Cheshire and Wirral Partnership NHS Foundation Trust

Quality Report

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Core services inspected	CQC registered location	CQC location ID
Acute wards for adults of working age and psychiatric intensive care units	Clatterbridge Hospital Bowmere Hospital Jocelyn Solly (Millbrook)	RXA54 RXA19 RXAAE
Wards for older people with mental health problems	Bowmere Hospital Clatterbridge Hospital Jocelyn Solly (Millbrook)	RXA19 RXA54 RXAAE
Long stay/rehabilitation mental health wards for working age adults	Soss Moss Site Jocelyn Solly (Millbrook) Bowmere Hospital	RXA72 RXAAE RXA19
Forensic inpatient/secure wards	Soss Moss	RXA72
Child and adolescent mental health wards	Pine Lodge Bowmere Hospital	RXAPL RXA19
Community-based mental health services for adults of working age	Bowmere Hospital Trust Board Offices, Redesmere	RXA19 RXAX2
Community-based mental health services for older people	Trust Board Offices, Redesmere	RXAX2

Summary of findings

Specialist community mental health services for children and young people	Trust Board Offices, Redesmere	RXAX2
Community mental health services for people with learning disabilities or autism	Trust Board Offices, Redesmere	RXAX2
Community health services for adults	Trust Board Offices, Redesmere	RXAX2
Community health services for children and young people	Trust Board Offices, Redesmere	RXAX2
Community 'end of life' services	Trust Board Offices, Redesmere	RXAX2
Mental health crisis services and health-based places of safety	Trust Board Offices, Redesmere	RXAX2
Wards for people with learning disabilities or autism	Eastway Greenway	RXAAC RXAQB

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

Summary of findings

Ratings

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

Overall rating for services at this Provider	Good 
Are Services safe?	**Requires improvement** 
Are Services effective?	**Good** 
Are Services caring?	**Outstanding** 
Are Services responsive?	**Good** 
Are Services well-led?	**Good** 

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

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

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

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

Summary of findings

Contents

Summary of findings

Overall summary

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

We found that the provider was performing at a level that led to a rating of 'Good' because;

- The trust was committed to and working towards reducing restrictive practices in line with their trust-wide campaign 'zero harm', which started in July 2014. The campaign focusses on encouraging staff to 'Stop, Think and Listen' and to continually reflect and review their everyday working life to identify possible practices that could result in unwarranted harm to patients. However, in the low secure forensic services, there were a number of restrictive practices not based on clinical risk.
- The trust had worked hard to improve staffing levels significantly over the six months to June 2015 although it continued to face staffing challenges on some wards. Overall, we found staffing levels were safe. Caseloads across the community teams were in line with current guidance.
- The trust was committed to improving the quality of services and had governance structures to support that aim Morale was good across services, and staff teams were motivated and committed to providing good care and treatment to patients in line with the trust's vision and values. This was shown through a number of initiatives staff had implemented to improve outcomes for patients and carers. We noted several examples of good practice where staff teams had 'gone the extra mile' to ensure patients' needs were being met.
- The trust board and senior managers we spoke with were open and transparent. They recognised areas that needed to be improved in addition to areas that were working well. There was a positive culture of learning and continuous improvement. When we raised concerns to the trust board about care in Saddlebridge Recovery centre during the inspection, they were very open in their responses and provided assurance that the issues we raised would be managed effectively.
- The trust acknowledged that there were some difficulties with their current information technology (IT) system, which had been escalated onto the board assurance framework risk register with actions to deal with them.
- We identified a number of issues regarding the way the trust dealt with complaints but the trust was aware of them and already had plans to manage complaints more effectively.

However;

- Some of the seclusion rooms did not comply with the Mental Health Act Code of Practice and some staff were not following trust policy and national guidance in relation to the use of seclusion rooms.
- Some of the acute mental health wards did not fully comply with the Department of Health required guidance on same-sex accommodation.
- In some services, individual patient risks were not always reviewed and updated in a timely manner and environmental risks were not always identified and mitigated.
- Within community (physical health) services for children and young people, the service did not maintain accurate, complete and contemporaneous records in respect of each service user. Records were not accessible to authorised people as necessary in order to deliver care and treatment in a way that meets their needs and keeps them safe.
- Compliance with mandatory training and appraisal of work performance was variable across services.
- Issues that had previously been raised through Mental Health Act monitoring visits in relation to patients detained under the Act had not been fully dealt with by the trust.
- Compliance with the Mental Capacity Act 2005 (MCA) was variable across the trust. Although we found

Summary of findings

good practices in relation to the MCA in some services, in others staff lacked confidence in assessing patients' capacity to make decisions about their care and did not feel that the current e-learning training sufficiently enabled them to develop their skills and confidence in this area.

Summary of findings

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

We always ask the following five questions of the services.

Are services safe?

Requires improvement 

We rated safe as 'Requires Improvement' because:

- In the community (physical health) services for children and young people, health records for children and families were unreliable and not fit for purpose in relation to safeguarding people from abuse. The service used both electronic and paper records for all children over two years of age. However, the records did not cross-refer to one another and did not highlight that another set of records existed or refer to any historic concerns. The records we reviewed did not comply with either the trust policy or the standard operating procedure. We also identified that once a safeguarding alert had been recorded on the electronic computer system, it could not be removed, which meant that the system did not necessarily show an accurate picture of current concerns.
- Also in the community (physical health) services for children and young people, we identified some concerns with staff working practices. We attended a home visit with a health visitor and noted that the mother was not asked about any other adult living at the property. We also reviewed some records that did not show whether this question was asked at the visit. This is contrary to the safeguarding of children policy for the trust.
- In the acute wards, risk assessments were used to assess and manage risks to individuals. However, some risk assessments were lacking in detail and some identified a list of past risk incidents without detailing how current risks would be managed.
- In the community mental health service for children and young people, staff had limited understanding of the lone working policy and did not follow it consistently.
- Some of the acute mental health wards did not fully comply with the Department of Health required guidance on same-sex accommodation.
- In the forensic services, staff were not aware of all the high-risk ligature points identified in the ligature audit in July 2014 and there were multiple blind spots throughout both units that could have compromised the safety of patients, visitors and staff. Ligature points are places to which patients intent on self-harm could tie something to strangle themselves.

Summary of findings

- Staff were not keeping accurate records of the temperature of the fridge and freezer in the rehabilitation kitchen in the Saddlebridge Recovery centre. This meant staff could not be assured that food was stored safely despite this issue having been raised at the staff team meeting in February 2015.
- The seclusion facilities at Millbrook were not fit for purpose but there were plans to improve them. Seclusion facilities continued to be used on Bollin ward although this room was not fully fit for purpose.
- In the wards for patients with learning disabilities, the seclusion rooms did not have a communication intercom fitted. This meant it was difficult for patients to communicate through the door which was not in line with the code of practice guidance. In addition, the Greenways seclusion room had a blind spot and its window was not fitted with a privacy screen so it could be viewed from the outside the building. Patients had to pass the room to get to their bedrooms. This compromised the privacy and dignity of patients in the seclusion room.
- In the Saddlebridge Recovery centre and Adelphi ward, staff did not always follow the Mental Health Act code of practice or trust policy in relation to seclusion. A patient had been secluded for several days when clinical records did not show that seclusion was clinically necessary for the prolonged period.
- On Adelphi ward we found that although venous thromboembolism (VTE) risk assessments were completed on admission, reassessment was not clearly documented before prescribing VTE prophylaxis.
- In community (physical health) services for adults, both nursing and therapy staff told us they were not always able to see every patient at the initial scheduled time due to staffing and time pressures.
- In the low secure forensic services, staff used a number of restrictive practices that were not based on clinical risk.

However;

- All the clinical areas we inspected were visibly clean and well maintained.
- Overall, we found that most services had comprehensive risk assessments in place to assess, manage and mitigate risks to individuals and within the clinical environments.
- Each locality held its own risk register, and risks were assessed and reviewed regularly, with escalation as appropriate to the strategic risk register.

Summary of findings

- The trust prioritised safeguarding of people from abuse and had used initiatives to further improve their safeguarding procedures and processes. Staff had a good understanding of safeguarding issues.
- The trust was committed to and working towards reducing restrictive practices in line with their trust-wide campaign 'zero harm' which started in July 2014. The campaign focusses on encouraging staff to 'Stop, Think and Listen' and to continually reflect and review their everyday working life to identify possible practices that could result in unwarranted harm to patients.
- Overall, the reporting and analysis of incidents of harm or risk of harm, and learning from incidents was a positive area within the trust.
- Staffing levels had improved significantly over the six months to June 2015 across the trust despite some of the continued challenges on some wards. Caseloads across the community teams were in line with current guidance.
- The trust had an effective medicines governance and incident reporting structure.
- The majority of teams were adhering to the Lone Working Policy.
- The majority of staff we spoke with understood the principles of the Duty of Candour and its relevance to their work. This involves staff explaining and apologising to patients when things go wrong.

Are services effective?

Good

We rated effective as 'Good' because:

- The trust had met or exceeded all Monitor compliance framework targets for 2013/2014 and achieved all of the quality improvement priorities it set out in the 2013/2014 Quality Account.
- In the majority of services, staff completed comprehensive assessments of the needs of patients. These included their social, occupational, cultural, physical and psychological needs and preferences.
- Within the physical health adults service, nursing staff had introduced care bundles to ensure that best practice was being followed for pressure ulcer care and catheter care. A bundle is a selected set of elements of care that, when implemented as a group, have an effect on outcomes beyond implementing the individual elements alone.

Summary of findings

- Regular and effective multidisciplinary team meetings and handovers of care took place throughout all services.
- The teams were using evidence-based assessment tools and national guidance, such as from the National Institute for Health and Care Excellence, to identify and meet patients' health and treatment needs.
- The trust had passed the 85% target it set for mandatory training compliance.
- The trust recovery college was established in the last five years and linked to the recovery and review role of the community mental health teams. This provided a learning centre offering courses based on people's personal recovery.
- The trust acknowledged that there were some difficulties with their information technology system, which had been escalated onto the board assurance framework risk register with actions to deal with them.

However;

- There were issues previously raised through Mental Health Act monitoring visits in relation to patients detained under the Mental Health Act had not been fully dealt with by the trust.
- Compliance with the Mental Capacity Act (MCA) assessments was variable across the trust. Although we found good practices in relation to the MCA in some services, in others staff lacked confidence in assessing capacity and did not feel that the current e-learning training enabled them to develop their skills and confidence sufficiently in this area.
- In the community (physical health) services for children and young people, the service did not maintain accurate, complete and contemporaneous records for each service user. Records were not accessible to authorised people as necessary in order to deliver care and treatment in a way that meets their needs and keeps them safe.

Are services caring?

Outstanding ☆

We rated caring as 'Outstanding' because:

- We used a Short Observational Framework for Inspection (SOFI) on the learning disability wards, which showed that interactions between patients and staff were outstanding, with staff using innovative approaches to communicate effectively with patients. SOFI is an observational tool used to help us collect evidence about the experience of people who use services, especially where they may not be able to fully describe them themselves because of cognitive or other problems.

- In the End of Life service, the team as a whole, worked to ensure that patients received all the emotional and practical advice and support they needed. We saw some outstanding examples of team members going the extra mile to try and ensure that patients' needs and wishes were met.
- Feedback we received from patients and carers in the three physical health services we inspected was all positive.
- Services held a range of patient community meetings to gather feedback and encourage involvement.
- Patients, families and carers were involved in decisions about care. Care plans were developed collaboratively with a person-centred focus.
- The trust had had received a second gold star from the national Carers Trust, recognising a commitment to improve support for unpaid carers and their families.
- The trust had signed up to the 'triangle of care' initiative. This was developed nationally to improve carer engagement in mental health acute inpatient and home treatment services. We saw information about the triangle of care displayed in the adult mental health services, including comments from people about the service they had received.
- On the Child and Adolescent Mental Health Service wards patients had established a participation and involvement group called the 'sloth' group. The group had been involved in plans for a new building and were offered training to sit on interview panels.
- In older people's inpatient services, Cherry ward had developed a carers and relatives' questionnaire, which was completed when a patient was discharged.
- In adult mental health services (community and inpatient), patients and former patients were acting as peer support workers and facilitating wellbeing groups.
- In total, we received 197 comment cards form people, of which the majority (169) were positive and 28 were negative.
- In the 2014 community mental health patient experience survey, the trust scored better than average in 11 out of 33 survey questions.

However:

- At Saddlebridge Recovery centre, there was an incident where a member of staff had removed comment cards from the comment box CQC had left on the ward and read them. The trust took appropriate and immediate action in line with trust policy.
- Although the majority of staff were respectful and in general patients' privacy and dignity were respected and upheld; staff

Summary of findings

on the forensic wards left the observation panels on bedrooms open and there was no mechanism inside the patients' bedrooms for them to close the panel. This could have a negative impact on their privacy.

Are services responsive to people's needs?

Good

We rated responsive as 'Good' because:

- The trust was meeting set targets for acute admissions gate kept by the crisis resolution home treatment team. Care programme approach follow-up contact within seven days of their discharge. Completed reviews within two months of discharge. Health visitor visits within 14 days of each birth.
- The trust was exceeding its target for days from referral to treatment for improving access to psychological therapies, podiatry and musculoskeletal physiotherapy.
- Within the community mental health services for children and young people and the learning disabilities wards, there were several examples of outstanding practices and initiatives the services had used to meet patients' needs and support their recovery.
- With the exception of Vale House, care pathways within the trust were clear and in line with national guidance to support a patient's journey through the trust's services.
- The trust had a four-year equality and diversity implementation action plan.
- In November 2014, Cheshire and Wirral NHS Foundation Trust teamed up with Cheshire Police in a new approach to policing incidents involving people with mental ill-health. The service had shown a reduction up to 92% in the number of people detained under section 136 of the Mental Health Act. This part of the Act gives police the power to take someone in a public place who appears to be in need of care and protection as a result of mental ill health to a place of safety.
- The forensic low secure units had a good record of successful discharges and worked closely with other units in the trust to arrange transfers of care where appropriate.
- The trust has been consistently below the England average for delayed transfers of care from April 2014 to April 2015. However; there was evidence to show that some staff were not following trust procedure and reporting these accurately.

Summary of findings

- The Patient Advice and Liaison Service (PALS) and complaints team had worked closely with staff teams to promote local resolution of complaints, which the trust believed was why fewer complaints were being upheld.

However;

- We identified a number of issues with the way the trust dealt with complaints. The trust was aware of them and had an action plan to deal with them. This included improving data collection and analysis, developing more appropriate written responses and recording lessons learnt better. The trust was also introducing a satisfaction survey to gather the views of those who had made a complaint.
- Some patient activity plans on the rehabilitation wards included activities that did not take place.
- Of the 23 inpatient mental health wards, nine had an average occupancy over 85%. When occupancy rates rise above 85%, it can start to affect the quality of care provided to patients and the orderly running of the ward and hospital.
- In the learning disability community service, 30 patients were waiting to see a psychologist following their initial assessment. Patients could wait up to 12 months for an appointment with a psychologist.
- On Beech ward, patients were not receiving regular input from the responsible clinician (RC), with some patients not seeing their RC for weeks.
- There was a lack of psychological therapy interventions on the acute wards.
- In the community health services for children, young people and families, staff said that some elements of the Healthy Child Programme were not undertaken in line with requirements and that health promotion and public health activity were not delivered consistently. This was mainly due to health visitor vacancies and the amount of work done on safeguarding families in school nursing.

Are services well-led?

Good

We rated Well led as 'Good' because:

- The trust had a clear vision, 'leading in partnership to improve health and well-being by providing high quality care'. This was

underpinned by the trusts seven strategic objectives and values, which were focussed on improving the quality of services provided. Staff at most levels of the organisation understood the vision, values and quality approach of the trust.

- The trust had recently begun to use the 6C's values (care, compassion, courage, commitment, communication and competency) to support appraisals of staff work performance. Senior staff and some staff from clinical areas had already started this practice.
- There was a robust governance structure that flowed from each clinical area up to the board and back down again.
- The trust had a 'promoting healthy minds at work' initiative to support staff and reduce the relatively high level of staff sickness. This was praised by staff in focus groups we held.
- Staff morale was good across the services we visited and staff mostly felt engaged with and proud to work for the trust. However; staff in the end of life care service and in the East locality felt disconnected from the trust.
- In the 2014 NHS staff survey, the trust performed in the top 20% for staff recommending the trust as a place to work and for staff agreeing that their role made a difference to patients. Overall, the trust scored better than the national average in five of the categories.
- We raised a number concerns to the trust board about care in the Saddlebridge recovery centre during the inspection. The board were very open in its responses and provided assurance the issues we raised would be managed effectively, which included increasing staff support and supervision from senior managers.
- The trust had signed up to the 'triangle of care' initiative, which was developed nationally to improve carer engagement in mental health acute inpatient and home treatment services.
- We saw several examples of how the trust had actively involved patients in the delivery of care and service development initiatives.
- The trust used a range of methods to engage and gather feedback from staff and carers, including focus groups and roadshows.
- The trust was meeting the requirements of the new fit and proper person requirements.

Summary of findings

- The trust had several core services that had received national accreditation.

However;

- There were some issues around data quality that the trust was aware of which meant some of data presented to the trust board was not always accurate. The problems with the information system had been escalated onto the trust's risk register with actions identified to improve this.

Summary of findings

Our inspection team

Our inspection team was led by:

Chair: Bruce Calderwood, Director Mental Health at Department of Health (retired)

Head of Inspection: Nicholas Smith, Care Quality Commission

Team Leaders: Sharon Marston, mental health, Care Quality Commission

Simon Regan, community health services, Care Quality Commission

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

Why we carried out this inspection

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

How we carried out this inspection

To fully understand the experience of people who use services', we always ask the following five questions of every service and provider:

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

Before visiting, we reviewed a range of information we hold about the trust and asked other organisations to share what they knew. We held focus groups at each main hospital for detained patients during the inspection. We also met with groups of carers before the inspection at a number of hospital locations. We held focus group sessions before the inspection with a range of staff groups, facilitated by CQC inspectors. We carried out announced visits to all core services on 23 and 25 June 2015.

During the visit, we held focus group sessions with staff, including nurses, doctors, psychologists, allied health professionals and administrative staff.

We also interviewed key members of staff, including the chief executive, chair, medical director, director of nursing, director of human resources, director of quality and safety , associate director of safe services, non-executive director for quality and safety, head of compliance, director of operations, associate director of safe services, Mental Health Act team manager, board lead for the Mental Health Act, non-executive director responsible for the Mental Health Act, safeguarding lead for children and the safeguarding lead for adults.

During this inspection, we also:

- spoke with 462 trust employees
- met with representatives from other organisations, including commissioners of health services and local authority staff
- spoke with 134 patients who use services, who shared their views and experiences of the core services we visited
- visited 15 people in their own homes
- observed how patients were being cared for
- talked with 63 carers and/or family members

Summary of findings

- reviewed 287 care or treatment records of patients who use services, of which we case-tracked 12
- looked at records, including clinical and management records
- attended 19 clinical meetings, including handovers, multi-disciplinary meetings and clinics.

We also used a Short Observational Framework for Inspection (SOFI) on the learning disabilities ward. SOFI is an observational tool used to help us collect evidence about the experience of people who use services, especially where they may not be able to fully describe these themselves because of cognitive or other problems.

Information about the provider

Cheshire and Wirral Partnership NHS Foundation Trust became the first mental health foundation trust in the North of England in July 2007.

The trust provided health and wellbeing services for a population of around 1,024,000 people. The trust provided mental health services, learning disability services and drug and alcohol services across Cheshire and the Wirral, as well as community physical health services (including end of life care) in West Cheshire and drug and alcohol services in East Cheshire.

The trust provided care in three localities: Cheshire East, Cheshire West and the Wirral.

Health Summary – Cheshire East

Deprivation was lower than average but about 11.9% of children (7,700) lived in poverty. Life expectancy for both men and women was higher than the England average.

In Cheshire West

Deprivation was lower than average but about 15.4%of children (9,000) lived in poverty. Life expectancy for both men and women was similar to the England average.

In Wirral

Deprivation was higher than average and about 23.4% of children (13,700) lived in poverty. Life expectancy for both men and women was lower than the England average.

Inpatient beds:

Number of total trust inpatient beds: 341

Number of wards providing inpatient beds: 23

Community services

Number of community teams: 147

Number of trust sites providing community services: 66

Staff Total: 3,009 (whole-time equivalent)

The trust worked in close partnership the following seven Clinical Commissioning Groups:

– Eastern Cheshire

– South Cheshire

– West Cheshire

– Wirral Clinical

– Vale Royal

– Trafford

The trust also worked with NHS England specialist commissioners and with the local authority as commissioners.

Financial position: 2013/14

– Total trust income: £159.5 million

– Operating expenditure: £155.8 million

The trust had 11 locations registered with the CQC. There had been 14 inspections across six of those sites in the year to June 2015:

• Bowmere Hospital (2 inspections)

• Clatterbridge Hospital (2)

• Eastway (3)

• Greenways (3)

• Kent House (3)

• Soss Moss Site (1).

At the time of the inspection all, the locations were compliant with the essential standards of quality and safety.

Summary of findings

The Care Quality Commission is responsible for protecting the interests of people detained and treated under the Mental Health Act 1983 in England, for making sure they are cared for properly, and for ensuring that the Act is used correctly.

We do this by monitoring the use of the Mental Health Act, and by visiting hospitals and speaking to patients. We appoint Mental Health Act Reviewers to do this and they visit every psychiatric ward in England where patients are detained on a regular basis. They also meet patients placed on supervised community treatment.

Cheshire & Wirral Partnership NHS Foundation Trust was visited on 10 occasions by Mental Health Act Reviewers in the year to June 2015.

Section 120B of the Mental Health Act allows us to require providers to produce a statement of the actions that they will take as a result of a monitoring visit.

During the course of the 10 visits, the reviewers raised 35 issues that required a response from the provider.

The most frequent type of issues were:

• documentation issues (4 locations)

• explanation of patient rights (4)

• issues with care plans (4)

• capacity to consent (4).

The following locations had the most issues:

• Saddlebridge (7 issues)

• Rosewood (7)

• Bollin (7)

• Adelphi (7).

The trust provided the following core services:

Mental health wards:

• acute wards for adults of working age and psychiatric intensive care units

• long stay/rehabilitation mental health wards for working age adults

• forensic inpatient/secure wards

• child and adolescent mental health wards

• wards for older people with mental health problems.

Community-based mental health and crisis response services:

• community-based mental health services for adults of working age

• community-based mental health services for older people

• mental health crisis services and health-based places of safety

• specialist community mental health services for children and young people

• community mental health services for people with learning disabilities or autism.

Community Health Services:

• community health services for adults

• community health services children and young people

• community end of life services.

We did not inspect the following service that the trust also provided:

• IAPT (Improving access to psychological therapies)

• Substance Misuse services, East Cheshire

• Eating Disorder services

What people who use the provider's services say

Comment cards (Mental health services only)

We received 197 comment cards form people, of which the majority (169) were positive and 28 were negative.

The Child and Adolescent Mental Health Service received the most comment cards (12), of which 11 were positive; the learning disability service received the second highest with 10 cards, all of which were positive.

Summary of findings

Positive themes related to staff having positive, caring attitudes and listening to people in addition to delivering good quality care to people.

Negative themes included poor staffing or resources, poor staff attitudes, people or their families not being listened to, and a poorly maintained care environment.

2014 CQC community mental health patient experience survey

The trust scored 8.6 out of 10 for treating people with respect. This was in line with the national average.

Focus group feedback

Patients on the wards said that they felt safe and that the majority of staff were caring. It was, however, suggested that staff were 'thin on the ground' and that more staff to help with activities would be helpful. Patients reported that escorted visits did not always take place because there were sometimes no staff available.

Patients also reported that there are instances of insufficient cleaning reported in shared bathrooms and the food was generally considered to be poor.

Staff in all groups generally considered the trust to be a good place to work. They felt supported well by colleagues.

Community health services

Feedback from people who used the service, their families and stakeholders was positive about the way staff treated people. Patients and families said that staff went the extra mile and that the care they received exceeded their expectations. Parents told us that they felt informed and involved in their child's healthcare. Staff were child and family focused and they looked at the family unit.

Mental health services

We used a Short Observational Framework for Inspection (SOFI) on the learning disability wards. SOFI is an observational tool used to help us collect evidence about the experience of people who use services, especially where they might not be able to fully describe them themselves because of cognitive or other problems. This showed that interactions between patients and staff were outstanding, with staff using innovative approaches to help them communicate effectively with patients.

The majority of patients and carers we spoke with were positive about the care and treatment they received from the trust. However, in the low secure services, some patients said that not all staff treated them with respect. There were also blanket restrictions on patients' freedoms that were not based on clinical risk. One patient said they were afraid to complete a comment card as they were worried staff would read them. An investigation by the trust confirmed this to be the case. The trust took immediate and appropriate action.

NHS Choices and Patient Opinion

The trust received 19 individual reviews on both sites. Positive comments related to caring, kind and compassionate staff, particularly at Bowmere Hospital and the Millbrook Unit. Areas for concern included comments about poor staff attitudes and instances of complaints being ignored by staff and management.

Share your experience survey

Five comments were received through the CQC 'share your experience' survey. Positive comments were made about caring and professional staff in the eating disorder service at the Millbrook Unit. Negative comments were about prescribing regimes and the provision of information.

Good practice

Specialist community mental health services for children and young people

- A 'my mind' website and a Twitter account had been created by young people. These provided information in an accessible format, including self-help resources for mental health needs and information about, services t provided by the trust and what to expect from them.
- Young people who used the service helped to run training for professionals on topics including self-harm.

Summary of findings

- 'Sloth' was the young people's participation and involvement group. The group had developed a hospital passport and had been involved in recruiting and selecting staff.
- The service provided a 'Kidstime', which was an out-of-hours activity jointly run with the adult mental health services and the youth theatre. This was specifically for young people whose parents had a mental health need. Mental health conditions were explained to young people in a meaningful way.
- The service had an education programme which provided mental health education in schools and mentoring by year 12 students, supported by school staff.

Child and adolescent mental health wards

- The education provision both on Maple ward and at Pine Lodge had been rated by Ofsted as outstanding. We observed individually tailored education during our inspection.

Community-based mental health services for adults of working age

- People who used services told us they were encouraged to act as peer supporters for other people attending the wellbeing group and acted as a point of contact before the group, providing refreshments and welcoming group members.

Community-based mental health services for older people

- The service at Upton Lea arranged for people with a new diagnosis of dementia to have a 'safe driving' assessment and held a 'What's next?' clinic to support them.
- The service at Vale House had established a care home liaison service.

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

- Wards employed peer support workers so patients were supported by a staff team that included people who had direct experience of mental illness.

Community-based services for people with learning disabilities and autism

- Some patients were involved in the recruitment and selection of new staff and we were told that if the patient did not approve of a potential member of staff then they were not appointed.
- The team worked with other organisations beyond what would normally be expected. Staff continued to offer help and advice long after patients were discharged into another service. For example, one service told us that a patient had been discharged to them six months ago but they could still ring up and get advice on care very easily. The same service also said they still received telephone calls from the Eastway team asking how the patient was progressing.

Wards for people with learning disabilities

- A panel of patients was involved in the recruitment and selection of new staff. If the panel did not approve of a potential member of staff then they were not appointed.

Mental health crisis services and health-based places of safety

- In November 2014, the trust teamed up with Cheshire Police in a new approach to policing incidents involving people with mental ill-health. The service had shown an up to 92% reduction in the number of people detained under section 136 of the Mental Health Act. That part of the Act gives police the power to take someone in a public place who appears to be in need of care and protection as a result of mental ill health to a place of safety.

Community health services for adults

- The cardiac rehabilitation service had gained national accreditation for the quality of its services and the early supported discharge service for stroke had won the trust's six Cs award for delivering an outstanding service to patients who had experienced a stroke.

Community end of life services

- The team worked to ensure that patients received all the emotional and practical advice and support they needed. We saw good examples of team members going the extra mile to try to ensure that patients were able to end their days in the place they chose.

Summary of findings

Areas for improvement

Action the provider MUST take to improve
An action that a provider of a service MUST take relates to a breach of a regulation that is the subject of regulatory action by the Care Quality Commission. Actions that we say providers SHOULD take relate to improvements that should be made but where there is no breach of a regulation.

Action the provider MUST take to improve

Specialist community mental health services for children and young people

- The trust must ensure that all young people using the service have a comprehensive individual risk assessment.

Community-based mental health services for adults of working age

- The trust must ensure that people subject to a community treatment order under the Mental Health Act have their rights are read to them so they understand the conditions of the order and that this is documented.

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

- The trust must review ward composition and practices to ensure they comply with the Department of Health required guidance on same-sex accommodation. On Adelphi and Bollin ward, female patients had to walk through corridor areas occupied by male patients to reach toilets and bathrooms; some wards did not have female-only lounge areas, and we saw a male and female patient entering a bedroom without staff seeing them.

The trust must improve standards of record keeping in the following areas:

- Recording rights of detained patients, including where patients refuse to cooperate, attempts made to read patients their rights and timely action taken where a patient does not understand their rights.
- Recording that qualifying patients are informed of the independent mental health advocacy service.
- Recording episodes of seclusion, including when a doctor attended seclusion and if there was a delay in the doctor's attendance, and the threshold for segregation and for determining the regularity of reviews when segregation is used.
- Recording consent and capacity to consent to administration of treatment for mental disorder and when other key decisions are made for patients where there may be doubts about their capacity.
- Recording of risks to ensure that risks are properly managed.
- The trust must improve its governance arrangements on the oversight of the Mental Health Act to deal with the identified issues.

Community-based mental health services for older people

- The trust must ensure that risks are assessed, identified, monitored and reviewed regularly, robustly and effectively.
- The trust must ensure that patients receive appropriate care and treatment that reflects their personal preferences.
- The trust must ensure that care pathways are clear.
- The trust must ensure that monitor and review the quality of services regularly.

Forensic inpatient/secure wards

- The trust must ensure that patients are cared for in the least restrictive manner and review blanket restrictions on patients' freedom.
- The trust must ensure that patients are cared for in seclusion in line with the Mental Health Act Code of Practice.
- The trust must ensure that staff are aware of environmental risks and that actions are taken to mitigate them as far as possible.
- The trust must ensure that patients are always treated with dignity and respect.

Summary of findings

- The trust must ensure that there are enough suitably skilled staff to meet the needs of patients.
- The trust must ensure that governance arrangements are robust enough to monitor the quality of care being provided effectively.

Community health services for adults

- The trust must ensure that there are enough suitably qualified, skilled and experienced nursing and other staff working in adult community services to meet the needs of the service.
- The trust must ensure that there are appropriate robust systems for incident reporting and investigation.
- The trust must ensure that systems to identify, mitigate and manage risk allow all local risks to be clearly identified and managed by staff at service level whilst clearly linking with trust-wide governance processes to ensure that all risks are recorded and monitored.

Community health services for children and young people

- The trust must ensure that alerts can be removed from individual electronic records to provide an accurate reflection of current concerns.
- The trust must ensure that medical records are kept in a way that allows professionals to access accurate, complete records for each child easily when required.

Action the provider SHOULD take to improve

Specialist community mental health services for children and young people

- The trust should ensure that they provide an effective system to keep staff safe when visiting people in the community, including increased understanding of and compliance with the lone worker policy.
- The trust should ensure that they complete an environmental risk assessment of the Hawthorn centre to identify risks and how they will be mitigated.
- The trust should ensure that they review the collation of the waiting list to monitor the risk of people waiting to be seen, including enabling team managers to find out how many young people are waiting and how long they have been waiting.

Child and adolescent mental health wards

- The trust should ensure that staff attend mandatory training to the trust's required level of 85%. Particular focus should be on the management of violence and aggression and the alternative courses for those staff excluded from the training.
- The trust should complete outstanding work on the seclusion room on Maple ward to make it fit for purpose and ensure that seclusion facilities are available on the ward if a patient requires seclusion.
- The trust should ensure that staff understand their role and responsibilities in relation to the Mental Capacity Act. Although staff had attended the training, they had limited understanding the Act applies to everyone 16 and over and the implications for the patients they were caring for.
- The trust should enable patients to access hot and cold drinks on Maple ward even if they are assessed as not being able to manage a fob to gain access into the dining room.

Community-based mental health services for adults of working age

- The trust should ensure that people's capacity to understand the risks and benefits of treatment offered to them is understood by staff to make sure people can decide if they want to accept it.
- The trust should ensure that information about how to make complaints and raise concerns is displayed in waiting rooms in languages other than English.

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

- The trust should continue to tackle the use of prone (face down) restraint episodes. In particular, the trust should ensure the time patients spent in prone restraint is properly recorded to support the effectiveness of the trust's initiatives.

Summary of findings

- The trust should ensure that patients on Beech ward have improved contact with the responsible clinician to review their detention and to consider their care and treatment, and that patients are seen before decisions are taken about issues such as leave.
- The trust should review the no smoking policy that was causing difficulties for patients and staff. In particular, it should consider whether the current policy and practice goes beyond legal powers –for example, searching patients for tobacco, cigarettes and lighters, confiscating them and not returning them until patients were discharged even if they went on overnight leave.
- The trust should ensure that systems for informing the CQC of an application to restrict the freedom of a patient and use of Deprivation of Liberty Safeguards (DoLS) are robust and ensure that we are routinely informed of the outcome of all applications.

Community-based mental health services for older people

- The trust should work with its partner agencies to ensure that information about patients is not duplicated or at risk of being missed.
- The trust should reduce the amount of staff time lost through inadequate computer systems.

Wards for older people with mental health problems

- The trust should ensure that staff on Cherry ward and Meadowbank ward have their mandatory training
- The trust should ensure all staff on wards have an annual appraisal of their work performance.

Units for people with learning disabilities

- The trust should ensure that seclusion rooms are fit for purpose and meet the guidelines of the Mental Health Act Code of Practice.
- The trust should ensure that prone (face down) restraint is not used without valid reasons.

Long stay/rehabilitation mental health wards for working age adults

- The trust should review the no smoking policy in rehabilitation wards as staff and patients were struggling to comply with it.
- The trust should ensure that confidential information displayed on office whiteboards cannot be viewed by anyone other than ward staff. Confidential information included contact numbers for patients and their relative/carers.
- The trust should ensure that patients have appropriate access to independent mental health advocates.
- The trust should ensure that patients are informed of their rights under section 132 of the Mental Health Act in line with the code of practice.

Mental health crisis services and health-based places of safety

- The trust should ensure that crisis resolution home treatment teams and liaison psychiatry teams are multi-disciplinary in composition in accordance with its own policy, the Crisis Care Concordat and Royal College of Psychiatrists' recommendations.
- The trust should provide easily accessible and safe toilet facilities in the health-based place of safety at the Countess of Cheshire Hospital to comply with the requirements of the Crisis Care Concordat.
- The trust should audit medicines management in accordance with its policy and national guidance to ensure that practice is reviewed.
- The trust should ensure that staff understand their responsibilities on assessing capacity for and consent to treatment and ensure that this is clearly documented in patient records.
- The trust should involve patients in their care planning and routinely offer them a copy of their care plan.
- The trust should provide a system to capture all the data requirements of the Crisis Care Concordat to assess, monitor and improve the quality and safety of the service.
    - The trust should ensure that staff receive regular managerial supervision and appraisal of their work performance and keep records of them.

Summary of findings

Community health services for adults

- The trust should provide robust medicines stock control and management systems in all physical health services in line with best practice requirements.
- The trust should ensure that all staff are adhering to the patient group directions for administration of medicines in line with trust policy. Patient group directions allow nurses to supply and/or administer prescription-only medicines to patients using their own assessment of patient need without necessarily referring back to a doctor for an individual prescription.
- The trust should review line management and professional leadership across the adult physical health services to maximise the role of the professional advisors and clinical leadership.
- The trust should ensure that all areas of service take part in record documentation audits to ensure best practice in line with trust policies.
- The trust should arrange for equipment to be tested in a timely manner to ensure that it is safe and fit for purpose.
- The trust should ensure that the process for providing pressure-relieving cushions is fair and equitable and in line with clinical need and assessment.
- The trust should review the strategic approach to services to ensure that there is an overall approach to service development and initiatives.
- The trust should encourage learning across the different teams to share best practice and closer working in line with the principles of integrated working.
- The trust should review the management of the dressing's clinic to provide maximum privacy and dignity for people using the service, particularly for mixed-sex patient appointments.
- The trust should ensure that all staff receive an appraisal of their work performance.

Community health services for children and young people

The trust should:

- Ensure that staff record the minimum and maximum fridge temperatures for each vaccination fridge on each working day in line with the trust's policy.
- Make all staff aware of the record-keeping policy and the standard operating procedure in health visiting and school nursing and ensure that all staff follow them.
- Ensure that staff receive appropriate and sufficient record-keeping training to reflect any changes in line with current practices.
- Do a full risk assessment before the school nursing records are archived by an external company.
- Ensure that the departmental risk register reflects the risks identified in relation to records management and that action is taken to mitigate the risks.
- Ensure that lessons learned from incidents of harm or risk of harm, from both within the team and trust wide, are shared with staff to avoid further occurrences.
- Ensure that services for children, young people and their families are consistently meeting key areas of the Healthy Child Programme, including a universal antenatal contact and two-year developmental review.

Community end of life services

- The trust should provide an overarching strategy for the specialist palliative care team in relation to their role in end of life care to ensure that their role is well defined and clear.
- The trust should review the strategic approach to developing end of life services, with a clear understanding of the impact of staff absence on patient care.
- The trust should provide enough suitably qualified, skilled and experienced staff to meet the needs of the service during periods of planned leave.
- The trust should measure the quality of end of life services to ensure that patients are receiving the appropriate care and treatment.

Summary of findings

- The trust should encourage feedback and share it among staff following incidents and complaints to ensure that learning is shared across all teams in line with the principles of integrated working.
- The trust should share the results of audits with staff to aid their learning and where potential improvements are identified ensure that action plans are developed, implemented and monitored.

Cheshire and Wirral Partnership NHS Foundation Trust

Detailed findings

Mental Health Act responsibilities

Section 120B of the Mental Health Act allows the CQC to require providers to produce a statement of the actions they will take as a result of a monitoring visit. During the course of the 10 visits CQC made to the trust in the previous 12 months, 35 concerns were raised requiring a response from the provider.

The most frequent concerns were:

- Documentation (four locations)
- Explanation of patient rights (four locations)
- Issues with care plans (four locations)
- Issues with capacity to consent (four locations)

Saddlebridge, Rosewood, Bolin and Adelphi all had seven matters raised.

Where patients were detained under the Mental Health Act 1983 (MHA), the necessary legal paperwork was present in the patient's files. In most cases this also included a copy of the approved mental health professional's report, although there was variation across the trust and patient files on some wards did not contain it.

There was a system to ensure that patients were advised of their rights in accordance with section 132 but we found problems with providing patients with this information in a timely manner on some wards. Patients were not regularly reminded of their rights on other wards. We also had concerns about how this information was provided to patients on some wards, as simply reading from an information sheet is not considered sufficient by the code of practice.

In the adult community mental health teams, where people were subject to a community treatment order (CTO) under the Mental Health Act there was no evidence in the paper or electronic system care notes that they were being read their rights. Records we reviewed showed that people did not have their rights explained to them routinely and that there was no documented evidence from the care coordinator.

There was an independent mental health advocacy (IMHA) service available to all patients. It was not clear how patients who lacked the capacity to instruct an advocate would be able to access one on some wards. On other wards we found that staff did not support and promote the use of advocates and consequently there was little take up.

Documentation relating to the authorisation of section 17 leave was well completed. There was evidence that risk assessments were completed before leave was authorised. We found that leave was granted on an individual basis according to need and stage of recovery.

(Note: If someone is detained in hospital under the Mental Health Act, it is against the law for them to leave without specific permission granted by the responsible clinician. Permission to leave the hospital grounds, to visit their family for example, or for a trial visit home prior to discharge can be given under section 17.)

In relation to section 58, we found that with few exceptions, prescribed medication was authorised by a form T2 (patient's consent) or T3 (doctor's authorisation). However, we were concerned about the inconsistent recording of the responsible clinician's (RC) assessment of a patient's capacity to consent to treatment. In some cases it was not possible to determine if a patient's capacity had been assessed at the point that medication had first been administered.

(Note: Section 58 of the Mental Health Act sets out the circumstances in which medication or treatment can be given to patients without their consent. Form T2 is a certificate of consent to treatment completed by a doctor to record that a patient understands the treatment being given and has consented to it. Form T3 is a Certificate of second opinion completed by a doctor to record that a patient is not capable of understanding the treatment he or she needs or has not consented to treatment but that the treatment is necessary and can be provided without the patient's consent.)

The quality of care plans was variable. On some wards the care plans showed that consideration had been given to minimum restrictions on a patient's liberty. Some care plans clearly documented patients' individual support needs and were regularly re-evaluated. However, on other wards care plans were less individualised and the section where patients could add their comments was left blank. We were unable to find any reasons for this omission.

The MHA manager and administrators had been proactive in acquiring funding to provide information leaflets and training on the MHA and Mental Capacity Act 2005 (MCA) to staff and

other stakeholders. The MHA office had just begun to produce an information newsletter to ensure that staff were kept up to date with the MHA and opportunities for further training. Staff confirmed that they knew how to contact the MHA office for advice when needed and said that regular audits were carried out throughout the year to check the MHA was being applied correctly.

Mental Capacity Act and Deprivation of Liberty Safeguards

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

There were 27 DoLS applications reported to CQC between May 2013 and May 2015. However; the trust in their factual accuracy response stated that they had submitted 52 DoLs notifications regarding the following locations: Millbrook 32; Bowmere 18; Thorn Heyes 1, Greenways 1. The trust was notifying us of DoLS applications as they were required to do. However, the numbers of DoLS applications reported to us did not match the number of applications the trust stated they had made. This discrepancy may be because the trust tell us when the outcome of the DoLS application was known and there were frequently delays in the local authority (the DoLS supervisory body) processing applications as a result of the increase following recent court judgements (for example, in a case called the Cheshire West judgement).

Compliance with the Mental Capacity Act (MCA) was variable across the trust. We have highlighted below our concerns with the assessment and recording of patients' capacity to consent to mental health treatment. However, the scope of the MCA goes beyond mental health treatment.

In some settings, staff were able to articulate how the best interests of patients would be assessed and the circumstances in which an independent mental capacity advocate would be required. However, in some services, staff told us that they lacked confidence in assessing capacity and did not feel that the current e-learning training sufficiently enabled them to develop their skills and confidence in this area. There was also some confusion about whose responsibility it was to assess and document capacity, with some nursing staff deferring to doctors and others not being aware that it was part of their role.

Detailed findings

Staff in the health-based places of safety and adult and older people's community mental health teams were not routinely assessing people's capacity to understand the risks and benefits of treatment offered to them.

On the child and adolescent wards, we found that although staff had attended the training they had limited understanding that the Act applies to everyone 16 and over and the implications for the patients they were caring for.

There was inconsistency in documenting patient's capacity across the trust. We found evidence on most wards that where there were concerns about a patient's capacity, the capacity assessment was not clearly recorded in the patient records. We found generic consent statements in some care records and it was unclear which decision was being referred to. It was not clear from the records that capacity was always taken into consideration before decisions were made.

We had particular concerns about the capacity of some patients to consent to an informal admission to hospital. Where concerns about capacity were documented, we were unable to find records of a formal assessment of capacity having been undertaken. The trust told us an assessment of capacity form was in development and that it should support the clear recording of capacity in accordance with the MCA.

However, we found that decision-specific assessments of capacity were consistently recorded in the learning disability inpatient service. There was evidence that a range of methods were used to support the staff to determine a patient's capacity and that applications for restrictions on patients' freedoms using Deprivation of Liberty Safeguards were appropriate.

Requires improvement

Are services safe?

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

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

Summary of findings

Our findings

Track record on safety

The Strategic Executive Information System (STEIS) records serious incidents and never events.

(Note: 'Never events' are serious, largely preventable patient safety incidents that should not occur if the available preventative measures have been implemented, so any 'never event' reported could indicate unsafe care.)

Trusts have been required to report any 'never events' through STEIS since April 2011. Between the 1 February 2014 and the 31 January 2015, the trust did not report any 'never events'.

The trust submitted data to the CQC regarding STEIS reporting levels which showed that in the previous 12 months they had reported 257 incidents including 91 deaths to STEIS. On the 10 June 2015 the trust submitted revised data to the CQC which showed they had undeclared 148 incidents including 21 deaths. This meant that in total 129 incidents including 70 deaths were reported to STEIS. The trust explained that in regards to STEIS reporting they followed a 'data completeness' approach and submitted all incidents. The trust then worked with STEIS to un declare incidents that did not meet STEIS reporting requirements. For example; the trust

had reported 100 grade 3 and 10 grade 4 pressure ulcers which were then reduced to nine grade 3 and three grade 4. These were reduced as they occurred in the community or the patients' homes and therefore did not 'belong' to the trust.

Of the 129 incidents submitted to STEIS, 104 were categorised as a serious incident which required further investigation. The majority of serious incidents reported were unexpected or avoidable death or severe harm to one or more patients, staff or member of the public (87 incidents; 84%) in a community setting. The most common of these was unexpected death of an outpatient in receipt of services (55). 15 incidents (14%) were allegations or incidents of physical abuse and sexual assault or abuse. 2 incidents (2%) related to adverse media coverage and loss of confidence in services. 53% (54) of all incidents occurred at the patient's home and 20% (21) occurred in a public place. 36% of all incidents reported on STEIS were overdue for closure.

The trust provided data that showed there were 92 overdue incidents as of 15 May 2015 (including cases where an extension may have been requested or the action plan was overdue). We received feedback from the clinical commissioning groups which indicated that the trust had frequently requested an extension to the date which root cause analysis reports were due to be submitted.

Some 66% of the incidents reported were categorised as Grade 1 with a 45 day investigation deadline. In their factual accuracy response, the trust stated that 46% of their reported STEIS incidents were grade 1 (once many incidents were undeclared to STEIS). 169 incidents were classified as grade 1 incidents and 87 as grade 2. One incident was classified as a grade 0.

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

A total of 1945 incidents (plus 14 updates) were reported to NRLS between 1 May 2014 and 30 April 2015. There were 53 incidents categorised as deaths during this period plus 13 updated incidents that were categorised as death. The number of incidents reported fluctuated throughout the year with a sharp decrease in the number of incidents classified under 'no harm' from August 2014 onwards. The incident category most frequently reported was 'self-harming behaviour'.

The core service that reported the most incidents was adult mental health with 42% of the total incidents reported. Of those incidents reported 58% were 'no harm' and 4% were deaths.

29% of incidents reported over the 12 month period have resulted in 'low' harm to the patient.

The lowest reporting service was health visiting / school nursing who reported four incidents. Two of these were no low harm, one was low harm and one was recorded as moderate harm.

The national staff survey results showed that 90% of staff had reported errors, near misses or incidents they had witnessed in the previous month. This is slightly below the national average of 92%.

Eighty percent of all NRLS incidents classified under implementation of care and ongoing monitoring / review were adjudged to have been of moderate severity. On average it took the trust 29 days to report an incident to the NRLS. Intelligent monitoring data showed no concerns over the trust's level or quality of reporting to NRLS when measured against comparable trusts nationwide.

The Department of Health issues patient safety alerts to trusts through the central alerting system. This is a web-based cascading system which trusts are required to submit assurance that they have responded to alerts before they are closed on the system. The trust had closed between 25%-50% of the CAS alerts with closing dates during the preceding 12 months late which indicated they were not being responded to and closed in a timely manner. However; the trust told us that they did not close CAS alerts until the action plan for that alert had been fully implemented. This is not in line with most other trusts as they tend to close alerts once an action plan has been formulated to manage and monitor the alert and not upon completion of the action plan. This accounts for why the trust had so many CAS alerts which remained open.

The Courts and Tribunals judiciary publishes, 'Reports to Prevent Future Death', which contain recommendations which have been made by coroners with the intention of learning lessons from the cause and prevention of deaths.

Detailed findings

Two reports have been identified dated 27 November 2014 and 30 January 2015 in relation to the trust. Both reports involved clinical procedures and medical management related deaths. The trust had to submit information to the coroner as instructed under Regulation 28, to identify action it intended to take to address the recommendation made by the coroner. Regulation 28 can be issued to providers of services by a coroner in relation to the death of a patient in receipt of mental health services.

Learning from incidents

The trust had an, 'Incident reporting and management' policy in place which was ratified in July 2013 and next due for review in July 2017. The policy identified clear time-scales for reporting incidents and the responsibilities of key staff within the trust in managing incidents.

The trust used an electronic system for reporting incidents which any member of staff could access. Staff were aware that incidents must be reported as soon as possible after they had become aware of the incident in line with trust policy. Incidents were graded from A to E with A being the most serious. All grade C, D and E incidents were investigated and managed locally. Incidents graded C were reviewed by the complaints or incident team within 48 working hours to ensure they were appropriately graded and did not require escalating to grade B or A. Incidents graded A or B were required to be immediately reviewed by the team and this review was signed off by a senior manager within 48 hours. A report was also completed within 72 hours for all incident grades. Grade B reviews were also investigated using a root cause analysis methodology within 45 working days and grade A within 60 working days. This could be extended up to six months for the most serious grade A incidents. All root cause analysis (RCA) investigations were undertaken by a minimum of three staff each of whom had one of the following key roles:

- RCA locality lead
- Investigating manager
- Medical lead.

The trust had recently integrated the human factors approach within RCA investigations as part of its 'zero harm strategy'. This meant the trust was not just looking at the outcome of the incidents but also using human factors to identify the root cause of incidents which enabled learning to be developed.

The trust policy stated that all RCA investigations must be approved within the locality by the relevant clinical director and the general manager. As part of this approval process, the clinical director and general manager must be assured that the investigation has been conducted to a high standard, that all reasonable outcomes have been drawn from the analysis contained in the investigation, and that the recommendations of the investigation are robust enough to act as mitigations against potential recurrence of an incident of a similar nature occurring again in the future.

We examined four serious incident RCA investigation reports which the trust had completed. All the incidents had been reported through STEIS. We found the investigation reports were thorough and had been completed in line with trust policy. Each report had identified recommendations which were incorporated into an action plan. These had clear timescales for implementation and identified leads.

During focus groups we held with staff, they feedback that learning from incidents was a positive area within the trust. However; during our inspection we found an example at Saddlebridge recovery centre where learning from a previous serious incident had not been sufficiently embedded. In 2014, there was a major incident at the centre which had led to the ward being closed for several months. The trust had put in place an action plan and was working to implement the 23 recommendations made in the investigation report.

Progress against action plans, and the recurrence of themes, was reported at each quality committee meeting which linked directly to the board. Lessons learnt were discussed in locality meetings. The trust had recently introduced locality quality data packs at locality, ward and community team levels. The packs included a range of data related to that specific team which included actions and learning from incidents. In addition, learning was shared across services through matron and senior manager meetings.

Safeguarding

Since May 2013, two safeguarding alerts and 16 concerns have been raised. Ten of the alerts or concerns have been closed with eight remaining open. Bowmere Hospital received the most notifications with one alert and seven concerns.

Detailed findings

The trust had an identified safeguarding lead for children and adults in the trust. There was an up to date safeguarding policy in place.

The trust reported to seven local authorities in relation to safeguarding procedures and seven safeguarding boards. Some of these boards dealt collectively with child and adult safeguarding concerns whilst some were either adult or child specific. The trust had representation at each of the seven boards through link nurses who worked within the trust. These included a children in care nurse in Cheshire West, a domestic violence safeguarding nurse and two trust wide safeguarding nurses, one for adults and the other for children.

The safeguarding risk register was reviewed by the trust safeguarding subcommittee which was chaired by the director of nursing. This committee fed into the quality committee which linked directly to the board. The safeguarding committee fed into locality meetings which were chaired by general managers and attended by the locality service leads. Safeguarding issues were cascaded to teams through local quality data sets and team meetings.

We met with the trust safeguarding leads for both children and adults. They told us the trust prioritised safeguarding and they felt supported in their role to make changes to improve how the trust managed safeguarding issues. They were able to provide examples of these improvements which included;

- Working closely with teams over the past year to ensure they were referring safeguarding concerns appropriately. They told us staff teams had not always recognised and escalated safeguarding concerns appropriately in the past. They had also been addressed also by use of the Datix incident reporting system which had a specific safeguarding section on the form for staff to complete if they identified a possible safeguarding concern.
- The safeguarding leads reviewed any incidents where staff had identified a possible concern on the Datix system at least weekly to ensure appropriate safeguarding procedures had been followed.
- The team regularly sampled team and family assessments (TAF) to ensure escalation of issues was occurring appropriately.
- The trust had completed a range of internal and external multi-agency safeguarding audits. They were developing their methodology to collect more qualitative data from cases to enable more effective analysis.
- The trust had developed 37 safeguarding link practitioners who were supported within this role through group supervision.
- Screening all invites to attending safeguarding conferences to ensure key practitioners are involved. They told us the trust had been criticised in the past for not attending conferences which was due to invites not always being picked up by the relevant member of staff. They now had a generic mailbox for all invites so these were not overlooked and a staff member was allocated to attend each one.
- The implementation of the, 'Think Family Approach' initiative which encourages all staff to consider the patient within the context of their wider family and social network.

The trust investigated incidents and developed action plans to ensure learning was disseminated throughout the trust. This was feedback through the trust wide committee and learning shared through the locality meetings.

On Saddlebridge Recovery centre, a patient raised concerns with us that a staff member had been reading patient comment cards that CQC use to gather patient's views. The trust took immediate action to investigate and found evidence to support the patients concerns. The trust referred the incident appropriately through local safeguarding procedures.

In the community (physical health) services for children and young people, health records for children and families were unreliable and not fit for purpose in relation to safeguarding. There was an electronic record system in place that had been implemented approximately two years ago. Paper records were also used for children born before the implementation of this electronic system but the paper records had not been scanned onto the electronic system. As a result, the service used both electronic and paper records for all children over two years of age. However, the records did not cross refer to one another. They did not highlight that another set of records was in existence or any historic concerns. The records we reviewed were not compliant with either the trust policy or the standard

operating procedure. We also identified that once a safeguarding alert had been recorded on the electronic computer system, it could not be removed which meant that the system did not reflect an accurate picture of current concerns.

Also in the community (physical health) services for children and young people we identified some concerns with the practice of staff. We attended a home visit with a health visitor and noted that the mother was not asked about any other adult living at the property. We also reviewed some records where it was not documented as to whether this was asked at the visit. This is contrary to the safeguarding of children policy for the trust, which states that 'all staff who have contact with families should obtain the details of any adult who is in regular contact with the child'.

Whistleblowing

The trust had a whistleblowing policy dated September 2012 which was due for review in September 2017. The policy provided details of how staff could raise a concern both within and outside of the trust. The trust also had a 'Speaking Up Guardian' to support staff to speak up and escalate any concerns they may have to the trust.

There have been three whistleblowing concerns raised with the CQC for the trust since 1 May 2013. Two of these concerned Bowmere Hospital and were related to staffing levels and the management of a member of staff. The other concerned the trust as a whole. All three concerns had been managed and dealt with by the trust and closed.

Assessing and monitoring safety and risk

The trust had a board assurance framework (BAF) dated 1 June 2015 which identified possible strategic risks to the trust. There were 15 risks identified within BAF. A number of these had been open since May 2010 and included;

- Adherence to mandatory training
- Ligature risks within in-patient wards
- Slips, trips and falls
- Poor incident management process
- Data quality issues
- Risk of adverse clinical incident due to quality of record keeping and dual record keeping systems
- Risk associated with not meeting cost improvement plan

The BAF identified;

Controls - what the trust were currently doing about the risk

Assurances- how the trust knew they were making an impact

Gaps in controls- further actions that would help achieve the target risk

We saw that some risks remained on the BAF even though action had been taken to reduce or mitigate the risk. For example; staffing was still recorded as a high risk even though the trust had recruited. The trust had changed the risk for staffing from the need to recruit staff to the need to induct the new staff recruited. They had recorded these as having the same level of risk instead of archiving the recruitment of staff from the register and adding the new risk associated with the induction of staff. This made it difficult to determine which mitigating risk factors and controls had been effective in reducing which risk.

Each locality held their own risk registers and risks were assessed and reviewed regularly with escalation as appropriate to the strategic risk register. This was signed off by the operational board. Staff understood how to raise and escalate incidents and risk. Although the wards and clinical teams did not have their own individual risk registers, ward managers and team leaders could feed into the locality risk register through their line management structure.

Incidents were reviewed by ward managers, team leaders and modern matrons to assess the severity of risk and identify any themes for learning.

Across most services, we found that comprehensive risk assessments were in place to assess and manage risks to individuals. The teams used the clinical assessment of risks to self and other (CARSO) in the assessment of patient risk in addition to the historical clinical risk management 20 within the forensic services. The CARSO was the standardised tool within the electronic patient record system. The electronic system incorporated alerts to ensure that staff were aware of incidents and risks. However, the monitoring system being used had identified that these were not always being documented at Vale House. This meant that staff were not always aware of risks

and thus did not take action to mitigate them. In the community mental health service for children and young people, we found that individual risk assessments for young people using the service were not comprehensive or completed in a timely manner after the needs of a young person changed.

On Bollin ward some patients risk assessments were lacking in detail and some identified a list of past risk incidents without detailing how current risks would be managed. At Vale House, there was a reliance on General Practitioners to identify risks at point of referral and the monitoring and reviewing of risks was not always robust and effective.

Within the acute wards, risk assessments were in place to assess and manage risks to individuals. However, some risk assessments were lacking in detail and some identified a list of past risk incidents without detailing how current risks would be managed.

The majority of services had completed environmental risk assessments however; at the Hawthorne centre, the environmental risk assessment was not available when requested.

The trust had a lone working policy in place. Within the staff focus groups we held, staff who worked within the community based teams reported that safety in buildings was good, with practices in place to make sure that staff left together. The lone working policy was considered good, with risk assessments carried out prior to home visits, a telephone number provided for emergencies and personal alarms available for staff. Although the majority of community teams we adhering to the policy, within the community mental health service for children and young people staff had limited understanding of the lone worker policy within the service and did not follow the trusts lone worker policy consistently. Team mangers also did not have information they needed available to them in a centralised system. This meant they could not monitor the waiting list for the service or take into account risks to young people waiting for the service.

Safe and clean environments

The trust participated in annual patient led assessment of the care environment (PLACE) visits. The trust overall score was above the England average for: condition, appearance and maintenance but they fell below the England average for: privacy, dignity and wellbeing and cleanliness.

Greenways was the lowest scorer for PLACE on three issues (cleanliness, privacy and condition) scoring more than 10% below the trust and England averages for each.

Alderely Unit, Limewalk House and Eastway House scored well on all aspects. Lime Walk House and Alderley Unit scored substantially higher than both the trust and England averages for cleanliness and Bowmere Hospital scored highest and higher than the England average for privacy, dignity and wellbeing.

Alderley Unit also scored higher than the trust and England average for condition, appearance and maintenance.

Rosemount Day Care Centre (Greenways), Bowmere Hospital and Pine Lodge scored lowest and substantially lower than the trust and England averages for cleanliness, privacy, dignity and wellbeing.

Greenways also scored lower than the trust and England averages for condition, appearance and maintenance

This meant there were inconsistencies across the trust in relation to cleanliness and the condition of clinical areas. However; we found that all the areas we inspected were clean and well maintained and the trust reported that recent PLACE visits had shown improvements in the results.

Within the child and adolescent wards, there were multiple blind spots and some ligature risks throughout both wards. However, staff were aware of these and reduced the risks to patients by increasing their supervision of patients. They also completed a weekly safety audit to highlight any risks that needed addressing which could have compromised the safety of patients, visitors and staff. The layout of Greenways and Eastway units also had blind spots. However, these had been mitigated by the use of mirrors to enable staff to observe patients when necessary.

There was no dedicated female lounge on Eastway unit which was mixed gender, but space could be identified and signage provided if patients did not want to mix.

All the acute wards were mixed gender. We found that some wards did not fully comply with the Department of Health required guidance on same sex accommodation. For example:

- Although wards had separate corridors for men and women, these were not always adhered to.

- Some bedrooms were not en-suite and, on some wards, women could access bathroom and toilet facilities only by passing through the male corridors.
- Not all wards had designated female-only lounges.
- There were not clear lines of sight within the corridors housing patients of different genders.
- We observed a male and female patient going into a bedroom area unobserved by staff.

This could compromise the safety and dignity of patients on these wards.

In the forensic services, staff working on the units were not aware of all the high-risk ligature points that had been identified in the ligature audit undertaken in July 2014 and there were multiple blind spots throughout both units which could have compromised the safety of patients, visitors and staff.

Staff were not keeping accurate records of the temperature of the fridge and freezer in the rehabilitation kitchen in the Saddlebridge Recovery centre despite this issue been raised at the staff team meeting in February 2015.

Seclusion

The trust had a seclusion policy dated March 2013 which was next due to be reviewed in March 2018. The policy also included the use of longer term segregation.

Out of the 19 wards reported, there were 114 uses of seclusion and two uses of long term segregation over the previous six months. (Note: Seclusion is the supervised confinement of a patient in a room, which may be locked. Its sole aim is to contain severely disturbed behaviour likely to cause harm to others.)

Longer term segregation (if seclusion episode exceeds more than seven days, consideration must be given to using the longer-term segregation procedure). This is defined as supporting an individual on their own, in an environment when not locked (which can be their own bedroom rather than a seclusion room). The individual may be supervised by nursing staff but does not have the freedom to exit the environment (under their own free will), or associate with other service users as would ordinarily be afforded to other service users on the ward. The MHA Code of Practice details longer term segregation in paragraphs 15.63-15.6. This must be individually care planned for each service user.

This plan may include periods of segregation, periods of mobilisation and must include provisions for supervision and periodic multidisciplinary review.

Brooklands ward, Willow ward, Greenways Assessment &Treatment Unit, Adelphi ward and Bollin ward reported the highest number of the use of seclusion with between 28 and 14 incidents each. Greenways Assessment &Treatment Unit and Eastway Assessment & Treatment Ward reported one use of segregation each.

There was a seclusion room on Maple Ward which had been refurbished to meet the code of practice guidance. The room was not in use at the time of inspection as they were waiting for a mattress to be delivered. There was a step down room that could be used if a patient needed a quieter environment with low stimulus. If a patient needed secluding staff had to use facilities on another ward, we were told that this happened on two occasions in the last six months. The patients were nursed by child and adolescent mental health service (CAMHS) staff on the extra care facility of an adult ward due to a lack of seclusion facility on Maple ward.

On some wards, there were different methods of recording seclusion and segregation with some records not reporting the correct details. This meant it was not always clear that the safeguards for seclusion or segregation were being met.

Risk assessments were in place to assess and manage risks to individuals. However, some risk assessments were lacking in detail and some identified a list of past risk incidents without detailing how current risks would be managed.

The seclusion facilities at Millbrook were not fit for purpose. Whilst there were plans to improve the seclusion facilities at Millbrook, seclusion continued to be used on Adelphi and Bollin wards in designated environments not fully fit for purpose

On Saddlebridge Recovery centre, staff did not always follow the Mental Health Act code of practice or trust policy in relation to seclusion. We found an example of where a patient had been secluded for several days where clinical records did not demonstrate that seclusion was clinically necessary for the prolonged period. This was raised with the trust which began a full investigation into the incident. The trust also introduced a system to monitor episodes of seclusion on the unit on a daily basis so that it was assured it was clinically required.

Detailed findings

We looked at the seclusion rooms within the wards for people with learning disabilities. On each ward we found that neither seclusion room had any way for patients to communicate through the door. In addition the Greenways seclusion room had a blind spot and its window was not fitted with a privacy screen, so it could be viewed from the outside of the building. This room was also positioned in such a way that patients had to pass it to access bedrooms. This compromised the privacy and dignity of patients in the room.

Restraint

The trust reported 396 incidents where restraint was used between October 2014 - March 2015. These occurred within 19 patient wards, units or teams and involved 156 service users. In 169 of these incidents, service users were restrained in the prone (face down) position. 84 of these incidents resulted in rapid tranquilisation. At six locations, Brooklands Ward, Maple Ward, Willow Ward, Adelphi Ward, Croft Ward and Eastway Assessment & Treatment unit, there were 30 or more incidents of restraint recorded.

Following approval at the trust's operational board on 18 March 2015, the trust commenced with a quality improvement project to accelerate a reduction in the number of prone position incidents of restraint, in order to support the implementation of the Department of Health's, "Positive & Proactive Care: reducing the need for restrictive practices" which was published in April 2014.

The programme was identified in response to benchmarked data which indicated that the trust's incident reporting profile for the use of prone position restraint was an outlier against comparator trust reporting.

The trust set up an, 'accelerating restraint reduction task and finish group' to implement the project. The group provided up-dates on progress to the patient safety & effectiveness sub- committee. Minutes of the sub-committee showed that the following reports were discussed and reviewed in meetings which took place on the 10 and 18 June 2015;-

- Analysis of prone restraint reflective reviews
- Locality data pack example – demonstrating restraint data set
- Meta-analysis of use of restraint – exploring all reporting fields associated with incidents of violence and aggression
- Interim findings from the retrospective clinical audit of restraint incidents
- Updated project plan
- Prone position incident reporting rates (per 100, 000 bed days)

15 of the 23 actions on the plan had been implemented and eight were in the process of being implemented.

The reports showed that from October 14 to March 15, the use of restraint within the trust was between 29 to 36 per month. Figures provided by the trust for April and May 2015 showed this figure had reduced to 19 and 15 respectively.

Between April and May 2015, the use of prone restraint per 100,000 bed days had significantly reduced on 12 of the 16 wards. However; use of restraint had increased slightly during this period on Bollin, Greenways, Rosewood and Pine Lodge wards. Records did not always document the time a patient had spent in the prone position within the acute wards. The incident reporting field did not enable staff to add this data. The trust identified that this was a data completeness issue, which was an improvement action identified by the trust as part of this quality improvement project.

During the course of the inspection, our inspectors saw posters on some of the wards which gave guidance to staff not to report level 1 or 2 physical interventions on the datix system. We raised this with the trust. The trust informed us that the poster was produced by a band 7 member of staff and had been approved by a band 8a manager. We were told it was then distributed to all inpatient units on 23 June 2015 although at this stage it had not been put on display on the majority of the wards. The trust stated they had not authorised the posters and immediately instructed the removal of all the posters by the modern matrons. The trust also informed all staff through the 'sharelearning' communication mechanism that all incidents of restraint required reporting. Despite this, there was evidence that staff were reporting level 1 and 2 incidents.

Medicines Management

The trust had an effective medicines governance and incident reporting structure but reported problems with ensuring appropriate medical representation at the medicines management group. This may impact on the effectiveness of the group's analytical and decision making processes. Patient group directions (PGDs) allowing

specified healthcare professionals to supply or administer a particular medicine in the absence of a written prescription were in use in some clinical areas in the trust. We checked a PGDs used by the musculoskeletal service. We saw that this had not been sent for review by the medicines management group in a timely way. The PGD was due for review in March 2015, contrary to good practice guidance; an extension sheet was signed in May 2015 re authorising its use for two months.

An audit programme was in place to assess medicines handling in accordance with the trusts medicines policies and national guidance, with the outcome of these audits beings shared at the medicines management group and at locality governance meetings.

The trusts annual medicines management audit had identified a "reduced awareness of the low molecular weight heparin (LMWH) and lithium patient safety alerts on inpatient wards". Although there was a 15% increase in the number of wards with copies of the LMWH safety alert (82%), there was a decrease of 7% in the number of wards displaying the dose calculation tool (64%). Additionally, the trusts own data showed only 55% compliance with Venous Thromboembolism (VTE) training. Whilst 86% of inpatient wards had copies of the safety alert for safer lithium therapy, this had fallen over the last two years. Conversely, there was a 32% improvement in community settings to 82%, over the same period.

On Adelphi ward we found that although VTE risk assessments were completed on admission, reassessment was not clearly documented prior to prescribing VTE prophylaxis. The junior doctors we spoke with were unclear as to where the VTE assessment should be documented. On the same ward, we found that a patient's care plan had not been updated to reflect their refusal of therapeutic drug monitoring.

The trust's audit of High Dose Antipsychotic Therapy showed that evidence of appropriate physical health monitoring was only in place for 65% of inpatients. A pilot audit in the community similarly found a lack of recorded evidence that regular physical health monitoring was completed. An action plan was in place with a target date for completion in December 2015.

Regular clinical pharmacy support was provided to all in patient wards and to the community physical health teams however, although pharmacist advice was available regular support was not extended to the community based mental health teams. The benefits of securing additional pharmacist support to community teams in reducing medicines related admissions through medicines optimisation had been highlighted in the trusts draft medicines management strategy. We found failure to complete and document medicines reconciliation on referral to the Cheshire West Home Treatment Team and that clear records of medicines administration were not made in Cheshire East. The locality pharmacist described plans to provide staff training in medicines reconciliation to the Cheshire West team. The pharmacy team engaged with service users and carers through delivery of medication sessions at well-being clinics and recovery colleges.

Pharmacy staff reconciled patients' medicines on admission to wards. However, contrary to current guidance 'Medicines optimisation: the safe and effective use of medicines to enable the best possible outcomes, NICE 2015 this was not completed within 24 hours for patients admitted onto wards at the weekend. All inpatients had the opportunity to speak with a pharmacist about their medicines whilst in hospital. The trust was not able to provide an electronic discharge summary to the patient's GP or primary care provider at the point of discharge, instead relying on fax and post. Funding for the implementation of electronic prescribing and medicines administration (EPMA) had been secured through the Finance Director with a target for rollout across the Trust by 2018 in line with NHS England's Safer Hospitals, Safer Wards programme.

Safe staffing

We reviewed the following documents in relation to staffing;

- Board papers dated 25 March and 27 May 2015
- The ward daily staffing reports for February, March and April 2015
- The first six monthly review of ward staffing dated November 2014 which was presented to the board in January 2015.
- Staffing levels both required and actual for each ward which were published on the trust website and included in the wards data packs.

It was evident that there had been previous staffing issues and these were understood by the board and escalated

onto the BAF risk register. There was a process in place to monitor staffing levels at both local and strategic level. A programme board had been established to oversee the implementation of the strategic action plan to address staffing issues in the Summer of 2014. We saw evidence that the trust had proactively recruited a number of staff during 2014-2015 to improve staffing levels within the trust although they did acknowledge that work continued to be needed to improve staffing levels in relation to the following areas;

- The number of nursing staff working unplanned hours
- Ward managers and members of the MDT required to support safe staffing levels
- Impact on patients' activities
- Impact on training and development of staff
- Skill mix

The matrons reported during the focus group we held with them that staffing levels had improved significantly over the previous six months across the trust. They told us they were confident that the actions which had been put in place were sufficient to keep the wards safe despite some of the continued challenges the trust faced regarding staffing in some areas.

However, in community (physical health) services for adults, the integrated care teams, both nursing and therapy staff, told us they were not always able to see every patient due to staffing and time pressures. In order to ensure that urgent patients were seen, the staff told us they had worked overtime or delayed non-urgent patients to the caseload for the next day. Staff had access to a priority caseload tool, which identified how to prioritise different clinical conditions. Staff we spoke with in a number of teams told us that the tool did not adequately account for the complexity of the patient conditions and that further work was required to make the tool more robust.

Within the community older people's mental health teams, there was no formal caseload management system in place with a reliance on staff needing to inform managers if they did not have the capacity to accept any more cases. However, the caseloads of staff within the community mental health teams were in line with national guidance.

By core service, the following services had the highest qualified staff nursing vacancies;

- Low secure forensic (34%)
- Adult and psychiatric intensive mental health wards (15.5%)
- Ward for older people (16%)
- Long stay rehabilitation wards (14.8%).

The lowest vacancies for qualified staff were in;

- Children, young people and families (0.3%)
- Older people mental health services (3.3%).

All other core services had vacancy rates below 10%.

Patients within the low secure services told us that activities were being cancelled due to staff shortages.

By team, Saddlebridge recovery centre, Rosewood Unit and Adelphi Ward had the highest number of qualified staffing vacancies with 34%, 13% and 11%. Oaktrees ward, Wirral child and adolescent mental health services team, primary care mental health, home treatment team Chester and Cars ward all had high qualified staff vacancies of between 13.6 – 18%.

The highest unqualified vacancy rates were in the following core services;

- CAMHS in patients (13.9%)
- Children, young people and families (12.7%)
- Community health – Adult (10.9%)
- Mental health crisis teams (13.4%).

The lowest unqualified vacancy rates were in the learning disability inpatient (0%) and community services (1.1%). All other core services had less than 10% vacancies for unqualified staff.

By team, the Chester home treatment team had the highest vacancy with 44% followed by Adelphi ward with 25.7%. Oaktrees and Cars ward both had just over 12% with all other wards and clinical teams having less than 10%.

The table below lists the wards / units use of bank or agency staff between 01/01/2015 – 31/03/2015). The first figure shows the number of shifts required to cover sickness, absence or vacancies and the second figure shows the number of shifts which were not filled.

Adelphi ward 189, 27

Detailed findings

Rosewood unit 105, 39

Eastway unit 52, 16

Saddlebridge Recovery centre 142, 42

Cars ward 156, 34

Oaktree ward 226, 38

Alderley unit 170, 39

Beech ward 145, 68

Brackendale 200, 48

Cherry ward 244 108

Croft ward 89, 29

Juniper ward 96, 65

Maple ward 111, 40

Meadowbank ward 307 88

Pine Lodge 181, 74

Willow ward 244, 23

The trust was only able to provide figures for in-patient areas as their 'staffing resilience service' did not hold the complete information for other areas.

Permanent staff sickness rates varied significantly across services within the trust. In the community health adult's service, three out of the 29 teams had sickness rates of over 10% and in the community health children's service and one of the six teams did. For the child and adolescent mental health services, one of the 18 teams had a sickness rate over 10% and one of the 13 mental health crisis teams did. In the adult community mental health service, four teams had a sickness rate of over 10% out of 32 teams.

Across the mental health in-patient wards, staff sickness rates were over 10% on the following wards; Eastway unit, Alderly ward, Saddlebridge recovery centre, Brackendale Ward and Willow ward. The highest figure reported was 18.06% at Saddlebridge recovery centre.

Blanket restrictions

The trust was committed and working towards reducing restrictive practices in line with their trust wide campaign 'zero harm' which was launched in July 2014. The campaign focussed on encouraging staff to, 'stop, think and listen' and continuously reflect on and review their everyday work life to identify possible practices which could result in unwarranted harm to patients.

However, on Saddlebridge Recovery centre, some patients raised concerns with us about the ward rules which restricted the numbers of items such as clothes and books that they could keep in their room. Patients and staff told us that there were different rules in place depending upon who was on duty. This meant that what patients were allowed to do was depend on who was on duty. For example, a staff member said sometimes patients would not be allowed to eat a sandwich with their soup. However, on other days this would be allowed.

The centre had introduced a blanket restriction associated with soft drinks, crisps and chocolate bars. Staff told us this was in line with attempts to support healthy eating and physical well-being and that these arrangements had been agreed in meetings with patients. Patients told us they were not happy that they were being restricted from buying the types of food and drink that they would prefer.

Following our inspection, the trust assured us they would review restrictive practices on the ward with patients and staff.

On Maple ward, hot and cold drinks were available in the dining room. However, a fob was required to access this room. This meant that patients assessed as not being able to manage a fob to gain access into the dining room were also unable to access hot and cold drinks when they wanted to.

Within the acute wards, the implementation of the no smoking policy within the trust was causing difficulties for some patients and staff. Patients were being asked to hand in any tobacco, cigarettes and lighters and, if searched, these items were being confiscated. These items were not returned until patients were discharged even if patient went on significant periods of leave off the hospital grounds or on overnight leave. The trust should consider whether the current policy

and practice of keeping patients' belongings in this way goes beyond the legal powers available to the trust.

Within the rehabilitation wards, staff were struggling to enforce the trust's policy on contraband items following the introduction of the smoking ban. Staff were aware that

patients were bringing tobacco and lighters on to the wards. Despite this, there were few documented incidents relating to searching patients or their rooms for contraband items.

Duty of Candour

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

The majority of staff we spoke with understood the underlying principles of the Duty of Candour requirements and the relevance of this within their work. However, we spoke with one senior member of staff who was unable to describe what Duty of Candour was. They confirmed they had not received training. Duty of Candour was not part of the trust's compulsory training requirements for staff. However, it was included in the incidents, complaints and claims essential training provided to managers

When we reviewed the incident management policy it referred to duty of candour in terms of NHS standard contracts rather than in relation to Regulation 20 of the Health and Social Care Act.

We saw examples of the trust meeting the requirement of duty of candour on Saddlebridge Centre and within the physical health services.

Good

Are services effective?

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

Summary of findings

Our findings

Assessment and delivery of care and treatment

Within the majority of services, staff completed comprehensive assessments of the needs of patients. These included their social, occupational, cultural, physical and psychological needs and preferences. However; staff at Vale House did not routinely consider physical health needs as part of the assessment process. Care plans were reviewed regularly with the involvement of patients and their carers, where appropriate.

Within mental health services, all patients had a comprehensive risk assessment completed on admission and these were regularly reviewed. Care plans were held electronically and were accessible to all staff including those in other departments within the trust. This meant staff had immediate access to patient records when a patient transferred to another service.

Within the physical health adults service, nursing staff had recently introduced care bundles to ensure that best practice was being followed for pressure ulcer care and catheter care. A bundle is a selected set of elements of care that, when implemented as a group, have an effect on outcomes beyond implementing the individual elements alone.

The Care Quality Commission Community Mental Health Patient Experience Survey scored the trust better than average in the areas of organising care, planning of care, and crisis care. Although we found that care plans were not always personalised or holistic and the quality varied across the teams.

Outcomes for people using services

The trust had met or exceeded all of the Monitor compliance framework targets which were set for 2013/2014 and also achieved all of the quality improvement priorities it set in the 2013/2014 Quality Account. The trust participated in both national and local clinical audits. Since July 2014, the trust has completed the following audits;

Dual Diagnosis

Record Keeping

National Audit of Schizophrenia

POMH-UK Topic 12b re-audit report, 'Prescribing for People with a Personality Disorder'

Medicines management

Controlled Drugs audit

Antibiotic audit.

The trust had local commissioning for quality and innovation (CQUIN) targets to support operational improvements in the quality of services. Information reviewed indicated the trust had completed local audits against various CQUIN targets. Some of these included the friends and family test, assessment and treatment of people with severe mental illness to improve their mental and physical health care.

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

- The Liverpool University neuroleptic side effect rating scale (LUNSERS) which was used by patients as a self-assessment tool for measuring the side-effects of antipsychotic medications
- The KGV, also known as the Manchester symptom severity scale which is an assessment tool developed by three psychiatrists
- The Malnutrition Universal Screening Tool which measures body mass index
- Health of the nation outcome scales were used to assess people. This covered 12 health and social

domains and enabled the clinicians to build up a picture over time of patients responses to interventions. However; within the older people's community mental health teams, this was not consistently completed.

- Mental health recovery star.
- Staff in the health visiting service were trained in the use of the Solihull approach. The Solihull approach is evidence based and is a psycho-therapeutic approach to working with children and families.
- Health visiting and family nurse partnership teams used the ages and stages questionnaire, to complete developmental assessments. This is a nationally recognised, evidence-based tool and is used within the family nurse partnership programme nationally.
- The speech and language therapy department used the Malcomess care aims model. This model uses labels to guide the planning, delivery and outcome measurement of care. This involves the use of one of seven labels which clarify and make explicit the purpose of each episode of care undertaken with a client. This ensured consistency and standardisation in the approach used by the therapists and also ensured evidence based care and treatment was being delivered.

The service had introduced the National Institute for Health and Care Excellence (NICE) guidance on the assessment and management of bipolar disorder in adults, children and young people in primary and secondary care published in September 2014. As part of the implementation process, the Ellesmere Port and Neston and Vale Royal teams were auditing the eleven recommendations contained within the guidance. The consultant leading on the audit had produced guidance to benchmark the interventions, services and prescribing of medicines used by the CMHT's against NICE guidance.

To improve patient outcomes, the podiatry service had reviewed 21 diabetes screening assessment forms for diabetes patients to streamline care and ensure that the most effective care and outcomes were achieved.

At Upton Lea, the team provided written information about dementia and dementia services. This is in line with NICE guidelines.

At Upton Lea, there was access to a 'safe driving' assessment although this was not local. This was in line with DVLA current medical guidance.

Staff Skill

The trust had set a target of 85% compliance with mandatory training for all staff. The trust as a whole has passed the 85% target for mandatory training.

The compliance rate for community mental health services was 88% overall;

• Child and adolescent mental health services 87%

• Adult community 82%

• Learning disability 93%

• Crisis teams 90%

• Older peoples' services 91%

The compliance rate for mental health in patient (clinical) services was 85% overall;

• Child and adolescent mental health services 81%

• Adult mental health 84%

• Learning disability 89%

• Forensic 83%

• Rehabilitation 87%

• Older peoples' services 78%

The compliance rate for community health services was 92% overall;

• Children, young people and families 91%

• Adult community health services 92%

• End of life care 100%.

Information governance, infection, prevention and control, basic life support, Mental Health Act courses, fire ward evacuation, moving & handling: people moving and venous thromboembolism had poor attendance across all mental health services.

Children, young people & families had good attendance across all courses. However; compliance with information governance, infection prevention & control, life support and the Mental Capacity Act was lower across the other two community health services.

Eighty six percent of staff had received an appraisal in the last 12 months which was slightly below the national average of 88%. The low secure wards had the lowest percentage of staff who had received an appraisal at 61.3%

followed by the mental health crisis team with 64.1%. The acute wards and PICU wards had highest appraisal rate at 89.2% followed by the child and adolescent wards with 87.1%.

Information from the General Medical Council showed that;

- 72.22% of fitness to practice enquiries were closed.
- 89.06% of all doctors were revalidated.
- 89.09 of speciality registrars were revalidated.

Multi-disciplinary working

Regular and effective multidisciplinary (MDT) meetings and handovers of care were in place throughout all services within the trust. We observed 19 MDT, handovers or clinical meetings during our inspection. These meetings provided effective handovers within the teams we visited to keep staff updated about patient risks and to oversee and manage team and individual caseloads.

Care programme approach review meetings routinely took place every three to six months. At these reviews all involved in care pathways were invited, subject to agreement by the patient. These included CPA care coordinators, family members and other disciplines involved in supporting the patient.

There was little evidence of real multi-disciplinary working in the CMHS at Vale House. The team consisted only of nurses and psychiatrists. However; there was access to other health professionals, such as social work staff and occupational therapists, within the trust but the staff we spoke with did not demonstrate that they recognised the benefit of closer working with such allied professionals.

In the majority of services, patients received regular input from medical staff. However; patients on Beech ward were not receiving regular input from the consultant psychiatrist with some patients not seeing a doctor for significant periods of time. One patient had not seen their psychiatrist for 20 days and another patient had not seen them for five weeks.

Within the acute wards, there was a lack of psychological interventions available for patients as there was no designated psychology input on the wards. Patients did not have direct access to cognitive behavioural and psychological therapies whilst an in-patient on the wards as guided by National Institute for Health and Care Excellence (NICE) although patients were offered psychology input when patients were being considered for discharge.

Information and Records Systems

The trust had an electronic patient record system which all authorised staff could access. The trust recognised and acknowledged that there were some difficulties with their current information technology (IT) system which had been escalated onto the board assurance framework risk register with actions to address this issue.

The current IT system did not enable to trust to elicit some specific information at ward or locality level. For example; the trust was unable to provide figures for agency and bank staff usage for community services as these figures were only available at trust level for in-patient wards.

We identified some concerns with records in the community (physical health) services for children and young people. This service did not maintain accurate, complete and contemporaneous records in respect of each service user. Records were not accessible to authorised people as necessary in order to deliver care and treatment in a way that meets their needs and keeps them safe. There was both a paper and electronic record for the majority of children in the service; however, there was no summary within the electronic record to identify historic concerns or issues. We also found that there was no reference in either paper or electronic records to alert professionals that there was another set of records for the child. In addition, it was identified that it would take a minimum of four hours for staff to retrieve archived paper records which presented a risk that historic concerns written in paper records may not be available in a timely manner.

Data quality issues had also been highlighted in relation to the trust's December 2014 submission to the mental health minimum data set. Of a total of 460 records that could have been completed: 25 were valid, 280 were invalid & 155 were missing.

The trust completed an Information Governance Toolkit self-assessment audit in both 2013-2014 and 2014-2015. Overall they scored satisfactory at 95% for the first audit and not satisfactory for the most recent with 94%. Although

the trust scored 'security assurance' between 93%-100% which is rated as satisfactory in all areas, they scored secondary use assurance at 83% which was much lower than the previous year's figure of 95%.

The issues with IT meant that the trust board was not always in receipt of accurate information on the trusts' performance and progress. This was also an issue which commissioners had highlighted during focus groups we held during the inspection and feedback we received prior to the inspection.

Consent to care and treatment

The trust reported that there were 136 DoLs applications made between 01/10/14 and 31/03/15. The majority of which were made by the Thorn Heys Respite Unit (55%).

There were 27 DoLs applications reported to CQC between May 2013 and May 2015. However; the trust in their factual accuracy response stated that they had submitted 52 DoLs notifications regarding the following locations: Millbrook 32; Bowmere 18; Thorn Heyes 1, Greenways 1. The trust was notifying us of DoLS applications as they were required to do. However the number of DoLS applications reported to us did not match the number of applications the trust stated they had made. This discrepancy may be because the trust tell us when the outcome of the DoLS application was known and there were frequently delays in the local authority (the DoLS supervisory body) processing applications as a result of the increase following recent court judgements (for example, in a case called the Cheshire West judgement).

Compliance with the Mental Capacity Act (MCA) was variable across the trust. We have highlighted below our concerns with the assessment and recording of patient's capacity to consent to mental health treatment. However, the scope of the MCA goes beyond mental health treatment.

In some settings, staff were able to articulate how the best interests of patients would be assessed and the circumstances in which an independent mental capacity advocate (IMCA) would be required. However, in some services, staff told us that they lacked confidence in assessing capacity and did not feel that the current e-learning training sufficiently enabled them to develop their skills and confidence in this area. There was also some confusion about whose responsibility it was to assess and document capacity with some nursing staff deferring this to doctors and others not being aware that it was part of their role.

Staff within the health based places of safety and adult and older people's community mental health teams were not routinely assessing people's capacity to understand the risks and benefits of treatment offered to them.

On the child and adolescent wards we found that although staff had attended the training they had limited understanding of the age that the act applies from and the implications for the patients they were caring for.

There was inconsistency in the documenting of capacity across the trust. We found evidence on most wards that where there were concerns about a patient's capacity, the capacity assessment was not clearly recorded within the patient files. We found generic consent statements on some files and it was unclear which decision was being referred to. It was not clear from the records that capacity was always taken into consideration prior to making decisions or taking action.

There were particular concerns around the capacity of some patients to consent to an informal admission to hospital. Where concerns around capacity were documented, we were unable to find that a formal assessment of capacity had been undertaken and documented.

We were informed that an assessment of capacity form was in development and this should support the clear recording of capacity in accordance with the MCA.

However, we found that decision specific assessments of capacity were consistently recorded within the learning disability in patient service. There was evidence that a range of methods were used to support the staff to determine a patient's capacity and that applications for Deprivation of Liberty Safeguards were used appropriately.

Assessment and treatment in line with Mental Health Act.

Section 120B of the Mental Health Act allows the CQC to require providers to produce a statement of the actions they will take as a result of a monitoring visit. During the course of the 10 visits CQC made to the trust in the previous 12 months, 35 concerns were raised requiring a response from the provider.

Good

Are services effective?

The most frequent concerns were:

• Documentation (four locations)

• Explanation of patient rights (four locations)

• Issues with care plans (four locations)

• Issues with capacity to consent (four locations)

The following locations had the most issues:

• Saddlebridge (7 issues)

• Rosewood (7 issues)

• Bollin (7 issues)

• Adelphi (7 issues)

Where patients were detained under the Mental Health Act 1983 (MHA), the necessary legal paperwork was present in the patient's files. In most cases this also included a copy of the approved mental health professional's report, although there was variation across the trust and patient files on some wards did not contain it.

There was a system in place to ensure that patients were advised of their rights in accordance with section 132. However, we found that there were problems with providing patients with this information in a timely manner on some wards. We also found that patients were not regularly reminded of their rights on other wards. There were also concerns about how this information was provided to patients on some wards, as simply reading from an information sheet is not considered sufficient by the code of practice.

In the adult community mental health teams, we found that where people were subject to a community treatment order (CTO) under the Mental Health Act there was no evidence in the paper or electronic system care notes that people were being read their rights. Records reviewed informed us people did not have their rights explained to them routinely and there was no documented evidence from the care coordinator.

There was an independent mental health advocacy (IMHA) service available to all patients. It was not clear how patients who lacked the capacity to instruct would be able to access an IMHA on some wards. On other wards we found that staff did not always support and promote the use of IMHAs and consequently there was little take up amongst the patients on these wards.

We saw that documentation relating to the authorisation of section 17 leave was well completed. There was evidence that risk assessments were completed before leave was authorised. We found that leave was granted on an individual basis according to need and stage of recovery.

(Note: If someone is detained in hospital under the Mental Health Act, it is against the law for them to leave without specific permission granted by the responsible clinician. Permission to leave the hospital grounds, to visit their family for example, or for a trial visit home prior to discharge can be given under section 17.)

In relation to section 58, we found that with few exceptions, prescribed medication was authorised by a form T2 or T3. However, we were concerned about the inconsistent recording of the responsible clinician's (RC) assessment of a patient's capacity to consent to treatment. In some cases it was not possible to determine if a patient's capacity had been assessed at the point that medication had first been administered.

(Note: Section 58 of the Mental Health Act sets out the circumstances in which medication or treatment can be given to patients without their consent. Form T2 is a certificate of consent to treatment completed by a doctor to record that a patient understands the treatment being given and has consented to it. Form T3 is a Certificate of second opinion completed by a doctor to record that a patient is not capable of understanding the treatment he or she needs or has not consented to treatment but that the treatment is necessary and can be provided without the patient's consent.)

The quality of care plans was variable. On some wards the care plans showed that consideration had been given to minimum restrictions on a patient's liberty. Some care plans clearly documented patients' individual support needs and were regularly re-evaluated. However, on other wards care plans were less individualised and the section where patients could add their comments was left blank. We were unable to find any reasons for this omission.

The MHA manager and administrators had been proactive in acquiring funding to provide information leaflets and training on the MHA and Mental Capacity Act (MCA) to staff and other stakeholders. The MHA office had just begun to produce an information newsletter to ensure that staff were kept up to date with the MHA and opportunities for

further training. Staff confirmed that they knew how to contact the MHA office for advice when needed and said that regular audits were carried out throughout the year to check the MHA was being applied correctly.

Outstanding ☆

Are services caring?

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

Summary of findings

Our findings

Dignity, respect and compassion

In all of the services we inspected we observed staff to be professional and caring in manner. Patients were treated with compassion and empathy. Engagement between staff and patients was positive, collaborative and meaningful. Patients were involved and encouraged to be partners in their care. Staff took time to offer support, discuss treatment and provide information to both patients and their families.

We observed staff in the end of life and inpatient learning disability services adapting communication methods to meet the need of the individual.

We carried out a Short Observational Framework for Inspection (SOFI) on the learning disability wards. SOFI is an observational tool used to help us collect evidence about the experience of people who use services, especially where they may not be able to fully describe these themselves because of cognitive or other problems. This showed that interactions between patients and staff were outstanding with staff using innovative approaches to assist them to effectively communicate with patients. For example; staff had provided one patient with different colour wristbands which represented different moods. This enabled the patient to communicate their mood and for staff to respond proactively.

In the end of life service, nursing staff told us it was a privilege to provide care and support to people at the end of their life and saw their role as vocational. This was reflected in the positive comments we received from people and their carers regarding the service. We received similar feedback from people using the community adult health and the community children, young people and families health services.

In total, we received 197 comment cards back from people of which the majority (169) were positive and 28 were negative. 124 comment cards related to the trust as a whole with 108 positive comments and 16 negative ones. The CAMHS received the most comment cards (12) of which 11 were positive and the community learning disability service received the second highest with 10 cards all of which were positive.

Positive themes which emerged were in relation to staff having positive, caring attitudes and listening to people in addition to delivering good quality care to people.

Negative themes included poor staffing or resources, poor staff attitudes, people or their families not being listened to and a poorly maintained care environment.

Delamare (8), Brackendale (4) and Beech (4) Eating disorder service (7) and the older people's service (5) all received positive comments only. Alderley Unit received one positive and one negative comment whilst Lakefield received four positive comments and two negative out of the six received. Eastway received five positive comments out of six received with one being negative. The community mental health teams received the highest percentage of negative comment cards received with five out of the seven cards being negative compared to two being positive.

For Saddlebridge, we received two responses both of which were negative and concerned staff attitude. At Pine Lodge, the three responses we received were all three were negative in nature and two related to poor staff attitudes. Two patients at Saddlebridge Recovery centre raised concerns over staff attitude. One individual stated that patients were afraid to complete CQC comment cards as they were worried that staff would read them. We raised this concern with the trust who carried out an investigation. The investigation found evidence to confirm that a staff member had removed comment cards from the box and read them. The trust took appropriate and immediate action.

Staff were respectful and in general patients' privacy and dignity were respected and upheld. The exception to this was on the forensic wards. All bedroom doors had adjustable panels to enable observations. However; we

saw that these were left open on each door and there was no mechanism inside the patient's bedroom to enable them to close the panel which could have a negative impact upon their privacy.

We were also concerned about the confidentiality of patient and carers information due to the location of the whiteboard used for the daily multi-disciplinary handover on Rosewood.

The patient led assessment of the care environment, England 2014 identified that the trust scored 87.4% for privacy, dignity and wellbeing overall which was below the England average.

Patients on Saddlebridge Recovery centre told us they attend and contribute to daily community meetings and they often raised concerns about the size of the meal portions. There were no minutes taken in these meetings. Concern with the size of portions were raised in the "my service my say" minutes but there are no actions recorded about what the staff were doing regarding this. The ward manager described that a dietician had recently attended the Saddlebridge Recovery centre but had not committed to providing ongoing interventions.

In the 2014 community mental health patient experience survey the trust scored better than average overall. The trust was better than average in 11 out of 33 survey questions. They scored particularly well in the areas of organising and planning care and in crisis care.

We received positive feedback from five private stakeholders who worked with the Eastway community learning disability team in relation to the quality of care provided by the team.

Feedback from the 'Patient Opinion' website showed the trust had rated 3.5 stars out of 5 for listening and 3.7 stars for respect. Both of these were based on 6 ratings. The trust received a score of 1.5 stars from six ratings on the NHS Choice website.

In the 2014 CQC community mental health patient experience survey the trust scored 8.6 for treating people with respect. This was in line with the national average.

Five comments were received through the 'share your experience' survey. Positive comments were made about caring and professional staff in the eating disorder service at the Millbrook Unit.

Negative comments were received regarding prescribing regimes and the provision of information.

Results from the friends and family test completed in quarter two 2014/15 showed that 60.9% of staff would recommend the trust as a place to work.

Involvement of people in the care that they receive

Overall, patients, families and carers were involved in decisions about care. Care plans were developed collaboratively with a person-centred focus. However this was not always reflected in the written care plan.

The trust scored 3.3 stars out of five for involved on the Patient Opinion website. This was based on six responses. In the CQC Community mental health patient experience survey (2014) the trust scored 7.9 for the question, 'Were you involved as much as you wanted to be in agreeing what care you will receive?' This was above the national average. The trust scored 8.3 for the question 'Does this agreement on what care you will receive take your personal circumstances into account?' This was above the national average.

Families and carers were invited and supported to attend appointments, ward rounds and CPA meetings. However there were some exceptions to this. For example within the inpatient mental health wards for adults of a working age the first half of review meetings on Brackendale ward were routinely held without patients and relatives. Patients and relatives were invited for the second half of the meeting to discuss the decisions that had been made.

Services held a range of patient community meetings to gather feedback and encourage involvement. For example in forensic services 'My service, my say' was held fortnightly. On the CAMHS wards patients had established a participation and involvement group called the 'sloth' group. The group had been involved in plans for a new building and were offered training to sit on interview panels.

Within older people's inpatient services Cherry ward had developed a carers and relatives questionnaire which was completed when a relative was discharged. The results and feedback of the survey were displayed at the entrance to the ward.

Patients were offered the opportunity to get involved with the delivery of services. For example within adult mental health services (community and inpatient) patients and

Are services caring?

former patients were acting as peer support workers and facilitating wellbeing groups. Within CAMHS young people were helping to develop and deliver training sessions to staff.

However, in the older people's community mental health teams, there was a lack of evidence to show how patient's views and experiences were gathered locally so they could be used to drive improvement or influence service development.

The trusts public board meetings were attended by the service user/carer governor and a member of the public. Patients in the learning disability services sat on interview panels and had a say in decisions on recruitment.

Emotional support for people

During the inspection we witnessed several examples of staff displaying supportive behaviour towards patients and their carers across services. For example in the CAMHS we observed support being offered to a parent whose child was transitioning to a new school. Staff attended the transition meeting with the new education provider along with the family. This helped assure the parent that the new provider understood their child's needs and eased anxiety over the move. Staff also acknowledged the impact on the wider family and arranged for the child's siblings to attend a support group. Within the learning disabilities wards we observed staff using a variety of techniques to encourage and support a patient to attend a leaving party for a fellow patient.

However, in the children and young people physical health service some parents reported seeing different health visitors at each contact. This impacted upon their ability to build up a positive relationship with the health visitor.

The trust had received national recognition for its carer support. The trust has received a second gold star from the national Carers Trust, recognising a commitment to improve support for unpaid carers and their families.

The trust had signed up to the 'triangle of care' initiative. The 'triangle of care' approach was developed nationally to improve carer engagement in mental health acute inpatient and home treatment services. We saw information about the triangle of care displayed in the adult mental health services including comments from people about the service they had received.

Advocacy services were available and promoted within services.

Good

Are services responsive to people's needs?

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

Summary of findings

Our findings

Planning and delivery of services

All admissions to the acute mental health in patient wards were gate kept by the crisis resolution home treatment (CRHT) team. Generally, the trust has remained within 1% of the England average over the year for admission gate kept by the CRHT.

The percentage of patients on the Care Programme Approach who received follow-up contact within seven days of their discharge from inpatient care was 97.7% against the trust target of 95%. The percentage of patients who had a formal review within two months of discharge from inpatient care was 96.2% against the trust target of 95%.

Over 98% of all patients admitted to inpatients services had access to crisis resolution home treatment teams against the trust target of 95%.

Within the community health services for children, young people and their families service the delivery of the healthy child programme was monitored for the service. Data from quarter 4 of 2014/15 showed that 94% of births were visited by a health visitor within 14 days, whilst only 80% of children received a development assessment between the required ages of two and two and a half. Managers identified that this lower level was as a result of the appointment system and that there was very limited clerical assistance within the health visitor teams.

School nurses and health visitors told us that some elements of the programme, such as antenatal contacts, were not undertaken in line with requirements and that health promotion and public health activity were not delivered consistently. This was mainly due to the existing health visitor vacancies and the amount of work spent with safeguarding families within school nursing.

Admissions and discharges from the low secure wards were overseen by the North West specialist commissioning team. The majority of patients were admitted directly from court, prison or stepped down from more secure services. The average length of stay was around two years. The outreach team undertake assessments contacts and visits prior to admission and maintained this contact after discharge from the units for a number of weeks. The units had a good record of successful discharges and worked closely with other units within Cheshire and Wirral Partnership NHS Foundation Trust such as Lime Walk rehabilitation ward to facilitate transfers where appropriate.

In November 2014 Cheshire and Wirral NHS Foundation Trust teamed up with Cheshire Police to participate in a new approach to policing incidents involving people with mental ill-health. The service has demonstrated up to 92% reduction in the number of people detained under section 136 of the mental health act.

The trust recovery college was established in the last five years and links into the recovery and review role of the community mental health teams. This provided a learning centre offering courses based on people's personal recovery. Examples of courses provided were: understanding mental health, which included mindfulness based cognitive therapy, understanding depression and coping with anxiety, 'rebuilding your life' which included managing sleep problems, moving forward, confidence building and an introduction to and development of wellness action plans.

At Vale House, there was a waiting time of six to eight weeks for patients to see a doctor but we were not told about any plans to reduce this. There were waiting lists at both Vale House and Upton Lea however, at Upton Lea steps had been taken to reduce waiting times and ensure access to care and treatment was timelier, such as introducing a nurse led review clinic.

There was no duty system at Vale House which only accepted referrals from GP but Upton Lea accepted from range of sources. At Vale House, care pathways were unclear and access was not always timely. Managers triaged each referral made to the CMHS but there was no clear system in place for prioritising referrals.

Within the community mental health services for children and young people and the learning disabilities wards, there

were several examples of outstanding practices and initiatives which the services had implemented to meet patients' needs and support their recovery. Activities and therapies were personalised and included both ward based and community based facilities.

However; we reviewed patient activity plans on the rehabilitation wards and found that some patients' plans included activities that did not actually take place.

Diversity of needs

Equality and Diversity within the trust was monitored via the Equality and Diversity Group which then escalates issues and learning to the Quality Committee via the Compliance, Assurance and Learning Sub-Committee.

We reviewed the trusts' equality and diversity monitoring report for 2013/14 and the trusts' four year equality and diversity implementation action plan.

The main priority outlined in the plan was for the trust to develop systems and practice so they could determine the impact their services had on people with different protected characteristics. The trust recognised and acknowledged that their current information systems did not fully support the monitoring of all the protected characteristics in all localities, services and groups of people including staff, trust members and service users. The trust was able to run reports for the whole trust to compare the equality and diversity needs of the population served against the staff employed. Workforce and skill mix were regularly reviewed at the equality and diversity meetings. However; it was not able to split this data by locality or team. This meant that the trust did not know if all teams and localities reflected the diverse needs of the population served in terms of service user need and staffing requirements.

The trust has put plans in place to address this issue which includes representation from the information technology clinical systems team at the trusts' equality and diversity committee.

An analysis of the data the trust did have available did not identify any areas of concern in relation to one particular protected characteristic group. The equality and diversity plan had a specific objective to engage more proactively with hard to reach groups such as gypsy and travellers and lesbian, gay, black and transsexual service users.

The trust had an initiative to implement the National Health Service competency framework for equality and diversity leadership into the roles of members of the trust board and trust wide group. The aim of this was to increase the profile of the protected characteristics of managers to become more diverse.

All the policies we saw had a comprehensive equality impact assessment.

Staff within the trust had access to translation services.

Within the older people's community mental health team, transport was available by the trust so that people could access the service.

Right care at the right time

The trust had a, 'bed management procedure' dated June 2015, an 'admission, discharge and transfer of care policy' dated April 2015 and a 'care planning (CPA and standard care) policy' dated May 2015 to support staff to ensure that patients' received the right care at the right time and assist with patient flow through teams and services. We reviewed these policies and found they were clear in relation to the expectations of practitioners in line with national guidance and contained easy to follow flow charts to support a patient's journey through the trust's services.

The Royal College of Psychiatrists reports that when occupancy rates rise above 85%, it can start to affect the quality of care provided to patients and the orderly running of the ward and hospital. We looked at the average bed occupancy figures for all 23 wards from October 2014 to March 2015. Of the 23 wards, nine had an average occupancy over 85%. Beech ward and Meadowbank ward were both over 100% occupancy when leave figures were included. The other wards were; Willow ward, Rosewood ward, Juniper ward, Brackendale ward, Croft ward, Cherry ward and the Alderley unit.

The trust was exceeding its target for improving access to psychological therapies across all services for days from referral to treatment for the period from 1 January to 31 March 2015. The trust target for access to treatment from referral within six weeks was 75% against an actual 86.3%. The trust target was 95% for start of treatment for patients referred within 18 weeks against an actual of 99%. However; in the learning disability community service,

there was a waiting list of 30 patients waiting to see a psychologist following their initial assessment. Patients could wait up to 12 months for an appointment with a psychologist.

Across the trust, the access time target for referral to treatment for the early intervention in psychosis service was 50% of patients being seen within 2 weeks. This figure was calculated using the national guidance for access time which reports upon the cohort of patients discharged in the reporting period following treatment for a new case of psychosis. Nine of the 12 services were meeting or exceeding this target. The three teams which were not were; East for in-patient new cases with 33%, Wirral for new cases in the community with 13.8% and Wirral for patients with new case of psychosis (combined aggregate total for all 3 Wirral cohorts) with 44.8%.

The West team had the best performance figure for exceeding the trust target with 100% for patients with new case of psychosis.

The trust was meeting its target of 95% for referral to treatment in 18 weeks for podiatry (100%), and musculoskeletal physiotherapy (100%) but not for speech and language therapy (92%) and adult musculoskeletal assessment and management service (85%).

Within the adult community mental health team's people who did not attend (DNA) their appointments or outpatient lithium, clozaril or depot clinics were followed up by the community teams. However; a consultant psychiatrist raised a concern at a focus group that insufficient medical secretarial support was contributing toward follow up letters not being sent out to people, which was supported by medical secretaries we interviewed. This is not in line with trust policy. Managers told us the monitoring of DNAs had recommenced in June 2015.

There was a waiting time of between six to eight weeks for people to be seen by a doctor at Vale House but we were not told about any plans to reduce this. There were waiting lists at both Vale House and Upton Lea however, at Upton Lea steps had been taken to reduce waiting times and ensure access to care and treatment was timelier, such as introducing a nurse led review clinic.

On Beech ward, patients were not receiving regular input from the responsible clinician (RC), with some patients not seeing their RC for weeks. There was also a lack of psychological therapy interventions on the acute wards.

Delayed Transfer of Care

The trust has been consistently outscoring the England average for delayed transfers of care from April 2014 to April 2015. On average, there have been two reported per month compared to the England average of between 16 and 23 per month. Staff reported they did not record delayed discharges until the case had been heard at funding panel assessments which could account for the low numbers. The primary cause of patient delays or delayed days was due to public funding, followed by the wait for nursing home placement or availability. Patients are usually referred panel where social care funding is required which is consistent with the primary cause for delay. This is not in line with the trusts 'delayed transfer of care' definition and process. The trust defined a delay in transfer of care occurring when;

- A clinical decision had been made that the patient was ready for transfer
- A multi-disciplinary team decision had been made that the patient was ready for transfer
- The patient was safe for discharge or transfer.

The trust commissioned Mersey internal audit agency to review the trusts performance data regarding delayed transfers of care. The audit concluded that although the trust's process for reporting and monitoring this was consistent, they recommended the trust reviewed its methodology to take into account the impact and timings of funding panel assessments.

From the figures the trust provided and evidence we reviewed, we concluded it was not possible to determine what the actual delayed transfer of care figures for the trust were as the recommendations from the audit had not been implemented at the time of inspection.

Learning from concerns and complaints

In the financial year 2014-2015 the trust reported 219 formal complaints. 27 of these were upheld. 39 were partially upheld. 72 complaints were ongoing. One complaint was referred to the Parliamentary and Health Service Ombudsman (PHSO). Complaints are referred to the Ombudsman when the complainant is not satisfied with the investigation of their complaint or its outcome.

Services which received the most complaints over this period were the adult mental health services east (45 complaints – 21%), adult mental health services west (30 complaints – 14%) and adult mental health services Wirral

Good

Are services responsive to people's needs?

(28 complaints – 13%). Medical professionals were the most complained about professional body within the trust followed by nursing, midwifery and health visitor professionals. This reflected complaints data for the previous two years (2012/2013 and 2013/2014).

The most common theme for complaints in 2014 – 2015 was staff attitude (77 complaints), communication and information (39 complaints), care planning (31 complaints) and dissatisfaction with access to services (30 complaints). Complaints data provided for 2012 – 2013 showed that the most common theme in complaints was 'all aspects of clinical treatment followed by 'attitude of staff'. In 2013-2014 this reversed with the most common complaint being about staff attitude followed by 'all aspects of clinical care'.

The trust had seen a steady decrease in the number of complaints that had been upheld. This was attributed to training provided by the PALS, complaints and Incidents team around the use of local resolution and dealing with issues that arise at a service level. It was unclear if all issues dealt with at a local level were classed as 'not upheld'. Staff we spoke to were aware of the process for local resolution and we saw some examples where local resolutions had taken place. However within community mental health services for older people we found that staff were sending complaints directly to the PALs service. This was not in line with the trust policy which refers to attempting local resolution and triaging complaints jointly with PALs.

Staff and patients that we spoke to knew how to complain and were aware of the complaints process. Information was on display in team areas and was also provided in welcome packs.

Complaints were discussed within the governance framework and reported to the trust board through the quarterly learning lessons report. Complaints data was also included in the Locality Data Packs sent to managers. The trust carries out an annual audit of complaints although this does not incorporate local resolutions. Staff told us that they received feedback on complaints through emails, team meetings and supervision sessions. Complaints were a standard agenda item on team meetings in several of the services that we visited.

We reviewed 20 complaint files. These included the five complaints most recently escalated to the Parliamentary and Health Service Ombudsman (PHSO), the 10 most recently raised complaints and the five most recently closed complaints. We found a wide variation in quality and compliance to the trust policy. Several of the files did not contain evidence of acknowledgement letters or ongoing communication with the complainant. In some cases where these documents were in place they were outside of the timescales detailed in the trust policy. Not all of the files contained action plans in response to the complaint findings. Of the five complaints escalated to the PHSO one had been upheld and one as partially upheld. One complaint had been referred to the Care Quality Commission. Two complaints were still under review by the PHSO.

In October 2014 the trust carried out a survey of individuals who had made a complaint and staff involved in the complaint process. The survey found that 21 out of 31 individuals who had made a complaint reported 'some level of dissatisfaction with how the trust listened and dealt with their concerns. Only seven individuals felt that they were listened to and that their complaint as taken seriously. The remaining three individuals felt they were listened to initially but that the rest of the process did not meet their needs.

11 staff returned the survey. Nine of the 11 felt that they did not have enough time to undertake complaint investigations and seven felt that further training would be beneficial. Six members of staff reported issues with the process and policy including unrealistic timeframes. Five staff members reported that they did not feel they got enough support from the complaints and incidents team. However three staff members reported that they were very well supported. Five members of staff stated that they would like better feedback. Two staff members stated that changes had been made to their investigation reports without their involvement.

The trust has an action plan in place in regard to the management of complaints. This included improving data collection and analysis, developing more appropriate written responses and better recording of lessons learnt. A satisfaction survey was also being introduced for those who had made a complaint.

Good

Are services well-led?

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

Summary of findings

Our findings

Vision and strategy

The trust had a clear vision, ' leading in partnership to improve health and well-being by providing high quality care'. In June 2013, the trust changed its values following a consultation with staff and stakeholders to reflect the Department of Health's 6C's:

- Care
- Compassion
- Courage
- Commitment
- Communication
- Competency

These underpinned the trust's seven objectives and a set of values which were;

- Deliver high quality, integrated and innovative services that improve outcomes
- Ensure meaningful involvement of service users, carers, staff and the wider community
- Be a model employer and have a caring, competent and motivated workforce
- Maintain and develop robust partnerships with existing and potential new stakeholders
- Improve quality of information to improve service delivery, evaluation and planning
- Sustain financial viability and deliver value for money
- Be recognised as a progressive organisation that is about care, well-being and partnership

These were further supported by a quality focussed approach of, 'zero harm' defined by three quality objectives which were included in the trust's annual Quality Account as detailed below:

- Patient Safety: to achieve a continuous reduction in avoidable harm and make measurable progress to embed a culture of patient safety in CWP, including through improved reporting of incidents
- Clinical Effectiveness: to achieve a continuous improvement in health outcomes for people using the trust's services by engaging staff to improve and innovate
- Patient Experience: to achieve continuous improvement in peoples' experience of healthcare by promoting the highest standards of caring through the implementation of the trust's values.

The trust had a number of supporting strategies to their 'zero harm' continuous improvement approach including an integrated governance strategy which was completed in January 2015.

The trust had made a clear statement in their quality account for 2013/14 that the quality improvement priorities would remain unchanged for at least three years and to reflect the recommendations of the Berwick report which promotes a primary focus on better care rather than focussing on meeting quantitative targets. They had not set targets against the three trust quality priorities, instead they stated they aspired to deliver continuous improvement year-on-year through a number of clinical outcomes such as a reduction in the use of restraint, seclusion, incidents, use of agency staff and complaints received with an increase in staff and patient reported satisfaction in survey results.

There was an emerging approach to continuous quality improvement that was yet to fully embed across the whole organisation. However; in many of the clinical areas we visited, the trust vision and values were on display as was a poster with the 'zero harm' strap line of, 'Stop, Think, Listen'. Staff at most levels of the organisation understood the vision, values and quality approach of the trust.

Good

Are services well-led?

The trust has recently begun to use the 6C's values, to support staff appraisals and we found that senior staff and some staff from clinical areas had implemented this approach in practice.

However; there wasn't a clear overriding strategy for the community end of life service, which could result in the service being under- utilised. At Vale House, staff had difficulty explaining their understanding of the trust's vision and values or how they incorporated them into their practice.

Governance

The trust board were accountable for the running of the trust and the overall strategic leadership to the trust. There was a council of governors who provided a link between the communities and board of directors. They understood they held the non-executives to account and provided assurance to members, stakeholder organisations and the public on compliance with the provider licence, the delivery of the strategic direction and the quality of services.

There was a governance structure in place that included six committees that fed directly into the board. These were:

- Audit committee
- Remuneration and nominations committee
- Charitable funds
- Council of governors
- Operational board
- Quality committee

The quality committee was the principal provider of assurance to the board and the operational board. The trust had oversight and assurance of clinical effectiveness, safety and patient experience through the committees and groups that reported into the quality framework.

The trust had developed three separate locality governance structures for East Cheshire, West Cheshire and the Wirral. Assurance was delivered through these locality governance structures up to the board. We looked at a number of minutes from the locality governance groups which took place monthly. The minutes followed a set agenda which included; risk registers, clinical audits, learning themes, complaints and incidents. Each clinical area had local governance meetings which linked into the three localities governance groups. This meant there was a robust governance structure in place which flowed from each clinical area up to the board and back down again.

Staff at team leader/ matron level and above could describe the trust governance structures and understood the reporting structures. Although staff below this level understood their local governance structures, they were not as clear about the overarching trust governance structures.

The trust had a quality improvement project plan to implement the, 'acceleration of restraint reduction' within the trust. Each locality had responsibility for ensuring the implementation of the plan within their locality. The action plan had 23 actions which were detailed, included the name of the person with overall accountability for that action and a target date for completion. The plan was up dated in June 2015. This showed that 15 out of the 23 actions had been completed. Of the eight that were not completed, three were reported to be, 'on-track', three were, 'on-going' and two were 'in progress'.

The trust had recently introduced locality quality data sets at locality, ward and community team levels. The packs included a range of data related to that specific team or ward which included;

• Actions and learning from incidents

• Staffing levels, variance in staffing levels, sickness absence, use of agency

• Number of incidents by type and grade including safeguarding

• Incidents of restraint, rapid tranquilisation and seclusion

• Internal and external a

• Bed occupancy figures, admissions and discharges

• Complaints and outcomes

• Compliance with mandatory training, appraisals and supervision

Team leaders, matrons and ward managers we spoke with told us they found them very helpful in assisting them to gain an overview of how their services were performing, identify areas requiring improvement and trends.

Good

Are services well-led?

However, we found that standards and quality were not being routinely monitored within the forensic service, such as the trust ligature risk assessment and its subsequent management plan, and the requirements to improve identified in the Mental Health Act review report 5 June 2015 had not been communicated to the Saddlebridge Recovery centre team manager who was not on duty during the visit. Ligature risks and blind spots that had not been recognised by the trust were identified during the inspection.

The trust board and quality committee received a, 'lessons learnt report' and quality account quarterly which included a quality data set that highlighted the progress of services against the key quality indicators. This could be broken down to team level. There were plans in place to increase the frequency they received this information to monthly.

This meant the board was provided with an overview of each services performance against key quality indicators every three months which were directly linked to the trusts seven strategic objectives.

However; there were some issues around data quality that the trust was aware of which meant some of this information was not always accurate. For example; figures for staff compliance with appraisal's and mandatory training were low on the board level consolidated quality data set. However, at locality level we were provided with evidence which showed the figures were significantly higher in reality. This meant that the board was being provided with information which showed the trust was underperforming in some areas which was not actually the case. This discrepancy was attributed to issues related to teams not always inputting data onto the information system in a timely manner, issues related to the functioning of the human resources department and systemic problems with the information system. The problems with the information system had been escalated onto the trusts' risk register with actions identified to improve this.

This issue was also raised during a focus group we held with trust governors. Some of the governors had experience of running commercial businesses and told us they believed the quality of data the trust produced was not robust enough to run a business.

Senior managers we spoke with told us that improvements which had been made to the functioning of the human resources department and staff motivation to ensure the new data packs they received reflected the actual activity for their area would improve the quality of information in the packs.

Leadership and Culture

The trust has a staff sickness rate target of 4.5%. At the time of the inspection the trusts sickness rate was 7.64%. Staff sickness was a particular problem at the Saddlebridge Recovery centre in the forensic service. The unit had been open for six months and experienced sickness rates during that period of between nine and 23%. At the time of the inspection the sickness rate was 19%.

The trust had a staff support and psychological wellbeing service and an occupational health department. The wellbeing service was praised in a focus group we held with staff. The trust had a 'promoting healthy minds at work' initiative. This provides support to staff experiencing mental health related concerns or mental health related sickness absence.

In general, morale was good across the services we visited. Staff in teams worked well together within a multidisciplinary framework and reported that they were well supported by their colleagues and managers. However staff at Saddlebridge Recovery centre reported tensions and some conflict within the team. This was related to the application of new operational rules and reduced restrictions. The issues were being managed through supervision with the support of senior management.

In general staff felt engaged with the trust. Not all staff considered senior management to be a visible presence within their service. However they did know who senior management were and reported they received regular emails from the trust. The trust intranet was also identified as a source of information. The national staff survey results showed that 29% of staff reported there was good communication between senior management and staff against a national average of 30%.

However some staff in the East locality told us that they felt like the 'poor relation' within the trust. They did not feel they were as well-resourced as the other two localities. However they acknowledged the role commissioning played in this. In addition staff within end of life care felt there was a disconnect between their service and the trust.

Good

Are services well-led?

There was a perception that the end of life services were seen as an addition to the main focal point of mental health services. We did not see evidence of discussion at board level regarding end of life care provision.

Most staff reported that they were proud to work for the trust. In the friends and family test (quarter 2 2014-2015) 61% of staff said they would recommend the trust as a place to work. This was in line with the national average. In the 2014 NHS staff survey the trust performed in the top 20% for staff recommending the trust as a place to work and for staff agreeing that their role makes a difference to patients.

Staff described an open and honest culture. Staff were aware of the whistleblowing policy and the Speak Up Guardian. They felt able to raise concerns without fear of victimisation. Managers were considered to be supportive and approachable. We saw examples of where staff had been supported following an incident.

We raised a number concerns during the inspection about the delivery of care on Saddlebridge Recovery centre. The trust board were very open in their responses. The trust provided information when requested and attended meetings to discuss concerns. The trust provided action plans and evidence to demonstrate their implementation. The actions looked at increasing the pace of change of culture for the unit in a sustainable manner. For example, senior staff from a neighbouring trust with more secure services had been brought in to support staff. Staff were being offered the opportunity to spend time in the supporting trust to enhance their skills.

Fit and Proper Person Requirement

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

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

We reviewed the personnel records of the 14 senior directors within the trust in line with the FPPR. Only one director had been appointed since the new regulation was introduced.

All 14 senior directors had a completed DBS check, contract of employment, health screening and solvency check and had a signed FPPR declaration form within their individual personnel file. All the files with the exception of one, had copies of references and proof of identification.

There were copies of directors' professional qualifications and evidence of registration with their professional governing bodies in the files. In addition, the files contained application forms or evidence of how the interview process had been adhered to. This meant that it was possible to determine that the interview process had been followed for these appointments in line with trust policy.

We concluded from the evidence we saw that the trust were fully meeting the requirements of the new FPPR regulation at the time of the inspection.

Engagement

We found that patients, families and carers were involved in the planning of their care. Patients we spoke to told us they had a say in decisions around treatment. We saw examples of families and carers being involved and supported to attend appointments, ward rounds and Care Programme Approach (CPA) meetings. The trust had signed up to the 'triangle of care' initiative. The 'triangle of care' approach was developed nationally to improve carer engagement in mental health acute inpatient and home treatment services.

The trust also involved patients in the delivery of care. For example former patients were employed as peer support workers within the adult mental health services. Patients in CAMHS had been involved in developing and delivering training to staff. CAMHS patients had also been involved in the design of a new building through the 'Sloth' patient involvement group.

The trust sought to capture the views of patients, families and carers. There were processes in place to capture complaints and compliments. Several services ran patient

Good

Are services well-led?

community meetings to gather feedback and encourage involvement. Results of the NHS Friends and Family test were discussed and analysed within the governance structure. Meadowbank ward had developed a carers and relatives questionnaire. Results were displayed at the entrance to the ward.

The trust involved patients, families and carers in decision making about the service. A patient/carer governor sat on the trust board and we saw evidence of patient involvement in recruitment.

The trust utilised a range of methods to engage and gather feedback from staff. A series of focus groups had been held including a communication and engagement focus group. Roadshows had been held on a series of topics including the trust's vision and values. Question and answer sessions had been ran across the trust. These gave staff an opportunity to question members of the executive team and senior management. The trust also held Schwartz rounds. Schwartz rounds are a multi-disciplinary format where clinical and non-clinical staff can discuss emotional and social issues that can arise in patient care.

The staff Friends and Family test was completed quarterly (including within the annual staff survey). The trust was reviewing the best way to use this data to generate improvement. In the 2014 staff survey the trust scored better than the national average in five of the categories including staff satisfaction with the quality of their work and patient care. It scored worse than the national average in five categories including good communication between senior management and staff and staff being able to contribute to improvements.

Continuous Improvement

The trust had several core services that had received national accreditations. These were;

- Accreditation for inpatient mental health schemes; Greenways, Oaktrees and Rosewood Unit.
- Electroconvulsive therapy accreditation service; Clatterbridge ECT Clinic.
- Home treatment accreditation service; Wirral Home Treatment Team.
- Memory services national accreditation programme; Chester Memory Service, and West Wirral memory assessment service.
- Psychiatry liaison accreditation network; liaison psychiatry team, Arrowe Park

  Hospital.
- Quality network for forensic mental health service; Saddlebridge recovery centre.
- Quality network for inpatient CAMHS; Maple Ward and Pine Lodge.

This section is primarily information for the provider

Requirement notices

Action we have told the provider to take

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

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Nursing care Treatment of disease, disorder or injury	Regulation 17 HSCA (RA) Regulations 2014 Good governance **Community (physical health) services for children and young people** The service did not maintain accurate, complete and contemporaneous records in respect of each service user. Records were not accessible to authorised people as necessary in order to deliver people's care and treatment in a way that meets their needs and keeps them safe. There was both a paper and electronic record for the majority of children in the service; however, there was no summary within the electronic record to identify historic concerns or issues. We also found that there was no reference in either paper or electronic records to alert professionals that there was another set of records for the child. It was identified that it would take a minimum of four hours for staff to retrieve archived paper records. Managers were not able to give assurance that, staff would be able to identify historic concerns written in paper records and share the information with the relevant services in a timely manner. Safeguarding alerts could not be removed from the electronic record system which meant the system could not be kept accurate with current concerns. **This was a breach of Regulation 17 (2) (c)** **Community (physical health) services for adults** Risks within the organisation were not always identified and those that had been identified were not always managed effectively. The service did not adequately monitor the quality of service provision to identify or manage risks in order to assure people's welfare and safety. **This was a breach of regulation17 (2) (a) (b) (f)**

This section is primarily information for the provider

Requirement notices

Community Mental Health services for older people

The provider had failed to establish and operate effective systems or processes to assess, monitor and improve the quality and safety of the services provided; assess, monitor and mitigate risks to the health, safety and welfare of patients; seek and act on feedback from patients and others for the purposes of evaluating and improving services or to evaluate and improve their practice in respect of processing the information.

We saw little evidence of robust local audits being carried out which could be used to ensure that systems were working and to drive improvement. A safety metrics audit was carried out every two months. However, the completed audit document we saw was not consistent. It scored the quality of care plans, crisis and contingency plans and risk assessments as 'high quality' but it also found that none of the five care plans audited contained goal-based outcomes and in three of the five there were gaps in recording identified risk.

There was a locality (regional) risk register but the teams did not hold local risk registers.

Health of the Nation Outcome Scales (HoNOS) were not being completed consistently. Scores were not collated so that progress could be measured or findings used to drive improvement. Staff told us that as the HoNOS were not being used to measure progress, they did not complete them consistently.

This was a breach of regulation 17 (1); 17 (2) (a) (b) (e) (f)

Low secure forensic inpatient service for adults of working age

On Saddlebridge Recovery centre, there were a number of environmental risks that had not been identified and mitigated against.

Actions identified in plans had not been completed in a timely manner. Some issues had recurred such as low staffing and blanket restrictions which had not been addressed effectively.

Monitoring systems had failed to identify when quality of records or care was not at the required standard.

This section is primarily information for the provider

Requirement notices

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

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

We found that the trust did not operate effective systems to ensure compliance with the regulations. This was due to not acting on feedback from the Care Quality Commission's Mental Health Act monitoring visit reports issued under our duties arising from s120 of the MHA. The trust did not operate effective processes to act on feedback from relevant persons for the purposes of continually evaluating and improving services.

We found at Clatterbridge Hospital Psychiatric Services, Bowmere Hospital and Jocelyn Solly (Millbrook) that:

Despite the trust's provider action statements provided to us following MHA monitoring visits which prescribed the action the trust has or would take to address the concerns found, we continued to find similar concerns relating to adherence to the MHA Code of Practice on this inspection. This led us to judge that the governance arrangements for oversight of adherence to the MHA were not effective.

This was in breach of regulation 17(2)(e)

We found that the trust did not operate effective systems due to poor recording of responsibilities relating to the Mental Health Act. This trust did not operate effective processes and maintain an accurate complete and contemporaneous record of decision taken in relation to care and treatment provided.

We found at Clatterbridge Hospital Psychiatric Services, Bowmere Hospital and Jocelyn Solly (Millbrook) that:

• The recording of rights to detained patients included unnecessary delays in giving rights when patients were first detained, did not include timely action taken to revisit the patient or record further action when a patient had refused the explanation.

• The recording of rights to detained patients did not include considering if patients who may not understand their rights would benefit from being referred to the Independent Mental Health Advocacy service to support them.

We found at Clatterbridge Hospital Psychiatric Services that:

This section is primarily information for the provider

Requirement notices

• The recording of episodes of seclusion did not always include the time the doctor attended seclusion or the cogent reasons if there was a delay in attendance.

• Episodes of segregation did not indicate how regularly the segregation should be reviewed.

This was in breach of regulation 17(1) and (2)(c)

Regulated activity	Regulation
Nursing care Treatment of disease, disorder or injury	Regulation 18 HSCA (RA) Regulations 2014 Staffing **Low secure forensic inpatient service for adults of working age** On Saddlebridge Recovery centre, there were not always sufficient numbers of staff on duty to provide care and meet the needs of the patients. **This was a breach of Regulation 18(1)**

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Treatment of disease, disorder or injury	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment **Community based mental health services for adults of working age** The trust must ensure where people are subject to a community treatment order (CTO) under the Mental Health Act, their rights are read to them as part of their care and treatment so they understand the conditions of the CTO and there is documentary evidence of their rights being read to them. **This was a breach of Regulation 12(1)(2)(a)** **Community mental health services for children and young people** The trust must ensure they consistently assess the risks to the health and safety of service users receiving care or treatment. Some care records did not have comprehensive risk assessments in place for the young people using the service.

This section is primarily information for the provider

Requirement notices

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

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

Wards did not always comply with the Department of Health gender separation requirements. The trust must ensure that care and treatment is provided in a safe way and the premises are used in a safe way.

We found at Clatterbridge Hospital Psychiatric Services, Bowmere Hospital and Jocelyn Solly (Millbrook) that there were two acute wards at each site with acute wards being mixed gender. Ward staff attempted to separate patients of the same gender into different corridors, depending on the gender of the patients admitted. However this was not always possible.

On some wards, bedrooms were not ensuite and on some wards, female patients had to pass a male corridor area to access toilet and bathroom facilities and visa versa.

There were blind spots including in corridors with bedrooms where male and female patients were together.

Not all wards had designated female only lounges.

Care plans and risk assessments did not consider providing care in a mixed gender environment.

We observed a male and female patient going into a bedroom area unobserved by staff.

This was in breach of Regulation 12 (1) and (2) (d)

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983	Regulation 9 HSCA (RA) Regulations 2014 Person-centred care

Low secure forensic inpatient service for adults of working age

On Saddlebridge Recovery centre, care plans did not always show that the patient had been involved in their development.

This section is primarily information for the provider

Requirement notices

Patients were not always asked about their preferences about how care was provided.

Blanket restrictions were in place which were not based on individual risk.

Community based mental health services for older people

The trust had not taken proper steps to ensure that each patient was protected against the risks of receiving care or treatment that was inappropriate or did not reflect their personal preferences.

Of the 11 care and treatment records we looked at, six contained information that was not complete. None of the six records contained a comprehensive assessment of physical health; for example, smoking status, medication and other illnesses were not recorded. We saw another record where a physical need was evident but not addressed. Four records did not record capacity assessments or consent comprehensively. The decisions requiring consent were broad and not specific or timed. One record contained no information in three of five domains for care planning.

Although a safety metrics audit was carried out every two months, the completed audit document was not consistent. It scored the quality of care plans, crisis and contingency plans and risk assessments as 'high quality' but it also found that none of the five care plans audited contained goal-based outcomes and in three of the five there were gaps in recording identified risk.

This meant staff did not have a clear and accurate understanding of individual needs thus may not always be providing appropriate care.

This was a breach of regulation 9 (1)(c) (3) (b) (c) (d)

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983	Regulation 13 HSCA (RA) Regulations 2014 Safeguarding service users from abuse and improper treatment

This section is primarily information for the provider

Requirement notices

Low secure forensic inpatient service for adults of working age

On Saddlebridge Recovery centre, a patient had been kept on seclusion for a prolonged period when records showed the patient was settled.

On Saddlebridge Recovery centre, Patients told us that some staff did not treat them with dignity and respect.

Patient comments boxes, provided by CQC for patients to provide feedback in confidence, had been opened by a member of staff and read in front of a patient.

This was a breach of Regulation 13(1)(2)