Care Quality Commission

Coventry and Warwickshire Partnership NHS Trust

Quality Report

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Core services inspected	CQC registered location	CQC location ID
Community-based mental health services for older people	Wayside House (Trust headquarters)	RYGCR
Long stay/rehabilitation mental health wards for working age adults	St Michael's hospital Hawkesbury Lodge Highfield House	RYG79 RYG51 RYG05
Acute wards for adults of working age and psychiatric intensive care unit	Caludon Centre St Michael's hospital	RYG58 RYG79
Wards for older people with mental health problems	Manor Hospital St Michael's hospital	RYGCW RYG79
Community-based mental health services for adults of working age	Wayside House	RYGCR
Mental Health crisis services and health based places of safety	Wayside House	RYGCR
Community mental health services for people with learning disabilities	Wayside House	RYGCR
Wards for people with learning disabilities	Brooklands Hospital	RYG12
Forensic inpatient/secure wards	Brooklands Hospital	RYG12

Summary of findings

Specialist community service mental health services for children and young people	Wayside House	RYGCR
Community health services for adults	Wayside House	RYGCR
Community health services for children, young people and families	Wayside House	RYGCR
End of life care	Wayside House	RYGCR
Community dental services	Wayside House	RYGCR

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?	**Requires improvement**	●

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

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

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

Summary of findings

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Summary of findings

Overall summary

The trust needs to take steps to improve the quality of their services and we find that they were in breach of five regulations. We have issued one warning notice and three requirement notices which outline the breaches and require the trust to take action to address. We will be working with them to agree an action plan to assist them in improving the standards of care and treatment.

We found that the trust was performing at a level which led to a rating of requires improvement because:

- Some of the wards did not provide a safe environment.

- The Department of Health guidance and Mental Health Act 1983 Code of Practice in relation to the arrangements for eliminating mixed sex accommodation were not met on six wards, Stanley, Pembleton, Ferndale, Sherbourne, Rowans and Hawkesbury Lodge. On Rowans ward, women were sleeping in the male area of the ward and a young person was not provided with a separate lounge due to the limited space on the ward.

- Some wards had many potential ligature anchor points with unclear management plans in place. On Larches ward there were multiple ligatures, for example bathroom taps, shower fittings and bedroom windows and handles. Ligature cutters were kept in clinic rooms which were locked. The problem with ligature points was compounded on some wards because of blind spots where staff could not observe patients easily.

- Anti-barricade doors on Spencer ward could not be opened because staff could not locate the correct key.

- On Larches ward there were two call bell systems in place. One system was de-activated but buttons still visible. Call bells were 'disabled' during original inspection. On a follow-up visit the bells were working, with the exception of one bathroom which remained broken.

- Medicines were not always stored safely nor disposed of correctly in the learning disabilities service.

- Record keeping was poor particularly in relation to the Mental Health Act documentation. Patients were not being told of their right to support from an Independent Mental Health Act Advocate (IMHA). Those patients lacking capacity were not referred to advocacy automatically in line with MHA code of practice. Section 17 leave forms did not always record who else had been given a copy other than the patient. Some care records showed no evidence of assessment of mental capacity. No records of Mental Health Act (MHA) paperwork or Ministry of Justice (MoJ) warrants or orders were available in paper or electronic forms at IPU 10-17, Swanswell Point. Ministry of Justice records were not available at the MHA office at the Caludon centre. Medical staff had made errors on consent to treatment documents (T2 and T3 forms) on two wards, relating to three patients. Prescribing did not adhere to the agreed plan, which made the treatment invalid for the detained patients in question. Community treatment order conditions were not included in the care plan for one patient. In the community health service overall, not all services had undertaken robust risk assessments to manage risks in the delivery of care and treatment. Not all records were kept in a secure storage area and some were not maintained in accordance with trust procedures.

- The trust had identified high levels of restraint and prone restraint used in 2014 and had completed an action plan to reduce this. A review of the action plan in 2015 identified that some recommendations had not been actioned, and some only partially actioned. This included doctors reviewing patients who had been restrained within two hours and for staff to explore alternative restraint methods. However, at the time of inspection we noted that doctor reviews were still not taking place and there had still been a high level of use of prone restraint, in particular on Amber ward.

- Not all teams achieved the compliance rate for MHA and Mental Capacity Act (MCA) training, the trust's target was 95%. Staff on adolescent units did not understand the Gillick competence and consequently did not have the knowledge and skills

to assess capacity. In the community adult nursing service, we found that there was a poor understanding of the Mental Capacity Act 2005 (MCA) and some teams had poor staff training compliance in this area.

• There were long waiting times in some of the community services.Data showed 138 young people in the children and adolescent mental health services had waited up to 24 weeks and 117 had waited from 25 to over 49 weeks to access treatment. In the community dental service, we found there was an excessive waiting list for children who had been referred to the service and were waiting for their first assessment appointment. Some patients had been waiting nine to ten months. We saw evidence of increasing demand and acuity in the community health therapy services leading to pressures on staff, which sometimes had an impact on waiting times.

• In the community dental service, there was no clearly defined strategy for the service in place to drive improvement and innovation. There was not a robust oversight and management of risks within the service.

However:

• Staff had a good understanding of how to protect patients from abuse. Staff could identify what would constitute a safeguarding referral, how to report, and who to report too. Staff regularly completed safety and security audits of the ward areas. Appropriate arrangements were in place for children visiting. Patients told us that they felt safe on the wards. 100% of staff who required safeguarding children level 3 were trained.

• For the community health services, we rated two services as being outstanding for caring - end of life care and children and young people and families services.

• Ward equipment was well maintained and the wards were clean, bright and airy. Interview and waiting areas used by patients were clean, well-maintained and safe.

• Staffing levels in community health services were appropriate and met patients' needs at the time of

inspection, despite some areas having staffing pressures. Staffing shortages were acted upon appropriately with the use of temporary staff and an effective induction process was in place.

• Patients' physical health needs were identified in most services. Medical staff documented physical health examinations and assessments following the patient's admission to the wards. Ongoing monitoring of physical health care problems was taking place. Patients accessed a range of physical healthcare services including podiatrists, district nurses, tissue viability nurses and opticians. Outcomes for patients using the services were monitored and audited. This included the monitoring of key performance indicators such as length of stay and readmissions within 30 days of discharge. Sherbourne ward had robust system to review physical healthcare needs weekly via implementation of a wellbeing clinic.

• In the community health services, we found that patients' needs were assessed and their care and treatment was delivered following local and national guidance for best practice. These services had effective evidence based care and treatment policies based on national guidance and had introduced an individualised plan for care for the dying person for patients with end of life needs.

• Nursing staff treated patients with care and respect and communicated in ways patients understood. Staff knew of individual needs and concerns, and spoke respectfully about patients. Staff were positive, experienced, confident, well-motivated and worked together well. They frequently expressed satisfaction in doing a good job in helping people in crisis.

• Staff helped patients with their personal care, this was done in private and patient dignity was maintained. We observed positive and meaningful interactions between staff and patients. Staff listened to patients and used appropriate forms of communication to ascertain people's thoughts and feelings when these were not easily expressed.

Summary of findings

- Community health services were planned and delivered to meet the needs of individual patients and of the local community. Effective relationships with key stakeholders and commissioners led to a coordinated approach to service design and delivery.

- In community health services, most staff and service leads were clear about their priorities and vision and felt involved with the development of services. Staff showed an awareness of the trust strategy for the service. There was good feedback from patient surveys. Leadership within community health services was effective. Most staff felt supported by their immediate managers and senior managers within the community.

- Staff told us they were aware of the trust vision and values. Ward managers said they had sufficient authority and felt able to carry out their role effectively. Staff knew who the most senior managers in the trust were.

Summary of findings

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

We always ask the following five questions of the services.

Are services safe?

We rated Coventry and Warwickshire Partnership NHS trust as requires improvement for safe because:

- We identified a number of concerns around safety. The Department of Health guidance and Mental Health Act 1983 Code of Practice in relation to the arrangements for eliminating mixed sex accommodation were not met on all wards. The trust breached the elimination of mixed sex regulations on six wards, Stanley, Pembleton, Ferndale, Sherbourne, Rowans and Hawkesbury Lodge. Rowans ward was unable to provide a young person with a separate lounge due to the limited space on the ward. Female patients were sleeping in the male area of the ward.

  On Larches ward there were two call bell systems in place. One system was de-activated but buttons still visible. Call bells were 'disabled' during original inspection. On a follow-up visit the bells were working, with the exception of one bathroom which remained broken.

  Concerns were identified regarding the number of ligature points on the wards with unclear management plans in place. On Larches ward there were multiple ligatures, for example bathroom taps, shower fittings and bedroom windows and handles. Ligature cutters were kept in clinic rooms which were locked. Individual risk assessments were not all up to date. Anti-barricade doors on Spencer ward could not be opened because staff could not locate the correct key. Wards had blind spots where staff could not observe patients easily and the risk had not been mitigated.

- Three patients with a criminal history, under supervision of the Ministry of Justice (MOJ), did not have their conditions included in their risk or care plans. The Ministry of Justice (MOJ) monitors and set conditions for the care, treatment, and whereabouts of mental health patients with a criminal history. Community treatment order conditions were not included in the care plan for one patient.

- In the older adults service a link corridor was used for de-escalation and the management of aggression. These incidents were recorded using the seclusion policy documentation. However the environment did not meet seclusion standards.

Requires improvement ●

Summary of findings

Patients were at risk of harming themselves in the seclusion room on Janet Shaw Clinic. There were panels on the walls in the ensuite area which could have been used for the purpose of harming self, or used as a potential weapon to harm others.

- Staff on Eden ward were did not consistently complete observation records fully. Forty-three percent of patient observation records had gaps in staff documentation. In addition, codes for patients' whereabouts were used incorrectly which presented a risk that staff may not have accurate information on patients' locations.

- Forensic wards worked below the identified levels of staffing on a regular basis. This meant that patients may not have received the care and treatment they required at the time they needed it.

- Staff did not always ensure that medications were stored and administered safely. In learning disabilities services staff were using four bottles of medication that were out of date and left medication on the side that was not secured. Staff could not account for this. Staff in some services discarded medication waste into the sharps bins, which is not in line with guidance on the safe disposal of medication. Staff could not demonstrate they completed medicine reconciliation in a timely manner as there were no indications on the charts for its completion. No emergency equipment was available on any site for adult community teams.

- Patients on some wards were unable to access hot drinks after 9pm, until the following morning. On two wards patients were unable to charge their mobile phones during the day. Staff displayed signs on the ward to this effect. Patients admitted to the first floor wards could not access outside garden space unless escorted by staff and staff were not always available.

- Not all crisis resolution staff were adhering to the lone worker policy by using the available electronic monitoring system.

- The CAMHS service had seven vacant posts for qualified nurses. Two teams did not have team managers in post. A total of 265 young people had not been allocated a care coordinator. Interview rooms were booked for adult community teams to use. This meant young people could be placed at risk if an adult did not accompany them to their appointment as there was only one waiting area.Two of these services did not have alarms fitted in interview rooms.

• In the community health service overall, not all services had undertaken robust risk assessments to manage risks in the delivery of care and treatment.

Summary of findings

• Not all risks in the environment and in the community health service had been recognized and addressed.

• Risk assessments regarding dental community visits and use of the mobile dental unit were not in place.

• Not all services in community health complied with infection control procedures to minimise the risk of transmission of infectious diseases. There was no requirement for any clinic based service to collect safety thermometer data. Staff within the adult community nursing services said they did not routinely collect safety thermometer data unless there was an identified harm such as a fall. Mangers were addressing this.

However:

- Ward equipment was well maintained and the wards were clean, bright and airy. Interview and waiting areas used by patients were clean, well-maintained and safe. Equipment was well maintained and fit for purpose.
- In older adults wards staff used the 'Modified Early Warning Signs' (MEWS) tool on all wards. Staff recorded physical observations using the MEWS ratings to make a decision about further action they should take. Falls assessments had been completed and care plans were in place. Staff in the crisis services closely monitored patients so they could respond swiftly to any change in their well-being.
- Staff had a good understanding of how to protect patients from abuse. Staff could identify what would constitute a safeguarding referral, how to report, and who to report too. Staff regularly completed safety and security audits of the ward areas. Appropriate arrangements were in place for children visiting. Patients told us that they felt safe on the wards. 100% of staff who require safeguarding children level 3 were trained.
- With the exception of the learning disabilities service there were good processes for the storage, recording and administration of medication. Clinic rooms were clean and tidy. Staff checked emergency equipment daily and it was in good working order. Staff had access to emergency medicine on all inpatient sites.
- Staff reported that ward managers were supportive when incidents occurred and held debriefs quickly for the benefit of staff and patients following incidents.
- There was rapid access to a psychiatrist when required in inpatient areas.
- The trust had calculated the number and grade of staff needed to care for patients. When necessary, regular bank and agency staff were used who knew the ward and patient group. The trust was continuing to recruit staff to vacancies.

Summary of findings

- The trust had ensured that Amber and Jade ward had been fitted with anti-ligature furnishings, and where there were ligature risks, they had identified the level of risk and mitigated these.
- Staffing levels in community services were appropriate and met patients' needs at the time of inspection, despite some areas having staffing pressures. Staffing shortages were acted upon appropriately with the use of temporary staff and an effective induction process was in place.
- In community services, we found that incident reporting occurred regularly and appropriately throughout most areas and staff received feedback when they reported an incident. We saw evidence of lessons learnt from incidents being shared across community services.

Are services effective?

Requires improvement ●

We rated Coventry and Warwickshire Partnership NHS trust as requires improvement for effective because:

- Record keeping was poor particularly in relation to the Mental Health Act documentation. Patients told us they were not being told of their right to support from an Independent Mental Health Act Advocate (IMHA). Records lacked evidence of staff reading rights to patients. Those patients lacking capacity were not referred to advocacy automatically in line with MHA code of practice. Section 17 leave forms did not always record who else had been given a copy other than the patient. Some care records showed no evidence of assessment of mental capacity. No records of Mental Health Act (MHA) paperwork or Ministry of Justice (MOJ) warrants or orders were available in paper or electronic forms at IPU 10-17, Swanswell Point. Two patient's Ministry of Justice records were not available at the MHA office at the Caludon centre. Medical staff had made errors on consent to treatment documents (T2 and T3 forms) on two wards, relating to three patients. Prescribing did not adhere to the agreed plan, which made the treatment invalid for the detained patients in question. In community health services not all records were kept in a secure storage area and some were not maintained in accordance with trust procedures.
- Patient's views recorded in the 'this is me' document were not included in the care plan. Not all patients had a copy of their care plan. Some care plans were not personalised or holistic.

Summary of findings

The quality of care plans was variable. Many care plans were not holistic, for example, they did not include the full range of patients' problems and needs. There was evidence of care plans not being up to date on all acute wards. Care plans were generic and did not always consider patient views.

- Case records were computer and paper based. We found that it was difficult to locate all the information and in some cases, staff had duplicated paper work. Teams across the trust used different recording systems. Staff at the community teams used the electronic system whereas doctors and inpatient ward staff used paper records. In the community children and young peoples' service we noted there were delays with updating some care records in the service which could affect the continuity of care for children and young people. Plans were in place to address this. There were difficulties with connectivity in relation to the use of laptops in some areas of the community children and young peoples' service. This was particularly an issue for the health visitor service. Plans were in place to resolve this concern.

• Staff did not consistently record supervision and not all staff received supervision on a regular basis.

- Staff on adolescent units did not understand the Gillick competence and consequently did not have the knowledge and skills to assess capacity. In the community adult nursing service, we found that there was a poor understanding of the Mental Capacity Act 2005 (MCA) and some teams had poor staff training compliance in this area.

However:

- Patient physical health needs were identified in most services. Medical staff documented physical health examinations and assessments following the patient's admission to the wards. Ongoing monitoring of physical health care problems was taking place. Patients accessed a range of physical healthcare services including podiatrists, district nurses, tissue viability nurses and opticians. Outcomes for patients using the services were monitored and audited. This included the monitoring of key performance indicators such as length of stay and readmissions within 30 days of discharge. Sherbourne ward had robust system to review physical healthcare needs weekly via implementation of a wellbeing clinic.
- A review of prescribing by a pharmacy inspector concluded that staff followed National Institute for Health and Care Excellence (NICE) guidance when prescribing medication. The trust provided psychological therapies recommended by NICE.

Summary of findings

- Staff held regular care reviews and care programme approach meetings to monitor and review patients' progress. The medical, nursing, occupational therapist, activities staff, practice nurses, psychologists and speech and language therapists worked well together to achieve good outcomes for the patients.

- In acute and PICU wards the Mental Health Act paperwork was stored correctly and the trust had systems in place to ensure the detention paperwork was lawful. Medical staff in learning disabilities services had correctly completed capacity forms for patients detained under a Section of the Mental Health Act, 1983, and these were kept with medication administration, recording sheets and audited weekly with medications to ensure accuracy.

- Staff were actively involved in clinical audit. The services used recognised outcome and monitoring measures to help assess the level of support and treatment required. Staff in CAMHS completed a variety of assessments to monitor, record severity and outcomes for young people.

- Teams had good links with other organisations. Crisis teams linked well with partner agencies. The place of safety team met monthly with the police, ambulance and social services.

- Staff were trained in a range of psychological interventions. The trust provided staff with an induction at the start of their employment. Staff meetings were held regularly. Staff could request additional training to support patients with different communication needs. Unqualified staff had opportunities to undertake a national vocational qualification in care, which could eventually lead to secondment to take a foundation degree and nurse training.

- In the community services, we found that patients' needs were assessed and their care and treatment was delivered following local and national guidance for best practice. The services had effective evidence based care and treatment policies based on national guidance. The trust had introduced an individualised plan for care for the dying person for patients with end of life needs.

- Across community services, we saw evidence of robust multidisciplinary working with staff, teams and services working together to deliver effective care and treatment. Staff had the necessary qualifications and skills they needed to carry out their roles effectively. Staff were supported to maintain and further develop their professional skills and experience.

Summary of findings

- Consent to care and treatment was obtained in line with legislation and guidance. Performance in national audits was better than the national average.
- Evidenced based practice was evident and there was a strong ethos of audit and research to support the "best practice" of children young people and patients.

Are services caring?   Good ●

We rated Coventry and Warwickshire Partnership NHS trust as good for caring because:

- For the community health services, we rated two services as being outstanding for caring, being the end of life care and children and young people and families' services.
- Across the trust we observed nursing staff treat patients with care and respect and communicate in ways patients understood. Staff knew of individual needs and concerns, and spoke respectfully about patients. We received positive feedback about staff from patients and carers. Patients told us that relatives were invited to their care review meetings. Patients said they had access to advocacy and we observed posters on the wall for advocacy services.

• When staff helped patients with their personal care, this was done in private and patient dignity was maintained. We observed positive and meaningful interactions between staff and patients. Staff listened to patients and used appropriate forms of communication to ascertain people's thoughts and feelings when these were not easily expressed.

- Patients were invited to and supported to attend the multidisciplinary reviews along with their family where appropriate. Visiting hours were in operation and there was an area for patients to see their visitors in most services.
- There was active involvement and participation of care planning. Most patients knew they had care plans and had been involved in developing these. Patients had their own copies of their recovery plans if they wanted them. When patients were unable to be fully involved in planning care, staff would include relatives in the planning process. Patients were actively involved in the running of wards through weekly community meetings.
- Staff in CAMHS offered parents access to a parent support group. Staff supported young people to be involved in the

Summary of findings

recruitment of new staff to the service and designing the CAMHS link on the trust website. Families and young people were able to give feedback on the care they receive by completing the families and friends test.

- We observed home assessments where we saw good relationships between staff and patients, including joint working and collaborative discussions. We observed a care programme approach meeting. The patient was encouraged to give their views on their strengths and needs and to participate in the review of their care plan.
- Advocates attended some wards weekly, including a named child advocate for patients admitted to the adolescent ward.
- Parents told us the service they received from the children, young people and family services had enabled their children to live full and active lives within the constraints of their clinical condition.

However:

- Evidence of patient and carer involvement was not always documented in records and care plans were not consistently recorded as being given to the patients.
- Staff had not always considered whether those patients under the age of 16 were Gillick competent before sharing information about them to parents.

Are services responsive to people's needs?
We rated Coventry and Warwickshire Partnership NHS trust as requires improvement for responsive because:

Requires improvement ●

- Data in child and adolescent mental health services (CAMHS) showed 138 young people had waited up to 24 weeks and 117 had waited from 25 to over 49 weeks to access treatment. Staff in community adult mental health services were not aware of key performance indicators concerning waiting lists for patients' assessments and there was variation in waiting list times at different services.
- In the community dental service, we found there was an excessive waiting list for children who had been referred to the service and were waiting for their first assessment appointment. Some patients had been waiting nine to ten months. There was increasing demand and acuity in the community health therapy services leading to pressures on staff, which sometimes had an impact on waiting times. Children and young people experienced some delays in accessing the autistic spectrum disorders' pathway.

Summary of findings

- In some wards, the facilities did not ensure that patients had privacy, comfort and a dignified experience of care. Patients in inpatient wards did not have keys to lock and unlock their bedroom doors. The bedrooms did not have secure space for patients to lock valuables. There was a cupboard where items can be handed to staff for safekeeping. One patient on Rowans had complained of a broken window latch in her bedroom, which meant she was very cold, particularly at night. Staff were unclear what action had been taken to resolve this. Inspectors reviewed this during the unannounced follow-up inspection. The window had not been repaired. However, staff were making every effort to resolve the issue.
- Staff left the viewing panels on bedroom doors open. Patients were unable to close the panels on several of the wards. This affected patient privacy and dignity.
- There was a high bed occupancy rate and a high length of stay on all wards for older adults. When patients went on leave their bed was used for another admission. If the patient needed to come back to hospital, a bed would be found on another ward. This meant the patient may not know the staff and not be familiar with the ward environment causing anxiety.

However:

- There were a number of leaflets available telling patients how to make a complaint, how to get in touch with advocacy services, local carer groups and about individual treatments. Easy read material was available, including menus, care plans and the complaints procedure.
- Wards had access to garden areas leading off from the lounge. They provided a spacious area for patients to be able to walk, share time with carers and to enjoy fresh air. Wards were accessible for patients with disabilities. Each ward had a disabled toilet and bathroom. Staff arranged specialist assessments such as speech and language therapy when needed.
- Staff took a proactive approach to engaging with patients who did not attend appointments. Staff would follow up patients who missed appointments and engage with these patients. Discharge planning was evident in most teams. Patients from the medium secure service could be referred to the low secure service, or vice versa if required.
- The trust collected patient feedback and looked to make changes to reflect this. The facilities across the service

promoted recovery. Most patients could make telephone calls in private if they wanted too. All services had a full range of rooms and age appropriate equipment to support treatment and care, including family and therapy rooms.

- We saw there was a range of choices provided in the menu that catered for patients' dietary, religious and cultural needs. We observed excellent interactions at lunchtime. Staff were responsive to requests. Staff ensured the mealtime experience was protected and a pleasurable experience. Patients could use the kitchen areas under supervision to make snacks and drinks. Spiritual support was available to patients for a range of faiths. Information was visible on notice boards and patients used this service. However, all patients we spoke with in the learning disabilities service told us they did not like the food, although the trust was working with patients to improve this.

- Crisis resolution teams contacted patients within four hours of referral. The Arden mental health acute team began assessments within 90 minutes of receiving referrals. The service offered flexible appointments and engaged with people who were reluctant to engage with the service. The service was supportive of people in crisis and helped identify additional help, enabling them to move on as required to more suitable locations.

• In CAMHS the acute liaison team assessed young people who had been admitted to a paediatric bed and 1:1 support was given for the duration of the admission. Data provided for community mental health teams showed the average waiting time for triage was three weeks. From triage to allocation, the waiting time was 15 weeks, which was within the trust's 18 week target. Staff we spoke with said they kept in contact with patients on waiting lists for allocation to a care co-ordinator. Staff at IPU 10 (early intervention), Avenue House were attending the central booking service to review referrals and speed up the triage to assessment process. Staff at IPU 3-8, Tile Hill centre had set up a clinic to reduce waiting lists. The trust had an established personality disorder service that community teams could refer to if required.

• The learning disabilities wards had a strict policy not to admit to beds when patients were on leave, so that patients could return immediately and without fear of losing their bed. Patients were supported to personalise their bedrooms. Educational services were on site so that adolescents could attend school.

Summary of findings

- Appropriate systems were in place to enable children and young people in the community health services to access treatment and support prior to a formal diagnosis.
- The community adult nursing service provided a range of interventions to prevent admission to hospital and to facilitate discharges from acute settings.
- Services were planned and delivered to meet the needs of individual patients and of the local community. Effective relationships with key stakeholders and commissioners led to a coordinated approach to service design and delivery.
- Staff had a good understanding of equality and diversity.
- Community health therapy and nursing teams had good knowledge of how to improve care for those living with dementia/complex needs. The patient's needs were detailed in care plans and were person centred.
- In the community adult nursing services, all patients were seen within the 18 week referral to treatment time with the exception of podiatry.
- Community end of life services enabled rapid discharge of patients from the acute hospital, providing support to meet patients' individual needs and wishes. The trust supported patients to achieve their preferred place of death either through rapid discharge to home, hospice or nursing home or by ensuring appropriate care for patients who wished to die at home.
- Across the majority of community health services, trends and themes from complaints and concerns were discussed at speciality and at local levels. Good practice advice and required learning was identified and actions taken. Information and learning was disseminated to staff.

Are services well-led?

We rated Coventry and Warwickshire Partnership NHS trust as requires improvement for well-led because:

- The trust did not have robust governance arrangements in relation to assessing, monitoring and mitigating risks of ligatures in the patient care areas. Whilst ligature risk assessments and action plans were in place, they did not address how to manage the risks. An unacceptable number of ligature risks remained on the acute wards.
- The trust had identified high levels of restraint and prone restraint used in 2014 and had completed an action plan to reduce this. A review of the action plan in 2015 identified that some recommendations had not been actioned, and some only partially actioned. This included doctors reviewing patients

Requires improvement ●

Summary of findings

who had been restrained within two hours and for staff to explore alternative restraint methods. However, at the time of inspection we noted that doctor reviews were still not taking place and there had still been a high level of use of prone restraint, in particular on Amber ward.

- All staff in the acute wards expressed concern, particularly around changes to the roster system, planned new shifts and the ten-minute handover. The planned imposition of car parking charges, particularly on those regarded as essential car users, had a negative impact on staff morale.

- At St Michael's hospital, staff said middle and senior management were rarely on site. Some staff we spoke to said they felt there was a disconnect between themselves and senior managers or the trust board. Staff expressed concerned about the possible change of use of the site and what this would mean to them as there had not been any communication from senior management.

- The trust kept Mental Health Act and Ministry Of Justice records at the Caludon centre, rather than at the site the patient was being cared for.

- There was a high level of staff vacancies in some wards, and in particular Jade ward had experienced a high level of staff turnover in the previous six months. Staff reported morale was low. There was higher than expected sickness levels on Jade and Tuxford ward. The trust aimed to achieve sickness under 4.5% but Jade ward had a 7.6% sickness level between December 2014 and 2015. It was unclear how these had been addressed.

- Staff recording of supervision was inconsistent across teams. Staff in the learning disabilities service had not received supervision in line with the trust guidelines of two monthly.

- The trust was not meeting the 95% compliance rate for mandatory training across all services. The trust expected 95% compliance for mandatory training, but the inpatient wards fell below this threshold.

- In the community dental service, we found that there was no clearly defined strategy for the service to drive improvement and innovation. There was no robust oversight and management of risks within the service. The specialist palliative care team did not have clear strategy in place for delivering end of life care services.

- In the integrated sexual health service (ISHS), the Deanery contract for trainee doctors in the ISHS was withdrawn in 2015.There were issues around clinical leadership, patient safety and educational supervision. Significant progress had been made in the ISHS since the previous visit. However, there

were concerns regarding the relationship between consultants in sexual health services which were still to be resolved. It was reported that if all issues were resolved, there was a possibility trainees could be reintroduced from August 2016. The service had not always taken timely action to address gaps in some clinical procedures, which meant that not all risks in this service had been addressed in a timely manner.

However:

- Staff told us they were aware of the trust vision and values. Ward managers said they had sufficient authority and felt able to carry out their role effectively. Staff knew who the most senior managers in the trust were.
- Staff told us that they would be confident to use the whistleblowing procedure and felt their concerns would be taken seriously. Staff we spoke with was aware of their responsibilities to be open and honest with patients and families when things went wrong.
- Staff said that there were opportunities for personal development and training. Staff reported that they enjoyed their roles and that, with the exception of acute and PICU, morale within the teams was good.
- Staff sickness and absence rates and poor performance were managed with human resources support. Sickness, absence and turnover rates were low. Staff frequently told us they had worked for the trust and the service for a number of years.
- There were well-developed audits in place to monitor the quality of the service. The trust used 'ward to board' reports to gauge the performance of the team. The reports were presented in an accessible format. Staff carried out clinical audits which were reviewed by ward managers and results were fed back during team meetings if improvements were needed.
- Staff were positive, experienced, confident, well-motivated and worked together well. They frequently expressed satisfaction in doing a good job in helping people in crisis.
- Team managers identified areas of risk within their teams and submitted them to the trust wide risk register.
- Staff in child and adolescent mental health services (CAMHS) were committed to improving the service by participating in Quality Network for Community CAMHS and research.
- The issues in ISHS were being addressed in line with the agreed action plan overseen by Health Education England and it was anticipated that trainees would be reintroduced in August 2016. There were clear governance frameworks in place and the outcomes of audits and governance meetings were shared with staff.

Summary of findings

- In community health services, staff and service leads were clear about their priorities and vision and felt involved with the re-design of the healthy lifestyle service and creation of an integrated neighbourhood team. Staff at all levels showed an awareness of the strategy for the service. There was feedback from patient surveys and action taken to improve services.
- Leadership within community services was effective. Most staff felt supported by their immediate managers and senior managers within the community. There was knowledge of the trust leadership team and of the executive link system. Staff said they felt able to suggest new initiatives for improving care and efficiency within their service, and felt involved in changes within community teams.
- In most areas, the community services had recognised the risks to patient safety and the quality of care and treatment, actions were clearly defined and staff felt the results were very positive. There was effective oversight and management of risks across most parts of the service.

Summary of findings

Our inspection team

Our inspection team was led by:

Chair: Paul Jenkins, Chief Executive, Tavistock and Portman NHS Foundation Trust

Team Leader: Julie Meikle, Head of Hospital Inspection, mental health hospitals, CQC

Inspection Manager: Margaret Henderson, Inspection Manager, mental health hospitals, CQC

The team included four inspection managers, 14 inspectors, four Mental Health Act reviewers, a pharmacy inspector, support staff and a variety of specialists. The specialists included consultant psychiatrists, specialist nurses in mental health, and learning disabilities, psychologists, occupational therapists, social workers and specialists in community health services.

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

Why we carried out this inspection

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

How we carried out this inspection

When we inspect, we always ask the following five questions of every service and provider:

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

Before visiting, we reviewed a range of information we hold about Coventry and Warwickshire

Partnership NHS Trust and asked other organisations to share what they knew. We spoke with commissioners, local healthwatch and local service user groups. We looked at information received from service users and carers and members of the public who had contacted the CQC about this trust.

We carried out an un-announced visit on 21 April 2016 to Ferndale, Rowans and Larches at St Michael's hospital.

Prior to and during the visit the team:

- Held focus groups with 13 different staff groups.

- Spoke with 147 patients and 35 carers and family members, collected feedback from 95 comment cards.
- Attended five multidisciplinary meetings.
- Attended five community treatment appointments, two clinics and 19 home visits.
- Looked at the personal care or treatment records of 366 patients and service users, including medication cards.
- Looked at patients' legal documentation including the records of people subject to a community treatment order.
- Observed how staff were caring for people.
- Interviewed more than 355 staff members.
- Looked at 18 staff records.
- Interviewed senior and middle managers.
- Reviewed information we had asked the trust to provide.

We visited a sample of the trust's hospital locations and community mental health services.

We inspected most wards across the trust including adult acute services, the psychiatric intensive care unit (PICU), rehabilitation wards and older people's wards. We looked

Summary of findings

at the trust's places of safety under section 136 of the Mental Health Act. We inspected learning disability, children and adolescent mental health services, adult mental health and older people's community services and the trust's crisis services. We visited a sample of adult community mental health services.

For the community health services of the trust we visited a sample of services provided in the community adult nursing, end of life care, children and young people and families and the community dental service.

Information about the provider

Coventry and Warwickshire Partnership NHS Trust has 19 registered locations serving mental health, community and learning disability needs, including six hospitals sites: Brooklands, Caludon Centre, Manor Hospital, St Michael's hospital, Aspen Centre and Woodloes House.

The trust delivers the following mental health services:

Community-based mental health services for older people

Long stay/rehabilitation mental health wards for working age adults

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

Wards for older people with mental health problems

Community-based mental health services for adults of working age

Mental Health crisis services and health based places of safety

Community mental health services for people with learning disabilities

Wards for people with learning disabilities

Forensic inpatient/secure wards

Specialist community mental health services for children and young people

In addition, the following community health services:

Community health services for adults

Community health services for children, young people and families

End of life care

Community dental services

The community dental service is based at the City of Coventry Health Centre. The service provides a special care

dental service for all age groups who require a specialised approach to their dental care and are unable to receive this in a General Dental Practice. There were nine surgery rooms available, but one was not in operational use at the time of our inspection. The service provides assessment and treatment for people with specific needs. The service also provides oral health promotion and education and orthodontic treatment.

The trust provides a range of community adult nursing services for people in Coventry. The trust provides community and day clinics as well as specialist services to a population of around 850,000 living within Coventry and Warwickshire and also to a wider geographical area in some of the specialist services. The trust's community services pathway incorporate integrated community matrons, nursing and therapy teams. These teams provide a response for urgent and unplanned care as well as on-going patient cases and care management for those with chronic disease and long term conditions. The trust offers rehabilitation services and support in the community, enabling independence and integration. The service provides opportunities for patients to maintain physical, emotional and social wellbeing for those patients living with disability and discomfort.

Care for patients approaching the end of life is provided by the trust's specialist palliative care team. Specialist palliative care nurses support community nurses who work in integrated teams to provide end-of-life care services to patients in their own homes, care homes and nursing homes. The trust also has community care staff trained to support people at the end of life. These are a team of health care assistants who had undertaken additional training in caring for patients with advanced illness in their home environment.

The children, young people and family services provide care and support to children and young people 0-19 years with complex health and support needs. Care teams for

Summary of findings

pre-school and school age children deploy nurses with specialist skills in epilepsy, specialist respiratory, specialist palliative care, therapists, play therapist, specialist school nurses and support workers in the children's continuing care team. Services include: community paediatrics, children's community nursing community children's nurse service, children's continuing care, health visiting family nurse partnership, immunisation and vaccination services, physiotherapy, occupational therapy, speech and language therapy service, the children's neurodevelopment service and the looked after children service and the children's learning disability service. The integrated sexual health service (ISHS) is part of the integrated community services for the trust. The service offers a fully integrated model of sexual health services, which includes sexual health screening and management, contraception, outreach and community services.

The trust was formed in 2006 and integrated with community services from NHS Coventry, in April 2011.

Coventry and Warwickshire Partnership NHS Trust has been inspected once under the new methodology of inspection (date of initial publication: April 2014) and was not rated by the CQC.

That inspection took place between 21 and 24 January 2014 and looked at these locations: Brooklands Solihull, St Michael's hospital, Caludon Centre, the Aspen Centre Warwick, Hawkesbury Lodge, Highfield House, the Manor Hospital, Woodloes Avenue Warwick, Lyndon House Solihull, Gramer and Holy House North Warwickshire, Bradbury House, the Birches and community based mental health and community based services. Actions were identified for the trust to take.

There have been 26 Mental Health Act reviewer visits since 2 July 2014 until 29 February 2016, all unannounced. In total over the 26 visits there were 171 issues found at locations across the trust.

What people who use the provider's services say

We spoke with 147 patients and 35 carers.

- Patients were positive about their care and treatment and said that staff were caring, understanding and respectful. Patients told us they enjoyed the ward activities. Patients told us they felt safe on the wards. Patients said staff did not always inform them of their rights on admission.
- Most patients we spoke with said they knew how to complain and felt able to raise concerns. Patients told us they knew how to access the advocacy services. Families and carers had the opportunity to be involved in care reviews.
- The latest patient led assessment of the care environment audit (PLACE) showed 99% for cleanliness at Coventry and Warwickshire. The trust scored higher than the England average for 2015, which was 98%.
- The PLACE scores for privacy, dignity and wellbeing for wards at Coventry and Warwickshire Partnership Trust showed 92% satisfaction. The trust scored higher than the England average for 2015, which was 86%.

- People in crisis told us they were able to get prompt responses from the service. We had no adverse comments from people about having to wait for appointments or having them cancelled.
- Families told us that waiting times to gain access to treatment in CAMHS were long, but once treatment started, it was very good. They were pleased that staff liaised with schools so that they could support the young person when at school. Parents reported that the parenting group was very good and that they learnt a lot from attending and found support from other families too.
- The percentage of respondents who would recommend the trust as a place to receive treatment was similar to the England average of 95% during the six-month period from July to December 2015.
- For the community health services of the trust, people were very positive about the services and told us that staff were very welcoming and took time to explain things. They said staff provided advice on wellbeing, health, diet and exercise.

Summary of findings

Good practice

In community health service for adults:

- The tissue viability services had been nominated for a Pride of Nursing Award (2016). The Pride of Nursing Awards gave patients the opportunity to recognise a nurse or nursing team who may have gone above and beyond the call of duty or who had demonstrated incredible compassion which made a difference to the patient and/or their family.

In the community end of life care service:

- The specialist palliative care team had been accepted to participate in a clinical research study by the NHS National Institute of Health Research. The objective of the Prognosis in Palliative Care Study II (PiPS2) was to identify the best method to accurately predict survival in patients with incurable cancer. This will be the first clinical trial undertaken by the SPCT. The team members were enthusiastic and looked forward to starting the study once ethical approval had been obtained.

In the community children and young peoples' service:

- There was a strong focus on and innovative approach to providing integrated pathways of care, particularly for children and young people with complex health needs. For example, development of autism assessment and treatment services.

In mental health:

- Sherbourne ward provided six hours protected time every six weeks to staff. The ward manager organised this time for local audit, specific training, peer supervision and psychology led patient discussions.

Across services:

- A significant reduction in the incidence of pressure ulcers has been achieved using a clinical audit programme.
- The work on nurse recruitment and, in particular the pre-nursing programme for HCAs, was effective and highly regarded.

Areas for improvement

Action the provider MUST take to improve

- The trust must review provision of inpatient beds to ensure compliance with the Department of Health guidance and Mental Health Act 1983 Code of Practice in relation to eliminating mixed sex accommodation.

- The trust must take action to remove identified ligature risks and ensure that ligature risk assessments contain plans for staff to manage risks. The trust must mitigate where there are poor lines of sight.

- The trust must ensure seclusion meets the Mental Health Act code of practice and provide clarity to staff about which seclusion rooms are in use.

- The trust must ensure that qualifying patients are referred to support from an Independent Mental Health Act Advocate (IMHA), in line with MHA code of practice. Section 17 forms must indicate to whom they had been given in addition to the patient.

- The trust must ensure that seclusion is carried out in adherence to the MHA code of practice.

- The provider must ensure that patients with CTO or MOJ conditions are recorded on care and risk plans. The provider must ensure that MOJ and MHA records and reports are accessible to all staff.

- The trust must ensure that there are enough staff on duty to meet the needs of the patients, that staff are given regular clinical supervision and that staff have training on the Mental Health Act (1983).

- The trust must ensure there is robust oversight and management of all risks within the community dental service.

- The trust must establish a clearly defined process to effectively manage the current waiting list in the community dental service.

- The trust must ensure that appropriate risk assessments and policies are in implemented regarding the mobile dental unit, community visits and the use of a local hospital to deliver care and treatment in the community dental service.

Summary of findings

Action the provider SHOULD take to improve

- The trust should ensure the safe disposal of waste medication.
- The trust should reconsider the restrictions such as hot drinks not being offered to patients at night, preventing patients from charging their mobile phone during the day.
- The trust should ensure that care plans have appropriate mental capacity assessments when required, that care plans are personalised and holistic and that a copy is given to the patient where appropriate. The provider should ensure staff record patient and carer involvement in care and treatment records.
- The trust should ensure patient confidentiality when putting names on doors to patient's bedrooms. The trust should consider providing privacy panels in bedroom doors for staff to observe patients when required.
- The trust should ensure physical health monitoring for all patients which is correctly documented.
- The trust should ensure that all staff adhere to the lone worker policy.
- The trust should ensure all eligible patients are allocated a care coordinator.
- The trust should develop a clearly defined strategy for the community dental service to drive improvement and innovation.
- The trust should review the storage space available within the community dental service to ensure appropriate facilities are provided.
- The trust should monitor that all chemicals hazardous to health were appropriately stored in the community dental service.
- The trust should ensure appropriate facilities are available for the secure storage of records in the community dental service.
- The trust should ensure that equipment is stored appropriately within the community adult nursing services.
- The trust should ensure staff wear the appropriate equipment when working in the workshops.

- The trust should ensure all records are reviewed to ensure they have the correct patient care and treatment information contained within in the adult community nursing service.
- The trust should ensure that staff use the correct protective equipment when providing care to patients in the clinics and community.
- The trust should ensure that all containers have the appropriate hand cleaning gel.
- To ensure all staff in the community adult nursing service have received Mental Capacity Act training.
- The trust should ensure that all complaints are reported to ensure themes are identified and lessons learnt are cascaded to staff in the adult community nursing service.
- The trust should develop a strategy and vision for end of life care services focused on achieving priorities identified by the end of life care service and delivering good, quality care.
- The trust should review safeguarding level 3 staff training requirements in the integrated sexual health service levels.
- The trust should review the clinical procedure for the insertion of contraceptive devices to include inserting the devices in a patient's home.
- The trust should review the policy for ordering, storing and handling of vaccines (NHS England 2015).
- The trust should ensure all patient records in the community children's and young people service are kept updated in a timely manner.
- The trust should review the use of laptops in the community children's and young people service to ensure staff are able to connect to the trust network when required.
- The trust should review processes in place to manage the high level of demand for the therapy and autism services.
- The trust should continue to work towards meeting the requirements of the integrated sexual health service and Health Education England (HEE) action plan to facilitate reintroduction of trainee doctors in the service.

Coventry and Warwickshire Partnership NHS Trust

Detailed findings

Mental Health Act responsibilities

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

- Not all teams achieved the compliance rate for MHA and Mental Capacity Act (MCA) training, the trust's target was 95%.

- In some teams there were some discrepancies with Mental Health Act (MHA) paperwork, for example, staff did not offer a copy of section 17 leave forms to the patients. Section 17 leave forms did not always record who else had been given a copy other than the patient. Staff did not fully complete patients' rights forms, under section 132 of the MHA. There was

  no evidence of staff reading detained patients their rights to have an Independent Mental Health Advocate (IMHA) upon admission to some wards.

- Trust staff carried out audits on the MHA but these did not always identify issues such as documenting reading of rights to patients and informing them of their right to access advocacy.

- Patients were not being told of their right to support from an Independent Mental Health Act Advocate (IMHA). Those patients lacking capacity were not referred to advocacy automatically in line with MHA code of practice. Some care records showed no evidence of assessment of mental capacity.

- No records of Mental Health Act (MHA) paperwork or Ministry of Justice (MOJ) warrants or orders were available in paper or electronic forms at IPU 10-17, Swanswell Point. Two patient's Ministry of Justice records were not available at the MHA office at the Caludon centre. Three patients with a criminal history, under supervision of the Ministry of Justice (MOJ), did not have their conditions included in their risk or care plans. The Ministry of Justice (MOJ) monitors and set conditions for the care, treatment, and whereabouts of mental health patients with a criminal history. Community treatment order conditions were not included in the care plan for one patient.

- There were errors on consent to treatment documents (T2 and T3 forms) on two wards, relating to three patients. Prescribing did not adhere to the agreed plan, which made the treatment invalid for the detained patients in question.

- There were 26 Mental Health Act reviewer visits since 2 July 2014 until 29 February 2016, all visits were unannounced. In total there were 171 issues found at locations across the trust. The highest category for issues was "purpose, respect, participation, least restriction with 60 issues, equating to 35% of the total. Spencer Ward at Caludon Centre was the only ward to be visited twice – six issues were found during the first visit and eight issues at the second. Snowdon Ward at Brooklands Hospital had the most issues in a single visit with nine. Eden Unit at Brooklands Hospital had the lowest number of issues in a single visit with three.

Detailed findings

Mental Capacity Act and Deprivation of Liberty Safeguards

The CQC have made a public commitment to reviewing provider adherence to Mental Capacity Act and Deprivation of Liberty Safeguards.

- Staff we spoke with showed varying degrees of knowledge about the Mental Capacity Act (MCA) and Deprivation of Liberty Safeguards (DoLS). Not all teams achieved the compliance rate for MHA and Mental Capacity Act (MCA) training, the trust's target was 95%. Staff on adolescent units did not understand the Gillick competence and consequently did not have the knowledge and skills to assess capacity. Staff on Tuxford Avenue adolescent wards had not always appropriately assessed patients' capacity.

- When decisions of capacity had been decided, there was not always evidence about how staff had reached decisions. For example, they had not carried out capacity assessments which included the patients, relatives, and advocates.

- Managers had systems in place to monitor adherence to MCA and staff knew where to access the policies relating to MCA. Relevant staff told us they were familiar with best interest meetings, and told us these were carried out on a decision specific basis, we saw evidence in the care records of best interest meetings having taken place. Staff told us they felt supported by the social workers in their teams when dealing with mental capacity issues.

- From 1 July 2015 to 31 December 2015 thirty one (47%) out of 66 DoLS applications were granted and 19 declined (29%). Quinton ward had the most DoLS applications with 25 followed by Swanswell with 11.The CQC records show that we received 60 Deprivation of Liberty Safeguarding Applications (DoLS) from the trust between 1 July 2015 and 31 December 2015. There were 54 for Caludon Centre, four for Brooklands and two (unspecified) for Coventry and Warwickshire Partnership NHS Trust.

- The trust informed us that in the 12 months up to March 2016 there had been 45 applications made at the Caludon, four at Brooklands, eight for St Michaels and three for Hawkesbury Lodge.

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 Coventry and Warwickshire Partnership NHS trust as requires improvement for safe because:

- We identified a number of concerns around safety. The Department of Health guidance and Mental Health Act 1983 Code of Practice in relation to the arrangements for eliminating mixed sex accommodation were not met on all wards. The trust breached the elimination of mixed sex regulations on six wards, Stanley, Pembleton, Ferndale, Sherbourne, Rowans and Hawkesbury Lodge. Rowans ward was unable to provide a young person with a separate lounge due to the limited space on the ward. Female patients were sleeping in the male area of the ward.

  On Larches ward there were two call bell systems in place. One system was de-activated but buttons still visible. Call bells were 'disabled' during original inspection. On a follow-up visit the bells were working, with the exception of one bathroom which remained broken.

  Concerns were identified regarding the number of ligature points on the wards with unclear management plans in place. On Larches ward there were multiple ligatures, for example bathroom taps, shower fittings and bedroom windows and handles. Ligature cutters were kept in clinic rooms which were locked. Individual risk assessments were not all up to date. Anti-barricade doors on Spencer ward could not be opened because staff could not locate the correct key. Wards had blind spots where staff could not observe patients easily and the risk had not been mitigated.

- Three patients with a criminal history, under supervision of the Ministry of Justice (MOJ), did not have their conditions included in their risk or care plans. The Ministry of Justice (MOJ) monitors and set conditions for the care, treatment, and whereabouts of mental health patients with a criminal history. Community treatment order conditions were not included in the care plan for one patient.

- In the older adults service a link corridor was used for de-escalation and the management of aggression. These incidents were recorded using the seclusion policy documentation. However the environment did not meet seclusion standards. Patients were at risk of harming themselves in the seclusion room on Janet Shaw Clinic. There were panels on the walls in the ensuite area which could have been used for the purpose of harming self, or used as a potential weapon to harm others.

- Staff on Eden ward were did not consistently complete observation records fully. Forty-three percent of patient observation records had gaps in staff documentation. In addition, codes for patients' whereabouts were used incorrectly which presented a risk that staff may not have accurate information on patients' locations.

- Forensic wards worked below the identified levels of staffing on a regular basis. This meant that patients may not have received the care and treatment they required at the time they needed it.

- Staff did not always ensure that medications were stored and administered safely. In learning disabilities services staff were using four bottles of medication that were out of date and left medication on the side that was not secured. Staff could not account for this. Staff in some services discarded medication waste into the sharps bins, which is not in line with guidance on the safe disposal of medication. Staff could not demonstrate they completed medicine reconciliation in a timely manner as there were no indications on the charts for its completion. No emergency equipment was available on any site for adult community teams.

Are services safe?

- Patients on some wards were unable to access hot drinks after 9pm, until the following morning. On two wards patients were unable to charge their mobile phones during the day. Staff displayed signs on the ward to this effect. Patients admitted to the first floor wards could not access outside garden space unless escorted by staff and staff were not always available.

- Not all crisis resolution staff were adhering to the lone worker policy by using the available electronic monitoring system.

- The CAMHS service had seven vacant posts for qualified nurses. Two teams did not have team managers in post. A total of 265 young people had not been allocated a care coordinator. Interview rooms were booked for adult community teams to use. This meant young people could be placed at risk if an adult did not accompany them to their appointment as there was only one waiting area.Two of these services did not have alarms fitted in interview rooms.

- In the community health service overall, not all services had undertaken robust risk assessments to manage risks in the delivery of care and treatment.

- Not all risks in the environment and in the community health service had been recognized and addressed.

- Risk assessments regarding dental community visits and use of the mobile dental unit were not in place.

- Not all services in community health complied with infection control procedures to minimise the risk of transmission of infectious diseases. There was no requirement for any clinic based service to collect safety thermometer data. Staff within the adult community nursing services said they did not routinely collect safety thermometer data unless there was an identified harm such as a fall. Mangers were addressing this.

However:

- Ward equipment was well maintained and the wards were clean, bright and airy. Interview and waiting areas used by patients were clean, well-maintained and safe. Equipment was well maintained and fit for purpose.

- In older adults wards staff used the 'Modified Early Warning Signs' (MEWS) tool on all wards. Staff recorded physical observations using the MEWS ratings to make a decision about further action they should take. Falls assessments had been completed and care plans were in place. Staff in the crisis services closely monitored patients so they could respond swiftly to any change in their well-being.

- Staff had a good understanding of how to protect patients from abuse. Staff could identify what would constitute a safeguarding referral, how to report, and who to report too. Staff regularly completed safety and security audits of the ward areas. Appropriate arrangements were in place for children visiting. Patients told us that they felt safe on the wards. 100% of staff who require safeguarding children level 3 were trained.

- With the exception of the learning disabilities service there were good processes for the storage, recording and administration of medication. Clinic rooms were clean and tidy. Staff checked emergency equipment daily and it was in good working order. Staff had access to emergency medicine on all inpatient sites.

- Staff reported that ward managers were supportive when incidents occurred and held debriefs quickly for the benefit of staff and patients following incidents.

- There was rapid access to a psychiatrist when required in inpatient areas.

- The trust had calculated the number and grade of staff needed to care for patients. When necessary, regular bank and agency staff were used who knew the ward and patient group. The trust was continuing to recruit staff to vacancies.

- The trust had ensured that Amber and Jade ward had been fitted with anti-ligature furnishings, and where there were ligature risks, they had identified the level of risk and mitigated these.

Are services safe?

- Staffing levels in community services were appropriate and met patients' needs at the time of inspection, despite some areas having staffing pressures. Staffing shortages were acted upon appropriately with the use of temporary staff and an effective induction process was in place.

- In community services, we found that incident reporting occurred regularly and appropriately throughout most areas and staff received feedback when they reported an incident. We saw evidence of lessons learnt from incidents being shared across community services.

Our findings

Safe and clean environment

- We identified a number of concerns around safety. The Department of Health guidance and Mental Health Act 1983 Code of Practice in relation to the arrangements for eliminating mixed sex accommodation were not met on all wards. The trust breached the eliminating mixed sex guidance on six wards, Stanley, Pembleton, Ferndale, Sherbourne, Rowans and Hawkesbury Lodge. Female patients were sleeping in the male area of the ward. Rowans ward was unable to provide a young person with a separate lounge due to the limited space on the ward. The trust did not conform to standards for accommodating young people admitted to adult wards. Department of Health guidance says, 'A young person's sleeping area should be in a securely separated area of the ward away from the opposite sex. All young people should bathe and wash in privacy and in areas separate from the opposite sex.' The environment on Rowans ward did not meet this guidance for the young person on the ward. However, the inpatient wards only admit young people as an exception. The environment is based on commissioned services for adults. The patient had been on the ward for two months.

- On Larches ward there were two call bell systems in place. One system was de-activated but buttons still visible. Call bells were 'disabled' during original inspection. On a follow-up visit the bells were working, with the exception of one bathroom which remained broken.

- Concerns were identified regarding the number of ligature points on the wards with unclear management plans in place. On Larches ward there were multiple ligatures, for example bathroom taps, shower fittings and bedroom windows and handles. Ligature cutters were kept in clinic rooms which were locked. Individual risk assessments were not all up to date. Anti-barricade doors on Spencer ward could not be opened because staff could not locate the correct key.

- Wards had blind spots where staff could not observe patients easily and the risk had not been mitigated. Medicines were not always stored safely nor disposed of correctly in the learning disabilities service.

- In the older adults service a link corridor was used for de-escalation and the management of aggression. These incidents were recorded using the seclusion policy documentation. However the environment did not meet seclusion standards. Patients were at risk of harming themselves in the seclusion room on Janet Shaw Clinic. There were panels on the walls in the ensuite area which could have been used for the purpose of harming self, or used as a potential weapon to harm others.

- Not all crisis resolution staff were adhering to the lone worker policy by using the available electronic monitoring system.

- Ward equipment was well maintained and the wards were clean, bright and airy. Interview and waiting areas used by patients were clean, well-maintained and safe.

- PLACE assessments are self-assessments undertaken by teams of NHS and private/independent health care providers, and include at least 50 per cent members of the public (known as patient assessors). They focus on different aspects of the environment in which care is provided, as well as supporting non-clinical services. The 2015 PLACE scores for cleanliness for Coventry and Warwickshire was 99.7% which is higher than the average of 97.8%.

- In CAMHS interview rooms were booked for adult community teams to use. This meant young people could be placed at risk if an adult did not accompany them to their appointment as there was only one waiting area. Two of these services did not have alarms fitted in interview rooms.

Are services safe?

- The trust provided a copy of their estates strategy. A number of estates programmes of work had been completed and had led to safer sites for patients to receive care and treatment within and for staff to deliver quality services. The trust identified some remaining risks which were managed locally and in accordance with the trusts risk management strategy.

- In the community dental services, a lack of suitable storage space meant that one of the surgery rooms was being used for purposes it had not been designed for. The service took immediate actions to address this. Not all chemicals hazardous to health were appropriately stored. The service took immediate actions to address this.

- In the community adult nursing service, equipment was not always stored appropriately. For example, in the storage room which was shared by the podiatry and acupuncture clinic and wheelchair services, we found the room being left unlocked and unattended with access to hazardous material and acupuncture needles. Staff within the wheelchair services did not use protective glasses when working in the workshop.

- During our visits to the clinics and community services, we observed that most staff did not comply with best practice regarding infection prevention and control policies. Staff were seen not washing their hands or using hand sanitising gel between patients. Staff did not always wear personal protective clothing whilst providing care to patients. There was no hand gel available in the containers provided in clinics at Newfield House which included the wheelchair services.

- In the community dental service, we found that for the mobile dental unit, risk assessments had not been undertaken to ensure it was a suitable environment to undertake clinical care. Policies and risk assessments were not in place for treatment delivered in the local acute hospital. Not all risks in the environment and in the service had been recognized and addressed. Risk assessments regarding community visits were not in place.

Safe staffing

- Data for between1 December 2014 and 30 November 2015 showed:

Total number of substantive staff was 3885

Total number of substantive staff leavers in the last 12 months 565

Total substantive leavers in the last 12 months 14.5%

Total vacancies overall (excluding seconded staff) 10.5%

Total permanent staff sickness overall 5.3%

Establishment levels qualified nurses (WTE) 1115

Establishment levels nursing assistants (WTE) 790

Number of WTE vacancies qualified nurses 153

Number of WTE vacancies nursing assistants 104

Shifts filled by bank or agency staff to cover sickness, absence or vacancies 8604

Shifts NOT filled by bank or agency staff where there is sickness, absence or vacancies 1113 (13%).

- Among the mental health services, wards for adults acute/PICU had the highest number of qualified nurse vacancies for mental health services with 36.5 vacancies, an 18% vacancy rate. Community CAMHS had the highest qualified nurse vacancy rate over the last year at 24%.

- Mental health wards acute/ PICU had the highest number of shifts filled by bank with 1494 bank shifts and 1010 agency shifts and the highest number of shifts not filled by bank was 101 and agency was 519.

- Mental health learning disabilities wards had the highest vacancy rate of 18.5% over the 12-month period (155 staff). Mental health community adults had the lowest vacancy rate 4% over the 12-month period (389 staff). Mental health long stay / rehabilitation wards had the highest staff sickness rate of 9.6% over the 12-month period (60 staff). Community LD had the lowest staff sickness rate of 4.5% over the 12-month period (95 staff).

- Community health services (CHS) for adults had the highest number of vacancies for qualified nurses within community health services with 29. CHS end of life services had the highest qualified nurse vacancy rate of 37% over the last year. CHS end of life care services have the highest vacancy rate of 37% over the 12-month period (25 staff) and the lowest staff sickness rate of 3% over the 12-month period.

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- CHS dental services had the lowest vacancy rate 6.4% over the 12-month period (35 staff). CHS sexual services had the highest staff sickness rate of 7.5% over the 12-month period (42 staff).

- The trust identified wards where nurse staffing fell short of the trust's standards and those where the standards have been significantly exceeded noting the reasons and outlining actions taken. Including:

• Significant improvement in achieving planned night time staffing levels in Learning Disabilities

• Continued challenges in mental health to provide registered nurse night shift cover

• Mental health is considering the appropriateness of adopting the buddy system of night shift cover recently implemented in Learning Disabilities

- Forensic wards worked below the identified levels of staffing on a regular basis. This meant that patients may not have received the care and treatment they required at the time they needed it. The CAMHS service had seven vacant posts for qualified nurses. Two teams did not have team managers in post. A total of 265 young people had not been allocated a care coordinator.

- The trust provided a copy of their training needs analysis. The figures regard the last 12 months of training data from the trust (as at 30 November 2015). The trust had a target of 95% for the following courses:

• Basic Life Support

• Equality & Diversity

• Fire Safety

• Health & Safety

• Infection Control

• Information Governance

• Manual Handling

• MH Act/MCA/DOLS Awareness

• Prevent

• Safeguarding Adults Level 1, Level 2, Level 3

• Safeguarding Children Level 1, Level 2, Level 3

- The trust as a whole, including all teams and courses, were at 85% completion on average. Mental Health Act, Mental Capacity Act, Deprivation of Liberty Safeguards awareness training showed a lower percentage of completion in most teams. The mental health services had mandatory training compliance rates ranging from 80% in community CAMHS, and 92% in the rehabilitation wards. Adults and children safeguarding level 1 training had the highest compliance rates with 94.6% and 94.7% respectively. The management and prevention of aggression (MAPA) Disengagement Foundation Refresher was the lowest percentage of staff eligible completing the course at 30%.

- All community health services had a mandatory training compliance rate above the trust average of 84%. In the integrated sexual health service levels of staff requiring Level 3 safeguarding training appeared to be lower than expected in light of the CQC safeguarding review (2015).

- Staffing shortages in community health services were acted upon appropriately with the use of temporary staff and an effective induction process was in place. Staff told us there were always enough staff to maintain the smooth running of the service and there were always enough staff on duty to keep patients safe. We saw records that demonstrated staffing levels and skill mix were in line with planned staffing requirements for the planned service delivery.

Assessing and managing risk to patients and staff

- Staff on Eden ward did not consistently complete observation records fully. Forty-three percent of patient observation records had gaps in staff documentation. In addition, codes entered did not fully correspond with codes on the form regarding patients' whereabouts, which presented a risk that staff may not have accurate information on patients' locations where patient were.

- Staff did not always ensure that medications were stored and administered safely. In learning disabilities services staff were using four bottles of medication that were out of date and left medication on the side that was not secured. Staff could not account for this. Staff in some services discarded medication waste into the sharps bins, which is not in line with guidance on the safe disposal of medication. Staff could not demonstrate they completed medicine reconciliation in a timely manner as there were no indications on the charts for its completion.

- The trust flagged 'risks' against the following indicators:

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• Proportion of registered nursing staff as at 30/09/2015. The observed rate was 39% compared to the expected rate of 53%.

• Providers should demonstrate that there are enough staff with the right competencies, knowledge, qualifications, skills and experience to meet the needs of people who use the services at all times.

• Ratio of occupied beds to all nursing staff as at 30 September 2015. The observed ratio was 8.2 compared to the expected ratio of 4. 5.

• Proportion of care spells where patients are discharged without a recorded crisis plan 1 July 2014 to 30 June 2015. Observed rate was 100% against an expected rate of 75%.

• There were 1,110 uses of restraint on 231 different services users of which 203 were uses of restraint in the prone position (18% of total restraints) and 58 resulted in rapid tranquilisation (5% of total restraints). There were four instances in the use of long-term segregation. The trust had identified high levels of restraint and prone restraint used in 2014 and had completed an action plan to reduce this. A review of the action plan in 2015 identified that some recommendations had not been actioned, and some only partially actioned.

• In the same period, there were 226 uses of seclusion, of which 174 occurred on the learning disability wards.

• The highest use of restraint occurred on learning disabilities wards (57% of incidents), followed by acute wards for adults of working age and PICUs (27% of incidents). These wards also had the highest use of restraint in the prone position - 56% occurred on learning disability wards and 26% occurred on Acute/PICU wards). For rapid tranquilisation, 71% occurred on acute wards for adults of working age and PICU wards.

Track record on safety

• We analysed data about safety incidents from three sources. Incidents reported by the trust to:

o the National Reporting and Learning system (NRLS)

o to the Strategic Executive Information System (STEIS)

o In addition, serious incidents reported by staff to the trust's own incident reporting system (SIRI).

• These three sources are not directly comparable because they use different definitions of severity and type and not all incidents are reported to all sources. For example, the NRLS does not collect information about staff incidents, health and safety incidents or security incidents. Providers are encouraged to report all patient safety incidents of any severity to the NRLS at least once a month. The most recent patient safety incident report covering 1 October 2014 to 31 March 2015 stated that for all mental health organisations, 50% of all incidents were submitted to the NRLS more than 26 days after the incident occurred.

• For the Coventry and Warwickshire Partnership NHS Trust, 50% of incidents were submitted more than 18 days after the incident occurred which means that it is considered to be a consistent reporter because they were reporting within a shorter timescale.

• The trust reported 9,270 incidents to the NRLS between 18 February 2015 and 17 February 2016. When benchmarked the trust were in the top 25% of reporters of incidents when compared with similar trusts. 22.5% of incidents (2,083) reported to NRLS resulted in no harm, 72.4% (6,713) of incidents were reported as resulting in low harm, 4.6% (425) in moderate harm, 0.06% (6) in severe harm and 0.5% (43) in death. The NRLS considers that trusts that report more incidents than average and have a higher proportion of reported incidents that are no or low harm have a maturing safety culture.

• Of the incidents reported to NRLS, 35% were related to disruptive, aggressive behaviour (includes patient-to-patient), 15% to self-harming behaviour and 9% to other.

• Trusts are required to report serious incidents to STEIS. These include never events (serious patient safety incidents that are wholly preventable). The trust reported 129 serious incidents between 18 February 2015 and 17 February 2016. None of these were never events. Never events are defined as: "Wholly preventable incidents, where guidance or safety recommendations that provide strong systemic protective barriers are available at a national level, and should have been implemented by all healthcare providers." Sixty two of the incidents occurred in adult community health services (48%), these were all pressure ulcers (43 meeting the serious incident criteria, 17 grade 3 and two

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grade 4). Of the mental health services, the highest number of incidents reported related to adult community mental health services with 27 incidents which was 21%.

- In the period 1 November 2014 to 31 October 2015, the trust reported 214 serious incidents through its serious incident requiring investigation (SIRI) reporting system. Of these, a majority (67%) were related to CHS adult services. Of the mental health services, mental health community adults services reported 30 serious incidents (14%). The majority of incidents were pressure ulcers (87), followed by unexpected/ avoidable death or severe harm of one or more patients, staff or members of the public (61) and withdrawn serious incidents (58).

- The NHS safety thermometer measures a monthly snapshot of areas of harm including falls and pressure ulcers. The trust recorded 120 new pressure ulcers between 1 November 2014 and 31 October 2015. The highest numbers recorded were 14 each in April 2015 and October 2015 with a prevalence rate of 2.9% and 3.6% respectively.

- The trust reported 206 falls with harm during this period with the highest totals being 26 in August 2015 with a prevalence rate of 6.4%.

- The trust reported 10 catheter and new urinary tract infection cases during this period with three each being reported in June 2015 and October 2015.

- The chief coroner's office publishes the local coroners Reports to Prevent Future Deaths which all contain a summary of Schedule 5 recommendations, which had been made, by the local coroners with the intention of learning lessons from the cause of death and preventing deaths.

- Over the last 12 months, one coroner's report was received by the trust in March 2015. The inquest related to the death of a 7 month old who died on 18 November 2012 due to brain injuries.

Reporting incidents and learning from when things go wrong

- The trust's mental health services notified CQC of 13 safeguarding concerns between January 2015 and February 2016. Seven of these were from the adult acute/PICU wards. There were no safeguarding alerts. Safeguarding alerts are where the CQC are the first

receiver of information about abuse or possible abuse, or where we may need to take immediate action to ensure that people are safe. Safeguarding concerns are where the CQC are not the first receiver of information about abuse, and there is no immediate need for us to take regulatory action. For example, where we are told about abuse, possible abuse or alleged abuse in a regulated setting by a local safeguarding authority or the police.

- The trust engaged with safeguarding boards across three different local authority areas (Coventry, Warwickshire and Solihull).In each, there were differing processes for safeguarding.As such, the trust's ability to report on referrals differed within each area.The trust shared some narrative outlining the specific working arrangements in place for the management and monitoring of safeguarding referral activity. There were 380 safeguarding referrals for adults made between 1 November 2014 and 4 January 2016.

- Referrals to children's social care teams were made in accordance with the processes set out by the local authority for that area. The process differed in each location and while the trust encouraged staff to share details of the referrals with the safeguarding team this was not always completed. Any forms that were shared with the team were logged.

- The range of services differed in each location.

• In Warwickshire there was secondary care mental health, CAMHS and community learning disabilities nurses.

• In Coventry there was also the addition of universal children's services, integrated community adult services, and learning disability short stay.

• In Solihull there was the Brooklands Hospital which was a learning disabilities hospital which takes patients from all over the country and a learning disabilities short stay unit.

• A total 0f 109 referrals for children were made across the trust between December 2014 and November 2015.

- Staff reported that managers were supportive when incidents occurred and held debriefs quickly for the benefit of staff and patients following incidents.

- In community health services, staff described how they would be open and transparent regarding any incidents. Staff demonstrated their understanding of how to raise

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concerns and report incidents and near misses. They said they were fully supported when they did so. All staff received a training manual on how to complete incidents electronically.

- We saw on display within the community services visited, a "learning alert" system. One example we saw was the need to ensure that any items staff could not obtain were reported as clinical incidents so appropriate management oversight could review the situation and take action to address the concern.

- The service had implemented clear guidance to reduce the number of pressure ulcers acquired within the community services. The simple steps to prevent pressure ulcers (SSKIN) model provided guidance on how to prevent and treat pressure ulcers. Staff said they were aware and used the SSKIN bundle. This was shown in the records reviewed.

- The community services had links with the tissue viability nurses who responded to any signs of skin changes and supported staff to follow the "React to Red – Prevention of Pressure Ulcers" programme.

Duty of Candour

- In November 2014 the CQC introduced a requirement for NHS trusts to be open and transparent with people who use services and other 'relevant persons' in relation to care and treatment and particularly when things go wrong. The duty of candour is a regulatory duty that relates to openness and transparency and requires providers of health and social care services to notify patients (or other relevant persons) of 'certain notifiable safety incidents' and provide reasonable support to that person.

- The trust shared its Complaints Management Procedure December 2015. The purpose of this report was to provide a brief overview of the complaints management procedure for the trust and how they demonstrated duty of candour. The trust stated that it demonstrated duty of candour by:

- Providing final response letters to complaints that acknowledge concerns and offer an apology when care and treatment did not go as planned.

- Being open and providing factual information when complaints are being investigated.

- Services responding quickly, directly and transparently when concerns are raised.

- Providing clear written and verbal information about the complaints process to patients, carers and families.

- Visiting complainants who are concerned about making a complaint.

- Actively engaging with complainants and agreeing timescales and actions for addressing their complaints.

- Listening to complainants and if they remain unhappy with the response to their complaint we consider a review of the findings.

- Identifying and implementing actions where shortcomings in the service are identified.

- Asking for feedback about the complaints process from complainants

- The trust had a policy to guide staff in relation to their responsibilities under duty of candour. Staff we spoke with knew about their responsibilities and the need for openness and transparency when things went wrong. We examined case records where patients had experienced a notifiable event to check that staff had been open and honest in their dealings with patients and carers. We found that the trust was meeting its duty of candour responsibilities.

- In the community health services, staff understood their responsibilities with regard to the duty of candour legislation. Staff said the dissemination of information was through electronic communications and their attendance at staff meetings.

- The community teams were able to describe a working environment whereby they would investigate and discuss any duty of candour issues with the patient and their family and/or representative and an apology given whether or not there had been any harm.

Anticipation and planning of risk

- The trust had an emergency planning policy to deal with a major incident or breakdown in service provision.

- Potential risks were taken into account when planning community health services, for example seasonal fluctuations in demand, the impact of adverse weather, or disruption to staffing.

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- Arrangements were in place to respond to emergencies and major incidents. A Business Continuity Plan was in place across community health services.

- There was good understanding amongst staff with regards to their roles and responsibilities during a major incident. Staff were able to signpost us to the trust wide policy which was located on the trust intranet.

- Checks of fire extinguishers and emergency lighting had taken place at regular intervals. We also saw records of recent fire drills and fire training within the last 12 months. We saw the fire evacuation procedure was clearly posted on the walls throughout the locations.

- Fire warden checklists were completed every month across most areas.

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 Coventry and Warwickshire Partnership NHS trust as requires improvement for effective because:

- Record keeping was poor particularly in relation to the Mental Health Act documentation. Patients told us they were not being told of their right to support from an Independent Mental Health Act Advocate (IMHA). Records lacked evidence of staff reading rights to patients. Those patients lacking capacity were not referred to advocacy automatically in line with MHA code of practice. Section 17 leave forms did not always record who else had been given a copy other than the patient. Some care records showed no evidence of assessment of mental capacity. No records of Mental Health Act (MHA) paperwork or Ministry of Justice (MOJ) warrants or orders were available in paper or electronic forms at IPU 10-17, Swanswell Point. Two patient's Ministry of Justice records were not available at the MHA office at the Caludon centre. Medical staff had made errors on consent to treatment documents (T2 and T3 forms) on two wards, relating to three patients. Prescribing did not adhere to the agreed plan, which made the treatment invalid for the detained patients in question. In community health services not all records were kept in a secure storage area and some were not maintained in accordance with trust procedures.

- Patient's views recorded in the 'this is me' document were not included in the care plan. Not all patients had a copy of their care plan. Some care plans were not personalised or holistic.

- The quality of care plans was variable. Many care plans were not holistic, for example, they did not include the full range of patients' problems and needs. There was evidence of care plans not being up to date on all acute wards. Care plans were generic and did not always consider patient views.

- Case records were computer and paper based. We found that it was difficult to locate all the information and in some cases, staff had duplicated paper work. Teams across the trust used different recording systems. Staff at the community teams used the electronic system whereas doctors and inpatient ward staff used paper records. In the community children and young peoples' service we noted there were delays with updating some care records in the service which could affect the continuity of care for children and young people.Plans were in place to address this. There were difficulties with connectivity in relation to the use of laptops in some areas of the community children and young peoples' service. This was particularly an issue for the health visitor service. Plans were in place to resolve this concern.

- Staff did not consistently record supervision and not all staff received supervision on a regular basis.

- Staff on adolescent units did not understand the Gillick competence and consequently did not have the knowledge and skills to assess capacity. In the community adult nursing service, we found that there was a poor understanding of the Mental Capacity Act 2005 (MCA) and some teams had poor staff training compliance in this area.

However:

- Patient physical health needs were identified in most services. Medical staff documented physical health examinations and assessments following the patient's admission to the wards. Ongoing monitoring of physical health care problems was taking place. Patients accessed a range of physical healthcare services including podiatrists, district nurses, tissue viability nurses and opticians. Outcomes for patients using the services were monitored and audited. This included the monitoring of key performance indicators such as

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length of stay and readmissions within 30 days of discharge. Sherbourne ward had robust system to review physical healthcare needs weekly via implementation of a wellbeing clinic.

- A review of prescribing by a pharmacy inspector concluded that staff followed National Institute for Health and Care Excellence (NICE) guidance when prescribing medication. The trust provided psychological therapies recommended by NICE.

- Staff held regular care reviews and care programme approach meetings to monitor and review patients' progress. The medical, nursing, occupational therapist, activities staff, practice nurses, psychologists and speech and language therapists worked well together to achieve good outcomes for the patients.

- In acute and PICU wards the Mental Health Act paperwork was stored correctly and the trust had systems in place to ensure the detention paperwork was lawful. Medical staff in learning disabilities services had correctly completed capacity forms for patients detained under a Section of the Mental Health Act, 1983, and these were kept with medication administration, recording sheets and audited weekly with medications to ensure accuracy.

- Staff were actively involved in clinical audit. The services used recognised outcome and monitoring measures to help assess the level of support and treatment required. Staff in CAMHS completed a variety of assessments to monitor, record severity and outcomes for young people.

- Teams had good links with other organisations. Crisis teams linked well with partner agencies. The place of safety team met monthly with the police, ambulance and social services.

- Staff were trained in a range of psychological interventions. The trust provided staff with an induction at the start of their employment. Staff meetings were held regularly. Staff could request additional training to support patients with different communication needs. Unqualified staff had

opportunities to undertake a national vocational qualification in care, which could eventually lead to secondment to take a foundation degree and nurse training.

- In the community services, we found that patients' needs were assessed and their care and treatment was delivered following local and national guidance for best practice. The services had effective evidence based care and treatment policies based on national guidance. The trust had introduced an individualised plan for care for the dying person for patients with end of life needs.

- Across community services, we saw evidence of robust multidisciplinary working with staff, teams and services working together to deliver effective care and treatment. Staff had the necessary qualifications and skills they needed to carry out their roles effectively. Staff were supported to maintain and further develop their professional skills and experience.

- Consent to care and treatment was obtained in line with legislation and guidance. Performance in national audits was better than the national average.

- Evidenced based practice was evident and there was a strong ethos of audit and research to support the "best practice" of children young people and patients.

Our findings

Assessment and delivery of care and treatment

- The quality of care plans was variable. Many care plans were not holistic, for example, they did not include the full range of patients' problems and needs. There was evidence of care plans not being up to date on all acute wards. Care plans were generic and did not always consider patient views. Patients' physical health checks were not consistently monitored across all teams. Patients' views recorded in the 'this is me' document were not always included in the care plan. Not all patients had a copy of their care plan. Some care plans were not personalised or holistic.

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- Case records were computer and paper based. We found that it was difficult to locate all the information and in some cases, staff had duplicated paper work. Teams across the trust used different recording systems. Staff at the community mental health teams used the electronic system whereas doctors and inpatient ward staff used paper records.

- Records within the clinical assessment service and podiatry service had incomplete information such as: no follow-up outcomes for appointments or guidance as to the conclusion of the treatment received, incomplete personal and environmental risk assessments and duplicate records. This was brought to the attention of senior staff who confirmed they would, as a result of our findings, conduct a full review of all records. Records were not kept in a secure storage area in the community dental service.

- The community children and young peoples' service had a mixture of paper and electronic care records. Copies of each were kept in the child or young person's home and a copy was stored at the Paybody Building, the organisational hub for children, young people and family services. We noted there were delays with updating some care records in the service which could affect the continuity of care for children and young people. Plans were in place to address this.

- There were difficulties with connectivity in relation to the use of laptops in some areas of the community children and young peoples' service. This was particularly an issue for the health visitor service. Plans were in place to resolve this concern.

- For the community end of life care service, The Priorities of Care for the Dying Person were published in June 2014 by the Leadership Alliance for the Care of Dying People. Taking the five priorities to; recognise, communicate, involve, support, plan and do, the SPC team, in partnership with the local acute trusts, had developed a personalised care plan for each patient in the last days of life with guidance for staff on how to best meet the five priorities of care.

- The personalised care plan, called the individual plan of care for the dying person, had been shared with other healthcare professionals, patient advisory bodies and groups in the area. This ensured all interested parties had an opportunity to comment and suggest amendments or alternatives.

- For the children and young peoples' and integrated sexual health services (ISHS) , policies, procedures and guidelines were available to nurses, doctors and support staff who were able to access them when necessary on the trust policy database.

- ISHS had care pathways in place to support patients in sexual health services, drugs and alcohol, life style risks, domestic violence and sexual assault.

- The children and young peoples' service had care pathways to support the healthy child, new birth assessments, six to eight week assessments and readiness for school.

Best practice in treatment and care

- Patient physical health needs were identified in some services. Medical staff documented physical health examinations and assessments following the patient's admission to the wards. Ongoing monitoring of physical health care problems was taking place. Patients accessed a range of physical healthcare services including podiatrists, district nurses, tissue viability nurses and opticians. Outcomes for patients using the services were monitored and audited. This included the monitoring of key performance indicators such as length of stay and readmissions within 30 days of discharge. Sherbourne ward had robust system to review physical healthcare needs weekly via implementation of a wellbeing clinic.

- The National Audit of Schizophrenia carried out in 2014 had found some aspects of prescribing practice were below the average for the trust. A higher proportion of service users were receiving more than one antipsychotic medication at a time or a higher dose than normally expected. A higher than average proportion of service users whose illness was not in remission did not appear to have an acceptable reason for not having had a trial of clozapine. However, a review of prescribing by a pharmacy inspector concluded that staff followed National Institute for Health and Care Excellence (NICE) guidance when prescribing medication. The trust provided psychological therapies recommended by NICE.

Are services effective?

- Staff were actively involved in clinical audit. The services used recognised outcome and monitoring measures to help assess the level of support and treatment required. Staff in CAMHS completed a variety of assessments to monitor, record severity and outcomes for young people. Health of the Nation Outcome Scales were used in all services.

- Between 1st May 2014 and 31st October 2015, 18 clinical audits were completed which was lower than would be expected. These included adults in community health services as well as mental health. Audits of compliance with NICE guidance and medication audits were carried out as part of this programme.

- The National Audit of Schizophrenia for the trust was conducted in 2014, notable findings for the trust included:

  Availability and uptake of cognitive behavioural therapy was average but was above average for family Intervention, though was still below what should be ideally provided.

  Performance in monitoring of physical health risk factors was average compared with other trusts and was well below the ideal. Provision of interventions for service users with abnormal results was above average.

- In the community health services, we found that patients' needs were assessed and their care and treatment was delivered following local and national guidance for best practice.

- The services had effective evidence based care and treatment policies based on national guidance. The trust had introduced an individualised plan for care for the dying person for patients with end of life needs.

- Parents told us the service they received from children young people and family services had enabled their children to live full and active lives within the constraints of their clinical condition. Evidenced based practice was evident and there was a strong ethos of audit and research to support the "best practice" of children young people and patients. The service had achieved accreditation for the UNICEF Baby Friendly Initiative Stage 3.

- The community dental service followed national and local guidance including guidance published by the Royal Colleges, British Dental Association and National Institute for Health and Care Excellence (NICE).

- All relevant NICE guidance had an action plan for implementation of the recommendations. We saw that clinical audits demonstrated the implementation of national guidance including: Dental Erosion and Consent.

- Children's community nursing, children's continuing care and sexual health services used NICE guidance to develop training competencies. Guidance informed policies for the care of children and young people with epilepsy, respiratory conditions, care of children requiring specialist palliative care, patients with HIV, sexual health and contraception.

Skilled staff to deliver care

- All mental health teams had access to a range of disciplines and professions. Multidisciplinary team working was effective.

- Overall 81.5% of non-medical staff had an appraisal within the last 12 months. The core service with the lowest appraisal rate was mental health community adults with 73.5%. In the NHS Staff Survey 2015, 90% of staff said they had been appraised in the last 12 months compared to a national average of 91%. This score has increased 1% since 2014.

- Supervision and appraisal rates varied across the trust with some teams achieving over 90% compliance and others a low rate at less than 70%. Staff did not consistently record supervision. New staff underwent an induction process and there was a 'buddy' system to support new staff during induction. Induction training included mandatory training, a period of shadowing and a workbook which had to be signed off to confirm competency levels.

- Staff were trained in a range of psychological interventions. The trust provided staff with an induction at the start of their employment. Staff meetings were held regularly. Staff could request additional training to support patients with different communication needs. Unqualified staff had opportunities to undertake a national vocational qualification in care, which could

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eventually lead to secondment to take a foundation degree and nurse training. Staff could access specific training such as epilepsy training, psychological interventions and diabetes training.

- Poor performance was addressed when required and support was available from the human resources department. The trust policy supported managers to address poor performance.

- In community health services, staff had the necessary qualifications and skills they needed to carry out their roles effectively. Staff were supported to maintain and further develop their professional skills and experience.

- Senior management said staff were able to receive either one-to-one supervision time every month or attend group supervision. Staff confirmed they received regular supervision.

Multi-disciplinary and inter-agency team work

- In the NHS Staff Survey 2015, the trust scored 3.8 with regards to effective team working. This was similar to the England average.

- Staff held regular multidisciplinary team meetings, care reviews and care programme approach meetings to monitor and review patient's progress. The medical, nursing, occupational therapist, activities staff, practice nurses, psychologists and speech and language therapists worked well together to achieve good outcomes for the patients.

- Staff held handovers between shifts on the wards, some staff said the time slot for handovers was short for them to make sure all relevant information was handed over.

- Teams had good links with other organisations. Crisis teams linked well with partner agencies. The place of safety team met monthly with the police, ambulance and social services.

- Across community health services, we saw evidence of robust multidisciplinary working with staff, teams and services working together to deliver effective care and treatment.

- The specialist palliative care team worked closely with the community nurses, all of whom supported people to remain in their homes rather than being admitted to

hospital. The care was coordinated through the team leader who ensured appropriate services attended, this reduced duplication and unnecessary repetition of assessments.

- They said they had a good rapport with GP surgeries and had regular contact with them. GP's held a gold standards framework (GSF) meeting fortnightly with community nurses and a special palliative care nurse to discuss the early contact for newly referred patients as well as reviewing on-going patients and their required facilities.

- The integrated sexual health service offered a fully integrated model of sexual health services. The model was dependent on effective multi-professional and interagency working to deliver sexual health screening and management, contraception, outreach and community services. The model had enabled designated GPs and pharmacy partners to deliver services directly to patients in line with agreed pathways.

Adherence to the Mental Health Act and the Mental Health Act Code of Practice

- The overall compliance rate for Mental Health Act, Mental Capacity Act and Deprivation of Liberty Safeguards training for the trust was 65.3%. This was a mandatory training course.

- Staff on adolescent units did not understand the Gillick competence and consequently did not have the knowledge and skills to assess capacity.

- Record keeping was poor particularly in relation to the Mental Health Act documentation. Patients were not being told of their right to support from an Independent Mental Health Act Advocate (IMHA). Those patients lacking capacity were not referred to advocacy automatically in line with MHA code of practice. Section 17 leave forms did not always record who else had been given a copy other than the patient. Some care records showed no evidence of assessment of mental capacity.

- No records of Mental Health Act (MHA) paperwork or Ministry of Justice (MOJ) warrants or orders were available in paper or electronic forms at IPU 10-17, Swanswell Point. Two patient's Ministry of Justice records were not available at the MHA office at the Caludon centre. Medical staff had made errors on

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consent to treatment documents (T2 and T3 forms) on two wards, relating to three patients. Prescribing did not adhere to the agreed plan, which made the treatment invalid for the detained patients in question. Three patients with a criminal history, under supervision of the Ministry of Justice (MOJ), did not have their conditions included in their risk or care plans. The Ministry of Justice (MOJ) monitors and set conditions for the care, treatment, and whereabouts of mental health patients with a criminal history. Community treatment order conditions were not included in the care plan for one patient.

- There were 26 Mental Health Act reviewer visits since 2 July 2014 until 29 February 2016, all visits were unannounced. In total there were 171 issues found at locations across the trust. The highest category for issues was "purpose, respect, participation, least restriction with 60 issues, equating to 35% of the total. Spencer Ward at Caludon Centre was the only ward to be visited twice – six issues were found during the first visit and eight issues at the second. Snowdon Ward at Brooklands Hospital had the most issues in a single visit with nine. Eden Unit at Brooklands Hospital had the lowest number of issues in a single visit with three.

Good practice in applying the Mental Capacity Act

- Not all teams achieved the compliance rate for MHA and Mental Capacity Act (MCA) training, the trust's target was 95%. Staff on adolescent units did not understand the Gillick competence and consequently did not have the knowledge and skills to assess capacity. Staff we spoke with showed varying degrees of knowledge about the Mental Capacity Act (MCA) and Deprivation of Liberty Safeguards (DoLS). Staff on 1 and 3 Tuxford Avenue adolescent wards had not always appropriately assessed patients' capacity.

- When decisions of capacity had been decided, there was not always evidence about how staff had reached decisions. For example, they had not carried out capacity assessments which included the patients, relatives, and advocates.

- Managers had systems in place to monitor adherence to MCA and staff knew where to access the policies relating to MCA. Relevant staff told us they were familiar with best

interest meetings, and told us these were carried out on a decision specific basis, we saw evidence in the care records of best interest meetings having taken place. Staff told us they felt supported by the social workers in their teams when dealing with mental capacity issues.

- Medical staff in learning disabilities had correctly completed capacity forms for patients detained under a section of the Mental Health Act, 1983, and these were kept with medication administration, recording sheets (MARS) and audited weekly with medications to ensure accuracy.

- From 1 July 2015 to 31 December 2015 thirty one (47%) out of 66 DoLS applications were granted and 19 declined (29%). Quinton ward had the most DoLS applications with 25 followed by Swanswell with 11.The CQC records show that we received 60 Deprivation of Liberty Safeguarding Applications (DoLS) from the trust between 1 July 2015 and 31 December 2015. There were 54 for Caludon Centre, four for Brooklands and two (unspecified) for Coventry and Warwickshire Partnership NHS Trust.

- The trust informed us that in the 12 months up to March 2016 there had been 45 applications made at the Caludon, four at Brooklands, eight for St Michaels and three for Hawkesbury Lodge.

- Across most community health services, we found that staff understood the relevant consent and decision making requirements of legislation and guidance, including the Mental Capacity Act 2005 and the Children Acts 1989 and 2004. Staff had a clear understanding of consent issues.

- In the community adult nursing service, we found that, there was a poor understanding of the Mental Capacity Act 2005 (MCA) which was reflected in a review of staff training records. For example, CAS showed training compliance at 27% and adult SLT at 43%. Senior management confirmed they had an MCA lead coming to work with the teams to improve their knowledge and provide additional training.

- Children and young people under 16 were able to give valid consent if they had been deemed competent and were involved in the consent process (Gillick competence). When seeking consent we observed the community children's nurse and support staff in the

Are services effective?

children's continuing care spending time with each child or young person and using terminology they could understand when explaining what they were going to do.

- When young people aged 16 and over lacked the mental capacity to make a decision, "best interest" decisions were made in accordance with legislation. Young people were supported to make decisions and follow up clinics were held at times to suit them and protected their confidentiality.

Are services caring?

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

Summary of findings

We rated Coventry and Warwickshire Partnership NHS trust as good for caring because:

- For the community health services, we rated two services as being outstanding for caring, being the end of life care and children and young people and families' services.

- Across the trust we observed nursing staff treat patients with care and respect and communicate in ways patients understood. Staff knew of individual needs and concerns, and spoke respectfully about patients. We received positive feedback about staff from patients and carers. Patients told us that relatives were invited to their care review meetings. Patients said they had access to advocacy and we observed posters on the wall for advocacy services.

- When staff helped patients with their personal care, this was done in private and patient dignity was maintained. We observed positive and meaningful interactions between staff and patients. Staff listened to patients and used appropriate forms of communication to ascertain people's thoughts and feelings when these were not easily expressed.

- Patients were invited to and supported to attend the multidisciplinary reviews along with their family where appropriate. Visiting hours were in operation and there was an area for patients to see their visitors in most services.

- There was active involvement and participation of care planning. Most patients knew they had care plans and had been involved in developing these. Patients had their own copies of their recovery plans if they wanted them. When patients were unable to be fully involved in planning care, staff would include relatives in the planning process. Patients were actively involved in the running of wards through weekly community meetings.

- Staff in CAMHS offered parents access to a parent support group. Staff supported young people to be involved in the recruitment of new staff to the service and designing the CAMHS link on the trust website. Families and young people were able to give feedback on the care they receive by completing the families and friends test.

- We observed home assessments where we saw good relationships between staff and patients, including joint working and collaborative discussions. We observed a care programme approach meeting. The patient was encouraged to give their views on their strengths and needs and to participate in the review of their care plan.

- Advocates attended some wards weekly, including a named child advocate for patients admitted to the adolescent ward.

- Parents told us the service they received from the children, young people and family services had enabled their children to live full and active lives within the constraints of their clinical condition.

However:

- Evidence of patient and carer involvement was not always documented in records and care plans were not consistently recorded as being given to the patients.

- Staff had not always considered whether those patients under the age of 16 were Gillick competent before sharing information about them to parents.

Our findings

Kindness, dignity, respect and support

- PLACE assessments are self-assessments undertaken by NHS and private/ independent health care providers,

Are services caring?

and include at least 50% members of the public (known as patient assessors). They focus on different aspects of the environment in which care is provided, as well as supporting non-clinical services.

- In relation to privacy, dignity and wellbeing, the 2015 PLACE score for Coventry and Warwickshire Partnership NHS Trust is 92%, which is above the England average of 86%. The Manor Hospital was the only site to score below the England average with 83.6%.

- We saw that nursing staff treated patients with care and respect and communicated in ways patients understood. Staff knew of individual needs and concerns, and spoke respectfully about patients. We saw when staff helped patients with their personal care, this was done in private and patient dignity was maintained. We observed positive and meaningful interactions between staff and patients. However, we observed an occasion when a patient was not well cared for. The staff member had not treated the patient with kindness or respect, and had not understood the needs of the patient or the reason for the patient's referral. The staff member had to abandon the assessment when the patient's anxiety level became too distressing for the patient to continue. One member of staff became inpatient when a patient was undecided in their choice of lunch.

- We observed home assessments where we saw good relationships between staff and patients, including joint working and collaborative discussions. We observed a care programme approach meeting. The patient was encouraged to give their views on their strengths and needs and to participate in the review of their care plan.

- In the community services, we saw and were told by patients, that all staff working in the service were kind, caring and compassionate at every stage of their treatment. People were treated respectfully and their privacy was maintained in person and through the actions of staff to maintain confidentiality and dignity.

- The data from the friends and family test (FFT) was positive across the community services with patients stating they had no problems with the service provided. There were arrangements to provide emotional support to patients and their families where required.

- Caring in the end of life care service was rated as outstanding and staff were highly committed to

providing care that was of a consistently high standard and focused on meeting the emotional, spiritual and psychological needs of patients as well as their physical needs.

- Overall, we rated the children's and young people's service as outstanding for caring because we saw staff that were extremely kind and compassionate and ensured privacy and dignity needs were met for children and their families at all times.

The involvement of people in the care they receive

- Seven individual comments were raised with the CQC via a Share Your Experience form between 1 March 2015 and 29 February 2016, all were negative comments. The comments related to poor practice in relation to moving and handling, staff complaining about being understaffed, poor attitude from a psychiatrist, staff training and poor attitude.

- The friends and family test was launched in April 2013. It asks people who use services whether they would recommend the services they have used; giving the opportunity to feedback on their experiences of care and treatment. The percentage of respondents who would, and those who would not recommend the trust as a place to receive treatment, was similar to the England average of 95%, during the six-month period from July to December 2015.

- The CQC Community Mental Health Survey 2015 surveyed people who had been in contact with community mental health services in England between 1 September and 30 November 2014. The survey involved 55 NHS trusts in England and had 13,292 respondents, a response rate of 29%.

- The trust scored worse than other mental health trusts in eight of the ten questions with the remaining two, organising your care and crisis care, scoring 'about the same'.

- The trust flagged the following indicator as a risk from the national community mental health survey 2015.

- service users had expressed concerns that medication issues were not always appropriately addressed and reviewed, and information needs were not adequately met, in the assessment and care planning processes. Staff who work with people using mental health services should promote active participation in decisions about

Are services caring?

treatment, and support people to manage their own condition. For people who are prescribed medication, this should include the impact that their medication has on their lives.

- Patients were invited to and supported to attend the multidisciplinary reviews along with their family where appropriate. Visiting hours were in operation and there was an area for patients to see their visitors in most services. Patients told us that relatives were invited to their care review meetings. Patients said they had access to advocacy and we observed posters on the wall for advocacy services.

- There was active involvement and participation of care planning. Most patients knew they had care plans and had been involved in developing these. Patients had their own copies of their recovery plans if they wanted them. When patients were unable to be fully involved in planning care, staff would include relatives in the planning process. Patients were actively involved in the running of wards through weekly community meetings.

- Staff in CAMHS offered parents access to a parent support group. Staff supported young people to be involved in the recruitment of new staff to the service and designing the CAMHS link on the trust website. Families and young people were able to give feedback on the care they receive by completing the families and friends test.

- Advocates attended some wards weekly, including a named child advocate for patients admitted to the adolescent ward.

- Evidence of patient and carer involvement was not always documented in records and care plans were not consistently recorded as being given to the patients.

- Staff had not always considered whether those patients under the age of 16 were Gillick competent before sharing information about them to parents.

- Across community health services, staff involved patients and those close to them in aspects of their care and treatment. Information about treatment plans was provided to meet the needs of patients. Patients we spoke with during our inspection were very positive about the way they were treated. All staff were sensitive to the needs of all patients and were skilled in supporting patients and young people with disabilities and complex needs.

- Children were active partners with the planning of their care whenever possible. Parents were closely involved throughout the assessment, planning and delivery of their child's care and were kept informed of changes and developments by members of the multidisciplinary team.

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 Coventry and Warwickshire Partnership NHS trust as requires improvement for responsive because:

- Data in child and adolescent mental health services (CAMHS) showed 138 young people had waited up to 24 weeks and 117 had waited from 25 to over 49 weeks to access treatment. Staff in community adult mental health services were not aware of key performance indicators concerning waiting lists for patients' assessments and there was variation in waiting list times at different services.

- In the community dental service, we found there was an excessive waiting list for children who had been referred to the service and were waiting for their first assessment appointment. Some patients had been waiting nine to ten months. There was increasing demand and acuity in the community health therapy services leading to pressures on staff, which sometimes had an impact on waiting times.Children and young people experienced some delays in accessing the autistic spectrum disorders' pathway.

- In some wards, the facilities did not ensure that patients had privacy, comfort and a dignified experience of care. Patients in inpatient wards did not have keys to lock and unlock their bedroom doors. The bedrooms did not have secure space for patients to lock valuables. There was a cupboard where items can be handed to staff for safekeeping. One patient on Rowans had complained of a broken window latch in her bedroom, which meant she was very cold, particularly at night. Staff were unclear what action had been taken to resolve this. Inspectors reviewed this during the unannounced follow-up inspection. The window had not been repaired. However, staff were making every effort to resolve the issue.

- Staff left the viewing panels on bedroom doors open. Patients were unable to close the panels on several of the wards. This affected patient privacy and dignity.

- There was a high bed occupancy rate and a high length of stay on all wards for older adults. When patients went on leave their bed was used for another admission. If the patient needed to come back to hospital, a bed would be found on another ward. This meant the patient may not know the staff and not be familiar with the ward environment causing anxiety.

However:

- There were a number of leaflets available telling patients how to make a complaint, how to get in touch with advocacy services, local carer groups and about individual treatments. Easy read material was available, including menus, care plans and the complaints procedure.

- Wards had access to garden areas leading off from the lounge. They provided a spacious area for patients to be able to walk, share time with carers and to enjoy fresh air. Wards were accessible for patients with disabilities. Each ward had a disabled toilet and bathroom. Staff arranged specialist assessments such as speech and language therapy when needed.

- Staff took a proactive approach to engaging with patients who did not attend appointments. Staff would follow up patients who missed appointments and engage with these patients. Discharge planning was evident in most teams. Patients from the medium secure service could be referred to the low secure service, or vice versa if required.

- The trust collected patient feedback and looked to make changes to reflect this. The facilities across the service promoted recovery. Most patients could

Are services responsive to people's needs?

make telephone calls in private if they wanted too. All services had a full range of rooms and age appropriate equipment to support treatment and care, including family and therapy rooms.

- We saw there was a range of choices provided in the menu that catered for patients' dietary, religious and cultural needs. We observed excellent interactions at lunchtime. Staff were responsive to requests. Staff ensured the mealtime experience was protected and a pleasurable experience. Patients could use the kitchen areas under supervision to make snacks and drinks. Spiritual support was available to patients for a range of faiths. Information was visible on notice boards and patients used this service. However, all patients we spoke with in the learning disabilities service told us they did not like the food, although the trust was working with patients to improve this.

- Crisis resolution teams contacted patients within four hours of referral. The Arden mental health acute team began assessments within 90 minutes of receiving referrals. The service offered flexible appointments and engaged with people who were reluctant to engage with the service. The service was supportive of people in crisis and helped identify additional help, enabling them to move on as required to more suitable locations.

- In CAMHS the acute liaison team assessed young people who had been admitted to a paediatric bed and 1:1 support was given for the duration of the admission. Data provided for community mental health teams showed the average waiting time for triage was three weeks. From triage to allocation, the waiting time was 15 weeks, which was within the trust's 18 week target. Staff we spoke with said they kept in contact with patients on waiting lists for allocation to a care co-ordinator. Staff at IPU 10 (early intervention), Avenue House were attending the central booking service to review referrals and speed up the triage to assessment process. Staff at IPU 3-8, Tile Hill centre had set up a clinic to reduce waiting lists. The trust had an established personality disorder service that community teams could refer to if required.

- The learning disabilities wards had a strict policy not to admit to beds when patients were on leave, so that patients could return immediately and without fear of losing their bed. Patients were supported to personalise their bedrooms. Educational services were on site so that adolescents could attend school.

- Appropriate systems were in place to enable children and young people in the community health services to access treatment and support prior to a formal diagnosis.

- The community adult nursing service provided a range of interventions to prevent admission to hospital and to facilitate discharges from acute settings.

- Services were planned and delivered to meet the needs of individual patients and of the local community. Effective relationships with key stakeholders and commissioners led to a coordinated approach to service design and delivery.

- Staff had a good understanding of equality and diversity.

- Community health therapy and nursing teams had good knowledge of how to improve care for those living with dementia/complex needs. The patient's needs were detailed in care plans and were person centred.

- In the community adult nursing services, all patients were seen within the 18 week referral to treatment time with the exception of podiatry.

- Community end of life services enabled rapid discharge of patients from the acute hospital, providing support to meet patients' individual needs and wishes. The trust supported patients to achieve their preferred place of death either through rapid discharge to home, hospice or nursing home or by ensuring appropriate care for patients who wished to die at home.

- Across the majority of community health services, trends and themes from complaints and concerns

Are services responsive to people's needs?

were discussed at speciality and at local levels. Good practice advice and required learning was identified and actions taken. Information and learning was disseminated to staff.

Our findings

Service planning

- The trust used information about the local population when planning service developments and delivering services. The trust had good working relationships with commissioners and other stakeholders. There were close links with the commissioners and ongoing discussions about developments to improve services.

- In the community health service, services were planned and delivered to meet the needs of individual patients and of the local community. Effective relationships with key stakeholders and commissioners led to a coordinated approach to service design and delivery.

- The health visitor service had undergone a radical service redesign to meet the needs of children and families. Health visitor caseloads had become geographically based and Coventry specific. This was to enable caseloads to be more equitable and meet the needs of children in the most deprived areas of Coventry.

Access and discharge

- Learning Disability Wards had bed occupancy rates of below 85% for the period 1 June 2015 to 30 November 2015. Whereas all other core services had bed occupancy rates of above 85%. The highest rates were within the acute/PICU wards (90-121%) and older adults wards.

- Since April 2015, there have been 14 patients in total placed outside of the Trust (all related to mental health adult/ PICU wards). The data showed that there was a significant increase in out of area placements over the month from 5 June to 6 July 2015. The trust told the CQC that the clinical commissioning group is informed of the need for any out of area placement at the time of referral and permission to go ahead is sought. At the time of the inspection April 2016 one patient had been placed outside of the trust.

- Staff took a proactive approach to engaging with patients who did not attend appointments. Staff would follow up patients who missed appointments and engage with these patients. Discharge planning was evident in most teams. In forensic services there was evidence of active and appropriate discharge planning for patients. Patients from the medium secure service could be referred to the low secure service, or vice versa if required.

- Crisis resolution teams contacted patients within four hours of referral. The Arden mental health acute team began assessments within 90 minutes of receiving referrals. The service offered flexible appointments and engaged with people who were reluctant to engage with the service. The service was supportive of people in crisis and helped identify additional help, enabling them to move on as required to more suitable locations.

- In CAMHS data showed 138 young people had waited up to 24 weeks and 117 had waited from 25 to over 49 weeks to access treatment. Staff in community adult mental health services were not aware of key performance indicators concerning waiting lists for patients' assessments and there was variation in waiting list times at different services. In CAMHS the acute liaison team assessed young people who had been admitted to a paediatric bed and 1:1 support was given for the duration of the admission.

- Data provided for community mental health teams showed the average waiting time for triage was three weeks. From triage to allocation, the waiting time was 15 weeks, which was within the trusts 18 week target. Staff we spoke with said they kept in contact with patients on waiting lists for allocation to a care co-ordinator. Staff at IPU 10 (early intervention), Avenue House were attending the central booking service to review referrals and speed up the triage to assessment process. Staff at IPU 3-8, Tile Hill centre had set up a clinic to reduce waiting lists.

- The trust recorded 99.6% of patients on the care programme approach were followed up within seven days of their discharge from inpatient services in from October to December 2015. This is above the England average of 96.9%.

Are services responsive to people's needs?

- The learning disabilities wards had a strict policy not to admit to beds when patients were on leave, so that patients could return immediately and without fear of losing their bed. Patients were supported to personalise their bedrooms. Educational services were on site so that adolescents could attend school. There was a high bed occupancy rate and a high length of stay on all wards for older adults. When patients went on leave their bed was used for another admission. If the patient needed to come back to hospital, a bed would be found on another ward. This meant the patient may not know the staff and not be familiar with the ward environment causing anxiety.

- Between 1 April and 30 November 2015 there were 137 delayed discharges reported across all wards. Amber Ward (a learning disabilities ward) at Brooklands with 34 and Ferndale ward (an adult mental health/PICU) at St Michael's hospital with 33 reported the highest number of delayed discharges. Adult mental health /PICUs overall were among the highest in both delayed discharges and readmissions within 30 days, in the case of readmissions significantly so. The average across all wards for delayed discharges was 5.5 and readmissions were 2.0. There were 51 readmissions within 30 days reported by the trust between 1 April and 30 November 2015 across 25 wards. All readmissions were in the adult mental health / PICU wards. The wards with the highest number of readmissions within 30 days were Larches ward (at St Michael's hospital) with 12 and Westwood ward (at Caludon) with nine.

- The community adult nursing service provided a range of interventions to prevent admission to hospital and to facilitate discharges from acute settings. In the community dental service, we found there was an excessive waiting list for children who had been referred to the service and were waiting for their first assessment appointment. Some patients had been waiting nine to ten months. The service was taking steps to identify inappropriate referrals and to review the patients the waiting list but there was not a clearly defined process surrounding this to effectively manage the waiting list.

- The community dental service reported in a large number of cases patients were referred to the service for short-term specialised treatment. On completion of treatment, patients were discharged back to their own dentist so that ongoing treatment could be resumed by the referring dentist. Each referral provided information about why the patient was visiting and any communication difficulties they may have so this enabled the service to determine how long the patient may need for an assessment.

- The community health dental service provided oral health care and dental treatment for children and adults that have impairment, disability and/or a complex medical condition and those who are nervous or dental phobic. Patients who were to this category were those with a physical, sensory, intellectual, mental, medical, emotional or social impairment or disability. Domiciliary dental services were provided where dental staff visited patients in their own home or a nursing and residential environment.

- We saw evidence of increasing demand and acuity in the community health therapy services leading to pressures on staff, which sometimes had an impact on waiting times. A service review was in place to respond to these pressures and waiting times had improved in the last two months.

- Children and young people experienced some delays in accessing the autistic spectrum disorders' pathway. However, appropriate systems were in place to enable children and young people to access treatment and support prior to a formal diagnosis.

- Community end of life services enabled rapid discharge of patients from the acute hospital, providing support to meet patient's individual needs and wishes. The trust supported patients to achieve their preferred place of death either through rapid discharge to home, hospice or nursing home or by ensuring appropriate care for patients who wished to die at home.

- All patients in community adult nursing services were seen within the 18 week referral to treatment time with the exception of podiatry services. The trust confirmed they were in consultation with the commissioners to resolve the situation.

The facilities promote recovery, comfort, dignity and confidentiality

- Patients did not have keys to lock and unlock the bedroom doors. The bedrooms did not have secure space for patients to lock valuables. There was a cupboard where items can be handed to staff for

Are services responsive to people's needs?

safekeeping. One patient on Rowans had complained of a broken window latch in her bedroom, which meant she was very cold, particularly at night. Staff were unclear what action had been taken to resolve this. Inspectors reviewed this during the unannounced follow-up inspection. The window had not been repaired; however, staff were making every effort to resolve the issue.

- Staff left the viewing panels on bedroom doors open. Patients were unable to close the panels on several of the wards. This affected patient privacy and dignity.

- Wards had access to garden areas leading off from the lounge. They provided a spacious area for patients to be able to walk, share time with carers and to enjoy fresh air. Patients were able to use the garden unescorted once unlocked unless their individual risk assessment stated otherwise. Wards were accessible for patients with disabilities. Each ward had a disabled toilet and bathroom. Staff arranged specialist assessments such as speech and language therapy when needed.

- Facilities and premises in the community dental service were appropriate for the services that were planned and delivered.

Meeting the needs of all people who use the service

- Staff from a range of disciplines raised concerns about the integrated practice unit (IPU) model of patient care. The model uses a care clustering approach to determine which teams' patients are treated by. Clusters 3-8 are for patients with a non-psychotic diagnosis and clusters 10-17 are for patients with a psychotic diagnosis. Staff spoke with us about their concerns for patients who do not fit in to this model. Carers told us they experienced problems dating back to the introduction of care clusters in 2014. They were of the opinion that continuity of care has suffered as a result with no clear consistent system of care co-ordination or medical input. Some carers and patients said they did not to know which cluster they belong. Clusters could change when a patient's condition changes. This could also impact on how patients experience continuity of care.

- There were a number of leaflets available telling patients how to make a complaint, how to get in touch with advocacy services, local carer groups and about individual treatments. Easy read material was available, including menus, care plans and the complaints procedure. Leaflets in different languages and interpretation services were available when required.

- All buildings we visited had disabled access. Reasonable adjustments were made so that disabled people could access and use the service on an equal basis to others.

- There was a range of choices provided in the menu that catered for patients' dietary, religious and cultural needs. We observed excellent interactions at lunchtime. Staff were responsive to requests. Staff ensured the mealtime experience was protected and a pleasurable experience. Patients could use the kitchen areas under supervision to make snacks and drinks. Staff described to us how they had supported patients with additional needs such as a learning disability. They ensured that patients were supported by their carer or a relative and that there was sufficient time to explain fully the care and treatment they were providing in a way patients understood. All patients we spoke with in the learning disabilities service told us they did not like the food, although the trust was working with patients to improve this.

- The trust collected patient feedback and looked to make changes to reflect this. The facilities across the service promoted recovery. Most patients could make telephone calls in private if they wanted too. All services had a full range of rooms and age appropriate equipment to support treatment and care, including family and therapy rooms.

- Spiritual support was available to patients for a range of faiths. Information was visible on notice boards.

- Staff received training in equality and diversity and the trust had produced a multi-cultural handbook as a resource for staff to help them meet the needs of all people who use the service.

- Staff in community services were aware of how to support people living with dementia and some had accessed the trust training programme in order to understand the condition and how to be able to help patients living with a dementia.

Are services responsive to people's needs?

- Therapy and nursing teams had good knowledge of how to improve care for those living with dementia/complex needs. The patient's needs were detailed in care plans and were person centred.

- The community health service for children and young people provided a highly responsive service for patients, children young people and their families who required specialist intervention and support in their outpatient, home or appropriate community setting. We saw holistic services (for example; health visitors, community children's nurses, children's continuing care teams, sexual health services, autism, looked after children the family health partnership) were meeting the specific needs of patients, children, young people and their families.

- For the end of life care service, equipment was provided to support patients who wished to die at home. This was delivered by an external provider quickly to patients' homes, to facilitate discharge or prevent unnecessary admission to hospital.

- In community health services staff ensured each patient, both children and adults, were treated as individuals, with their needs, preferences and their ethnicity, language, religious and cultural backgrounds being respected.

- The community dental service was commissioned to specifically provide access to dental services for vulnerable adults and children. In order to improve the oral health of this vulnerable group of patients, we observed plenty of time was allowed for patient appointments with the average time for appointments being 45 minutes.

- The integrated sexual health service offered outreach sessions in areas of high deprivation to vulnerable people in Coventry. Protocols were in place in sexual health services to manage vulnerable people. For example, sex workers and those at risk of sexual exploitation: sexual violence and domestic abuse, and those who misused drugs and alcohol.

Learning to and learning from concerns and complaints

- Data showed 106 written complaints were received in 2014/15 by the trust, three less than in 2013/2014. The number of upheld complaints rose from 38% in 2013/2014 to 53% in 2014/2015. The majority of complaints received (90%) in 2014/2015 related to the mental health services.

- There were 48 formal complaints made against the trust in total. Of these 71% were upheld (either fully or partially), 6% were referred to the parliamentary and health service ombudsmen. Of the 48 complaints made trust wide, mental health community adults services received the most with 16 complaints (33%). Four were fully upheld and eight partially upheld.

- The trust received 602 compliments during the 12 months December 2014 to November 2015.Community adult services received the highest number of compliments with 25 (42%)

- All patients we spoke with knew how to complain. Complaints were logged and investigated and lessons identified where relevant. Learning was shared at team meetings. Staff knew how to handle a complaint. Across the community health services, trends and themes from complaints and concerns were discussed at speciality and at local levels. Good practice advice and required learning was identified and actions taken. Information and learning was disseminated to staff.

- In some community adult nursing teams, staff would speak to anyone raising an informal complaint at the time they raised it. The aim was to try and resolve the problem or complaint at the time it was raised. Staff confirmed they did not always complete a patient advice and liaison service (PALS) form should the matter be resolved locally. The trust informed us that informal complaints were reported monthly to the divisional Safety and Quality Meeting via the heads of service report which facilitated shared learning. However, we found no evidence to support this during our visit to the community health services for adults which meant that we could not ensure that learning from complaints had been implemented.

- If staff were unable to deal with the complaint they referred the patient to PALS.

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 Coventry and Warwickshire Partnership NHS trust as requires improvement for well-led because:

- The trust did not have robust governance arrangements in relation to assessing, monitoring and mitigating risks of ligatures in the patient care areas. Whilst ligature risk assessments and action plans were in place, they did not address how to manage the risks. An unacceptable number of ligature risks remained on the acute wards.

- The trust had identified high levels of restraint and prone restraint used in 2014 and had completed an action plan to reduce this. A review of the action plan in 2015 identified that some recommendations had not been actioned, and some only partially actioned. This included doctors reviewing patients who had been restrained within two hours and for staff to explore alternative restraint methods. However, at the time of inspection we noted that doctor reviews were still not taking place and there had still been a high level of use of prone restraint, in particular on Amber ward.

- All staff in the acute wards expressed concern, particularly around changes to the roster system, planned new shifts and the ten-minute handover. The planned imposition of car parking charges, particularly on those regarded as essential car users, had a negative impact on staff morale.

- At St Michael's hospital, staff said middle and senior management were rarely on site. Some staff we spoke to said they felt there was a disconnect between themselves and senior managers or the trust board. Staff expressed concerned about the possible change of use of the site and what this would mean to them as there had not been any communication from senior management.

- The trust kept Mental Health Act and Ministry Of Justice records at the Caludon centre, rather than at the site the patient was being cared for.

- There was a high level of staff vacancies in some wards, and in particular Jade ward had experienced a high level of staff turnover in the previous six months. Staff reported morale was low. There was higher than expected sickness levels on Jade and Tuxford ward. The trust aimed to achieve sickness under 4.5% but Jade ward had a 7.6% sickness level between December 2014 and 2015. It was unclear how these had been addressed.

- Staff recording of supervision was inconsistent across teams. Staff in the learning disabilities service had not received supervision in line with the trust guidelines of two monthly.

- The trust was not meeting the 95% compliance rate for mandatory training across all services. The trust expected 95% compliance for mandatory training, but the inpatient wards fell below this threshold.

- In the community dental service, we found that there was no clearly defined strategy for the service to drive improvement and innovation. There was no robust oversight and management of risks within the service. The specialist palliative care team did not have clear strategy in place for delivering end of life care services.

- In the integrated sexual health service (ISHS), the Deanery contract for trainee doctors in the ISHS was withdrawn in 2015.There were issues around clinical leadership, patient safety and educational supervision. Significant progress had been made in the ISHS since the previous visit. However, there were concerns regarding the relationship between consultants in sexual health services which were still to be resolved. It was reported that if all issues were resolved, there was a possibility trainees could be

Are services well-led?

reintroduced from August 2016. The service had not always taken timely action to address gaps in some clinical procedures, which meant that not all risks in this service had been addressed in a timely manner.

However:

- Staff told us they were aware of the trust vision and values. Ward managers said they had sufficient authority and felt able to carry out their role effectively. Staff knew who the most senior managers in the trust were.

- Staff told us that they would be confident to use the whistleblowing procedure and felt their concerns would be taken seriously. Staff we spoke with was aware of their responsibilities to be open and honest with patients and families when things went wrong.

- Staff said that there were opportunities for personal development and training. Staff reported that they enjoyed their roles and that, with the exception of acute and PICU, morale within the teams was good.

- Staff sickness and absence rates and poor performance were managed with human resources support. Sickness, absence and turnover rates were low. Staff frequently told us they had worked for the trust and the service for a number of years.

- There were well-developed audits in place to monitor the quality of the service. The trust used 'ward to board' reports to gauge the performance of the team. The reports were presented in an accessible format. Staff carried out clinical audits which were reviewed by ward managers and results were fed back during team meetings if improvements were needed.

- Staff were positive, experienced, confident, well-motivated and worked together well. They frequently expressed satisfaction in doing a good job in helping people in crisis.

- Team managers identified areas of risk within their teams and submitted them to the trust wide risk register.

- Staff in child and adolescent mental health services (CAMHS) were committed to improving the service by participating in Quality Network for Community CAMHS and research.

- The issues in ISHS were being addressed in line with the agreed action plan overseen by Health Education England and it was anticipated that trainees would be reintroduced in August 2016. There were clear governance frameworks in place and the outcomes of audits and governance meetings were shared with staff.

- In community health services, staff and service leads were clear about their priorities and vision and felt involved with the re-design of the healthy lifestyle service and creation of an integrated neighbourhood team. Staff at all levels showed an awareness of the strategy for the service. There was feedback from patient surveys and action taken to improve services.

- Leadership within community services was effective. Most staff felt supported by their immediate managers and senior managers within the community. There was knowledge of the trust leadership team and of the executive link system. Staff said they felt able to suggest new initiatives for improving care and efficiency within their service, and felt involved in changes within community teams.

- In most areas, the community services had recognised the risks to patient safety and the quality of care and treatment, actions were clearly defined and staff felt the results were very positive. There was effective oversight and management of risks across most parts of the service.

Our findings

Vision, values and strategy

- The trust's vision was "To improve the wellbeing of the people we serve and to be recognized for always doing the best we can". The trust statement stated that the four values and the behaviours that represented those values were:

Compassion in action

Are services well-led?

Working together

Respect everyone

Seeking Excellence

- The behaviours underlying each value were detailed in the trust's vision statement leaflet. The statement was updated in January 2014, following feedback from staff, stakeholders, and from service users, patients and their carers.

- Staff told us they were aware of the trust's vision and values. Ward managers said they had sufficient authority and felt able to carry out their role effectively. Staff knew who the most senior managers in the trust were.

- One of the key areas of focus for the trust's five year integrated business plan for 2014 to 2019 was the creation of integrated multidisciplinary teams in community health services for adults to help people to stay healthy and well in the community and avoid unnecessary admission to hospital. The trust had re-designed the healthy lifestyle service and created an integrated neighbourhood team.

- There were plans for a culture change in services. The shift in philosophy and culture from one of giving answers and solutions to that of co-production was visible. However we found that this was not as far forward with middle managers and more junior staff as the board thought it was.

- Some staff we spoke to said they felt there was a disconnect between themselves and senior managers or the trust board. Staff expressed concerned about the possible change of use of the site and what this would mean to them as there had not been any communication from senior management.

- Across the community health service, staff were clear about the trust wide vision and values. Staff were able to articulate the vision of the service was to continuously improve the quality of the services in order to provide the best care and optimise health outcomes for each and every patient accessing the services.

- The community dental service did not have a defined specific strategy but we saw that there was a 'Service Specification for the Coventry Community Dental service' which outlined the composition and function of the service. However, this was not dated and whilst still current, senior staff told us of plans to develop a new strategy for the service, with full engagement across the staff team.

- There was no end of life strategy in place. However we were told the team planned to look at the development of a strategy across end of life care services. No date had been set for the implementation of the plan. We saw a copy of the team's work plan for end of life care and priorities for 2016. The main priorities were listed as service development, education and surveys.

Good governance

- The trust provided their Board Assurance framework, detailing five strategic objectives:

- Strategic Objective 1

  To deliver an exceptional patient experience first time, every time.

- Strategic Objective 2

  To provide excellent care, ensuring effective, person-centred clinical outcomes.

- Strategic Objective 3

  To be an employer for whom people choose to work.

- Strategic Objective 4

  To be an active partner, always ready to improve by working with others .

- Strategic Objective 5

  To be an efficient organisation providing excellent services .

- There were well-developed audits in place to monitor the quality of the service. The trust used 'ward to board' reports to gauge the performance of the team. The reports were presented in an accessible format. Staff carried out clinical audits which were reviewed by ward managers and results were fed back during team meetings if improvements were needed. However, the trust did not have robust governance arrangements in relation to assessing, monitoring and mitigating risks of ligatures in the patient care areas. Whilst ligature risk assessments and action plans were in place, they did not address how to manage the risks. An unacceptable number of ligature risks remained on the acute wards.

Are services well-led?

- The trust had identified high levels of restraint and prone restraint used in 2014 and had completed an action plan to reduce this. A review of the action plan in 2015 identified that some recommendations had not been actioned, and some only partially actioned. This included doctors reviewing patients who had been restrained within two hours and for staff to explore alternative restraint methods. However, at the time of inspection we noted that doctor reviews were still not taking place and there had still been a high level of use of prone restraint, in particular on Amber ward.

- All staff in the acute wards expressed concern, particularly around changes to the roster system, planned new shifts and the ten-minute handover. The planned imposition of car parking charges, particularly on those regarded as essential car users, had a negative impact on staff morale.

- The trust was actively recruiting to vacant posts but there was still a high rate of vacancies in some services.

- The trust was not meeting its 95% compliance rate for mandatory training across the services. The trust had set a target of 95% compliance for mandatory training, but the inpatient wards fell below this threshold. The trust was monitoring this.

- The trust provided a copy of its strategic risk register and action plan, dated 25 November 2015. This document highlighted 45 risks split by directorate and detailed actions undertaken against each of these and the progress. The risks provided were extracted from the electronic system and all had a risk score of 15 or more. 36 of the risks related to community health services or corporate trust wide issues.

- Risks included risks related to low staffing, especially in occupational therapy and psychology, environmental risks in relation to ligature risks, inconsistent staff safety practices and financial risks.

- Team managers identified areas of risk within their teams and submitted them to the trust wide risk register. However, the community dental service did not have its own defined risk register and any risks pertaining to the service would be held on the local integrated community services risk register. From information provided by the trust, there were currently no local risks on this register for the dental service at the time of the inspection. Therefore, risks identified during the inspection had not been recognised by the service, including the waiting list of 400 patients, a lack of risk assessments governing the use of the mobile dental unit and a lack of a policy and risk assessment processes for patient care and treatment provided by the service at the local acute hospital.

- In the other parts of community health service, there was an effective governance framework to support the delivery of the strategy and good quality care. There was a standardised format for the safety and quality meetings to ensure the same messages were shared across the directorate. There was also a section for "things to celebrate" whereby teams received praise. The safety and quality meetings contained for example; feedback on incidents, complaints, risk register and medicine management.

- In the integrated sexual health service (ISHS), the service had not always taken timely action to address gaps in some clinical procedures, which meant that not all risks in this service had been addressed in a timely manner.

Fit and proper persons test

- The trust provided three documents which detailed their policy and procedures relating to fit and proper persons requirement (FPPR) checks. We reviewed the files for six directors and the trust had met these requirements and had ongoing monitoring for regular reviews of FPPR. We reviewed 18staff files and the trust followed correct recruitment processes in all.

Leadership and culture

- The staff friends and family test was launched in April 2014 in all NHS trusts providing acute, community, ambulance and mental health services in England. It asks staff whether they would recommend their service as a place to receive care, and whether they would recommend their service as a place of work. The trust had a higher staff response rate than the England average (22% compared to 11%) from 1 July to 31 September 2015. The percentage of staff who would recommend the trust as a place to receive care was considerably lower than (63% compared to 79%) and the percentage of staff who would not recommend the trust as a place to receive care considerably higher than (16% compared to 7%)the England average.

Are services well-led?

- The percentage of staff who would recommend the trust as a place to work was lower than the England average (49% compared to 62%). A similar trend was found for staff who would recommend the trust as a place to work as was found for staff who would recommend the trust as a place to receive care. Staff were positive, experienced, confident, well-motivated and worked together well. They frequently expressed satisfaction in doing a good job in helping people in crisis.

- Staff sickness and absence rates and poor performance were managed with human resources support. Sickness, absence and turnover rates were low. Staff frequently told us they had worked for the trust and the service for a number of years.

- There was a high bed occupancy rate and a high length of stay on all wards for older adults. When patients went on leave their bed was used for another admission. If the patient needed to come back to hospital, a bed would be found on another ward. This meant the patient may not know the staff and not be familiar with the ward environment causing anxiety. Such practices impact on patient safety, recovery and satisfaction.

- Staff said that there were opportunities for personal development and training. Staff reported that they enjoyed their roles and that morale within the teams, with the exception of acute and PICU, was good. The pre-nursing scheme was widely praised and recognised as beneficial

- Staff told us that they would be confident to use the whistleblowing procedure and felt their concerns would be taken seriously. Staff we spoke with were aware of their responsibilities to be open and honest with patients and families when things went wrong. Since September 2011 there were six qualified whistle-blower reports to CQC – five of these have been since January 2014. The main themes of these whistleblowing notifications were:

• insufficient staff numbers

• bullying and vindictive culture among staff

• insufficient training

• poor staff suspension processes/ assertion

• backlash towards whistle-blowers.

- Community health services had strong local leadership teams who worked cohesively together and were highly visible. Staff told us that leaders in the service were open and visible.

- Nurses, health care professionals and support staff were all aware of who their immediate managers were. Clinical leads and service line managers were described as being supportive, approachable and visible and we saw evidence of this during our inspection.

- Staff said the chief executive, chairman and director of nursing and quality were approachable and seen around the trust and were known by staff. Both the chief executive and the chair were quite new and were seen to be positive forces for improvement. The model for engagement with staff around the change in culture was impressive. This involved co-production with staff at all levels being partners in change rather than consultation and senior staff delivering.

- Health Education England withdrew the Deanery contract for trainee doctors in the integrated sexual health service in July 2015. There were issues around clinical leadership, patient safety and educational supervision. An action plan was put in place and overseen by Health Education England. A follow-up visit took place in December 2015.Significant progress had been made in the service since the previous visit. However, there were concerns regarding the relationship between consultants in sexual health services which were still to be resolved. A further follow up meeting was planned with Health Education England in May 2016.In the follow-up letter (December 2015) it was reported that if all issues were resolved, there was a possibility trainees could be reintroduced from August 2016.

- We saw friendly and open engagement between all groups of staff. Nurses, doctors, health care professions and support workers we spoke with were proud of the care and service they provided to patients and children and young people. Service leads were clear that staff placed patients, and children and young people at the heart of everything they did.

Are services well-led?

- We observed staff being positive about working for the trust. Staff felt committed to providing good quality care and understood the contribution they made personally to the care and treatment of patients. All managers we spoke with said they were proud of their team.

- Staff told us of the various ways the trust engaged with them such as at the trust's "big conversation" events, Equal Active newsletters and via Core Brief and all staff user emails.

- The service gathered feedback from staff through staff meetings and discussions. Staff told us they would not hesitate to give feedback and discuss any concerns or issues with colleagues and management.

Engagement with the public and with people who use services

- The trust participated in national surveys such as the community mental health community survey, friends and family test and the national audit of schizophrenia.

- Patients were asked for their feedback on a regular basis in most teams. Ward staff held regular patient meetings.

- Patients and cares we spoke with said they could feedback about services and raise concerns if they needed to. Patient stories were used to gain an understanding of the healthcare experience of individuals in order to provide focus and improve the quality of services and each month, a patent story was presented at the trust's board meeting.

- The trust collated information from patients, families, and carers using the friends and families test and information and feedback was passed back to local teams.

- The service line manager with responsibility for patient experience in children and young people and families' services told us about opportunities to engage with children and young people across Coventry and Warwickshire. For example, involvement in staff recruitment interviews, dedicated newsletters and websites for specialist services. A patient assembly had been established to engage parents / carers to enable the service to understand their experiences of the service and to inform service developments and standards for the future.

- On line resources were available for young people and parents accessing the ISHS. For example, "Be savvy" which provide information on relationships and sexual advice. The resource was provided by Coventry city council and included information relating to a wide range of subjects, a directory of services in the Coventry area and resources for sexual health professionals.

- A young person's engagement worker (across all young people's related services) was appointed to improve the service user engagement agenda. For example, input into secondary school assemblies to engage young people in the mental health agenda.

Quality improvement, innovation and sustainability

- Staff in CAMHS were committed to improving the service by participating in Quality Network for Community CAMHS.

- Amber Unit achieved accreditation for inpatient mental health services (AIMS) accreditation in June 2015.

- Lakeview (ECT) clinic achieved electroconvulsive therapy accreditation service (ECTAS) accreditation in March 2015.

- Jade ward, Brooklands Hospital, is currently being assessed for the Quality Network for Inpatient Learning Disability Services (QNLD).

- The trust is an affiliated member of the Memory Services National Accreditation Programme. Accreditation is expected June or July 2017.

- The clinical lead for Arden mental health assessment team is a contributory author to Psychiatric Liaison Accreditation Network standards.

- The children, young people and families' service had achieved accreditation for the UNICEF Baby Friendly Initiative Stage 3.

- Staff from all areas told us they felt supported to implement new innovations and ideas.

- Senior staff confirmed that staff could nominate an individual or team for a "Q" award. The aim of the scheme was to recognise staff/teams that had gone above and beyond their call of duty whilst showing resilience to get the best outcome for patients.

Are services well-led?

- Healthy lifestyles staff voluntarily attended events in the community out of hours which affected health promotions. They were conscientious to endorse inner-city communities services which promoted family structures.

- The tissue viability services had been nominated for a Pride of Nursing Award (2016). The Pride of Nursing Awards gave patients the opportunity to recognise a nurse or nursing team who may have gone above and beyond the call of duty or who had demonstrated incredible compassion which made a difference to the patient and/or their family.

- The community services worked alongside the tissue viability nurses to include the react to red programme to prevent pressure ulcers.

- Community matrons had led a pilot for a targeted approach to support staff in a local care home to better understand patients' needs to reduce hospital admissions.

- In the specialist palliative care team, two Band 6 (junior sisters) had been recruited to work with partner organisations across Coventry. The aim was to provide education and development to the health and social care workforce and any voluntary sector teams to ensure they have the necessary skill and knowledge to provide high quality end of life care.

- The integrated sexual health service had led a successful "Go Red" campaign to raise awareness of HIV across Coventry. Local football and rugby teams and social media were involved. The team were visited by the chief executive and chairman and praised for their innovative approach to increasing awareness around HIV.

- The neurodevelopmental team were developing an innovative approach to the management of children and young people with a possible diagnosis of autistic spectrum disorder. Nurses and doctors talked with confidence about the developments and how the approach would enable children and young people to achieve a better diagnosis and treatment for their clinical condition. An adult pathway for 0-25 years had also been developed by the neurodevelopmental team.

Action we have told the provider to take

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

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Treatment of disease, disorder or injury	**Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment** • **Concerns were identified regarding the number of ligature points on the wards with unclear management plans in place. On Larches ward there were multiple ligatures, for example bathroom taps, shower fittings and bedroom windows and handles. Ligature cutters were kept in clinic rooms which were locked. Individual risk assessments were not all up to date.** • **Wards had blind spots where staff could not observe patients easily and the risk had not been mitigated. Medicines were not always stored safely nor disposed of correctly.** • In the older adults service a link corridor was used for de-escalation and the management of aggression. These incidents were recorded using the seclusion policy documentation. However the environment did not meet seclusion standards. Patients were at risk of harming themselves in the seclusion room on Janet Shaw Clinic. There were panels on the walls in the ensuite area which could have been used for the purpose of harming self, or used as a potential weapon to harm others. The MHA code of practice states that seclusion should only take place in a designated seclusion facility that is not used for any other purpose. There was one seclusion room for the whole acute service based on Sherbourne ward (PICU). There was no two-way communication system and the patient had to shout through the door to communicate. There was a metal frame to the window in the toilet area, which had very sharp edges. The doorway into the seclusion room was very small and cramped which staff reported caused problems when trying to support patients into the room. There was a lack of clarity in forensic wards which seclusion room was in use.

This section is primarily information for the provider
Requirement notices

This was a breach of regulation 12(1)(2)(a)(b)(d)

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Treatment of disease, disorder or injury	Regulation 17 HSCA (RA) Regulations 2014 Good governance • Record keeping was poor particularly in relation to the Mental Health Act documentation. Patients were not being told of their right to support from an Independent Mental Health Act Advocate (IMHA). • Those patients lacking capacity were not referred to advocacy automatically in line with MHA code of practice. Section 17 leave forms did not always record who else had been given a copy other than the patient. Some care records showed no evidence of assessment of mental capacity. • No records of Mental Health Act (MHA) paperwork or Ministry of Justice (MOJ) warrants or orders were available in paper or electronic forms at IPU 10-17, Swanswell Point. Two patient's Ministry of Justice records were not available at the MHA office at the Caludon centre. • Three patients with a criminal history, under supervision of the Ministry of Justice (MOJ), did not have their conditions included in their risk or care plans. Community treatment order conditions were not included in the care plan for one patient. **This was a breach of regulation 17(2)(c)(d)**

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Treatment of disease, disorder or injury	Regulation 18 HSCA (RA) Regulations 2014 Staffing • Not all teams achieved the compliance rate for MHA and Mental Capacity Act (MCA) training, the trust's target was 95%. Staff on adolescent units did not understand the Gillick competence and consequently did not have the knowledge and skills to assess capacity. • Staff did not consistently record supervision and not all staff received supervision on a regular basis.

Requirement notices

- There were high rates of vacancies in some services. Among the mental health services, wards for adults acute/PICU had the highest number of qualified nurse vacancies for mental health services with 36.5 vacancies, an 18% vacancy rate.

- Community CAMHS had the highest qualified nurse vacancy rate over the last year at 24%. Mental health wards acute/ PICU had the highest number of shifts filled by bank with 1494 bank shifts and 1010 agency shifts and the highest number of shifts not filled by bank was 101 and agency was 519.

- Mental health learning disabilities wards had the highest vacancy rate of 18.5% over the 12-month period (155 staff).

- Community health services (CHS) for adults had the highest number of vacancies for qualified nurses within community health services with 29. CHS end of life services had the highest qualified nurse vacancy rate of 37% over the last year. CHS end of life care services had the highest vacancy rate of 37% over the 12-month period (25 staff).

This was a breach of regulation 18(1)(2)(a)

Action we have told the provider to take

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

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Treatment of disease, disorder or injury	Regulation 10 HSCA (RA) Regulations 2014 Dignity and respect • **The trust was not effectively ensuring that the care and treatment of patients is appropriate, meets their needs, and reflects their preferences.** • **The trust was not effectively ensuring that patients are treated with dignity and respect.**