staff supported patients to make decisions on their care for themselves. They understood the provider's policy on the Mental Capacity Act 2005 and most staff assessed and recorded capacity clearly for patients who might have impaired mental capacity.

However,

- On Byron ward, which cared for people with a learning disability or autism, the trust did not provide a range of treatments suitable to the needs of the patients and in line with national guidance about best practice. The ward team did not include the full range of specialists required to meet the needs of patients on the wards. Staff did not receive specialist training for their role.
- At the assessment and home treatment teams, care plans and capacity assessments had not been completed in some of the records reviewed.
- Although the trust had introduced new supervision software and undertaken work to improve the quality of and access to supervision, not all staff had access to clinical supervision. This was particularly an issue within the forensics and specialist community mental health services for children and young people core services. Some teams had not met the trust target for non-medical staff appraisals.

Are services caring?

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

- At this inspection we rated four of the five core services that we inspected as good for caring and one as requires improvement. When these ratings were combined with other existing ratings from previous inspections, 10 trust services were rated good for caring, one was rated outstanding and one was rated requires improvement.
- Across all services staff treated patients with compassion and kindness. In most services, staff respected patients' privacy and dignity. They understood the individual needs of patients and supported patients to understand and manage their care, treatment or condition.

Summary of findings

- Staff in most services involved patients in care planning and risk assessment and actively sought their feedback on the quality of care provided. Within the forensic inpatient service, there had been several strategies to improve patient engagement, including the recruitment of a peer support worker. Staff ensured that patients had easy access to independent advocates.
- Staff in most services supported, informed and involved families or carers. Within the forensic inpatient service there had been improvements in identifying carers and making initial contacts, providing information and advice including about carers assessments and the development of a carers information pack.

However,

- Staff on Byron ward, which cared for patients with a learning disability or autism, did not always inform and involve families and carers appropriately. They did not involve patients in care planning and risk assessment and did not seek their feedback on the quality of care provided. The inspection team observed staff talking about a patient in front of other patients. There were occasions where they observed staff did not give patients help, emotional support and advice when they needed it.
- It was not clear how patients who had been assessed and treated within the health-based places of safety could provide feedback on the quality of care they had received.

Are services responsive?

Our rating of responsive improved. We rated it as good because:

- At this inspection we rated four of the five core services that we inspected as good for responsive and one as requires improvement. When these ratings were combined with other existing ratings from previous inspections, 10 trust services were rated good for responsive and two were rated requires improvement.
- Staff planned and managed discharge well. They liaised well with services that would provide aftercare and were assertive in managing the discharge care pathway. As a result, patients did not have excessive lengths of stay and discharge was rarely delayed for other than a clinical reason.
- The design, layout, and furnishings of the inpatient services supported patients' treatment, privacy and dignity. On the inpatient services that we inspected, each patient had their own bedroom and could keep their personal belongings safe. There were quiet areas for privacy.
- The food was of a good quality and staff supported patients to make meal choices.
- Most services met the needs of all patients who used the service – including those with a protected characteristic. Staff helped patients with advocacy and cultural and spiritual support.
- The service treated concerns and complaints seriously, investigated them and learned lessons from the results, and shared these with the whole team and the wider service.

However,

- It was not clear how the trust were maintaining the privacy and dignity of patients in the health based place of safety at Atherleigh hospital when more than one patient was treated at a time. Within the specialist community mental health services for children and young people service at Knowsley, there was no separation between the staff office and the reception desk and those visiting that service had a clear unobstructed view of the office and could hear staff talking.

Summary of findings

- Within the mental health crisis core service, two of the teams within the specialist community mental health services for children and young people were outside the trust targets for referral to treatment time, so patients had to wait a significant length of time for their treatment. The Wigan Assessment team was under pressure in terms of workload and managing referrals to the team. Although a process had been agreed around how the referrals were managed, managers noted there was a backlog on the waiting lists.

Are services well-led?

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

- At this inspection we rated three of the five core services that we inspected as good for well led and two as requires improvement. When these ratings were combined with other existing ratings from previous inspections, 10 trust services were rated good for well led and two were rated requires improvement.
- Leaders had the skills, knowledge and experience to perform their roles, had a good understanding of the services they managed, and were visible in the service and approachable for patients and staff.
- Staff in most services knew and understood the provider's vision and values and how they were applied in the work of their team.
- Staff felt respected, supported and valued. They reported that the provider promoted equality and diversity in its day-to-day work and in providing opportunities for career progression. They felt able to raise concerns without fear of retribution.
- Teams had access to the information they needed to provide safe and effective care and used that information to good effect.
- Within the specialist community mental health services for children and young people, managers worked closely with other local healthcare services and organisations (schools, public health, local authority, voluntary and independent sector) to ensure that there was an integrated local system that met the needs of children and young people living in the area. There were local protocols for joint working between agencies involved in the care of children and young people.

However,

- Within the mental health crisis services and health based places of safety there was a lack of consistent policies and procedures to ensure good governance. Processes were not operating effectively at team level and performance and risk were not always managed well. Although staff collected data about outcomes and performance, the process of reviewing and making use of this information was inconsistent across the teams visited. Learning and developments across the three health-based places of safety and teams visited was not routinely shared. We observed different good practice being created and used by the teams but these had not been shared across the trust.
- Within the wards for people with a learning disability or autism service, managers did not ensure that patients were cared for by staff with the necessary skills and experience to provide good quality care. Managers did not ensure that staff had opportunities for specialist training for their role and care planning for individual patient needs to ensure the service was effective. The service did not provide opportunities for patients and carers to give feedback on the service in a meaningful way.
- Within the specialist community services for children and young people, managers did not ensure that referral to treatment targets were met.
- Within the forensic inpatient service, the provider's senior leadership team had not successfully communicated the provider's vision and values to the frontline staff.

Summary of findings

Ratings tables

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

Outstanding practice

We found examples of outstanding practice in all one of the services we inspected:

- Wards for older people with mental health problems

For more information see the Outstanding practice section of this report.

Areas for improvement

We found areas for improvement including breaches of four regulations of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 that the trust must put right: Regulation 9 Person Centred Care; Regulation 12 Safe care and treatment, Regulation 17 Good Governance and Regulation 18 Staffing.

There were 12 things the trust must put right in relation to breaches of these four regulations. In addition, we found 26 things that the trust should improve to comply with a minor breach that did not justify regulatory action, to prevent breaching a legal requirement, or to improve service quality.

For more information see the areas for improvement section of this report.

Action we have taken

We issued requirement notices in respect of the four regulations that had been breached within four core services.

For more information on action we have taken, see the sections on Areas for improvement and Regulatory action.

What happens next

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

Outstanding practice

Wards for older people with mental health problems:

- Due to the outbreak of an infectious illness on Kingsley Ward the staff team had worked extremely hard on infection control and prevention. There was a new clinic room on the ward that was specifically for wound care. This had dressings that would be used regularly specifically for skin of older people that can be more prone to tears. There were regular spot checks from the infection control team (the last spot check before the inspection scored 98%). Staff on the ward had completed courses in tissue viability and attended a workshop on the importance of hand hygiene.
- The staff on Kingsley Ward had done a lot of work around staff culture since the last inspection. This included staff away days, staff surveys to gauge progress and heavy involvement from senior leaders on the ward. At the beginning

Summary of findings

of this work a survey completed by staff found high levels of staff wanting to leave the ward and feeling unhappy at work. After the development of this work staff on the ward completed the survey again and these results showed that 100% of staff were happy on the ward and nobody wanted to leave for anything other than career progression opportunities.

Areas for improvement

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

Action the trust **MUST** take to improve

We told the trust that it must take action to bring services into line with legal requirements. These 12 actions related to four core services.

Wards for patients with a learning disability or autism:

- The trust must ensure patients have access to a full multidisciplinary team to enable patients to receive interventions in line with best practice. (Regulation 9)
- The trust must ensure that staff follow good practice in relation to assessing and supporting patients with epilepsy and communication needs. (Regulation 9)
- The trust must ensure that training is provided to staff in the specific needs of the patients including learning disability, autism and epilepsy. (Regulation 18)
- The trust must ensure they involve carers in the care of their relative by sharing information and inviting them to meetings if consent allows. (Regulation 9)

Mental health crisis services and health based places of safety:

- The trust must ensure that an observation policy for the use of health-based places of safety is available to staff. (Regulation 12)
- The trust must ensure that staff are appropriately trained to safely support patients in the health-based places of safety when medication has been used or restraint is required. (Regulation 12)
- The trust must ensure that the doors at the Atherleigh Park and Hollins Park health-based places of safety are reviewed and repaired as required. (Regulation 12)
- The trust must ensure that 136 records and care and treatment records are up-to-date and complete. (Regulation 12)
- The trust must consider how the privacy, dignity and safety of patients within the Atherleigh Park health-based place of safety is managed when more than one patient is in the health-based place of safety to ensure it is meeting the Code of Practice. (Regulation 12)
- The trust must ensure that appropriate oversight and governance processes are in place to monitor the use, effectiveness and efficiency of the health-based places of safety. To consider how the trust are assured that staff are aware of their responsibilities when managing the places of safety and that these are in line with the trust expectations. (Regulation 17)

Forensic inpatient services:

- The trust must complete remedial work as detailed in the ligature risk assessment for Marlowe ward. (Regulation 12)

Summary of findings

Specialist community mental health services for children and young people

- The trust must ensure that the time between patients being referred and accessing treatment is within the trust target in all services. (Regulation 17)

Action the trust SHOULD take to improve

We told the trust that it should take action to comply with a minor breach that did not justify regulatory action, to prevent breaching a legal requirement in future or to improve service quality. These are the 26 actions related to the whole trust and five core services.

Trust wide:

- The trust should ensure that there are sufficient permanent medical staff to provide safe care and treatment to patients.
- The trust should ensure staff across all services have access to supervision and appraisals.
- The trust should ensure that complaints are managed and responded to in a timely manner and in line with trust policy.

Wards for people with a learning disability or autism:

- The trust should ensure the blind in the seclusion room is repaired.
- The trust should review the allocation of patient bedrooms to ensure there is separation between male and female bedrooms.
- The trust should include the ligature risk assessment and location of the ligature cutters to the staff induction to ensure staff are aware of the risks within the environment and how to respond.
- The trust should ensure that individual risk assessments are reviewed in line with trust policy.
- The trust should review the seclusion recording and ensure staff are competent with their role within the seclusion process and the recording of this.
- The trust should ensure that staff respect patients' confidentiality and ensure they are not talking about patients in front of other patients.
- The trust should review how it communicates information to patients regarding the running of the ward, including activities and staffing to ensure information is accessible to patients.

Mental health crisis services and health based places of safety:

- The trust should consider how to reduce the potential delays in staff attending the health-based places of safety due to the Wigan and Warrington teams being based off-site.
- The trust should ensure that a clock is available to patients in the Atherleigh Park health-based place of safety.
- The trust should ensure that all signage and materials contain correct and up-to-date information for patients.
- The trust should ensure that staff who attend the health-based places of safety are appropriately trained in the use of health-based places of safety and consider if specific training for the use of the places of safety is necessary.
- The trust should ensure that management supervision is taking place on a regular basis.
- The trust should ensure that contingency plans are created where significant issues are identified. The trust should ensure that staff are aware of these plans and what they are required to do in these situations.

Summary of findings

- The trust should consider how data and information gathered within the health-based places of safety is reviewed and analysed to make improvements or changes as necessary.
- The trust should consider how feedback from people who have used the health-based places of safety is gathered to evaluate their experiences and whether any improvements can be made.

Forensic inpatient wards:

- The trust should ensure they have a policy or procedure to enable patients to self medicate.
- The trust should ensure all staff receive an annual appraisal of their work.
- The trust should ensure that staff on forensic wards are aware of who the senior managers for their service are and that communication between the senior management level and ward based staff is improved.

Wards for older people with mental health problems:

- Although the trust has worked hard to ensure breaches in mixed sex accommodation are reported, the trust should ensure they reduce the amount of mixed sex accommodation breaches across the service.

Specialist community mental health services for children and young people

- The trust should ensure patient privacy and confidentiality is maintained at the Knowsley service.
- The trust should ensure staff safety is continually assessed and review the provision of personal alarms.
- The trust should ensure all staff receive appraisals and supervision.
- The trust should consider how to engage carers and patients for more formal feedback about the service as not all areas had patient participation groups and none had carers groups.

Is this organisation well-led?

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

- There was effective leadership across the organisation. We rated three out of the five core services we inspected as good for well-led and two as requires improvement. Ten out of the twelve core and specialist services for the trust are rated as good. Two are rated as requires improvement.
- The trust had an experienced leadership team with appropriate skills and abilities. They recognised the training needs of managers at all levels, including themselves, and worked to provide development opportunities for the future of the organisation.
- The board and senior leadership team had set a clear vision, values and behaviours that were at the heart of all the work within the organisation. They worked hard to make sure staff at all levels understood them in relation to their daily roles.
- The newly developed trust strategy was linked to the vision and values. The trust involved clinicians, patients and groups from the local community in the development of the strategy. There was a clear five year plan to provide high quality care and financial stability. This included a plan of the trust joining with another health and social care provider.

Summary of findings

- There was a values-based culture which was positive and open. Senior leaders made sure they visited services and fed back to the board to discuss challenges staff and the services faced.
- Work on equality and diversity had progressed and workforce race equality was monitored. There had been a deterioration in one measure with the others improving or staying the same.
- Staff were able to speak up and were supported with their well-being.
- The trust had effective governance structures, systems and processes. Governance was a priority at all levels and the board had oversight of performance, quality and risk. Committees worked well with set agendas and the ability to be responsive if additional items needed to be reviewed.
- The trust had systems in place to identify learning from incidents, complaints and safeguarding alerts and make improvements. There had been recent improvements in investigating serious incidents. Staff knew how to safeguard patients.
- Staff could report and escalate risk and appropriate mitigations for risks were in place. The board had oversight of risk.
- Cost improvement plans were assessed to consider their impact on quality of patient care. Financial performance of the trust was stable and achieving requirements set by regulators.
- Information on service quality and sustainability was used and reviewed. Staff could access the data they needed and had the information technology to undertake their roles. The trust had invested in information technology through being the Global Digital Exemplar programme.
- The trust made sure that it included and communicated with patients, staff, the public, and local organisations. The trust was focused on improving engagement with a new engagement strategy. Patients and carers were able to give feedback and contribute to improvements.
- The trust was committed to improving services by learning from when things go well and when they go wrong.

However:

- Vacancies for medical staff had improved but remained high and were having an impact on some services.
- Not all staff had access to clinical supervision. Some teams had not met the trust target for non-medical staff appraisals.
- Complaints were not always responded to in a timely way.

Ratings tables

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

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

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

Ratings for the whole trust

Safe	Effective	Caring	Responsive	Well-led	Overall
Good ↔ Feb 2020	Good ↔ Feb 2020	Good ↔ Feb 2020	Good ↑ Feb 2020	Good ↔ Feb 2020	Good ↔ Feb 2020

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

Ratings for a combined trust

	Safe	Effective	Caring	Responsive	Well-led	Overall
Community	Good Oct 2018					
Mental health	Good ↔ Feb 2020	Good ↔ Feb 2020	Good ↔ Feb 2020	Good ↑ Feb 2020	Good ↔ Feb 2020	Good ↔ Feb 2020

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

Ratings for community health services

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

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

Ratings for mental health services

	Safe	Effective	Caring	Responsive	Well-led	Overall
Acute wards for adults of working age and psychiatric intensive care units	Good Oct 2018	Good Oct 2018	Good Oct 2018	Good Oct 2018	Good Oct 2018	Good Oct 2018
Forensic inpatient or secure wards	Requires improvement ↓ Feb 2020	Good ↔ Feb 2020	Good ↔ Feb 2020	Good ↔ Feb 2020	Good ↔ Feb 2020	Good ↔ Feb 2020
Wards for older people with mental health problems	Good ↑↑ Feb 2020	Good ↔ Feb 2020	Good ↔ Feb 2020	Good ↑ Feb 2020	Good ↑↑ Feb 2020	Good ↑↑ Feb 2020
Wards for people with a learning disability or autism	Good ↑ Feb 2020	Inadequate ↓ Feb 2020	Requires improvement ↔ Feb 2020	Good ↑ Feb 2020	Requires improvement ↔ Feb 2020	Requires improvement ↔ Feb 2020
Community-based mental health services for adults of working age	Good Oct 2018	Good Oct 2018	Good Oct 2018	Requires improvement Oct 2018	Good Oct 2018	Good Oct 2018
Mental health crisis services and health-based places of safety	Requires improvement ↓ Feb 2020	Good ↔ Feb 2020	Good Feb 2020	Good ↔ Feb 2020	Requires improvement ↓ Feb 2020	Requires improvement ↓ Feb 2020
Specialist community mental health services for children and young people	Good ↔ Feb 2020	Good ↔ Feb 2020	Good ↔ Feb 2020	Requires improvement ↓ Feb 2020	Good ↔ Feb 2020	Good ↔ Feb 2020
Community-based mental health services for older people	Good Feb 2016	Good Feb 2016	Good Feb 2016	Good Feb 2016	Good Feb 2016	Good Feb 2016
Community mental health services for people with a learning disability or autism	Good Feb 2016	Good Feb 2016	Good Feb 2016	Good Feb 2016	Good Feb 2016	Good Feb 2016

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

Specialist community mental health services for children and young people

Good   

Key facts and figures

North West Borough's specialist community health services for children and young people provide a mental health service for young people up to their 18th birthday, who may be experiencing a range of severe and complex difficulties with their mental health. The service is divided into six areas covering Halton, Knowsley, St Helens, Wigan, Warrington and Bolton. There is also two eating disorder teams which covered the trust area base at Knowsley and Wigan.

We inspected all locations except the Bolton based team as they delivered the service in partnership with another local health service.

All teams were based in trust buildings, but they also saw patients in a wide variety of other settings including schools, GP surgeries, children's centres and patient's homes. There was also an assessment and urgent response team based at St Helens covering the trust area.

The teams were location based and formed part of a wider children's service offering reporting to area operational managers who were responsible for all children's services.

This was an unannounced three-day inspection in line with the CQC inspection programme and this was the first time this service had been inspected since July 2015.

The service was inspected against the five key questions and rated against them. The five questions we give ratings for were whether services were safe, effective, caring, responsive and well-led.

During the inspection visit, the inspection team:

- Visited the service including the eating disorder and urgent response teams and spoke with members of staff from all the areas covered by the service;
- Spoke with 11 patients and seven carers of the service;
- Spoke with three area operational leads to which the service reported;
- Spoke with six location managers or their deputies;
- Spoke with 31 other members of staff including quality matrons;
- Reviewed 25 sets of clinical care records;
- Observed four family therapy sessions and outpatient's appointments;
- Attended three clinical team meetings;
- Looked at a wide range of policies, procedures, audits and other documents relating to the running of this service.

Summary of this service

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

Specialist community mental health services for children and young people

- The service provided safe care. Clinical premises where patients were seen were safe and clean. The number of patients on the caseload of the teams, and of individual members of staff, was not too high to prevent staff from giving each patient the time they needed. Staff managed waiting lists well to ensure that patients who required urgent care were seen promptly. Staff assessed and managed risk well and followed good practice with respect to safeguarding.
- Staff developed holistic, recovery-oriented care plans informed by a comprehensive assessment and in collaboration with families and carers. They provided a range of treatments that were informed by best-practice guidance and suitable to the needs of the patients. Staff engaged in clinical audit to evaluate the quality of care they provided.
- The teams included or had access to the full range of specialists required to meet the needs of the patients. Staff worked well together as a multidisciplinary team and with relevant services outside the organisation.
- Staff understood the principles underpinning capacity, competence and consent as they apply to children and young people and managed and recorded decisions relating to these well.
- Staff treated patients with compassion and kindness, respected their privacy and dignity, and understood the individual needs of patients. They actively involved patients and families and carers in care decisions.
- The service was easy to access. Staff assessed and treated patients who required urgent care promptly and those who did not require urgent care did not wait too long to start treatment. The criteria for referral to the service did not exclude children and young people who would have benefitted from care.
- The service was well led and the governance processes ensured that procedures relating to the work of the service ran smoothly.

However,

- Two services were outside the trust targets for referral to treatment time so patients had to wait for their treatment.
- At Knowsley, the reception desk was open plan exposing the clinical staff office directly behind the receptionist. Visitors to the service had a clear unobstructed view of the office and could hear staff talking.
- Staff only had access to personal alarms at two locations. Staff at Wigan told us they felt particularly vulnerable as the design of the building meant consultation rooms were away from staff offices.
- The number of staff receiving appraisal and supervision was below the trust target of 90%.
- Not every location had a functioning young person's group and there was no consultation group for adults.

Is the service safe?

Good ● → ←

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

- All clinical premises where patients received care were safe, clean, well equipped, well-furnished and well maintained.
- The service had enough staff, who knew the patients and received basic training to keep patients safe from avoidable harm. The number of patients on the caseload of the teams, and of individual members of staff, was not too high to prevent staff from giving each patient the time they needed.

Specialist community mental health services for children and young people

- Staff assessed and managed risks to patients and themselves. They responded promptly to sudden deterioration in a patient's health. When necessary, staff worked with patients and their families and carers to develop crisis plans. Carers with young people waiting for a first appointment were encouraged to contact the CART team directly if there was a change in circumstances.
- Staff understood how to protect patients from abuse and the service worked well with other agencies to do so. Staff had training on how to recognise and report abuse, and they knew how to apply it.
- Staff kept detailed records of patients' care and treatment. Records were clear, up to date and easily available to all staff providing care.
- The teams had a good track record on safety with no serious incidents recorded. The service managed patient safety incidents well. Staff recognised incidents and reported them appropriately.

However;

- Staff at Wigan told us they felt particularly vulnerable as the design of the building meant consultation rooms were away from staff offices and they did not have personal alarms.

Is the service effective?

Good ● → ←

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

- Staff assessed the mental health needs of all patients. They worked with patients and families and carers to develop individual care plans and updated them when needed. Care plans reflected the assessed needs, were personalised, holistic and recovery-oriented.
- Staff provided a range of treatment and care for the patients based on national guidance and best practice.
- Staff used recognised rating scales to assess and record severity and outcomes. They also participated in clinical audit, benchmarking and quality improvement initiatives.
- The teams included or had access to the full range of specialists required to meet the needs of patients under their care. Managers made sure that staff had a range of skills needed to provide high quality care. Managers provided an induction programme for new staff.
- Staff from different disciplines worked together as a team to benefit patients. They supported each other to make sure patients had no gaps in their care. The teams had effective working relationships with other relevant teams within the organisation and with relevant services outside the organisation.
- Staff understood their roles and responsibilities under the Mental Health Act 1983 and the Mental Health Act Code of Practice.
- Staff supported patients to make decisions on their care for themselves proportionate to their competence. They understood how the Mental Capacity Act 2005 applied to young people aged 16 and 17 and the principles of Gillick competence as they applied to people under 16. Staff assessed and recorded consent and capacity or competence clearly for patients who might have impaired mental capacity or competence.

However;

- The appraisal rate for staff for the service was below the trust compliance rate of 90% at 85%.
- The overall core service formal supervision rate was 65.8%.

Specialist community mental health services for children and young people

Is the service caring?

Good ● → ←

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

- Staff treated patients with compassion and kindness. They understood the individual needs of patients and supported patients to understand and manage their care, treatment or condition.
- Staff involved patients in care planning and risk assessment and actively sought their feedback on the quality of care provided. They ensured that patients had easy access to advocates when needed.
- When appropriate, staff involved families and carers in assessment, treatment and care planning.

However;

- Not every location had a functioning young person's group and there was no consultation group for carers.

Is the service responsive?

Requires improvement ● ↓

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

- Two of the services were not meeting the trust target of 18 weeks (126 days) from first appointment to treatment. The average time from first to second appointment was 97 days. However, patients of CAMHS Wigan Tier 2 team waited 181 days for treatment and patients of St Helens Autism Spectrum Disorder service waited 209 days for treatment.
- At Knowsley, there was no separation between the staff office and the reception desk, those visiting that service had a clear unobstructed view of the office and could hear staff talking.

However;

- The service was easy to access. The service had adopted the iThrive model. iThrive is a framework for person centred care within communities based on need. This meant that other children's services could be allocated referrals on a need basis. Its referral criteria did not exclude patients who would have benefitted from care. Staff assessed and treated patients who required urgent care promptly and most patients who did not require urgent care did not wait too long to start treatment. Staff followed up patients who missed appointments.
- The service ensured that patients, who would benefit from care from another agency, made a smooth transition. This included ensuring that transitions to adult mental health services took place without any disruption to the patient's care.
- The service met the needs of all patients including those with a protected characteristic. Staff helped patients with communication, advocacy and cultural and spiritual support.
- The service treated concerns and complaints seriously, investigated them and learned lessons from the results, and shared these with all staff.
- The service had provided staff training with Children and Young Person's Improving Access to Psychological Therapies programme.

Specialist community mental health services for children and young people

Is the service well-led?

Good   

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

- Leaders had the skills, knowledge and experience to perform their roles, had a good understanding of the services they managed, and were visible in the service and approachable for patients and staff.
- Staff knew and understood the provider's vision and values and how they were applied in the work of their team.
- Staff felt respected, supported and valued. They reported that the provider promoted equality and diversity in its day-to-day work and in providing opportunities for career progression. They felt able to raise concerns without fear of retribution.
- Our findings from the other key questions demonstrated that governance processes operated effectively at team level and that performance and risk were managed well.
- Teams had access to the information they needed to provide safe and effective care and used that information to good effect.
- Staff collected analysed data about outcomes and performance and engaged actively in local and national quality improvement activities.
- Managers worked closely with other local healthcare services and organisations (schools, public health, local authority, voluntary and independent sector) to ensure that there was an integrated local system that met the needs of children and young people living in the area. There were local protocols for joint working between agencies involved in the care of children and young people.

However;

- Leaders did not ensure that patients could access treatment in a timely manner in all services or that all the services were meeting trust targets for referral to treatment times.

Areas for improvement

We found areas for improvement in this service.

The trust must:

- The trust must ensure that the time between patients being referred and accessing treatment is within the trust target in all services. (Regulation 17)

The trust should:

- The trust should ensure patient privacy and confidentiality is maintained at the Knowsley service.
- The trust should ensure that staff safety is continually assessed and review the provision of personal alarms.
- The trust should ensure all staff receive appraisals and supervision in line with trust policy.
- The trust should consider how to engage carers and patients for more formal feedback about the service as not all areas had patient participation groups and none had carers groups.

Wards for people with a learning disability or autism

Requires improvement   

Key facts and figures

Byron ward is provided by North West Boroughs Healthcare NHS Foundation Trust. The ward provides an assessment and treatment service for adults with a learning disability or autism. North West Boroughs Healthcare NHS Foundation trust provides inpatient services for adults with a learning disability or autism from the boroughs of Halton, Knowsley, St Helens and Warrington. Wigan Clinical Commissioning Group has recently stopped funding the service for the people of Wigan.

Byron ward has 12 beds, however there were five patients on the ward at the inspection and managers told us that five was the maximum number of patients they would have on the ward, in agreement with commissioners.

Our inspection was short notice announced (staff knew we were coming approximately an hour before we arrived) to enable us to observe routine activity.

This core service was last inspected in June 2018. The service was rated as requires improvement overall and in each of the five domains. We issued four requirement notices for Regulation 9 Person centred care, in relation to restrictive practices and positive behaviour support. Regulation 12 Safe care and treatment, in relation to personal emergency evacuation plans. Regulation 13 Safeguarding service users from abuse and improper treatment in relation to staff attitudes, behaviour and interactions with patients. Regulation 15 Premises and equipment regarding safety testing of emergency equipment which was not in date.

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

During the inspection visit, the inspection team:

- visited the ward, looked at the quality of the ward environment and the clinic rooms;
- completed two short observational frameworks for inspection; observing how staff were caring for patients;
- spoke with four patients who were using the service;
- spoke with four carers;
- spoke with two senior managers within the specialist services borough;
- spoke with the acting ward manager and six other staff members; including doctors, psychologists, nurses, healthcare assistants, pharmacists and activity coordinator;
- attended and observed one handover;
- looked at five care and treatment records of patients;
- carried out a check of medication management on the ward and reviewed prescription charts for all patients;
- looked at a range of policies, procedures and other documents relating to the running of the service.

Summary of this service

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

Wards for people with a learning disability or autism

- The service did not provide a range of treatments suitable to the needs of the patients cared for in a ward for people with a learning disability (and/or autism) and in line with national guidance about best practice.
- Leaders did not ensure that the ward team included the full range of specialists required to meet the needs of patients on the wards. Staff did not receive specialist training for their role.
- There was an occasion where staff did not protect the confidentiality of patients, by talking about them in front of other patients.
- Staff did not always understand the individual needs of patients.
- Staff did not inform and involve families and carers appropriately and keep them updated on their loved one's care.

However:

- The service provided safe care. The ward environments were safe and clean. The wards had enough nurses and doctors. Staff assessed and managed risk well, managed medicines safely, followed good practice with respect to safeguarding and minimised the use of restrictive practices. Staff had the skills required to develop and implement good positive behaviour support plans to enable them to work with patients who displayed behaviour that staff found challenging.
- Staff understood and discharged their roles and responsibilities under the Mental Health Act 1983 and the Mental Capacity Act 2005.
- Staff treated patients with compassion and kindness.
- Staff planned and managed discharge well and liaised with services that would provide aftercare. As a result, discharge was rarely delayed for other than a clinical reason.
- Improvements had been made since the last inspection in June 2018. Managers ensured that staff received positive behaviour support training, supervision and appraisal. The governance processes ensured that ward procedures ran smoothly.

Is the service safe?

Good  

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

- All wards were safe, clean, well equipped, well furnished, well maintained and fit for purpose.
- The service had enough nursing and medical staff, who knew the patients and received basic training to keep patients safe from avoidable harm.
- Staff assessed and managed risks to patients and themselves well and achieved the right balance between maintaining safety and providing the least restrictive environment possible in order to facilitate patients' recovery. Staff had the skills required to develop and implement good positive behaviour support plans and followed best practice in anticipating, de-escalating and managing challenging behaviour. As a result, they used restraint and seclusion only after attempts at de-escalation had failed.
- Staff understood how to protect patients from abuse and the service worked well with other agencies to do so. Staff had training on how to recognise and report abuse, and they knew how to apply it.
- Staff had easy access to clinical information and it was easy for them to maintain high quality clinical records – whether paper-based or electronic.

Wards for people with a learning disability or autism

- The service used systems and processes to safely prescribe, administer, record and store medicines. Staff regularly reviewed the effects of medications on each patient's physical health. They knew about and worked towards achieving the aims of the STOMP programme (stop over-medicating people with a learning disability).
- The wards had a good track record on safety. The service managed patient safety incidents well. Staff recognised incidents and reported them appropriately.

However:

- Staff did not adhere to trust policy when documenting one episode of seclusion.
- Male and female patients had bedrooms on the same corridor.
- The environmental risk assessment and location of the ligature cutters was not included in the ward induction.
- Staff did not review patient's risk assessments in line with trust policy in three of the five records we reviewed.

Is the service effective?

Inadequate ● ↓

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

- Staff did not provide a range of care and treatment interventions suitable for the patient group and consistent with national guidance on best practice. This included access to psychological therapies, to support for self-care and the development of everyday living skills, and to meaningful occupation.
- The ward team did not include full range of specialists required to meet the needs of patients on the ward. They did not have staff with a range of skills needed to provide high quality care.
- Managers did not ensure staff had accessed training in the specific needs of the patients including Learning Disability, Autism and Epilepsy.
- Staff were not following best practice in relation to assessing and caring for patients with epilepsy and following the Accessible Information Standard.

However:

- Staff assessed the physical and mental health of all patients on admission.
- Since the last inspection, a variety of training in positive behaviour support had been provided to the staff team with 88% compliance. Managers supported staff with appraisals and supervision. Managers provided an induction programme for new staff.
- The ward team had effective working relationships with staff from services that would provide aftercare following the patient's discharge and engaged with them early on in the patient's admission to plan discharge.
- Staff understood their roles and responsibilities under the Mental Health Act 1983 and the Mental Health Act Code of Practice and discharged these well. Managers made sure that staff could explain patients' rights to them.
- Staff supported patients to make decisions on their care for themselves. They understood the provider's policy on the Mental Capacity Act 2005 and assessed and recorded capacity clearly for patients who might have impaired mental capacity.

Wards for people with a learning disability or autism

Is the service caring?

Requires improvement ● → ←

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

- Staff did not inform and involve families and carers appropriately and keep them updated on their loved one's care.
- Staff did not involve patients in care planning and risk assessment and did not seek their feedback on the quality of care provided.
- We observed staff talking about a patient in front of other patients.
- There were occasions where we observed staff did not give patients help, emotional support and advice when they needed it.

However:

- Staff treated patients with compassion and kindness.
- Easy read care plans had been created using symbols which had been tailored to individual needs of patients.
- Staff directed patients to other services and supported them to access those services if they needed help. This included referrals to the dysphagia team and ongoing contact with their community learning disability teams and accommodation providers.

Is the service responsive?

Good ● ↑

Our rating of responsive improved. We rated it as good because:

- Staff planned and managed discharge well. They liaised well with services that would provide aftercare and were assertive in managing the discharge care pathway. As a result, patients did not have excessive lengths of stay and discharge was rarely delayed for other than a clinical reason.
- The design, layout, and furnishings of the ward/service supported patients' treatment, privacy and dignity. Each patient had their own bedroom and could keep their personal belongings safe. There were quiet areas for privacy.
- The food was of a good quality and staff supported patients to make meal choices.
- The wards met the needs of all patients who used the service – including those with a protected characteristic. Staff helped patients with advocacy and cultural and spiritual support.
- The service treated concerns and complaints seriously, investigated them and learned lessons from the results, and shared these with the whole team and the wider service.

However:

- The information board regarding staffing and activities for the day was in written form and not accessible to all patients.

Wards for people with a learning disability or autism

Is the service well-led?

Requires improvement ● → ←

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

- Leaders did not ensure that the service had the right staff with the right skills, knowledge and experience to provide high quality care for patients.
- Managers did not ensure that staff had opportunities for specialist training for their role or that the service provided care and treatment that was based on national guidance and best practice.
- The trust did not provide opportunities for patients and carers to give feedback on the service in a meaningful way.

However:

- Staff knew and understood the provider's vision and values and how they were applied in the work of their team.
- Staff felt respected, supported and valued. They felt able to raise concerns without fear of retribution.
- Ward teams had access to the information they needed to provide safe and effective care and used that information to good effect.

Areas for improvement

We found areas for improvement in this service.

The trust must:

- The trust must ensure patients have access to a full multidisciplinary team to enable patients to receive interventions in line with best practice. (Regulation 9)
- The trust must ensure that staff follow good practice in relation to assessing and supporting patients with epilepsy and communication needs. (Regulation 9)
- The trust must ensure that training is provided to staff in the specific needs of the patients including learning disability, autism and epilepsy. (Regulation 18)
- The trust must ensure they involve carers in the care of their relative by sharing information and inviting them to meetings if consent allows. (Regulation 9)

The trust should:

- The trust should ensure the blind in the seclusion room is repaired.
- The trust should review the allocation of patient bedrooms to ensure there is separation between male and female bedrooms.
- The trust should include the ligature risk assessment and location of the ligature cutters to the staff induction to ensure staff are aware of the risks within the environment and how to respond.
- The trust should ensure that individual risk assessments are reviewed in line with trust policy.
- The trust should review the seclusion recording and ensure staff are competent with their role within the seclusion process and the recording of this.

Wards for people with a learning disability or autism

- The trust should ensure that staff respect patients' confidentiality and ensure they are not talking about patients in front of other patients.
- The trust should review how it communicates information to patients regarding the running of the ward, including activities and staffing to ensure information is accessible to patients.

Wards for older people with mental health problems

Good   

Key facts and figures

North West Boroughs NHS Foundation Trust provides inpatient services for older adults with mental health problems.

The trust had four inpatient wards for older adults.

At Knowsley resource and recovery centre there was one ward

- Rydal ward, a 12 bed mixed sex ward for people with a diagnosis of an organic mental health problem.

At Atherleigh Park, Leigh, there were two wards

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

At Hollins Park, Warrington, there was one ward

- Kingsley ward, a 16 bed mixed sex ward for people with an organic mental health problem.

We visited all four wards in this core service.

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

The service had previously been inspected in October 2018. We rated the service as inadequate. We rated safe as inadequate, effective and caring as good, responsive requires improvement and well led as inadequate. An action plan was developed by the provider to address these issues.

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

During the inspection visit, the inspection team:

- visited all four wards, looked at the quality of the ward environment and observed how staff were caring for patients;
- spoke with seven patients who were using the service;
- spoke with five carers;
- spoke with the ward managers or their deputy at each ward;
- spoke with 20 other staff members; including support workers, doctors, nurses, occupational therapy staff, pharmacists and domestic staff;
- attended and observed one safety huddle meeting;
- attended and observed one falls group meeting;
- looked at 13 care and treatment records of patients;
- attended and observed ward based activities, including breakfast group, craft group, baking group and a pet therapy session;

Wards for older people with mental health problems

- carried out a specific check of the medication management on all four wards;
- reviewed 15 prescription charts and
- looked at a range of policies, procedures and other documents relating to the running of the service.

Summary of this service

Our rating of this service improved. We rated it as good because:

- The service provided safe care. The ward environments were safe and clean. The wards had enough nurses and doctors. Staff assessed and managed risk well. They minimised the use of restrictive practices, managed medicines safely and followed good practice with respect to safeguarding.
- Staff developed holistic, recovery-oriented care plans informed by a comprehensive assessment. They provided a range of treatments suitable to the needs of the patients and in line with national guidance about best practice. Staff engaged in clinical audit to evaluate the quality of care they provided.
- The ward teams included or had access to the full range of specialists required to meet the needs of patients on the wards. Managers ensured that these staff received training, supervision and appraisal. The ward staff worked well together as a multidisciplinary team and with those outside the ward who would have a role in providing aftercare.
- Staff understood and discharged their roles and responsibilities under the Mental Health Act 1983 and the Mental Capacity Act 2005.
- Staff treated patients with compassion and kindness, respected their privacy and dignity, and understood the individual needs of patients. They actively involved patients and families and carers in care decisions.
- The service managed beds well so that a bed was always available locally to a person who would benefit from admission and patients were discharged promptly once their condition warranted this.
- The service was well led and the governance processes ensured that ward procedures ran smoothly.

However,

- On Golborne and Rydal wards the most up to date fire risk assessment was not in the fire folder. We requested the most up to date assessments and found that Golborne wards had been completed on time but was not in the relevant folder. Rydal wards had been delayed to facilitate a fire audit by the local fire service of the whole building. The risk assessment had been completed on 1st November 2019.
- Despite the fact the trust had worked hard to ensure that mixed sex accommodation breaches were reported, there were high levels of incidents across the service.
- Some of the furniture on Rydal ward was worn and in need of some attention.

Is the service safe?

Good   

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

- All wards were safe, clean, well equipped, well furnished, well maintained and fit for purpose.

Wards for older people with mental health problems

- The service had enough nursing and medical staff, who knew the patients and received basic training to keep patients safe from avoidable harm.
- Staff assessed and managed risks to patients and themselves well and followed best practice in anticipating, de-escalating and managing challenging behaviour. Staff used restraint and seclusion only after attempts at de-escalation had failed. The ward staff participated in the provider's restrictive interventions reduction programme.
- Staff understood how to protect patients from abuse and the service worked well with other agencies to do so. Staff had training on how to recognise and report abuse and they knew how to apply it.
- Staff had easy access to clinical information and it was easy for them to maintain high quality clinical records – whether paper-based or electronic.
- The service used systems and processes to safely prescribe, administer, record and store medicines. Staff regularly reviewed the effects of medications on each patient's physical health.
- The wards had a good track record on safety. The service managed patient safety incidents well. Staff recognised incidents and reported them appropriately. Managers investigated incidents and shared lessons learned with the whole team and the wider service. When things went wrong, staff apologised and gave patients honest information and suitable support.

However,

- On Golborne and Rydal wards the most up to date fire risk assessment was not in the fire folder. We requested the most up to date assessments and found that Golborne wards had been completed on time but was not in the relevant folder. Rydal wards had been delayed to facilitate a fire audit by the local fire service of the whole building. The risk assessment had been completed on 1st November 2019.
- Despite the fact the trust had worked hard to ensure that mixed sex accommodation breaches were reported, there were high levels of incidents across the service.

Is the service effective?

Good   

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

- Staff assessed the physical and mental health of all patients on admission. They developed individual care plans, which they reviewed regularly through multidisciplinary discussion and updated as needed. Care plans reflected the assessed needs, were personalised, holistic and recovery-oriented.
- Staff provided a range of care and treatment interventions suitable for the patient group and consistent with national guidance on best practice. They ensured that patients had good access to physical healthcare and supported patients to live healthier lives.
- Staff used recognised rating scales to assess and record severity and outcomes. They also participated in clinical audit, benchmarking and quality improvement initiatives.
- The ward teams included or had access to the full range of specialists required to meet the needs of patients on the wards. Managers made sure they had staff with a range of skills needed to provide high quality care. They supported staff with appraisals, supervision and opportunities to update and further develop their skills. Managers provided an induction programme for new staff.

Wards for older people with mental health problems

- Staff from different disciplines worked together as a team to benefit patients. They supported each other to make sure patients had no gaps in their care. The ward teams had effective working relationships with other relevant teams within the organisation and with relevant services outside the organisation.
- Staff understood their roles and responsibilities under the Mental Health Act 1983 and the Mental Health Act Code of Practice and discharged these well. Managers made sure that staff could explain patients' rights to them.
- Staff supported patients to make decisions on their care for themselves. They understood the provider's policy on the Mental Capacity Act 2005 and assessed and recorded capacity clearly for patients who might have impaired mental capacity.

Is the service caring?

Good   

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

- Staff treated patients with compassion and kindness. They respected patients' privacy and dignity. They understood the individual needs of patients and supported patients to understand and manage their care, treatment or condition.
- Staff involved patients in care planning and risk assessment and actively sought their feedback on the quality of care provided. They ensured that patients had easy access to independent advocates.
- Staff informed and involved families and carers appropriately.

Is the service responsive?

Good  

Our rating of responsive improved. We rated it as good because:

- Staff managed beds well. This meant that a bed was available when needed and that patients were not moved between wards unless this was for their benefit. Discharge was rarely delayed for other than clinical reasons.
- The design, layout, and furnishings of the ward/service supported patients' treatment, privacy and dignity. Each patient had their own bedroom with an en-suite bathroom and could keep their personal belongings safe. There were quiet areas for privacy.
- The food was of a good quality and patients could make hot drinks and snacks at any time.
- The service met the needs of all patients who used the service – including those with a protected characteristic. Staff helped patients with communication, advocacy and cultural and spiritual support.
- The service treated concerns and complaints seriously, investigated them and learned lessons from the results, and shared these with the whole team and the wider service.

However,

- Some of the furniture on Rydal ward was worn and in need of some attention.

Wards for older people with mental health problems

Is the service well-led?

Good   

Our rating of well-led improved. We rated it as good because:

- Leaders had the skills, knowledge and experience to perform their roles, had a good understanding of the services they managed, and were visible in the service and approachable for patients and staff.
- Staff knew and understood the provider's vision and values and how they were applied in the work of their team.
- Staff felt respected, supported and valued. They reported that the provider promoted equality and diversity in its day-to-day work and in providing opportunities for career progression. They felt able to raise concerns without fear of retribution.
- Our findings from the other key questions demonstrated that governance processes operated effectively at ward level and that performance and risk were managed well.
- Ward teams had access to the information they needed to provide safe and effective care and used that information to good effect.
- Staff engaged actively in local and national quality improvement activities.

Outstanding practice

- Due to the outbreak of an infectious illness on Kingsley Ward the staff team had worked extremely hard on infection control and prevention. There was a new clinic room on the ward that was specifically for wound care. This had dressings that would be used regularly specifically for skin of older people that can be more prone to tears. There were regular spot checks from the infection control team (the last spot check before the inspection scored 98%). Staff on the ward had completed courses in tissue viability and attended a workshop on the importance of hand hygiene.
- The staff on Kingsley Ward had done a lot of work around staff culture since the last inspection. This included staff away days, staff surveys to gauge progress and heavy involvement from senior leaders on the ward. At the beginning of this period a survey completed by staff found high levels of staff wanting to leave the ward and feeling unhappy at work. After the development of this work staff on the ward completed the survey again and these results showed that 100% of staff were happy on the ward and nobody wanted to leave for anything other than career progression opportunities.

Areas for improvement

There were areas for improvement for this service.

The trust should:

- Although the trust has worked hard to ensure breaches in mixed sex accommodation were reported, the trust should ensure they reduce the amount of mixed sex accommodation breaches across the service.

Mental health crisis services and health-based places of safety

Requires improvement  

Key facts and figures

The trust provides health-based places of safety for men and women at the following locations:

- Atherleigh Park (one suite)
- Knowsley Resource and Recovery Centre, Whiston Hospital (one suite)
- Hollins Park Hospital (one suite)

The trust had assessment and home treatment teams across the following boroughs:

- Wigan
- Knowsley
- St Helens
- Warrington
- Halton

The trust also provides street triage services, mental health liaison services and works in partnership with other local trusts in a police control room triage service. These teams were not included in our inspection.

On the inspection we looked at all five key questions. Our inspection was unannounced (staff did not know we were coming) to enable us to observe routine activity.

We inspected all three of the health-based places of safety and the teams which were responsible for managing these places of safety; Wigan Assessment team for Atherleigh Park, Knowsley Assessment and Home Treatment Team for the Knowsley Resource and Recovery Centre and the Warrington Assessment and Home Treatment Team for Hollins Park Hospital.

Before this inspection, we reviewed information that we held about the service. During the inspection, we:

- spoke with 16 staff including heads of quality, operational managers, team managers, deputy team managers, nurses, support workers and a consultant psychiatrist;
- spoke with eight patients;
- attended and observed a home visit to a patient;
- reviewed 31 care records across the health-based places of safety and assessment and home treatment teams;
- carried out a tour of all three health-based places of safety and the interview rooms for the assessment and home treatment teams visited;
- received feedback from three police forces;
- looked at a range of policies, procedures and other documents relating to the service.

Mental health crisis services and health-based places of safety

A comprehensive inspection of mental health crisis services and health-based places of safety was last carried out by the Care Quality Commission in 2015. At this inspection, the overall rating for the core service and the rating for the safe, effective and responsive domains was good; well led was requires improvement and caring was not rated due to insufficient evidence. A follow-up inspection of well led was carried out in 2016 where the rating improved from requires improvement to good.

Summary of this service

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

- The trust did not have a specific observation policy for the use of the health-based places of safety. Staff described how they would manage observations whilst patients were in the places of safety, but this was not consistent across the three locations visited. This meant the trust could not be assured that staff were completing observations and managing the places of safety safely.
- The trust did not have a policy or process that staff managing the health-based places of safety should follow when medication had been administered to patients within the places of safety, in terms of observing and monitoring the effects on patients. Staff managing the places of safety did not receive specific training to safely support patients when medication had been used or restraint was required.
- The trust stated that the health-based place of safety at Atherleigh Park was at full capacity with two patients. The place of safety could be split so that patients were kept separate although there was only one bedroom which is not in line with Code of Practice guidance. The trust did not have a written process in place for managing multiple patients in the health-based place of safety. It was not clear how the trust was assured that the place of safety would be safe during these periods. The walls were not sound-proof and it was not clear how the trust was assured that the privacy and confidentiality of patients was maintained in these situations.
- The teams responsible for managing the health-based places of safety at Atherleigh Park and Hollins Park were based at offices off-site. This meant there could be avoidable delays in staff attending the places of safety when needed. The Wigan Assessment team were under pressure at the time of the inspection.
- We observed inconsistent recording in care and treatment records. The 136 records at Atherleigh Park had not been fully completed. At the assessment and home treatment teams, care plans, crisis plans and capacity assessments had not been completed in some of the records reviewed.
- Governance processes were not always operating effectively at team level and performance and risk were not always managed well.

However;

- The mental health crisis teams included or had access to the full range of specialists required to meet the needs of the patients. Managers ensured that these staff received training and appraisals. Staff worked well together as a multidisciplinary team and with relevant services outside the organisation.
- Staff understood and discharged their roles and responsibilities under the Mental Health Act 1983 and the Mental Capacity Act 2005.
- Staff treated patients with compassion and kindness and understood the individual needs of patients. They actively involved patients and families and carers in care decisions.

Mental health crisis services and health-based places of safety

- The mental health crisis service and the health-based places of safety were easy to access. Staff assessed patients promptly. Those who required urgent care were taken onto the caseload of the crisis teams immediately. Staff and managers managed the caseloads of the mental health crisis teams well. The services did not exclude patients who would have benefitted from care.

Is the service safe?

Requires improvement ● ↓

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

- The trust did not have a specific observation policy for the health-based places of safety. Staff could explain how they managed observations, however, there were differences across the three places of safety visited. This meant the trust was not assured that staff were safely and appropriately managing the health-based places of safety.
- The trust did not have a policy or process that staff managing the health-based places of safety should follow when medication had been administered to patients within the places of safety, in terms of observing and monitoring the effects on patients. Staff managing the places of safety did not receive specific training to safely support patients when medication had been used or restraint was required.
- The trust stated that the health-based place of safety at Atherleigh Park had a capacity of two patients. The place of safety could be split so that patients were kept separate although there was only one bedroom which is not in line with Code of Practice guidance. The trust did not have a written process in place for managing multiple patients in the health-based place of safety. It was not clear how the trust was assured that the place of safety would be safe during these periods.
- There were some issues with the physical environment. The trust had identified issues with magnetic locks on the doors at Atherleigh Park and Hollins Park health-based places of safety following incidents. There were gaps underneath and to the side of the outside gate at Atherleigh Park. The trust was acting to address these issues.
- We observed inconsistent recording in care and treatment records. The 136 records at Atherleigh Park had not been fully completed. At the assessment and home treatment teams, we observed that care plans, crisis plans and capacity assessments had not been completed in some of the records reviewed.
- The health-based places of safety at Atherleigh Park and Hollins Park were staffed by teams based off-site. We had concerns about the potential length of time it took staff to attend the places of safety when required, particularly at the Atherleigh Park health-based place of safety.
- Management supervision figures for the six months prior to the inspection were low for two teams visited.

However;

- Staff assessed and managed risks to patients and themselves. They responded promptly to sudden deterioration in a patient's health. When necessary, staff working in the mental health crisis teams worked with patients and their families and carers to develop plans. Staff followed good personal safety protocols.
- Staff understood how to protect patients from abuse and the service worked well with other agencies to do so. Staff had training on how to recognise and report abuse and they knew how to apply it.
- The teams had a good track record on safety. The service managed patient safety incidents well. Staff recognised incidents and reported them appropriately. Managers investigated incidents and shared lessons learned with the whole team and the wider service. When things went wrong, staff apologised and gave patients honest information and suitable support.

Mental health crisis services and health-based places of safety

Is the service effective?

Good  → ←

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

- Staff assessed the mental health needs of all patients. Staff working for the mental health crisis teams worked with patients and families and carers to develop individual care plans and updated them when needed. Although there was inconsistent completion of care plans in the records reviewed, where care plans were in place these generally reflected the assessed needs, were personalised, holistic and recovery-oriented.
- Staff working for the mental health crisis teams used recognised rating scales to assess and record severity and outcomes. Staff working for the crisis teams and in the health-based places of safety participated in clinical audits.
- The mental health crisis teams included or had access to the full range of specialists required to meet the needs of patients under their care. Managers made sure that staff had a range of skills needed to provide high quality care. They supported staff with appraisals and opportunities to update and further develop their skills. Managers provided an induction programme for new staff.
- The teams at Knowsley and Warrington had introduced either safety huddles or daily multidisciplinary meetings to review and discuss cases and any issues. Staff were very positive about the introduction of these initiatives.
- Staff from different disciplines worked together as a team to benefit patients. They supported each other to make sure patients had no gaps in their care. The teams had effective working relationships with relevant services outside the organisation.
- Staff understood their roles and responsibilities under the Mental Health Act 1983 and the Mental Health Act Code of Practice.
- Staff supported patients to make decisions on their care for themselves. They understood the provider's policy on the Mental Capacity Act 2005. Staff were aware of how to assess capacity and we observed this taking place.

However;

- There was inconsistent recording of capacity on the care records that we reviewed.
- The supervision compliance rates for two of the three teams visited was 50% or below for the six months prior to the inspection. The trust provided data prior to the inspection that indicated that the appraisal compliance rate for one team was low at 26%.
- There was inconsistent recording of care and treatment records across the teams that we visited.
- Areas of good practice were not routinely shared across the teams that we visited.

Is the service caring?

Good 

We rated caring as good because:

- Staff treated patients with compassion and kindness. They understood the individual needs of patients and supported patients to understand and manage their care, treatment or condition.

Mental health crisis services and health-based places of safety

- Staff in the mental health crisis teams involved patients in care planning and risk assessment. They ensured that patients had easy access to advocates when needed.
- Staff informed and involved families and carers appropriately.

However;

- It was not clear how patients who had been assessed and treated within the health-based places of safety could provide feedback on the quality of care they had received. Staff advised that there were methods available, but these were not routinely promoted for patients.

Is the service responsive?

Good ● → ←

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

- The mental health crisis service was available 24-hours a day and was easy to access – including through a dedicated crisis telephone line. The referral criteria for the mental health crisis teams did not exclude patients who would have benefitted from care. Staff generally assessed and treated patients promptly.
- The health-based places of safety were available when needed and there was an effective local arrangement for young people who were detained under Section 136 of the Mental Health Act. Section 12-approved doctors and approved mental health professionals attended promptly when required.
- The services met the needs of all patients who use the service – including those with a protected characteristic. Staff helped patients with communication, advocacy and cultural support.
- The service treated concerns and complaints seriously, investigated them and learned lessons from the results, and shared these with all staff.

However;

- We had concerns about the health-based place of safety at Atherleigh Park being used for more than one patient. The trust stated that the capacity of the place of safety was two patients and separate areas could be created for patients. However, the walls were not sound-proof and it was not clear how the trust was assured that patient's privacy and dignity was maintained when more than one patient was in the place of safety.
- The Wigan Assessment Team was under pressure in terms of workload and managing referrals to the team. Although a process had been agreed around how the referrals were managed, managers noted there was a backlog on the waiting lists.

Is the service well-led?

Requires improvement ● ↓

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

Mental health crisis services and health-based places of safety

- We had concerns about the lack of certain policies and procedures being in place for this core service. The trust did not have a specific observation policy for the health-based places of safety and it was not clear how the trust was assured that the places of safety were being managed safely in all situations. The trust did not have a specific training programme for staff responsible for managing the health-based places of safety, which could lead to inconsistencies across the three locations.
- Governance processes were not operating effectively at team level and performance and risk were not always managed well.
- There were staffing pressures in the Wigan Assessment Team that had been apparent for some time and staffing levels showed a deteriorating picture.
- Although staff collected data about outcomes and performance, the process of reviewing and making use of this information was inconsistent across the teams visited.
- Learning and developments across the three health-based places of safety and teams visited was not routinely shared. We observed different good practice being created and used by the teams but these had not been shared across the trust.
- The Warrington Assessment and Home Treatment Team had noted a concern about access to approved mental health professionals in the local area. Whilst managers could explain how this situation was managed, a specific contingency plan or process had not been created to ensure staff managed these situations appropriately.

However;

- Leaders had the skills, knowledge and experience to perform their roles, had an understanding of the services they managed, and were visible in the service and approachable for patients and staff.
- Staff knew and understood the provider's vision and values and how they were applied in the work of their team.
- Staff felt respected, supported and valued. They felt able to raise concerns without fear of retribution.
- There were effective, multi-agency arrangements to agree and monitor the governance of the mental health crisis service and the health-based places of safety. Managers of the service worked actively with partner agencies to ensure that people in the area received help when they experienced a mental health crisis; regardless of the setting.

Areas for improvement

We found areas for improvement in this service.

The trust must:

- The trust must ensure that an observation policy for the use of health-based places of safety is available to staff. (Regulation 12)
- The trust must ensure that staff are appropriately trained to safely support patients in the health-based places of safety when medication has been used or restraint is required. (Regulation 12)
- The trust must ensure that the doors at the Atherleigh Park and Hollins Park health-based places of safety are reviewed and repaired as required. (Regulation 12)
- The trust must ensure that 136 records and care and treatment records are up-to-date and complete. (Regulation 12)
- The trust must consider how the privacy, dignity and safety of patients within the Atherleigh Park health-based place of safety is managed when more than one patient is in the health-based place of safety to ensure it is meeting the Code of Practice. (Regulation 12)

Mental health crisis services and health-based places of safety

- The trust must ensure that appropriate oversight and governance processes are in place to monitor the use, effectiveness and efficiency of the health-based places of safety. To consider how the trust are assured that staff are aware of their responsibilities when managing the places of safety and that these are in line with the trust expectations. (Regulation 17)

The trust should:

- The trust should consider how to reduce the potential delays in staff attending the health-based places of safety due to the Wigan and Warrington teams being based off-site.
- The trust should ensure that a clock is available to patients in the Atherleigh Park health-based place of safety.
- The trust should ensure that all signage and materials contain correct and up-to-date information for patients.
- The trust should ensure that staff who attend the health-based places of safety are appropriately trained in the use of health-based places of safety and consider if specific training for the use of the places of safety is necessary.
- The trust should ensure that management supervision is taking place on a regular basis.
- The trust should ensure that contingency plans are created where significant issues are identified. The trust should ensure that staff are aware of these plans and what they are required to do in these situations.
- The trust should consider how data and information gathered within the health-based places of safety is reviewed and analysed to make improvements or changes as necessary.
- The trust should consider how feedback from people who have used the health-based places of safety is gathered to evaluate their experiences and whether any improvements can be made.

Forensic inpatient or secure wards

Good   

Key facts and figures

The forensic inpatient/secure wards are part of the secure mental health services delivered by North West Boroughs Partnership NHS Foundation Trust. Secure services are based at the Hollins Park Hospital site and contain three units designated as low secure and step-down/ rehabilitation.

The service comprises:

Chesterton Unit, a 20 bed low-secure unit for women. There were 13 patients on the ward.

Tennyson Unit, an eight bed low-secure step-down rehabilitation unit for women. There were seven patients on the ward.

Marlowe Unit, a 15 bed low-secure unit for men. There were 15 patients on the ward.

We visited all three wards in this core service.

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

The service had previously been inspected in July 2016. We rated the service as good.

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

During the inspection visit, the inspection team:

- visited all three wards, looked at the quality of the ward environment and observed how staff were caring for patients;
- spoke with 12 patients who were using the service;
- spoke with one carer;
- spoke with the ward managers or their deputy at each ward;
- spoke with 12 other staff members; including support workers, nurses, occupational therapy staff, clinical psychologists, pharmacists and the service social worker;
- attended and observed two living life well/safety huddle meetings;
- attended and observed one multidisciplinary review meeting;
- looked at nine care and treatment records of patients;
- attended and observed ward based activities, including a Halloween party;
- observed one medicines administration round;
- carried out a specific check of the medication management on all three wards;
- reviewed 10 prescription charts and
- looked at a range of policies, procedures and other documents relating to the running of the service.

Forensic inpatient or secure wards

Summary of this service

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

Wards were clean and tidy. Clinic rooms were fully equipped, with accessible resuscitation equipment and emergency drugs that staff checked regularly. Staff had completed and kept up-to-date with their mandatory training. Staff completed risk assessments for each patient on admission / arrival, using a recognised tool, and reviewed this regularly, including after any incident.

Staff developed comprehensive care plans for each patient that met their mental and physical health needs. Care plans were personalised, holistic and recovery-orientated. Staff provided a range of care and treatment suitable for the patients in the service. Staff made sure patients had access to physical health care, including specialists as required.

Patients said staff treated them well and behaved kindly. Staff supported patients to understand and manage their own care treatment or condition.

Staff made sure patients had access to opportunities for education and work, and supported patients. The service had a full range of rooms and equipment to support treatment and care. Staff and patients could access the rooms.

Staff felt respected, supported and valued. Staff felt positive and proud about working for the provider and their team.

However:

There was no ligature risk assessment completed on Tennyson ward in the last 12 months.

There was no timescale for work to be completed on Marlowe ward to reduce the risks identified in the ligature risk assessment.

Patients within the step-down service were not able to self-medicate as there was no provider policy or procedure for this.

Staff did not all have completed yearly constructive appraisals of their work.

The provider's senior leadership team had not successfully communicated the provider's vision and values to the frontline staff in this service.

Patients and carers were not involved in decision-making about changes to the service.

Patients and staff did not meet with members of the provider's senior leadership team and governors to give feedback.

Is the service safe?

Requires improvement ● ↓

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

There was no ligature risk assessment completed on Tennyson ward in the last 12 months.

There was no timescale for work to be completed on Marlowe ward to reduce the risks identified in the ligature risk assessment.

Patients within the step-down service were not able to self-medicate as there was no provider policy or procedure for this.

However:

Forensic inpatient or secure wards

Staff made sure cleaning records were up-to-date and the premises were clean.

Clinic rooms were fully equipped, with accessible resuscitation equipment and emergency drugs that staff checked regularly.

Staff had completed and kept up-to-date with their mandatory training.

Staff completed risk assessments for each patient on admission / arrival, using a recognised tool, and reviewed this regularly, including after any incident.

Managers debriefed and supported staff after any serious incident.

Is the service effective?

Good   

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

Staff developed a comprehensive care plan for each patient that met their mental and physical health needs.

Care plans were personalised, holistic and recovery-orientated.

Staff provided a range of care and treatment suitable for the patients in the service.

Staff made sure patients had access to physical health care, including specialists as required.

The service had a full range of specialists to meet the needs of the patients on the ward.

Managers supported staff through regular, constructive appraisals of their work.

Staff held regular multidisciplinary meetings to discuss patients and improve their care.

Ward teams had effective working relationships with external teams and organisations.

Staff understood their roles and responsibilities under the Mental Health Act 1983 and the Mental Health Act Code of Practice and discharged these well.

There was a clear policy on Mental Capacity Act and deprivation of liberty safeguards, which staff could describe and knew how to access.

However:

Staff did not all have completed yearly constructive appraisals of their work.

Is the service caring?

Good   

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

Staff were discreet, respectful, and responsive when caring for patients.

Staff gave patients help, emotional support and advice when they needed it.

Staff supported patients to understand and manage their own care treatment or condition.

Patients said staff treated them well and behaved kindly.

Forensic inpatient or secure wards

Staff involved patients and gave them access to their care planning and risk assessments.

Staff supported, informed and involved families or carers.

Is the service responsive?

Good ● → ←

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

Managers and staff worked to make sure they did not discharge patients before they were ready.

Staff carefully planned patients' discharge and worked with care managers and coordinators to make sure this went well.

Staff supported patients when they were referred or transferred between services.

The service had a full range of rooms and equipment to support treatment and care. Staff and patients could access the rooms.

The service had quiet areas and a room where patients could meet with visitors in private.

Staff made sure patients had access to opportunities for education and work, and supported patients.

Patients, relatives and carers knew how to complain or raise concerns.

Is the service well-led?

Good ● → ←

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

Leaders had the skills, knowledge and experience to perform their roles.

Leaders had a good understanding of the services they managed. They could explain clearly how the teams were working to provide high quality care.

Staff had the opportunity to contribute to discussions about the strategy for their service, especially where the service was changing.

Staff felt respected, supported and valued.

Staff felt positive and proud about working for the provider and their team.

Staff maintained and had access to the risk register at ward or directorate level. Staff at ward level could escalate concerns when required.

Staff had access to the equipment and information technology needed to do their work. The information technology infrastructure, including the telephone system, worked well and helped to improve the quality of care.

However:

The provider's senior leadership team had not successfully communicated the provider's vision and values to the frontline staff in this service.

Patients and carers were not involved in decision-making about changes to the service.

Forensic inpatient or secure wards

Patients and staff did not meet with members of the provider's senior leadership team and governors to give feedback.

Areas for improvement

We found areas for improvement in this service.

The trust must:

The trust must complete remedial work as detailed in the ligature risk assessment for Marlowe ward. (Regulation 12)

The trust should:

The trust should ensure they have a policy or procedure to enable patients to self medicate.

The trust should ensure all staff receive an annual appraisal of their work.

The trust should ensure that staff on forensic wards are aware of who the senior managers for their service are and that communication between the senior management level and ward based staff is improved.

This section is primarily information for the provider

Requirement notices

Action we have told the provider to take

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

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

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

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

Regulated activity

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

Treatment of disease, disorder or injury

Regulation

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

Regulated activity

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

Treatment of disease, disorder or injury

Regulation

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

Regulated activity

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

Treatment of disease, disorder or injury

Regulation

Regulation 17 HSCA (RA) Regulations 2014 Good governance

Regulated activity

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

Treatment of disease, disorder or injury

Regulation

Regulation 18 HSCA (RA) Regulations 2014 Staffing

Our inspection team

The team included a Head of Inspection and Inspection Manager, seven inspectors, one assistant inspector, one pharmacy inspector, 10 specialist advisers and three experts by experience. An expert reviewer also supported the well-led review.

Executive reviewers are senior healthcare managers who support our inspections of the leadership of trusts. Specialist advisers are experts in their field who we do not directly employ. Experts by experience are people who have personal experience of using or caring for people who use health and social care services.