Requires Improvement

Worcestershire Health and Care NHS Trust

Quality Report

Isaac Maddox House
Shrub Hill Road
Worcester
WR4 9RW
Tel: 01905 760006
Website: www.hacw.nhs.uk

Date of inspection visit: 19-23 January 2015
Date of publication: 18/06/2015

Core services inspected	CQC registered location	CQC location ID
Acute wards for adults of working age and PICU	Robertson Centre Hillcrest Newtown Hospital	R1AY2 R1APQ R1AX7
Long stay/Rehabilitation for adults of working age	Cromwell House Keith Winter Close Trust Headquarters	R1AAV R1A22 R1AZ3
Wards for people with a learning Disability or Autism	Osborne Court Princess of Wales Community Hospital Ludlow Road	R1ACY R1ACG R1A58
Wards for older people	Princess of Wales Community Hospital Newtown Hospital	R1ACG R1AX7
Community services for adults of working age	Trust headquarters	R1AZ3
Crisis and HBPoS	Trust headquarters	R1AZ3
Community services for children and young people	Trust headquarters	R1AZ3
Community based services for older people	Trust headquarters	R1AZ3
Community LD and Autism	Trust headquarters	R1AZ3

Summary of findings

Adult Social Care	Tudor Lodge	R1A41
Community health services – adults	Kidderminster Health Centre Princess of Wales Community Hospital Droitwich Medical Centre Evesham Health Centre Pershore Hospital Tenbury Community Hospital John Antony Centre	R1A R1AY1 R1A R1A R1AY1 R1AY4 R1AZ3
Community health services – children	Tenbury Community Hospital Princess of Wales Hospital Pershore Medical Centre & Community Hospital The John Anthony Centre Isaac Maddox House	R1AY4 R1AY1 R1AX9 R1AY8 R1AZ3
Community health services – inpatient	Tenbury Community Hospital Evesham Community Hospital Malvern Community Hospital Pershore Community Hospital Princess of Wales Community Hospital	R1AY4 R1AAH R1A96 R1ACW R1ACG
End of life services	The Primrose Unit at Princess of Wales Community Hospital The Macmillan Unit at Evesham Community Hospital	R1ACG R1AAH

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

Summary of findings

Ratings

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

Overall rating for services at this provider	Requires Improvement 
Are services safe?	**Requires Improvement** 
Are services effective?	**Requires Improvement** 
Are services caring?	**Good** 
Are services responsive?	**Requires Improvement** 
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.

During the whole of this inspection, we found that patients, their relatives, staff and senior managers where all willing to engage in an open and frank way.

We rated this provider requires improvement and although we found areas of good practice across most care areas there are some patient safety issues that need to be addressed. At times, the trust did not provide effective care that met the standards of recognised good practice and some teams were not always responsive to the needs of patients and their carers.

Across the mental health services some good standards of patient safety were achieved however, we found unmanaged ligature risks on Harvington ward and in the rehabilitation units. While the service had carried out a ligature risk assessment, they had in some cases, taken no action to address the identified risks. On Keith Winter and Cromwell House there was some confusion about the expectation to address this and the inspection team found an inconsistency of approach to managing ligature risk in this area.

Some teams there had taken an innovative approach to tackling the problems of unsuitable ward environment by using mirrors to enable staff to have improved sight on some ward this was not in place. On Harvington ward there was restricted sight throughout the area to ensure effective patient safety.

In most areas medicines were managed safely however, there were some instances where we found unsafe practice. We found minor concerns across a range of settings including non-adherence to the policy for self-administration and inappropriate or inadequate storage and record keeping.

There was an inconsistent approach to training, ensuring staff understood their responsibilities regarding the Mental Capacity Act (MCA), and in some areas the Mental Health Act (MHA) which was relevant to their role. However, there was high adherence to mandatory training. We found that staff carried out treatment and care in line with recognised evidence based practice.

The care provided by this trust, with the exception of one ward, was of a good standard and we found that the services were well led in most core services with strong senior leadership driving through change and developments. The teams worked to uphold the values and vision of the trust and provide good care for patients.

Across the community health services, we found overall, the services were delivered to a good standard, with the exception of two patient safety concerns at each of the two injuries units where we found an unsuitable mattress, equipment not maintained and inappropriate storage of hazardous products.

We found in the community inpatients wards that arrangements to minimise risks to patients were in place with measures to prevent falls and pressure ulcers. We saw evidence of good practice including the use of safety dashboards; clean clinical areas and good infection prevention and control practice.

In the end of life services, we found a new audit process, delivered by peers, was producing a new energy and motivation about fundamental aspects of nursing care such as infection control, record keeping, risk assessment and medicines management.

We had positive feedback from patient, carers and we saw that interventions were delivered in a sensitive and dignified way. There were some exceptions to this and in Harvington ward, we found that staff were not able to respond to all patients in a timely manner.

Complaints were handled effectively the feedback and learning was shared at local level and via the executive team if necessary. Trust premises were, in the main, accessible for patients. Interpreters were available and staff knew how to access the service if needed. The inspection team noted that information was available to patients and carers in a range of languages.

Across all core services, staff knew how to support people who wanted to make a complaint.

Summary of findings

However, access to treatment in some core services was not responsive to patient need. In the CAMHS and community mental health service, we found long wait times to access some treatments.

The trust displayed the vision, values and strategy across the wards and patients areas. The staff told us the senior leadership had high visability and welcomed the patient safety walkbouts carried out by the chair and the chief executive.

Staff morale, in the main, was good and staff told us that they felt it was a good place to work. Mostly, we saw services being well led at local level and staff teams felt supported in their role.

The trust were keen to learn from incidents and feedback and showed a commitment to improving practice by participating in a range of external peer review and service accreditation schemes. The trust were keen to improve their record on staff appraisal and discussed this with the inspection team as a priority action for the coming year.

Overall, the inspection team found the trust had some issues that needed to be addressed but that the leadership and senior team were best placed to make the changes required.

Mental Health Act responsibilities

The governance structure for the monitoring of the Mental Health Act (MHA) was undertaken by the MHA Monitoring Group which was chaired by a non-executive director and attended by further non-executive directors and associate managers. MHA governance is separate from the wider governance arrangements, resulting in a lack of a consistent approach to auditing and monitoring of the MHA. The MHA monitoring group does not have any representation from the quality team but does report into this group. However, this does not allow the rich data available from the independent group of managers to be fed into the quality governance or patient experience. There is an annual MHA report to Trust Board

The MHA administration team clearly demonstrated their roles, systems and processes. The team members could provide a clear outline of their arrangements for assuring the powers and duties of the MHA are completed. The MHA administration team were very clearly focused on documentation for admission, renewal and hearings.

Other statutory papers were seen to be outside their scope, including checks on consent to treatment forms and section 17 (leave of absence) forms. These documents therefore did not receive any review or scrutiny beyond the clinical team.

Issues identified on the wards are detailed later in the report.

Mental Capacity Act and Deprivation of Liberty Safeguards

Knowledge and practice of the Mental Capacity Act (MCA) was variable. Some staff where well informed about their legal responsibilities under the MCA which was reflected in practice.

In older people's services, staff were aware that capacity could fluctuate and that lack of capacity in one area did not mean capacity was restricted in other areas. Patients were involved in their care and we observed on a number of occasions that staff obtained verbal consent before carrying out any interventions.

People were supported to make decisions where appropriate and when they lacked capacity, decisions were made in their best interests, recognising the importance of the person's wishes, feelings, culture and history. There were records of best interests meetings in some patient files. In some teams, MCA assessments were discussed in multi-disciplinary meetings.

However, some consent to treatment forms were signed by carers when it had been assessed that a patient lacked capacity to consent. This would only be lawful if the carer had lasting power or attorney for personal welfare which was not evident in the notes.

Staff's knowledge and understanding of the Mental Capacity Act was less evident in some of the inpatient services and rehabilitation team. In some teams staff felt they did not have any responsibility under the MCA and did not know how the legislation applied to their work with patients. It appeared that some staff had a limited understanding that capacity was linked to specific decisions and some records showed that where it was assessed that the patient lacked mental capacity this was for all decisions the patient would make.

The trust informed us that MCA training was covered in safeguarding training and not a mandatory requirement for staff. Records seen demonstrated that in some

services training in the MCA and DoLS formed part of the locally agreed training programmes, but in other services it was not monitored. Some staff were not able to tell us who they would contact as the lead person on MCA within the trust

Issues identified on the wards are detailed in the core services report.

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 adult mental health services, we identified 3 teams where actions following on from ligature risk assessments were still awaiting action.
- The trust recognise the issues with some estate buildings however, the inspection team are concerned that mitigating actions had not been taken to address known risks. Across the mental health acute care wards, there was impaired vision so that patients could not be monitored safely.
- We found minor concerns across a of range settings regarding medicines management including non-adherence to the policy for self-administration and inappropriate or inadequate storage and record keeping.
- Where a risk to patient's safety was identified there are often prolonged delays before the matter is redressed. Staff told us on several occasions that risks noted by the inspection team had been reported and in one case as far back as June 2014.

However, inspection teams found that reporting and learning from incidents was adopted throughout the trust and staff were very positive about the benefits of the electronic reporting system.

Staff were able to tell us about the duty of candour regulations and we saw staff incorporating the principles into their team meetings demonstrating open and honest discussions. We saw examples of incidents when patients and families have had the outcome of investigations shared with them.

Staffing levels for inpatient wards are monitored and maintained centrally by the trust. The trust was ensuring safe staffing levels in inpatient services and where needed using temporary staff. The trust was actively recruiting staff to vacant posts. They had identified a staffing challenge in CAMHS and inpatient services and had taken steps to address these issues.

Please refer to the 'Actions we have asked the provider to take' section of the report.

Are services effective?

Requires Improvement

We rated effective as **requires improvements** because:

- There was inconsistency in the obtaining and recording of consent across the services for both adults and children.

Summary of findings

- Overall, staff did not show that they had a good understanding of the Mental Capacity Act (MCA) and Deprivation of Liberty Safeguards (DOLS).
- In two core services, staff did not always use the Mental Health Act and the accompanying Code of Practice correctly.
- Staff supervision had not been taking place regularly and consistently across all services.
- The trust recognised there is a risk in relation to record keeping and information sharing, with the range of electronic, paper based systems in use. Staff teams face an additional challenge regarding storing records and access particularly out of hours. This was not effectively managed across all core services resulting in varied level of risk.

However, we found there is widespread adherence to interventions and practices that were evidence based and all staff had regular training so that they provided care safely. Completion rates for mandatory training ranged from 94.92% - 86.75%. In most locations, clinical audits were carried out regularly to monitor the effectiveness of the service. We saw good multi-disciplinary and inter-agency working across most teams and at a senior level. Care records, across the mental health services, showed that physical examinations had been undertaken and that there was ongoing monitoring of physical health problems.

Please refer to the 'Actions we have asked the provider to take' section of the report.

Are services caring?

Good

We rated caring as **good** because:

- The inspection team saw patients were treated with dignity and respect. Staff showed a good understanding of individual needs on the basis of gender, race, religion, sexuality, ability or disability.
- The majority of feedback we received from patients, families and carers was positive and they spoke highly of the care they were given.
- There were good examples of engaging patients in care planning across the core services
- The palliative care and older persons' team were told by families the care is of an 'excellent standard'.
- Access to advocacy services was available and promoted across the wards

Summary of findings

However, we found that due to staffing pressures some patients in Harvington told us that staff were always too busy to spend time with them and there were often no staff present in the ward area.

Some patients raised concerns regarding privacy of some environments.

Please refer to the 'Actions we have asked the provider to take' section of the report.

Are services responsive to people's needs?

Requires Improvement

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

- A blanket restriction was applied on Harvington ward that prevented patients using the canteen.
- The environment in Harvington did not promote patients recovery. On Harvington and Holt ward it was cold and staff could not control the heating.
- Young people often experienced long wait times for treatment. Young people using crisis services did not always have an assessment by appropriately skilled staff.
- There were no agreed waiting times for urgent and non-urgent referrals across adult community mental health teams. This did not promote equity for people waiting to be allocated a named worker and commence the treatment process. In addition, there were long waiting lists and times for psychological interventions.

However, we found examples of robust bed management systems in place and people did not often move between wards in the mental health services.

In the community health inpatient ward, services had been developed to ensure the local population could access care and treatment as close to home as possible.

Trust premises were, in the main, accessible for patients. Interpreters were available and staff knew how to access the service if needed. The inspection team noted that information was available to patients and carers in a range of languages.

Across all core services, staff knew how to support people who wanted to make a complaint.

Please refer to the 'Actions we have asked the provider to take' section of the report.

Are services well-led?

Good

We rated well-led as **good** because:

Summary of findings

- We saw that the trust values and vision were prominently displayed and staff were working to uphold these values.
- We noted that high visibility of the chief executive and the chair and most staff knew who they were. Staff spoke positively about the executive walkabout and welcomed their involvement at ward, unit or service level.
- The vision and overall direction of the trust was coherent and clear. There were effective governance arrangements for the identification of risk and systems were in place for the measurement of quality and patient safety.
- The senior leadership was well respected and there was a clear emphasis patient feedback to improve performance. There was a culture of compliance and continuous improvement.
- The trust rewards and recognises achievements by staff either individually or as a team.
- The trust participated in a number of external peer review and service accreditation schemes.
- Across the trust, staff were positive about their experiences of working in the service. They reported that they felt confident in and supported by their colleagues and managers.

However, we found low morale in some areas. Some staff expressed concern about change and not feeling listened to when they raise concerns. There was evidence in some areas that where risks and issue had been identified these were not always addressed and actioned appropriately. The strategic approach to long term risk management was underdeveloped.

Please refer to the 'Actions we have asked the provider to take' section of the report.

Summary of findings

Our inspection team

Our inspection team was led by:

Chair: Dr Ros Tolcher, Chief Executive, Harrogate and District NHS Foundation Trust

Head of Hospital Inspection: Pauline Carpenter, CQC

Team leader: Ken Jackson, inspection manager, CQC & Jo Naylor-Smith, inspection manager, CQC

The mental health inspection team included CQC inspectors and a variety of mental health specialist such as consultant psychiatrists, nurses and social workers, and allied health professionals. Teams who visited services also included experts by experience and Mental Health Act Reviewers.

The community health focussed team included a range of professionals with specialist knowledge of palliative and end of life care, children's health care and adult community health services.

In total, there were 75 members of the inspection team on site.

Why we carried out this inspection

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

How we carried out this inspection

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

- 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 Worcestershire Health and Care NHS Trust and asked other organisations to share what they knew. We met with representatives from other organisations including commissioners of health services and local authority personnel.

We held listening events in the local communities and reviewed 226 comment cards completed by patients, carers and staff.

We carried out announced visits on 20, 21, and 22 January 2015. An unannounced inspection was carried out on 28 January 2015.

During the visit, we held focus groups with a range of staff who worked within the service, such as nurses, doctors, psychologists, allied health professionals, and administrative staff. We spoke with over 256 individual staff members including managers of the core services. We met with over 27 managers and service leads.

We held structured interviews with all executive directors and met with the chair and some non-executive directors who had specific roles in chairing key committees.

We met with in excess of 65 people who use services who shared their views and experiences of the core services we visited. We observed how patients were being cared for and talked with over 33 carers and/or family members. We reviewed more than 196 care or treatment records of service users. We looked at a range of records including clinical and management records, policies and procedures, performance reports and training records.

We observed a range of staff meetings including handovers, ward rounds and multi-disciplinary meetings. We carried out structured observations of staff interactions with patients, families and relatives. We reviewed the clinical environments, staff rooms and other

Summary of findings

trust areas. We looked at the safety of the equipment, medicine and records storage to ensure it was fit for purpose. In the community health services, we went with some district nurse carrying out home visits.

During the inspection week, we carried out an unannounced inspection of Tudor Lodge. Tudor Lodge is registered to provide adult social care services and was inspected using the methodology designed for inspecting this sector. The rating provided for this service are not included in the aggregated rating for the trust.

Information about the provider

Worcestershire Health and Care NHS Trust was established on 1 July 2011 in response to the Department of Health's 'Transforming Community Services' initiative.

The trust manages the vast majority of the services that were previously managed by Worcestershire Primary Care NHS Trust's Provider Arm, as well as the mental health services that were managed by Worcestershire Mental Health Partnership NHS Trust which is now dissolved.

The organisation now provides services from more than 125 sites with an income of about £179.2 millio. They employ more than 3924 staff.

Community and mental health services are provided to a population of approximately 560,000 across Worcestershire's 500 square miles. This covers the city of Worcester together with the towns of Bewdley, Bromsgrove, Droitwich, Evesham, Kidderminster, Malvern, Pershore, Redditch, Stourport, Tenbury Wells and Upton-Upon-Severn.

Worcestershire Health and Care NHS Trust are aspiring to become a Foundation Trust.

The trust works closely with the three local Clinical Commissioning Groups (Redditch & Bromsgrove, Wyre Forest and South Worcestershire), Worcestershire Acute Hospitals NHS Trust, and Worcestershire County Council.

The trust provides the following core services:

Mental health inpatient wards

- Acute wards for adults of working age and psychiatric intensive care units.
- Long stay/rehabilitation mental health wards for working age adults.
- Wards for older people with mental health problems.
- Wards for people with learning disabilities or autism.

Community-based mental health and crisis response services

- Community services for adults of working age
- Mental health crisis services and health-based places of safety.
- Specialist community mental health services for children and young people.
- Community mental health services for people with learning disabilities or autism.
- Community based services for older people

Community health services

- Community health services – adults
- Community health services – children, young people and families
- Community health services – inpatient
- End of life and palliative care services

Adult social care

- Tudor Lodge

In addition the trust also provides specialist primary health services which were not included in this inspection.

Worcestershire Health and Care NHS Trust have been inspected 10 times since registration. Out of these, there have been 5 inspections covering 22 locations that are registered with CQC.

HMP Hewell is the only location in the trust where one standard is non-compliant

Summary of findings

What people who use the provider's services say

During the inspection

We spoke with more than 64 patients during our inspection. The majority of the patients we spoke with were happy with the quality of the care and treatment they were receiving and with the approach of the staff. They told us that they felt involved in decisions about their care. We include their comments in the core service reports.

Community Focus Groups

Before the inspection, we held two hosted focus groups. We did this to enable people who use or have used the services provided by the trust, to share their experiences of care. The focus groups provided a wide range of responses to the five questions we always ask about services.

A focus group event held on the 7 January in Redditch which was hosted by Healthwatch. Members of the public who had used Worcester Health Care Trust Services were invited, however this event was not advertised to the general public. Eight people attended some to discuss their own care and others represented charities or volunteer groups in the area. Services that people wanted to discuss were the CAMHS service in Redditch, which was described as difficult to access and housed in a poor environment, and the John Anthony (sexual health service) which was reported to be very accessible and friendly and provided a good confidential service.

We met with a range of people in 8th January in Worcester. In total 9 people attended and gave feedback about services provided in mental health and learning disabilities. In the learning disabilities services, people told us they did not got the support they needed from the community team and that information is not available to people about access to services or which services are available. In the mental health services, we were told there was lack of beds and added pressure on reduced services. Some people felt that information about services and access to specialist treatments was unclear. Some people told us that there was poor discharge planning.

Comment cards

Before the inspection we left comment cards in various places throughout the trust. People were able to share their experiences of the trust services. People posted their comments in sealed boxes that we opened and looked at as part of the inspection.

We placed comment boxes in 46 locations. 226 comment cards were received, 60 of which were in 'easy read' format.

Thirty seven locations had positive comments for the caring domain and 12 locations had negative comments for the responsive domain.

The main theme in negative comments were staff shortages. The comments were from both staff and patients. Other issues raised included: staff unable to meet all demands and not always being available. Staff commented that they did not feel listened to and there was with low morale and high stress levels.

This information informed our site visit and we used this as a key line of enquiry to corroborate the feedback received.

Good practice

We noted **good practice** in the following areas:

- The stroke team had created an information pack for people diagnosed with stroke. The information pack is made up of three books that covered; being diagnosed and learning about stroke, rehabilitation and life after stroke. We saw that the books were in an easy to read format with pictures as visual aids.
- In the Wyre Forest community mental health team, a pilot initiative was identified to reduce referrals from GP to secondary services. A CPN was located in GP surgery to assess and screen all referrals. They were involved in counselling people or referring people on to primary care to receive cognitive behavioural

Summary of findings

therapy. This had proved to be successful with a reported reduction of referrals from 19% to 10% over a two year period. This initiative had been supported by the clinical commissioning group (CCG) and GPs.
- The early intervention lead for the trust led on a physical health project 'SHAPE' through joint working with a local university. The aim was to support young people experiencing a first early psychosis through a physical health and wellbeing intervention programme. There was internal recognition of good practice as staff had been involved in research published trials.
- A 'Young Person's Board' had been created and was helping shape service delivery throughout the children's service.
- We saw good integration of physical and mental health work to the benefit of people using the older people's service. We noted this particularly in the Evesham team.
- The rehabilitation and long stay wards had employed peer support workers, with lived experience, trained in mental health to offer support, share ideas and skills.
- In the community health inpatient wards, we saw good multidisciplinary and integrated working taking place, which clearly placed the patient at the centre of care.

Areas for improvement

Action the provider MUST or SHOULD take to improve

Action the provider MUST take to improve

- All staff working in the mental health acute and rehabilitation wards must be clear about the steps they need to take to reduce the risks of ligature to patients.
- Action must be taken to reduce blind spots in the wards so that staff can observe patients in all parts of the ward.
- There must be sufficient staff in Harvington ward to safely meet patients' needs.
- There must be systems in place to ensure that patients' capacity to consent is assessed and their human rights are respected in all cases.
- Heating systems on all wards must be sufficient to assure patients comfort, safety and wellbeing.
- Trust managers must ensure that staff follow the 'Self-Administration of Medicines Policy' by carrying out a risk assessment to identify risks posed to that individual and other patients living at the unit so that medicines are kept safe and secure.
- The trust must review its contingency arrangements for sickness and absence in staffing to ensure young people in CAMHS receive assessment and treatment without long delays.
- The trust must review its procedures for assessing and monitoring environmental risks to ensure that young people's health and safety is maintained.
- The trust must, in light of planned IT changes, review the current IT/paper records system and should look at ways of improving access to all records including out of hours.
- The trust must review its provision of crisis services for young people to make sure that young people using crisis services have an assessment by appropriately skilled staff in a timely way.
- The trust must ensure that all medicines that it is responsible for are properly recorded and stored safely.
- The trust must ensure that all equipment is reviewed regularly and appropriately maintained
- The trust must review all mattresses to ensure they are fit for purpose.
- The trust must ensure that all cleaning materials are suitably stored.

Action the provider COULD take to improve

Action the provider SHOULD take to improve

- The trust should ensure that 'The Healthy Child Programme (2009)' is delivered across all schools.
- The trust should consider that all information regarding performance was readily available to managers and staff on the units.
- Staff should make sure that all patients have copies of their care plans.
- The service should ensure that the lone working policy and use of panic alarms are embedded across the service.

Summary of findings

- The trust should ensure that all staff receive clinical supervision.
- The trust should ensure that there is consistent approach to receiving feedback from people who use the service.
- The trust should monitor the training that all staff receive in MCA and DoL's.

Worcestershire Health and Care NHS Trust

Detailed findings

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

We rated safe as requires improvement because:

• In adult mental health services, where ligature assessment had taken place three teams had taken no action to address or in some cases mitigate the risks identified.

• The trust recognise the issues with some estate buildings however, the inspection team are concerned that mitigating actions had not been taken to address known risks. Across the acute care wards, there was impaired vision so that patients could not be monitored safely.

• We found minor concerns across a of range settings regarding medicines management including non-adherence to the policy for self-administration and inappropriate or inadequate storage and record keeping.

• Where a risk to patient's safety was identified there are often prolonged delays before the matter is redressed. Staff told us on several occasions that risks noted by the inspection team had been reported and in one case since June 2014.

However, inspection teams found that reporting and learning from incidents was adopted throughout the trust and staff were very positive about the benefits of the electronic reporting system.

Staff were able to tell us about the duty of candour regulations and we saw staff incorporating the

principles into their team meetings demonstrating open and honest discussions. We saw examples of incidents when patients and families have had the outcome of investigations shared with them.

Staffing levels for inpatient wards are monitored and maintained centrally by the trust. The trust was ensuring safe staffing levels in inpatient services and where needed using temporary staff. The trust was actively recruiting staff to vacant posts. They had identified a staffing challenge in CAMHS and inpatient services and had taken steps to address these issues.

Please refer to the 'Actions we have asked the provider to take' section of the report.

Our findings

Track record on safety

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

A never event is classified as such because they are so serious that they should never happen. Trusts have been required to report any never events through STEIS since April 2011.The trust had not reported any never events through STEIS.

From the data analysis, the majority of incidents reported via STEIS were developed category 3/4 pressure ulcers. The highest number of serious incidents were regarding the district nurse Redditch cluster service (6%) and were all developed category 3/4 pressure ulcers that occurred mainly within a community setting. This figure includes avoidable and unavoidable pressure ulcers.

Of 272 serious incidents 149 incidents relate to grade 3/4 pressure ulcers, 65% of the 20 abscond incidents were regarding patients failing to return from section 17 leave.

Seventy eight percent of the incidents reported on STEIS have been closed, however 13 of the 272 serious incidents are overdue their 45 day investigation deadline at the point of data collection.

5585 incidents were reported to the National Reporting and Learning System (NRLS) between 1st November 2013 and 31st October 2014.

The incident category that was most frequently report was "implementation of care and ongoing monitoring/review" followed by 'patient accident'.

There were 47 incidents categorised as deaths during this period. Of those deaths unexpected death of community patient (in receipt of care) 13, unexpected death of outpatient (in receipt of care) 11, death in custody 8, unexpected death of inpatient (not in receipt of care) 5, unexpected death of inpatient (in receipt of care) 3, unexpected death (general) 6. The majority of patient deaths were people who were known to have committed suicide or suspected to have committed suicide.

Eight safeguarding concerns and one safeguarding alert have been raised with the CQC in the last 24 months.

Learning from incidents

From the data analysis, none of the indicators relating to reliable systems, processes and practices for safety and safeguarding were flagged as potential risks.

The trust had in place an electronic system of recording safety incidents, which, the staff group reported, had a positive impact on patient care. Most staff said the data generated was used to inform practice and improve care. Incident reporting was discussed at team meetings and meeting minutes confirmed this.

Board summaries and minutes reviewed showed that there was appropriate levels of scrutiny of serious incidents and lessons learnt by the trust board. The quality and risk committee, chaired by non-executive director, reviewed themes and lessons learnt on a quarterly basis and reported by exception to the board. This learning was cascaded to the staff by regular email and alerts and newsletters.

Safeguarding

There were clear safeguarding policies and procedures in place that staff understood and were easily accessible. Staff knew who they should speak with if required. Staff received training on safeguarding adults and children at the required level for their role and responsibilities. At the time of our inspection, 93.25% of staff had received safeguarding adults training and 94.17% had received training in safeguarding children. Staff were able to describe what actions would constitute abuse. They were able to apply this to patients and described in detail what actions they were required to take in response to any concerns.

Detailed findings

Assessing and monitoring safety and risk

The current data collection and assurance systems were resource intensive and an IT solution was being sourced which will provide greater confidence and quicker response to the identified need. We were told there are currently assurance systems in place which the trust recognise need to improve including better articulation of the procedures and processes to provide greater assurance and transparency.

Each service delivery unit (SDU) had identified quality leads that are responsible for incidents, risks, audits, policies and ensuring investigations are completed. They also represent the SDU at the quality forums. The quality forum meets bi-monthly and helps share learning across the trust.

Action logs are in place for complaints and serious incidents. This includes a tracker for the action plans with a central log available. This is overseen by the quality leads who work with others to make sure actions are up to date and learning is shared.

Monitoring takes place via a centrally produced dashboard that is split by service line. The quality lead can drill into the report to look at the individual details for different teams and areas.

Each SDU had access to the risk register to monitor and mitigate identified risks and discuss themes at monthly meetings. Managers and team members know how to escalate risks through the quality forum to trust board.

We saw evidence that each ward assessed ligature risk however, identified issues had not all been redressed in Harvington ward, Cromwell House and Keith Winter Close .

The trust had taken action to address some of the ligature risks identified, such as changing windows and replacing wardrobes and making the environment ligature free. It was not clear when plans to reduce other identified ligature risks would be implemented. Managers told us that it was a long process to get funding agreed and ratified. There was some confusion regarding the need to be ligature free on Cromwell House and Keith Winter Close. The ligature assessment was undertaken, and risks noted with some changes implemented however, the manager felt that as the patients had access to the community they did not need to address all the ligature points identified in the audit. This position is in conflict with actions taken to make the areas ligature free.

The layout of some wards did not allow staff to observe all parts of the ward. Mirrors had been installed in Hillcrest to reduce these risks but this had not been implemented Harvington ward which had a similar challenge.

The trust had reliable systems in place to prevent and protect people from a healthcare-associated infection. There was a policy and associated procedures in place. We saw evidence on the wards of infection control audits taking place. We also saw that cleaning schedules were in place to support routine cleaning daily and ad hoc basis. The wards were generally in a good state of repair and cleaned to a good standard. However, within the minor injuries unit at the Princess of Wales hospital we found a torn mattress which had been in use since June 2014. This created an infection control risk to people who use the service.

We found that 91.08% of staff were up to date with their infection control training in September 2014.

The pharmacy team, which includes Lloyd's pharmacy, provide advice, training and support to ensure safe management. Medicine incidents are reported, risk assessed and lessons learnt which are shared across the trust. This is achieved through training, newsletters and meetings. However, the inspection team found minor concerns regarding medicine storage in Wardon clinic that could not produce an accurate record of medicines received or taken out by staff. In John Anthony Centre, there was no monitoring system in place for prescription use. There was no risk assessment in place to support the self-administration of medicines at Cromwell house. In addition the trust were informed during our inspection the controlled drug books used did not comply with best practice guidance and took steps to address this.

Overall, we saw that staffing levelson the wards were safe. Staffing levels for inpatient wards are monitored and maintained by the trust. The trust were ensuring safe staffing levels in inpatient services and where needed was using temporary staff. The trust was actively recruiting staff to vacant posts. The trust identified a staffing challenge in CAMHS and inpatient services. There was a 16% staff vacancy and an additional impact of staff sickness across the CAMHS teams. The CMHT expressed concern about the over use of bank and agency staff to cover posts. This issue is of immediate concern as there is a widespread belief that the funding for these posts stops in April.

Detailed findings

From the intelligence monitoring there were no indicators related to staff fill rate flagged as potential risks.

Potential risks

We found cleaning materials within the minor injuries unit were not stored appropriately as required under the health and safety guidance. We found the Princess of Wales hospital was not adhering to safety regulations for the control of substances hazardous to health. Chlorine-based cleaning materials were stored in an unlocked cupboard in a room accessible to people who use the service.

Emergency equipment, including automated external defibrillators and oxygen, was in place in clinical areas. Staff checked the emergency equipment in line with the trust policy to ensure it was fit for purpose and could be used effectively in an emergency. Staff were trained in its use and local systems were in place to maintain staff safety.

The trust recognised there have been challenges surrounding disparate processes and systems inherited from legacy organisations and that there is no consistent medical device log in place. At the time of the interview, no risk to staff was deemed to be present. The risk highlighted is in relation to the infrastructure

The trust had good lone working policies and arrangements however these were not embedded across all teams.

Overall, the trust had adhered to national guidance on same sex accommodation (SSA) with the exception of some learning disability respite units that did not provide separate lounge for male and female patients.

Requires Improvement

Are services effective?

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

Summary of findings

We rated effective as requires improvements because:

• There was inconsistency in the obtaining and recording of consent across the services for both adults and children.

• Overall, staff did not show that they had a good understanding of the Mental Capacity Act (MCA) and Deprivation of Liberty Safeguards (DOLS).

• In two core services, staff did not always use the Mental Health Act and the accompanying Code of Practice correctly.

• Staff supervision had not been taking place regularly and consistently across all services.

• The trust recognised there is a risk in relation to record keeping and information sharing, with the range of electronic, paper based systems in use. Staff teams face an additional challenge regarding storing records and access particularly out of hours. This was not effectively managed across all core services resulting in varied level of risk.

However, we found there is widespread adherence to interventions and practices that were evidence based and all staff had regular training so that they provided care safely. Completion rates for mandatory training ranged from 94.92% - 86.75%. In most locations, clinical audits were carried out regularly to monitor the effectiveness of the service. We saw good multi-disciplinary and inter-agency working across most teams and at a senior level. Care records, across the mental health services, showed that physical examinations had been undertaken and that there was ongoing monitoring of physical health problems.

Please refer to the 'Actions we have asked the provider to take' section of the report.

Our findings

Assessment and delivery of care and treatment

The trust had an effective clinical audit strategy in place which was monitored by the quality committee and fed into the trust board. The trust participated in national audit and had CQUIN targets for the upcoming year. Three national audits were completed. Local audit programmes were in place that were linked to local National Institute for Clinical Excellence (NICE) compliance, local risk, complaints and trends identified through incident reporting.

Over the last 18 months, the trust have been performing at a very similar rate to the national average for the proportion of admissions to acute wards gate kept by the CRHT team. In last 6 months, the local rate has risen to 0.8% above the national average.

Across the core services, we saw a range of local audits and programmes underway that informed practice. However, in some cases this information was not used to create change. The ligature audits carried out in on some mental health wards did not result in action to deliver change.

We saw examples of care delivered in line with the NICE guidelines in a range of core services. CAMHS referrals were made to the single point of access team (SPA) and staff were using the 'Choice and Partnership Approach'.

Most care records contained up to date, personalised, holistic and recovery-oriented care plans. Where people's needs had changed or input from other professionals had identified changes, treatment plans were updated in a timely manner. Assessments and care plans were completed with systems for ensuring these were updated as needs changed.

The early intervention lead for the trust led on a physical health project called SHAPE through joint working with the local university. The aim was to support young people experiencing a first early psychosis through a physical health and wellbeing intervention programme. There was internal recognition of good practice as staff had been

involved in research published trials. People using the service were offered a SHAPE referral and this covered for example, smoking cessation and the development of a health passport.

It is of note, that liaison meeting minutes with the acute trust, detailed that the Mental Health Liaison Team was not always assessing young people out of hours and these young people were sometimes admitted to acute wards. Young people are not assessed in a timely manner by CAMHS professionals and delay experienced in some cases.

In the crisis and health based place of safety service, we saw good crisis care plans that included what family should do information to ensure safety and out of hours support which showed people's involvement in care plans and goal attainment.

The Robertson Centre was rated 87.18% for food in the 2014 PLACE scores – lowest score compared to other locations. However, in the community inpatient wards we found that protected meal times took place on all the wards we visited. This allowed patients to eat without being interrupted and meant staff were available to offer assistance were required and patients told us that the food was of good quality and that they had plenty to eat and drink throughout the day.

Outcomes for people using services

The trust has taken part in national benchmarking groups including MH Benchmarks, community FT's and West Midlands quality review.

Intelligence monitoring of current legislation, standards and evidence-based guidance indicators show no risk.

The use of the HBPoS had led to a significant reduction in the use of the police station as a place of safety within the last 12 months, only 8% of Section 136 detentions were taken to the police station. Work was ongoing with the police to reduce this from happening at all, resulting in no use of police stations for the last three months prior to our visit.

From the data the trust provided we were aware that a single point of access (SPA) has been launched for adult mental health community teams in south Worcestershire with the aim of creating a seamless transition of care. Where teams did not work to a single point of access system, referrals were triaged by a 'duty' member of staff who ensured that people's needs were established through an initial meeting and assessment process. Urgent referrals were identified and prioritised for assessment. Staff we spoke with described the inefficiencies of not having a gatekeeper for referrals in teams that did not operate on the SPA model.

CAMHS redesigned service has led to reduced waiting times for a first appointment from 18 weeks to five weeks. Seventy eight percent of children reported that their difficulties were "much better" or "a bit better" since receiving services.

Harvington Ward – Robertson Centre Kidderminster, had the highest number of readmissions with 90 days (20).

Malvern Ward – Malvern Community Hospital had the highest number of delayed discharges in the past six months (24). We found that patients sometimes remained in hospital after they had been assessed as 'medically fit for discharge'. This was usually due to delays in the local social services being able to arrange suitable packages of care, particularly when complex needs are identified

Primrose Ward – Princess of Wales Community Hospital had zero delayed discharges and re-admissions in 9 days of the last six months. Information provided showed the average length of stay for patients at the community hospitals was 22 days, compared with the national average of 28 days.

Staff skill

The trust told us the 5-year workforce strategy informs its annual workforce plan. While required to make cost improvement savings the trust gain assurance that posts lost are not adversely impacting on patient care through monitoring at quality impact and equalities group.

The workforce plan, informed by the clinical commissioning groups, ensures the staff skill mix meet the need of local services. The trust works with Health Education West Midlands and the University of Worcester.

Recruitment of suitable staff is an ongoing issue particularly CAMHS and inpatient services. We saw details of a new recruitment campaign. The trust ran a rotational scheme for Band 5 occupational therapists across the services. This scheme offered them the opportunity to consolidate skills learnt in training and to experience a

range of practices prior to specialisation. The aim of the rotational scheme is to develop a range of clinical skills across the health and community teams whilst developing effective, competent staff.

Overall, there was a suitable mix of qualified and unqualified nurses on duty. However, we found that at times, staffing levels impacted on outcomes for detained patients. This meant that planned activities and section 17 leave could be cancelled at short notice so patients could not always leave the ward as planned. Psychology input was limited in some mental health ward areas as there was only one clinical psychologist across the mental health acute wards and PICU.

Across the trust, we saw evidence of staff receiving effective induction, mandatory training, regular supervision, appraisals and team meetings, with some exceptions. On Athelon, ward staff told us they were well supported, but they had recently not received regular supervision, owing to the manager's time being prioritised in ward shifts.

In the learning disabilities, service staff with specialities shared their knowledge across the teams. For example, a behavioural nurse specialist worked across all of the teams to give expertise and guidance.

Records showed that most staff were up-to-date with statutory and mandatory training. Staff had received an annual appraisal and said the format of this had changed so it was more useful and supportive to their role. There was recognition by the trust that there are improvements to be made to ensure that themes from appraisals inform the training plans.

Multi-disciplinary working

There was evidence at strategic level of working with partners to resolve countywide pressure within the health system. There were strong link with local authority, Worcester acute and urgent care and third sector providers at an operational and executive level.

Across the trust, we found good multi – disciplinary working practice. We observed good collaborative working within the multi-disciplinary teams following the care programme approach (CPA) framework. We saw examples of linking with GPs, hospitals, district nursing, community support teams, citizens advice bureau, Department of Works and Pensions (DWP) and social care.

Assessment and treatment handovers between teams within the trust team took place. We saw good links with other external teams and evidence of flexible working with adult services where patients were supported by the team most relevant to their individual need rather than services being strictly defined by age limits. Ward teams reported that they had access to the full range of allied health professionals and team members described good, collaborative working practice.

In palliative care services, we were told about the Palliative Care and End of Life Network Group. This was a quarterly meeting involving commissioners, acute and community hospital trusts, hospices, consultants, pharmacists, local care providers, user representatives, GPs and nurses. We saw the notes of these meetings and saw that it provided an opportunity for county-wide strategic and operational discussions for all those involved in palliative and end of life care

In Harvington, there were daily 'rapid review' meetings with the MDT, including community mental health teams. This had improved communication however, not all the information was recorded in the same place and not all information was handed over to staff on the late shift.

Information and Records Systems

The trust recognises the issues with recording systems within the service and had at the time of the inspection identified a preferred provider to deliver a new IT infrastructure.

Different record systems were used across the mental health wards and in community teams. This meant that information about a patient could be lost when they moved between teams and was not available to staff when they needed it. In Hillcrest, staff had mitigated the risks and ensured that the information about each patient was available to those who needed it.

Some workarounds have not always been systematically applied. In Harvington the whiteboard which was used to record patient information, had not been updated so it was not possible to see how many patients were on the ward, what their risks were and who was detained under the Mental Health Act (MHA).

Requires Improvement

Are services effective?

In some core services, we saw that relevant information was available to all staff that needed it. This included the learning disabilities services, the adult community services and the palliative care teams.

CAMHS staff were involved in the trust Information technology (IT) project and had requested to trial the new integrated IT record system. At South Worcestershire and Redditch and Bromsgrove teams, young people's records were not always held securely. Due to lack of space, files and staff post were held in lockable cabinets in corridors. We found some of these were unlocked, despite guidance issued to staff by managers.

Staff spoke positively about the incident reporting system which they used to drive service improvements and provide feedback to the teams.

Consent to care and treatment

We saw positive approach to seeking consent across the core service with clinicians seeking permission and consent before performing any required intervention. However, we saw examples when this did not occur and not all the records we looked at noted consent to treatment.

However, despite the largely positive reports of the medicines management practices on wards, our second opinion appointed doctor (SOAD) and pharmacist reported a number of errors in respect of the consent to treatment for detained patients. Of a total of 62 detained patients on the 8 wards we visited, there were 24 patients to whom the consent to treatment provisions applied at the time of our visit. We found 12 of these patients (50%) with errors in their treatment. These ranged from people being given unauthorised medication while staff were not aware of the certification being in place, to minor administrative errors on forms. The MHA administration team do not scrutinise the forms but rely upon the clinicians taking responsibility for ensuring the forms are correct. This leaves consent to treatment without independent scrutiny or the benefits of the quality governance approaches to safety and effectiveness that we have been told about in other areas of practice.

Assessment and treatment in line with Mental Health Act

A number of MHA issues arose in the course of our visits to wards and services.

We found staff were able to discuss and demonstrate a good understanding of the Mental Health Act, the Code of Practice and the guiding principles. We saw community treatment orders were being used appropriately in people's best interests and being properly documented.

People had their rights under the MHA explained to them at the start of treatment and routinely thereafter. People we spoke to confirmed that they understood their rights. Leaflets were provided in other languages when needed.

Consent to treatment and capacity requirements were adhered to, including good assessment, recording and review of capacity to consent to treatment.

Support and legal advice on implementation of the MHA and its Code of Practice was available from a central team. Staff worked well with other mental health professionals from social services and advocacy.

People had access to Independent Mental Health Advocacy (IMHA) services and staff were clear on how to access and support engagement with the IMHA if necessary. However not all qualifying patients were aware of this.

The quality of documentation in respect of section 17 leave varied. In some settings patients had not been given a copy of their section 17 leave form. Most section 17 leave forms detailed the time of the leave and whether this was escorted or unescorted.

There were a number of errors against detained patients' consent to treatment. There were both patients awaiting second opinion appointed doctor (SOAD) visits and others for whom there were errors in their treatment plan. In some settings records did not show statutory consultees' discussions with the SOAD, nor were there records to show that patients had been informed of the outcome of the SOAD visit.

The outcomes of hospital managers' hearings panel reports were not always available in patient files on the acute wards. Approved mental health professional (AMHP) reports at the time of initial detention were not available in some files.

Good

Are services caring?

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

Summary of findings

We rated caring as good because:

- The inspection team saw patients were treated with dignity and respect. Staff showed a good understanding of individual needs on the basis of gender, race, religion, sexuality, ability or disability.
- The majority of feedback we received from patients, families and carers was positive and they spoke highly of the care they were given.
- There were good examples of engaging patients in care planning across the core services
- The palliative care and older persons' team were told by families the care is of an 'excellent standard'.
- Access to advocacy services was available and promoted across the wards

However, we found that due to staffing pressures some patients in Harvington told us that staff were always too busy to spend time with them and there were often no staff present in the ward area.

Some patients raised concerns regarding privacy of some environments.

Please refer to the 'Actions we have asked the provider to take' section of the report.

Our findings

Dignity, respect and compassion

Patients told us that staff treated them with respect, even when restrictions in relation to their care and treatment were in place.

We observed positive interactions between staff and patients. The language used was compassionate, clear and simple and demonstrated positive engagement and willingness to support patients.

Staff responded to people in distress in a calm and respectful manner. De-escalation techniques were used throughout the trust. Staff appeared interested and engaged in providing good quality care to patients.

In the community adult inpatient wards we observed lunchtime on six wards at three of the hospitals. Lunch was supervised by three or four healthcare assistants. We spent time observing how staff interacted with patients. We saw patients were encouraged to eat their meal in a sensitive and caring manner by staff.

When staff spoke to us about patients, they discussed them in a respectful manner and showed a good understanding of their individual needs.

In Holt and Hillcrest, we observed that staff interacted with patients in a positive and respectful way. Patients were treated with care and staff respected their dignity. However, in Harvington ward, we observed that staff stood at the side of the ward particularly during mealtimes and did not engage with the patients. On Harvington ward a patient asked us if we could support them to use the toilet. The patient needed two staff to support them. Only one staff member was available so they asked the patient if they could wait. The patient said they could not wait, so staff had to ask another member of staff to assist with this. Staff did not talk with the patient when supporting them or apologise for the delay.

Male patients in Holt ward told us and we saw that privacy windows were not provided in the bedroom areas, so they were overlooked by neighbouring wards and properties. We raised this with staff who had not previously identified this as an issue. The privacy and dignity of patients at Tenbury hospital was compromised by there being only curtains surrounding the patient areas.

Involvement of people using services

We observed that patients were involved in planning their care, however, this was not always recorded. Patient's families and carers were involved where this was appropriate

We saw that young people from the Youth Board had been involved in the clinical service manager interviews and there were plans to involve them in other senior

Good

Are services caring?

appointments. Young people had been involved in the redesign of team meeting rooms and waiting areas in some teams. The trust website detailed how young people and carers give feedback and raise queries using social media sites, twitter and Facebook.

Several services used questionnaires to collect feedback from patients and their families about how they felt about the care provided. We saw the result of a people's experience questionnaire which showed that 79% of people said they were able to discuss what was important to them in managing their health care needs. Ninety two percent of people said they had not experienced any delays in the care they received.

In the crisis team we observed on home visits that patients were provided with an initial care plan. A "little book of mental health" booklet was provided together with guidance to the metal health website. Consent form sharing information with other agencies on a need to know basis was explained to patients before completion.

The staff told us that they had an open culture for people to feedback how they felt about the service provided. Some staff told us that they had been encouraged to be innovative and put forward new ways of working.

The trust had actively promoted the use of patient feedback to help shape service development and used a patient story at every board to encourage greater understanding and act as a reminder of their purpose.

Emotional support for people

Patients had access to advocacy services who offered a level of support required.

We saw that there were good supplies of patient information leaflets that covered a wide range of relevant topics available for patients and their relatives.

Requires Improvement

Are services responsive to people's needs?

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

Summary of findings

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

- A blanket restriction was applied on Harvington ward that prevented patients using the canteen.
- The environment in Harvington did not promote patients recovery. Two wards were cold and staff could not control the heating.
- Young people often experienced long wait times for treatment. Young people using crisis services did not always have an assessment by appropriately skilled staff.
- There were no agreed waiting times for urgent and non-urgent referrals across all adult community mental health teams. This did not promote equity for people waiting to be allocated a named worker and commence the treatment process. In addition, there were long waiting lists and times for psychological interventions.

However, we found examples of robust bed management systems in place and people did not often move between wards in the mental health services.

In the community inpatient ward, services had been developed to ensure the local population could access care and treatment as close to home as possible.

Trust premises where, in the main, accessible for patients. Interpreters were available and staff knew how to access the service if needed. The inspection team noted that information was available to patients and carers in a range of languages.

Across all core services staff knew how to support people who wanted to make a complaint.

Please refer to the 'Actions we have asked the provider to take' section of the report.

Our findings

Planning and delivery of services

From the data provided by the trust all 18-week targets were met for the average number of days waited between referral to assessment. The trust does not undertake admitted patient care or diagnostic tests, these elements of the pathway are the responsibility of alternative providers. Where the patient is not referred on to an alternative provider, treatment commences at the first appointment.

The trust does not apply referral to treatment time (RTT) methodology to mental health services as the referrals are made to generic community mental health teams or specialist teams. In line with national guidance, the trust is in the process of rolling out full RTT waiting time management to mental health services by April 2015.

The proportion of patients who were followed up within seven days of discharge from psychiatric inpatient care has been above the England average, except from July-September 2013, when it fell slightly below.

Health economy workshops originally set up by Arden Clinical Commissioning Group enable, people to provide feedback. This helps shape the strategic plan. A specific example of where feedback has informed the strategic plan can be seen at the children's respite service based at Ludlow Road. Potential capacity was discussed and feedback from families was taken on board when planning closures to match the needs of families in respite care.

We found there were no agreed waiting times for urgent and non-urgent referrals across the CMHT. This did not promote equity for people waiting to be allocated a named worker and commence the treatment process. It was confirmed by the community lead and managers across the team that waiting times were not being monitored to ensure that people were seen in a timely manner.

Young people could wait long periods before receiving treatment in children's SDU (CAMHS). Data showed that referral to treatment times varied in October to December 2014 there was a wait of 11 weeks in Wyre Forest to 22 weeks in Redditch and Bromsgrove. The SDU risk register at South Worcestershire detailed there had been a 10-12 month wait. In addition treatment was not available close to home and the records demonstrated that young people were referred for in-patient treatment to Manchester or

Requires Improvement

Are services responsive to people's needs?

Devon. This service was not commissioned to provide a 24 hour service. Out of hours, the crisis service could be contacted. A consultant CAMHS psychiatrist was available for telephone advice.

When a child or younger adult was admitted to the HBPoS unit then the other two places of safety were closed until the individual has been discharged or transferred elsewhere. For children/younger adults or for individuals with a learning disability an appropriate specialist would be involved in the assessment as soon as could be arranged but that this isn't always possible during out of hour's periods.

In Harvington we observed the mealtimes on each of the three times we visited. There were not enough dining chairs and tables available so several patients ate their food using trays on their laps. Patients told us that they got used to eating sat on the sofas as there were not enough chairs and tables. We observed arguments between patients about who could sit where. Staff did not engage with patients during mealtimes but observed from the side of the ward. Staff told us that patients used to be escorted to the canteen area in the community teams office area for meals. However, this had stopped as some patients had absconded and there were not enough staff to support this.

We were told by staff at Cromwell House that patients had experienced delayed discharges due to lack of suitable placements which adequately meet patient's needs in the community. The teams had now employed the housing officer as part of the MDT and that had helped. We saw that in this service discharges were well co-ordinated, managed and there were good links with the local authority.

We saw good examples, from school nurses based at the Prince Henry High School, who had developed health packages for the school which included advice on puberty, hand washing, dental and healthy eating packs. Priorities and actions for school health were agreed jointly between school and health services.

On the inpatients ward for adults' patients were informed that when they went on leave their bed could not be kept open due to pressure on beds. However, there was evidence that patients were not discharged until they were ready to leave. There was good discharge planning and liaison with community teams to ensure that the patient was supported in the way they needed following discharge.

The trust had a hospital admission prevention service whose aim was to avoid unnecessary adult community hospital admission and support people who may otherwise have been taken into hospital unnecessarily. Examples included the monitoring of people's condition and/or prescribed medicines within the home.

Older adults' mental health community teams operated a duty and triage system which ensured people were seen promptly. Urgent referrals were seen within 24 hours. Non-urgent referrals were seen within acceptable time limits. We saw examples of health professionals responding promptly to urgent referrals. People who used the service were very positive about the responsiveness of the service. The integrated teams were able to take active steps to engage with people who found it difficult or were reluctant to engage with mental health services.

To ease the winter pressures on beds and flex to need, several community hospitals had a greater bed capacity than was currently in operation. This meant that options to increase capacity were available, if required. During our inspection visit, we saw that additional beds had been made available at three of the community hospitals. The matrons we spoke with told us additional beds were only opened when they could be adequately staffed.

Diversity of needs

We saw that patients' diversity and human rights were respected. Staff attendance at equality and diversity training was 94.92%. Training was available for staff in meeting the needs of specific groups of people such as those with learning disabilities, dementia, anxiety and depression if it was not the core service delivered.

We were told that interpreter services were available for patients and their families whose first language was not English.

Staff used pictures and symbols, along with specific individual communication aids to make information accessible where required.

Across the trust, food options took account of people's dietary requirements and any religious and cultural needs.

Right care at the right time

Intelligence monitoring showed delayed transfers of care attributable to social care are high and have been flagged as potential risks.

Requires Improvement

Are services responsive to people's needs?

The ratio of the number of patients whose transfer of care was delayed to the average daily number of occupied beds open overnight between July and September 2014 (where the delay was attributable to Social Care) was 5%. Against an expected rate of 1%, this is flagged as a 'risk'.

The ratio of the total number of days delayed to the total number of occupied beds between July and September 2014 (where the delay was attributable to Social Care) was 4.3%. Against as expected rate of 0.9%, this is also flagged as a 'risk'

Our data analysis showed that over the last 12 months 28.5 % of all delayed discharges were a result of patients awaiting nursing home placement or availability

In the community health service, we found occasions, where the evening service were handed visits that the district nursing service had not managed to attend due to emergencies throughout the day. For example, we saw 15 visits handed over with four being handed back in the morning. Senior staff told us they were aware of the problem but confirmed that all cases were reviewed to ensure that treatment could be safely deferred to the morning. However, this service was flexible according to the needs of the patient and was based on a rapid response process from the time when the problem is identified. Normally the service is provided for 24-72 hours and included overnight cover.

In the CMHT pathways were used where appropriately to refer to the drug alcohol team who carry out assessments where needed. Some staff expressed difficulties in accessing specialist services across the county. Staff said that urgent outpatient appointment waiting times would vary depending on which consultant people were allocated to. There had been a number of cancelled outpatient appointments since July 2014. We were told appointments were rebooked. For non-urgent appointments people using the service could experience a long waiting time between appointments.

There was a robust bed management process across the adult mental health wards. The ward and community practiteams had regular contact with the bed manager. This helped to reduce the risks of patients being placed out of area and being moved between wards without justification on clinical grounds.

Learning from concerns and complaints

The quality leads had an active role in ensuring lessons learnt were understood across the service delivery units. We saw the complaints policy clearly displayed at each location. Staff we spoke with were able to describe the complaints process and explain how they would advise patients to raise a complaint.

All locations displayed poster and had leaflets explaining how to access Patient Advice and Liaison Service (PALS) if patients or their relatives wanted support in raising concerns. The trust website gave details on how to make a complaint and the actions that the trust had taken as a result of complaints.

Mangers told us complaints relating to their service were shared amongst the teams during team meetings and in staff newsletters. We had very positive feedback from staff regarding the reporting system to manage monitor and learn from incidents. Learning was also shared through trust newsletters and the monthly head of department meetings. There was evidence of feedback, learning and changes to practice as the result of complaints made in most cases.

Monthly reports to the board identify themes from complaints or concerns raised by patients, which is monitored through the quality forum.

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

We rated well-led as **good** because:

- We saw that the trust values and vision were prominently displayed and staff working to uphold these values.
- We noted that high visibility of the chief executive and the chair and most staff knew who they were. Staff spoke positively about the executive walkabout.
- The vision and overall direction of the trust was coherent and clear. There were effective governance arrangements for the identification, management and mitigation of risk and systems were in place for the measurement of quality and patient safety.
- The senior leadership was well respected and there was a clear emphasis patient feedback to improve performance. There was a culture of compliance and continuous improvement.
- The trust rewards and recognises achievements by staff either individually or as a team.
- The trust participated in a number of external peer review and service accreditation schemes.
- Across the trust, staff were positive about their experiences of working in the service. They reported that they felt confident in and supported by their colleagues and managers.

However, we found low morale in some areas. Some staff expressed concern about change and not feeling listened to when they raise concerns. There was evidence in some areas that where risks and issue had been identified these were not always addressed and actioned appropriately. The strategic approach to long term risk management was underdeveloped.

Please refer to the 'Actions we have asked the provider to take' section of the report.

Our findings

Vision and strategy

The trust described a clear vision and strategy.

The trust have 4 strategic goals:

- We will always provide excellent patient experience
- Our services will be safe and effective
- We will work in partnership to improve the integration of health and care
- Our organisation will be efficient, inclusive and sustainable.

The vision and values were promoted throughout all the core services and shared on induction by the CEO with all new starters. We were told by the executive team and staff that the values were developed in consultation with members of the executive team, staff and service users. Staff were clear what these were and were saw evidence of staff working to uphold them.

The leadership team reviews quality and risk through the board assurance framework (BAF). The chair and head of inspection were unclear about the effectiveness of the (BAF) in place. The BAF did not appear to accurately reflect the longer term risks to the trusts strategy or the actions to mitigate these. The trust were made aware of the concerns at the time of inspection and had taken action to consider this.

We were confident that board members seek to respond to quality risks and saw evidence that there was an uplift in staffing in some areas following review of information submitted to the board regarding quality. The director of finance told us that where a service cannot be delivered to a high quality, demonstrated through key metrics and the quality dashboard, the board would consider the risk and agree whether or not to stop providing this service.

The trust told us that the current integrated business plan requires a review / refresh. This plan is informed by clinical strategy. For example, when looking at co-locating services, quality impact assessment (QIAs) are conducted and risks

Good

Are services well-led?

and challenges escalated to quality and safety committee (QSC). The risks highlighted within the QIAs were then used to inform strategy and provide learning and adaption of the plans where necessary.

The board checks progress against the plan by monitoring the aggregated report of each SDU's priorities and risks on a 6-month time scale. Any slippage against plan is acted upon immediately.

Prior to the inspection we met with the health overview and scrutiny committee who spoke positively about the services provided by the trust. We were told the trust has been working closely with its partners around a number of key strategies, including urgent care, being well connected, the five-year health and care strategy and the mental wellbeing and suicide prevention strategy. The HOSC is supportive of moves towards integration between health services and social care services and the benefits of this can be seen in the development of "virtual wards" and the integrated care programme in Wyre Forest. The told us that the trust has been responsive to any requests from the committee to do further consultation, e.g. with continence services. The trust also took on board the HOSC's comments about its 2013 Quality Account and in 2014 produced a version that was much clearer and easier to read.

Similarly, we spoke with clinical commissioning and quality leads who told us all quality assurance visits undertaken in this financial year have provided good levels of assurance, with minimal recommendations for improvement.

Some staff told us there was a lack of vision and clear strategy in some core services and some of the consultants we spoke with felt that the vision from the trust did not always match the resources available.

During our inspection, we saw that most teams demonstrated a good understanding of their team objectives and how they fit with the organisation's values and objectives.

Governance

The trust had a range of overarching reporting systems in place and produced a plethora of information however this information did not always result in direct action. We noted that in some core services the information produced did not translate to change or action.

There were strong quality assurance layers in place to ensure learning from serious incidents and complaints were shared and the Ulysses programme was welcomed from staff who felt this had a positive effect on patient care. The services had access to a performance dashboard which produced monthly reports however, this information was not always available to all staff leading teams.

The director of quality received direct reports for quality, patient safety, infection control, training and development, human resources, community engagement and patient relations. Oversight and assurance of clinical effectiveness and clinical assurance was gained through the quality and safety committee.

The aim of this committee is 'to ensure a true and fair representation of assurance is provided to the board'. The trust has an early warning system in place so if a risk rating of 8 or above is identified this is escalated to the Q&S committee for consideration. Additional assurance is sought from PALS /patient feedback and safety walkabouts.

When change is required or proposed a quality impact assessment (QIA) is conducted. The risks highlighted within the QIAs were then used to inform strategy and planning. Any ongoing assessment provide learning and adaption of the plans at any point where necessary.

In most core areas, the trust was able to demonstrate clear lines of accountability and operating structures. With the exception of Harvington ward where it was not clear who is the clinical lead for acute inpatient services. Each ward had a different arrangement for consultants and junior doctors. This meant that a single doctor did not take overall responsibility for the acute inpatient services.

The electronic incident reporting system, corporate and ward based audits and outcome measures as well as electronic staff training records was not always easily accessible to all managers. We found some examples of this information not being used to effect change and improvement.

Leadership and culture

Patient safety walkabouts by the executive team are widely recognised as having a positive impact on staff morale. The chair and the chief executive were promoting this across

Good

Are services well-led?

the senior leadership team and leading by example. Some staff told us they would like senior managers to engage across the team and not just with the manager of the wards and units.

The trust identified one of its key strengths in its leadership programmes. Some of the staff we spoke with told us that leadership development had been encouraged and spoke positively of the impact.

Staff told us they felt the welfare of the patients and wellbeing of the staff was very important to the organisation. Most staff were very enthusiastic they felt valued and listened to. Morale was generally good which was a view shared by some families and carers we spoke with.

Overall, we found the units to be well led with good leadership at team or ward level. They had an open culture and willing to listen to new ideas from staff and patients in order to improve the service. Staff told us that most managers were very approachable, had an open door policy and encouraged openness.

There were some notable exceptions. In the CAMH service we found a disconnect between risks and issues described by staff and those reported to and understood by senior managers. Several staff expressed low morale and lack of communication from managers regarding actions taken particularly at Wyre Forest. In Harvington ward we found that there lines of responsibility were not always clear. All staff felt responsible and this meant that some tasks were not done and it was not clear who was responsible for not doing them.

Current staff survey results showed the number of staff experiencing harassment, bullying, or abuse from patients/relatives in last 12 months has increased from 21% to 29%. There were systems and processes in place to monitor patient/relative incidents, staff informed us, and records showed that training had taken place to manage violence and aggression. Staff side representatives had not had feedback from members and the issue was not raised in focus groups or staff interviews.

The trust demonstrated a willingness and openness to scrutiny and challenge from the local team through to senior executive managers.

The non executive board came from diverse backgrounds and brought a range skills however, there was only one nonexecutive director with a clinical qualification.

Fit and Proper Person Requirement

We saw the trust fit and proper person requirement register was complete and all necessary checks carried out. We saw paperwork created which demonstrates that all executive board members meet the requirements. At the time of the inspection, the chair was waiting to provide the necessary assurance to TDA.

Engagement with people and staff

To improve patient engagement each board meeting would commence with a patient story delivered by those using services in a range of formats.

We were told by staff side representative there was an excellent relationship between staff side and management and the trust were open and transparent in their communications.

The trust recognise the 'you said – we did' actions from the staff survey is still a work in progress.

Most staff felt supported by their managers and teams but some staff did not feel that their concerns would necessarily be actioned. They felt the pending changes were being communicated but not the rationale behind the change taking place. Doctors we spoke with felt they were supported by the medical and clinical directors.

The trust has commissioned a productivity initiative from a third party. It is acknowledged that front line staff may find it difficult to raise issues of capacity, particularly in community services. This has caused some suspicion across the staff group and reports from staff side about a lack of robust communication about this matter. Overall, staff side representatives were positive about engaging with the senior team and described an open door policy from the chief executive.

We saw a range of local initiatives to gain feedback from people who use services and their carers. In the CAMHS and CYP service, the Community Engagement Team set up a 'Youth Board' for young people aged 14-24 years to obtain young peoples' views, recommendations and feedback about services. We heard that young people had been involved in staff interviews and service development programmes. We were told that parents had been involved

Good

Are services well-led?

in the interview process for the recruitment of student health visitors so that their views could inform this outcomes. The school health nursing team have set up a twitter account to update service users on key initiatives.

All locations displayed posters and had leaflets explaining how to access Patient Advice and Liaison Service (PALS) if patients or their relatives wanted support in raising concerns. The trust website gave details on how to make a complaint and the actions that the trust had taken as a result of complaints.

However, the trust website lacked oversight and scrutiny. We found the site promoted services that were no longer under the trusts responsibility and we heard that the responsibility for uploading change remained with managers and service leads but was not regularly maintained in all circumstances.

Quality improvement, innovation and sustainability

The trust operates a rewards scheme 'Living the Values Award' – this was awarded to staff for recognition of their achievements.

The trust participate in national accreditation schemes including:

- Royal College of Psychiatry AIMS - mental health inpatients and HTAS teams
- Royal College of Psychiatry accreditation - ETC. and mental health liaison

The LD CAMHS team won the trust's staff achievement award for, 'Excellence in integrating services'. The manager on Athelon told us the ward was preparing for AIMS accreditation. They saw this as a positive and beneficial move.

Staff told us they participated in the "Stop the Pressure" which is a national campaign encouraged to reduce pressure ulcers and to make life better for people who use the service. The end of life and palliative care teams were aligning their work to the NHS Improving Quality approach set out in the document 'One Chance to Get it Right'.

Impact on care quality and cost efficiencies is monitored through quality and equality impact assessments process informed by key metrics that include patient and staff feedback, performance dashboard and incident reporting.