

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	RYG79 RYG51
Acute wards for adults of working age and psychiatric intensive care units	Caludon Centre St Michael's Hospital	RYG58 RYG79
Wards for older people with mental health problems	Manor Hospital St Michael's Hospital	RYGGCW 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
Specialist community service mental health services for children and young people	Wayside House	RYGCR
Community dental services	Wayside House	RYGCR

Summary of findings

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

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

Following the inspection in June 2017, we have rated Coventry and Warwickshire Partnership NHS Trust as Requires Improvement because:

- The trust had not made the necessary improvements from the previous inspection to change our rating. The trust had not completed its works programme to reduce ligature risks on acute mental health wards.
- There was long waiting times for children and young people to access treatment for mental health problems. We also found long waits for children and young people to be assessed for a neurodevelopment disorder, such as autism. There was a backlog of referrals waiting to be triaged in specialist community mental health services for children and young people. We found 600 referrals that required triage in this core service and there was not sufficient staff to complete the task.
- The trust had not provided staff with specialist training to undertake their role on all wards for older people. Staff were not monitoring patients' physical and mental health sufficiently to reduce risk. We issued the trust with a warning notice to improve care and treatment. The trust had not challenged the warning notice and had put in immediate plans to address the problems we found.
- The trust training compliance rate for the Mental Health Act was low. This was similar to the previous CQC inspection.
- We found temperatures in clinic rooms across the trust were high and this had the potential to affect

medicines. The trust had issued advice to vary the shelf life of medicines where safe storage could not be maintained. Not all services monitored clinic temperatures and there was not a consistent approach across the trust to reduce the risk despite standard operating procedures being in place.

- The workforce race equality scheme required organisations to demonstrate progress against a number of indicators of workforce equality. The trust had reported on the nine indicators, however, specific strategic directions related to action plans and objectives to address the workforce race equality indicators were missing.

However;

- Staff working across the trust were kind, caring and respectful. We saw some services that went above and beyond to meet patient and carer needs. Patients and carers feedback was positive and highlighted the staff as a caring group.
- The trust had engaged local communities to develop its equal partners strategy. The trust was involved in new models of care with partner agencies across the West Midlands to improve the quality and safety of care to patients.
- The trust had developed its approach to how patients were managed when presenting with challenging behaviours. The trust had developed person-centred positive behaviour support plans and had significantly reduced the number of patients who were restrained.
- The trust had an innovative approach to safeguarding children and adults. The trust had developed a specific team to meet with external stakeholders and support staff across clinical services. Staff were aware of forms of abuse and knew how to raise concerns.

Summary of findings

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

We always ask the following five questions of the services.

Are services safe?

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

- Following requirement notices issued following the CQC inspection in April 2016 in relation to ligatures, we found that on this most recent inspection, the trust had not yet completed its plan to reduce ligature risks .
- Across the trust, we found significant problems with the room temperatures of clinic rooms. Four of the core services had poor systems in place for the management, storage and transportation of medicines. We also found that two services had no safe storage for prescriptions that meant that there was a risk that blank prescriptions could be used fraudulently.
- Staff in specialist community mental health services for children and young people were not undertaking robust supervision of children at risk. Staff in this core service were applying practice from a trust policy that was due for review and followed national guidance that was outdated.
- The wards did not adhere to all safeguards relating to long-term segregation, in accordance with the Mental Health Act Code of Practice, for the patients nursed in long-term segregation. There was no evidence of external three monthly reviews taking place.

However:

- Almost all patient areas were visibly clean and well ordered. The trust average PLACE score for cleanliness was 97%. All but one core service routinely serviced equipment in line with manufactures' guidelines.
- In all but two services, the trust ensured there were sufficient numbers of suitably trained and experienced staff to deliver care to patients.
- The trust had improved access to, and increased the numbers of staff, who completed mandatory training.
- The trust demonstrated that they learned from incidents and made improvements to the way they delivered services as a result.
- Staff in most services carried out and updated risk assessments for all patients.
- The trust had policies and procedures to support staff to stay safe when they were working alone.

Requires improvement



Summary of findings

- The trust did not operate blanket restrictions. The trust carried out environmental risk assessments to check the safety and quality of its buildings and facilities.

Are services effective?

We rated Coventry and Warwickshire Partnership NHS Trust as

Requires Improvement for effective because:

- We identified significant concerns with the monitoring of physical healthcare on wards for older people with mental health problems. The trust did not provide staff with appropriate training in dementia or physical healthcare. This meant that older people did not receive appropriate healthcare.
- At the previous inspection in April 2016, the trust was issued with a requirement notice to improve staff access to clinical supervision and the recording of supervision. The trust had not met its own target with the clinical supervision rate at 71%. The lowest compliance rate was wards for older people at 42%.
- The trust had not met the requirement notice to improve staff compliance in training in the Mental Health Act.

However:

- Most care records we looked at were holistic and person centered. The trust delivered a range of specialist psychological therapies and treatment programmes.
- Most staff were skilled and experienced and patients had access to multidisciplinary teams. The trust delivered a range of specialist psychological therapies and treatment programmes.
- Staff were skilled and knowledgeable in the Mental Capacity Act and Deprivation of Liberty Safeguards.
- The trust had a programme of audit and shared learning across the trust.

Requires improvement



Are services caring?

We rated Coventry and Warwickshire Partnership NHS Trust as **Good** for caring because:

- Throughout the trust, we found staff to be caring, kind and considerate towards patients. Feedback from patients, carers and families during the inspection was consistently positive in how staff treated them.
- Feedback from the 2017 family and friends test showed that over 95% of patients would recommend the trust as a place to receive care and treatment.

Good



Summary of findings

- The trust, in partnership with patients, families, staff and the third sector, had introduced an equal partner's strategy. Patients and carers were involved trust and service developments. Patients were involved in the recruitment of staff. The trust had improved media communications with patients and carers.

Are services responsive to people's needs?

We rated Coventry and Warwickshire Partnership NHS Trust as

Requires Improvement for responsive because:

- At the time of the previous inspection of April 2016, we found long waiting lists for children and young people to access treatment for their mental health. One hundred and seventeen had waited between 25 to 49 weeks. At this most recent inspection, we found serious concerns relating to the triage of children and young people in mental health services and the waiting times for access to treatment in neurodevelopment services. We found a backlog of 600 referrals that required clinical triage at the time of this inspection.
- Staff, patients, families and carers told us of long waits for specific treatment interventions to begin within specialist community mental health service for children and young people. On the anxiety/depression pathway, children and young people would wait up to 49 weeks and 82 weeks for the attention and hyperactivity disorder pathway.
- Across adult mental health acute and rehabilitation wards, we found the practice of 'sleepovers' had grown significantly since the last inspection. Bed occupancy beds for adult acute mental health beds were consistently above 100%.

However:

- Following the previous CQC inspection in April 2016, the trust had improved waiting times in community dental services.
- Across the trust, urgent referrals were seen quickly. The trust reported that 99% of patents received at minimum, a phone call within four hours of referral, this met the trusts targets.
- Staff in core services understood their patient group and adapted their approach dependent on patient need. Services also looked at local demographics to support vulnerable patients groups. There was easy access to a range of interpreters and signor's across the trust. Many staff was able to speak diverse languages or sign when working in particular services.

Requires improvement



Summary of findings

Are services well-led?

We rated Coventry and Warwickshire Partnership NHS Trust as

Requires Improvement for well-led because:

- We were not assured that the trust board had sufficient oversight of all governance arrangements to fully understand the risks and support care and treatment across its services. We concluded that there was a lack of collective leadership across the trust.
- The trust did not complete disclosure and barring checks for non-executive directors.
- Although the trust had addressed a number of the requirement notices following the previous inspection in April 2016, we found a number of new problems during this inspection that required attention.
- The trust did not have robust arrangements in place to assess, monitor and treat patients in wards for older people. Staff were not adequately trained and provided with sufficient supervision to undertake their role effectively. The physical healthcare of patients did not meet appropriate standards for care and treatment.
- The trust had not completed all the environmental works to sufficiently reduce ligature risks in acute mental health wards.
- Staff trained in the Mental Health Act was very low. Not all services across the trust had sufficient staff undertaking and recording clinical supervision.

However:

- Although not embedded across core services, the trust had developed strategies to promote patient and carer inclusion, and recruit and retain staff. Staff across the trust knew and promoted the trust vision and values. Senior and middle managers were more visible across the trust.
- The trust had reduced the use of restraint across its services.
- The trust had increased the number of staff that participated in the NHS staff survey 2016 and more staff recommended the trust as a place to work and receive care. Staff were positive, motivated and worked well together across the trust.

Requires improvement



Summary of findings

Our inspection team

Our inspection team was led by:

Team Leader: James Mullins, Head of Hospitals Inspection, Care Quality Commission

Inspection Manager: Paul Bingham, Inspection Manager, Care Quality Commission

The team of 74 people included:

- three CQC inspection managers
- 14 CQC inspectors
- one CQC assistant inspector
- one analyst
- one planner
- one CQC quality of delivery officer
- four experts by experience, who have personal experience of using, or caring for someone who uses, the type of services we were inspecting

- one Mental Health Act reviewer
- one CQC pharmacist
- 15 nurses from a wide range of professional backgrounds
- four senior doctors
- five occupational therapists
- three psychologists
- six social workers
- one dental hygienist
- nine people with governance experience

A representative of the National Institute for Health and Care Excellence (NICE) and a representative from the New Zealand office of the ombudsman joined our inspection to observe how the CQC carries out a comprehensive inspection.

Why we carried out this inspection

We inspected the Coventry and Warwickshire Partnership NHS Trust to find out if it had made improvements to its services since our last comprehensive inspection in April 2016 where we rated the trust as **requires improvement** overall.

We rated the trust in the five CQC domains as:

- Safe: Requires Improvement
- Effective: Requires Improvement
- Caring: Good
- Responsive: Requires Improvement
- Well-led: Requires Improvement

When we last rated the trust in April 2016, we rated:

- acute wards for adults of working age and psychiatric intensive care units as **requires improvement** overall. We rated this core services as inadequate in safe, requires improvement in effective, good in caring, requires improvement in responsive, and requires improvement in well-led.

- community dental services as **requires improvement** overall. We rated this core services as requires improvement in safe, good in effective, good in caring, requires improvement in responsive, and requires improvement in well-led.
- community mental health services for people with learning disabilities or autism as **requires improvement** overall. We rated this core services as requires improvement in safe, requires improvement in effective, good in caring, good in responsive, and requires improvement in well-led.
- community health services for adults as **good** overall. We rated this core services as requires improvement in safe, good in effective, good in caring, good in responsive, and good in well-led.
- community health services for children, young people and families as **good** overall. We rated this core services as good in safe, good in effective, outstanding in caring, good in responsive, and good in well-led.

Summary of findings

- community-based mental health services for adults of working age as **requires improvement** overall. We rated this core services as requires improvement in safe, requires improvement in effective, good in caring, good in responsive, and good in well-led.
- community-based mental health services for older people as **requires improvement** overall. We rated this core services as good in safe, requires improvement in effective, requires improvement in caring, good in responsive, and requires improvement in well-led.
- forensic inpatient/secure wards as **good** overall. We rated this core services as requires improvement in safe, good in effective, good in caring, good in responsive, and good in well-led.
- long stay/rehabilitation mental health wards for working age adults as **requires improvement** overall. We rated this core services as requires improvement in safe, requires improvement in effective, good in caring, requires improvement in responsive, and requires improvement in well-led.
- mental health crisis services and health-based places of safety as **good** overall. We rated this core services as good in safe, good in effective, good in caring, good in responsive, and good in well-led.
- specialist community mental health services for children and young people as **good** overall. We rated this core services as good in safe, good in effective, good in caring, requires improvement in responsive, and good in well-led.
- wards for older people with mental health problems as **requires improvement** overall. We rated this core

services as requires improvement in safe, requires improvement in effective, good in caring, requires improvement in responsive, and requires improvement in well-led.

- wards for people with learning disabilities or autism as **requires improvement** overall. We rated this core services as requires improvement in safe, requires improvement in effective, good in caring, good in responsive, and requires improvement in well-led.
- end of life care as **good** overall. We rated this core services as good in safe, good in effective, outstanding in caring, good in responsive, and good in well-led.

In April 2016, we issued the trust with three requirement notices that affected a number its services. These related to the following regulations under the Health and Social Care Act 2015 (Regulated Activities):

- Regulation 12: Safe care and treatment
- Regulation 17: Good governance
- Regulation 18: Staffing

In April 2016, we issued the trust with one warning notice. This related to the provision of inpatient beds to ensure compliance with the Department of Health guidance 'eliminating mixed sex accommodation in hospitals', November 2010, and the Mental Health Act 1983 Code of Practice in relation to eliminating mixed sex accommodation. These related to the following regulations under the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014:

- Regulation 10: Privacy and dignity.

How we carried out this inspection

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

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

Before visiting, we requested and reviewed a range of information about Coventry and Warwickshire Partnership NHS Trust and asked other organisation what they knew.

They included NHS England, NHS Improvement, NHS Health Education England, Healthwatch, clinical commissioning groups (CCGs), the General Medical Council, the Royal College of Nursing, the Parliamentary and Health Services Ombudsman, NHS Litigation Authority and local authorities.

We held focus groups with three CCGs, one local authority, Healthwatch, a patients group and a families and carers group, with 18 people in attendance overall.

Summary of findings

We reviewed the previous report of July 2016 and focussed our inspection on the key areas where services required improvement in community health services and all services across mental health and learning disability.

As a result, in June 2017 we inspected:

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

We did not inspect the following services based on their previous rating of good:

- community health services for adults
- community health services for children, young people and families
- end of life care

During the inspection visit, we:

- visited most of the trust's location and many of the bases from which it provides its community mental health services and dental services
- held 13 focus groups with staff who provide front line care and support to people who use services, including doctors, nurses, allied health professionals, social workers, modern matrons, student nurses and administrative staff
- held 19 interviews with senior managers with specific responsibility for the governance of the trust including, the chief executive officer, the chair of the trust, medical director, director of nursing, director of finance, human resources manager, director of business and strategy, chief pharmacist and non-executive directors
- held 18 focus groups with managers and staff who support the governance and operations of the trust, including quality improvement leads, the safeguarding team, contracting and performance team, the nursing, quality and safety team, the professional development team and the engagement team
- talked with 607 staff
- talked with 140 people who used services and with 57 carers and/or family members
- reviewed 285 care or treatment records of people who used services
- how people were being cared for and attended community treatment appointments.

We also carried out further visits to six wards and services in the 10 days following the comprehensive inspection. They included wards for older people, forensic wards, learning disability wards, community mental health services for adults of working age, crisis services and long stay rehabilitation wards.

Information about the provider

Coventry and Warwickshire Partnership NHS Trust was formed in 2006 and integrated with community services from NHS Coventry in 2011. The organisation now provides services from more than 60 locations with an income of £200 million and employs more than 3000 staff.

The trust also provides inpatient, community and day clinics as well as specialist services to a population of about one million living within Coventry, Warwickshire and Solihull and to a wider geographical area in some of their specialist services.

Summary of findings

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, 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 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 diseases 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 their 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 had community care staff trained to support people at the end of life. This is 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 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.

Summary of findings

Coventry and Warwickshire Partnership NHS Trust has been inspected twice under the new methodology of inspection. The first inspection was undertaken in April 2014 and the trust was not rated by the CQC. The second inspection was undertaken in April 2016 and the trust was rated as requires improvement overall.

The CQC undertook an unannounced inspection of the Aspen Centre, a specialist eating disorders ward, in May 2017. The report had not been published at the time of this inspection however, it will be published in August 2017.

There were four Mental Health Act monitoring visits between 1 April 2016 and 5 April 2017, all were unannounced. In total, 24 issues were found and 38% of the issues found related to protecting patients' rights and autonomy, followed by assessment, transport and admission to hospital. The trust returned a provider action statement following each monitoring visit.

What people who use the provider's services say

Prior to the inspection, we met with a group of people who had used community health and mental health services in the trust. We also met with a group of carers and families, in addition to Healthwatch representatives from Coventry and Warwickshire.

The 12 people who had used trust services were highly complementary of the care and treatment they had received from multidisciplinary professionals. In particular, they praised stroke and tissue viability teams. There was mixed feedback about the administration of appointment times and hospital transport, and they felt the environment at the Caludon Centre could be more friendly.

The six carers we spoke to were very complementary of the care and treatment their family had received. Particular mention of staff at Hawksbury Lodge who were responsive and provided support towards discharge. Further complements were for support in the community for dementia and children's services, with carers detailing how informed and included in the care of relatives.

Across trust services, we spoke to many patients and carers. The vast majority were complimentary about the care and support they received from staff. On occasion, they spoke of staff going above and beyond in what they should do.

Healthwatch were positive of the open, transparent and responsive approach from the trust, and in particular, of the CEO and Chair. Feedback from patients and carers overall was positive. However, they had concerns about the quality of physical healthcare at St Michael's hospital, delays in diagnosis and treatment in CAMHS, a lack of activities on inpatient wards and not enough staff to do the job. They also thought the senior leadership were stretched due to covering secondments and external work with new care models.

Patient-led assessments of the care environment (PLACE) are self-assessments undertaken by NHS and independent health care providers, and see local members of the public (known as patient assessors) as part of the assessment team. The team assesses how the hospital environment supports patients' privacy and dignity, food, cleanliness and general building maintenance. The trust score of 97% was slightly lower than the national average.

Good practice

During the inspection we found evidence of good practice by the service including:

In community mental health services for people with learning disabilities or autism:

- Staff had recognised some patients had increased levels of anxiety about feeling safe in their accommodation and their safety in crowds. Staff produced information in easy read and pictorial formats to explain how to stay safe. The team and other medical professionals synchronised their

Summary of findings

availability to allow all the interventions to be completed whilst the patient was under the anaesthetic. Staff supported local GP practices to increase their skills and knowledge on learning disabilities and autism patients. Ashby and Shirley house provided personal place mats for patients. These highlighted any dietary needs of the patients including swallowing, drinking needs and food likes, allergies and individual routines and needs.

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

- Wards subject to Private Finance Initiatives often complain that contractual restrictions limit what they can do to make wards homely and patient friendly, staff on Sherbourne ward, had created a homely, welcoming and patient-friendly environment, which was commented favourably on by patients and visitors.

Mental health crisis services and health-based places of safety:

- The Arden mental health acute team had developed a weekly newsletter for staff to impart information about developments within the trust and news relevant to their service.

Wards for people with learning Disabilities or Autism:

- Managers from Brooklands Hospital attended formulation meetings every week where all prone or 15-minute long restraints were reviewed. Restraints had significantly reduced since the implementation of positive behaviour support plans. (PBS). Multidisciplinary staff from Jade and Amber wards had delivered presentations and facilitated training workshops to external providers in order to improve discharge pathways. This had resulted in a reduction in readmission rates.

Community dental services:

- The service coordinated treatment input for patients living with complex needs who were undergoing general anaesthesia. This included podiatry, venepuncture and other interventions that would be distressing to the patient. The oral health education and promotion team provided effective care and treatment to patients in the community setting by visiting schools, rehabilitation centres and voluntary organisations in the community. It also reached out to homeless patients living in the city of Coventry.

Areas for improvement

Action the provider MUST take to improve

- The trust must ensure that there is consistency in the ongoing monitoring and reduction of identified physical and mental health care risks in wards for older people.
- The trust must take action to reduce the practice of sleepovers from acute mental health wards. It must ensure that patients' care and treatment is not adversely affected by this practice.
- The trust must take action to complete its work to remove identified ligature risks.
- The trust must ensure that seclusion rooms are fit for purpose and, the risk to patients and staff when accessing and leaving seclusion rooms is reduced.
- The trust must ensure that all safeguards of long-term segregation are managed in accordance with the code of practice including maintaining external three monthly reviews.
- The trust must ensure that all referrals are clinically triaged on the day of receipt in specialist community mental health teams for children and young people.
- The trust must ensure that waiting lists to access to treatment are reduced in specialist community mental health teams for children and young people.
- The trust must ensure that staff receive Mental Health Act training and updates.
- The trust must ensure that staff have access to and record clinical supervision.

Summary of findings

- The trust must ensure there are safe and effective contingency plans to respond to high clinic room temperatures that affect medicines.
- The trust must ensure safe medicines management, including the storage of medicines and prescriptions.
- The trust must ensure patient data and identifiable documentation is securely transported by staff while in the community.

Action the provider SHOULD take to improve

- The trust should reduce waiting lists for occupational therapy and psychology assessments to be completed to meet national targets.
- The trust should ensure they have procedures in place to monitor and check for out of date clinical items.
- The trust should ensure cleaning records are maintained and across all its services.
- The trust should ensure that all staff who have direct contact with young people have completed level three safeguarding training.
- The trust should ensure that there is proper food hygiene monitoring across all its services.
- The trust should ensure that it protects confidential patient information and ensure that it is not visible to other people.
- The trust should ensure the complaints form is available in an easy read format for patients with a learning disability.
- The trust should ensure that confidential patient records are stored securely at all times.
- The trust should ensure that all staff follow standard infection control precautions across all its services.
- The trust should ensure that consent to care and treatment is always obtained in line with legislation and guidance across all its services.
- The trust should ensure that staff inform all patients detained under the Mental Health Act of their rights on an on-going basis, in line with local policy, and after any change in their status.
- The trust should ensure that its children's safeguarding policy reflects current guidance.
- The trust should ensure that the all of the required safety checks have been carried out as per water safety regulations for the control of legionella and, hot water dispensers have up to date safety checks.
- The trust should ensure that specific strategic directions, action plans and objectives related the workforce race equality scheme are addressed.

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.

The trust had a lead for the Mental Health Act and the medical director supported the role. The trust had oversight of implementation of the Mental Health Act through trust meetings. The trust employed Mental Health Act administrators to support clinical staff.

There were four Mental Health Act monitoring visits between 1 April 2016 and 5 April 2017, all were unannounced. In total, 24 issues were found and 38% of the issues found related to protecting patients' rights and autonomy, followed by assessment, transport and admission to hospital. The trust returned a provider action statement following each monitoring visit.

Trust training rates for staff in the Mental Health Act was low. Although the trust had introduced a programme of training in March 2017, the planned uptake of training meant that the trust would not have sufficiently trained staff to meet its Mental Health Act requirements beyond 2017.

Across the trust, we found that staff were knowledgeable in the Mental Health Act and they had access to staff who had received specialist training.

The trust had improved their processes for storage and recording of Mental Health Act paperwork. This included access to Mental Health Act documentation related to the Ministry of Justice.

Patients were regularly informed of their rights under the Mental Health Act. Patients were able to access independent mental health advocacy (IMHA) services and staff would refer patients when they required advocacy support.

Mental Capacity Act and Deprivation of Liberty Safeguards

Most staff were trained in and had a good understanding of the Mental Capacity Act 2005, in particular the five statutory principles. The trust had appointed a manager in the Mental Capacity Act. Mental Capacity Act training was mandatory for appropriate clinical staff and there was sufficient numbers trained across the trust. Advice regarding the Mental Capacity Act was available through the trust lead, trust policy and the intranet.

The Mental Capacity Act is not applicable to children under the age of 16. Staff assessed using Gillick competence, which balances children's rights with the responsibility to keep children safe from harm, for those under 16. Gillick competence is used in medical law to decide whether a child (16 years or younger) is able to consent to his or her medical treatment, without the need for parental permission or knowledge. Training in Gillick competence was incorporated into Mental Capacity Act training. Staff working in specialist community mental health child and adolescent services demonstrated good knowledge of Gillick competence and its application in practice.

Detailed findings

When decisions of capacity had been decided, we saw staff were skilled and knowledgeable. Staff carried out capacity assessments with the involvement of patients and carers. Patients had access to an independent mental capacity advocate (IMCA).

Are services safe?

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

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

Summary of findings

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

- Following requirement notices issued following the CQC inspection in April 2016 in relation to ligatures, we found that on this most recent inspection, the trust had not yet completed its plan to reduce ligature risks.
- Across the trust, we found significant problems with the room temperatures of clinic rooms. Four of the core services had poor systems in place for the management, storage and transportation of medicines. We also found that two services had no safe storage for prescriptions that meant that there was a risk that blank prescriptions could be used fraudulently.
- Staff in specialist community mental health services for children and young people were not undertaking robust supervision of children at risk. Staff in this core service were applying practice from a trust policy that was due for review and followed national guidance that was outdated.
- The wards did not adhere to all safeguards relating to long-term segregation, in accordance with the Mental Health Act Code of Practice, for the patients nursed in long-term segregation. There was no evidence of external three monthly reviews taking place.

However:

- Almost all patient areas were visibly clean and well ordered. The trust average PLACE score for cleanliness was 97%. All but one core service routinely serviced equipment in line with manufactures' guidelines.
- In all but two services, the trust ensured there were sufficient numbers of suitably trained and experienced staff to deliver care to patients.
- The trust had improved access to, and increased the numbers of staff, who completed mandatory training.

- The trust demonstrated that they learned from incidents and made improvements to the way they delivered services as a result.
- Staff in most services carried out and updated risk assessments for all patients.
- The trust had policies and procedures to support staff to stay safe when they were working alone.
- The trust did not operate blanket restrictions. The trust carried out environmental risk assessments to check the safety and quality of its buildings and facilities.

Our findings

Safe and clean care environments

- The physical environment around the trust were visibly clean, well maintained and was appropriately decorated to meet the needs of patients. Cleaning schedules were in place across the trust except for the Health Based place of Safety.
- Patient-led assessments of the care environment (PLACE) are self-assessments undertaken by NHS and independent health care providers, and local members of the public (known as patient assessors) as part of the assessment team. The team assesses how the hospital environment supports patients' privacy and dignity, food, cleanliness and general building maintenance. The trust score of 97% was slightly lower than the national average.
- The trust had an estates strategy that linked to the trust risk register. The trust had undertaken significant actions since the previous inspection to reduce the number of risks across its wards and services. The trust had responded to a central alert system (CAS) issued in 2014 that related to fire dampeners across its premises. The central alerting system is a web-based cascading system for issuing patient safety alerts, important public health messages and other safety critical information and guidance to the NHS and others, including independent providers of health and social care. This

Are services safe?

meant that some wards did not have the necessary precautions to safely control a fire if it started. The concern related to its private finance initiative (PFI) buildings. The trust had met most of its actions to make buildings safe, that included an immediate response to areas of greatest risk. Outstanding work was planned for completion in October 2017 and related to completion of inventories and ongoing programmes of repair. Fire procedures and equipment were in place at all services. Staff received fire safety training and knew what to do in the event of an emergency.

- The trust had improved lines of sight across its wards and had installed convex mirrors in key areas that helped staff observe patients. Following the previous inspection, the trust had reduced the risk of patients tying a ligature to harm themselves by installing anti-ligature fixtures and fittings. However, this was not complete in all areas. We found that acute mental health wards for adults of working age had not made the environments risk free. For example, showers were designed to prevent a person tying a ligature but taps were not adapted to prevent this risk. In long stay rehabilitation wards, the trust had assessed ligature risk and put in place a risk management plan to reduce risk to patients. However, planned environmental work on Hawksbury Lodge was not due for completion until December 2017. At this inspection, we found that ligature cutters were in place and accessible on all wards.
- Following the previous inspection, the trust had reviewed its policy and procedures on mixed sex accommodation. The trust had changed its wards to single sex accommodation to comply with the previous requirement notice. The Department of Health guidance 'eliminating mixed sex accommodation in hospitals', November 2010 and Mental Health Act 1983 Code of Practice in relation to the arrangements for eliminating mixed sex accommodation was met across the Trust.
- The trust had improved seclusion facilities in the Janet Shaw Clinic following the last inspection and had reduced the risk of patients harming themselves. The seclusion room on Sherbourne ward, a male only psychiatric intensive care unit, had a narrow entrance to the seclusion door. This made it difficult to transfer patients who were being restrained. This meant patients and staff were placed at risk of harm. There was no seclusion room on Larches ward, the female psychiatric intensive care ward. This meant patients who required seclusion would need to transfer to a service outside of the trust.
- We found variability across the trust in how clinic rooms were equipped and how equipment was maintained. Most clinic rooms were clean, fit for purpose and had appropriate and well-maintained equipment. In specialist community mental health teams for children and young people and the health-based place at safety at the Caludon centre, the trust did not calibrate its physical health care equipment in line with manufacturers' guidelines. This meant that staff could not be assured the accuracy of monitoring a patients physical health wellbeing. There was no emergency equipment in learning disability respite services where, patients had physical healthcare needs such as epilepsy. In health-based places of safety, a system was not in place to ensure out of date items were removed from clinic rooms.
- We found wide variation in the monitoring of fridge temperatures and the temperatures in clinic rooms. To cool temperatures in clinic rooms across the trust, portable air conditioning units were issued to wards. This did not always have the impact of maintaining an acceptable room temperature to support the safe storage of medicines. The trust had issued advice to vary the shelf life of medicines where safe storage could not be maintained.
- In community dental services, we were unable to find evidence of water quality checks although we found a risk assessment for legionella. The service had no oversight of water quality, as these were checks carried out by an external landlord.
- Most trust staff followed infection control principles including handwashing. This was an improvement following the previous inspection. However, not all staff in community dental services followed standard infection control principles therefore we not assured that patients were not being exposed to unnecessary risk of infection. Wards and community buildings displayed information on how to apply infection control principles.
- Staff used alarms and appropriate nurse call systems across the trust. Staff knew how to access personal alarms, how they would be used and alarms were regularly tested. Following the previous inspection in April 2016, the trust had corrected the problems on

Are services safe?

Larches ward and nurse call buttons were working. However, in older people's wards, there were no nurse call alarms in Ferndale ward and not in bedrooms at Woodloes House.

Safe staffing

- Data showed that between 01/02/2016 and 31/01/2017:
 - Total number of substantive staff was 3418
 - Total number of substantive staff leavers in the last 12 months was 473
 - Average percentage of staff leavers was 13.8%
 - Total vacancies overall was 407
 - Total vacancies overall was 10.5%
 - Total permanent staff sickness overall was 5.2%
 - Establishment levels of qualified nurses (whole time equivalent) was 1131
 - Establishment levels of nursing assistants (WTE) was 1554
 - Registered nurse vacancy rate was 11.8%
 - Nursing assistant vacancy rate was 13.5%
- The trust reported that the highest vacancy rate was on wards for people with learning disabilities, which had a rate of 24.9%. The lowest vacancy rates were in specialist community services for children and community dental services. The vacancy rate for registered nurses reduced from 13.7% at the last inspection in April 2016 to 11.8%. The vacancy rate for health care assistants was 13.7% that was similar to the previous inspection.
- Between 1 February 2016 and 31 January 2017, the average sickness rate for the trust was 5.4%. This was similar to the sickness rate of 5.3% reported at the time of the last inspection in April 2016. The core service with the highest average sickness rate across the period was wards for older people with mental health problems, with 10.6%.
- Between 1 February 2016 and 31 January 2017, 30% of shifts across the trust were filled by bank staff to cover sickness, absence or vacancy. Two per cent of shifts were not covered by bank staff. In the same time period, 50% of shifts were covered by agency staff and 5% were not covered by agency staff. The core service with the highest proportion of shifts covered by bank staff was mental health crisis services and health based places of safety at 60%. The core service with the lowest proportion among those that used any bank staff was adult community mental health services for adults of working age.
- The trust had improved processes for the use of bank staff and worked closely with NHS Professionals to provide appropriate staff who knew services. As a result, the use of agency staff had reduced since the previous inspection in April 2016.
- The trust had 473 (13.8%) staff leavers between 1 February 2016 and 31 January 2017. This is slightly lower than the 14.5% reported at the time of the last inspection. Wards for people with learning disabilities was the core service with the highest leaver rate, and was one of six core services that had a leaver rate above the trust average.
- In most services we inspected, there was sufficient staff to meet the needs of patients. The trust had improved staffing levels in forensic and learning disability wards. However, in specialist community mental health services for children and young people, there were not sufficient numbers of skilled and qualified staff to provide an effective single point of entry service. This meant the referrals were not always clinically triaged in a timely manner. Staffing for the whole of the core service was on the trust risk register at the time of our inspection. In health-based places of safety, the additional duties that staff had to undertake meant that when two patients were admitted into the Caludon site, patients and staff were placed at risk. Across all older people's wards, a registered nurse was not always present in communal areas of the ward because of other duties they had to administer.
- Across inpatient wards, there was enough staff to undertake regular one-to-one work with patients. Although leave was sometimes cancelled as a result of clinical activity or risk, most leave was used as planned.
- Across community services, there were good arrangements in place to assess, manage and monitor caseloads. Most services had caseloads that were manageable and staff said they had time to visit patients. However, staff in early intervention services had higher caseloads than recommended and they were concerned about the impact on the service they provided. In specialist community mental health services for children and young people, staff undertook additional duties that would impact on their ability to see patients when needed.

Are services safe?

- Across the trust, there was good access to psychiatrists, junior doctors and GPs. Staff were able to access psychiatrists in an emergency.
- The trust had improved compliance with mandatory training since the CQC inspection in April 2016. The trust target for mandatory training was 95%. The trust had increased the training rate from 84% to 90% at this inspection. All core services reported training rates above 86%. The trust ran 19 mandatory training programmes but some were role specific. The programme with the highest attendance was safeguarding adults level 3 at 100% compared with, manual handling people at 31%. Manual handling objects training was at 86%.
- Training in the Mental Health Act was not considered mandatory. We were unsure why training in the Mental Health Act was not considered mandatory in a trust that predominantly provided mental health services. In response to the inspection in April 2016 where this issue was also raised, the trust had developed a three-yearly core training programme for the Mental Health Act and this commenced in March 2017. The trust had a designated trainer to deliver the Mental Health Act training programme. We received trust-training figures for June 2017 that showed that 31% of staff had completed Level 2 training and 11.7% had completed Level 1. Qualified nurses received Level 2 training and unqualified staff received Level 1. Not all services provided local training data that meant managers locally did not always monitor staff who attended training.

Assessing and managing risk to patients and staff

- The trust had policies and procedures in place to assess and manage risk effectively. Risk was routinely discussed across all services we inspected. Most services had multidisciplinary staff to identify and manage risk at the point of admission to wards and community teams. The trust had introduced an electronic patient recording system and when that was used, risk assessments were accessible to staff. Specialist risk assessment tools were used in a number of services, including forensic wards and specialist community mental services for young people. We reviewed over 285 care records that had risk assessments in place. The majority had completed risk assessments on admission and were regularly reviewed. Teams were supported by local managers to triage risk and escalate to the trust quality and safety team.
- The trust had a specific team to monitor and support safeguarding process and procedures. The team included a designated lead for safeguarding children and adults, and a named nurse for child protection. The trust and the safeguarding team regularly met with local safeguarding children's boards and represented their committees. Section 75 agreements were in place to support integrated care across health and social care provision locally. The trust complied with statutory requirements and Department of Health mandates and guidance in relation to safeguarding children and adults. The trust had governance oversight of safeguarding policies and procedures. A number of policies supported safeguarding practice across the trust and when working with external agencies such as clinical commissioning groups (CCGs) and local authority safeguarding teams. There was up to date children and adults safeguarding policies, and a policy on domestic abuse. However, the child safeguarding policy did not reflect up-to-date guidance from the Department of Education document 'Working Together to Safeguard Children' (2015). Most staff described situations that constituted abuse and could demonstrate how to, and who to, report concerns. The safeguarding team provided training to the teams and to the board. They also provided safeguarding supervision to staff working with children however, the system was not robust. Staff self-selected cases taken to supervision that may not identify high-risk cases. Cases discussed did not differentiate between child protection and children in need cases. Between 1 April 2016 and 31 March 2017 there were 353 adult safeguarding referrals and 121 children's safeguarding referrals. Of the 353 adult referrals, community mental health teams reported the most with 223. Similarly, specialist community mental health teams for children and young people reported child and adolescent mental teams made 66 referrals.
- The trust had significantly reduced the number of patients who were restrained in the prone or face down position since the last inspection. The trust had a policy in place to support staff manage patients who potentially become aggressive or violent. A sub-group of the trusts violence and personal safety group developed

Are services safe?

a trust wide restrictive intervention reduction plan, and incorporated the Department of Health guidance; 'Positive and Proactive Care: reducing the need for restrictive interventions'. The trust had a specialist training team to deliver training to staff and this was tailored to meet the needs of patients and staff. Training incorporated the guidance from positive and proactive care by the Department of Health. The model of training was accredited through the British Institute for Learning Disabilities (BILD). The policies and training were in line with guidance from the National Institute for Health and Care Excellence (NICE). Between May 2016 and April 2017, the trust had reduced the number of restraints from 2,440 to 2,110. In the same time period, the number of prone restraints had reduced from 437 to 294.

- Personal safety and lone working principles were in place across the trust. The community IPU team had a lone working protocol that included a buddy system where nominated staff were contactable when a member of staff worked beyond 5pm. Where alarms were not fitted in community buildings, the trust provided staff with personal alarms. Violence and personal safety training for staff incorporated the principles of lone working.
- The trust had an up-to-date policy in the use of seclusion and long-term segregation. Between May 2016 and April 2017, the trust had recorded that 121 patients were placed in seclusion compared with 353 in the previous 12 months. Acute mental health wards for adults of working age saw a reduction of 21 uses of seclusion to 78 and most other services showed comparable results. Forensic wards increased the use of seclusion from two to 11 although this was mainly due to the care and treatment of one patient. There was eight recorded incidents of long-term segregation of patients and these were all on the Brooklands site. Five were in forensic wards and three across wards for people with a learning disability. The trust were not applying the appropriate safeguards to patients in long term segregation. A three-monthly external review was not undertaken.
- The trust medicines management department provided a medicines optimisation service. The dispensing and supply function of the pharmacy service had been subcontracted to independent third party providers. These supplied the medicines for stock, inpatient named patient, outpatient supplies, and community

mental health team stock. There was no out of hours pharmacist on-call service, for either clinical advice or dispensing. However the trust advised, and staff substantiated, that the trust's staff could use subcontracted community pharmacists which were available Monday to Saturday up to 10pm and Sunday up to 5PM. These pharmacies were also available to provide pharmaceutical advice. The chief pharmacist indicated that there were currently no plans to move to 24/7 working. We saw clinical pharmacy involvement in multidisciplinary meetings, with several staff praising their input into the meetings. Additionally, pharmacy technician support around audits and safe and secure handling of medicines was mentioned and clearly documented on several occasions within different inpatient wards. However, there was a variable amount of support within the community-based mental health teams. Doctors undertook medicines reconciliation for each patient admitted to the trust. The medicines management teams took responsibility for conducting a more in depth medicines reconciliation at the next available opportunity.

- Across the trust, we found portable air conditioner units had been located in clinic rooms because of recent hot weather. In many of the clinic rooms, we found them to be hot and inappropriate for the safe storage and dispensing of medicines. We found that room temperatures were not routinely monitored. Similarly, we found that fridge temperatures were not always monitored and were outside of standards expected for safe storage of medicines. Where the trust had found temperatures not in line in line with medicines manufacturing guidelines staff were issued with advice to change the shelf life for safe storage. Therefore, there was a risk of medicines being stored incorrectly and reducing their efficacy. Storage of prescription pads, known as FP10s, varied across the trust. We saw FP10s left unsecured and accessible to non-clinical staff in health-based places of safety and the memory service in Rugby.
- In response to the NHS England and MHRA patient safety alert: Improving medication error incident reporting and learning (March 2014) the chief pharmacist had undertaken the role of the trusts medicine safety officer (MSO). All staff we spoke to discussed the process for reporting and investigating medicine incidents and described awareness of recent incidents within the trust demonstrating that learning

Are services safe?

from incidents was shared. A multidisciplinary medicines error group monitored and investigated medication incidents at the trust. The learning from medicine related incidents was then shared with staff. The medicines management newsletter, “Learning from Medicines Errors”, was mentioned by different staff as a good source of information.

Track record on safety

- NHS trusts are required to submit notifications of incidents to the National Reporting and Learning System (NRLS) and to the Strategic Executive Information System (STEIS). Trust staff reported serious incidents to the incident reporting system (SIRI). When compared to similar trusts nationally, it was in the highest 25% of reporters of incidents. Between February 2016 and January 2016, 8064 incidents were reported through NRLS. The most common category was ‘disruptive, aggressive behaviour’. The majority of incidents were ‘low harm’ (66%) or recorded as ‘no harm’ (29%). The number of incidents reported is lower than the previous inspection in April 2016. Between 1 February 2016 and 31 January 2017, the most common category for serious incidents both in the trust’s own reporting systems and STEIS was pressure ulcers, followed by ‘self-harming’. The core services with the most incidents were community health adult services and community based mental health services for adults.
- There was 28 deaths reported by the trust in the 12 months leading up to the inspection. In this period, there was no prevention of future death reports sent to the trust by the Coroner’s office.
- The trust reviewed mortality through its serious incident group. Whilst progress had been made to meet the national expectation for ‘learning from deaths’, it was unclear which non-executive director had responsibility for oversight of the process. The trust need to be clear on how they identify the deaths of people who have accessed their service but where the trust was not the primary carer. We were told by a trust senior manager that not all deaths were reported as an incident.
- Serious incidents were reviewed at local and board level. Oversight of incidents rested with the quality and safety team and there was an embedded culture to share and learn from incidents.

Reporting incidents and learning from when things go wrong

- The trust had a system in place to capture incidents, and to learn from them when things went wrong. The trust quality and safety group oversaw risk and supported incident reporting. Overall, staff working in the trust were able to explain the process to report incidents through the trust reporting system.
- In wards for people with a learning disability, managers held a weekly meeting to discuss incidents and restraints. Learning from these meetings had supported the reduction in the use of restraint and increased the use of positive behaviour support plans.
- Across the trust we saw that staff were offered and participated in debrief sessions following incidents. Debrief would occur locally and was facilitated by local managers, and in services such as forensic wards, by psychologists.

Duty of Candour

- The trust had a ‘Being Open (Duty of Candour) Policy’ that was up to date and due to for review in November 2018. The duty of candour means that every healthcare professional must be open and honest with patients when something that goes wrong with their treatment or care causes, or has the potential to cause, harm or distress. It may lead to an apology to the patient (or, where appropriate, the patient’s advocate, carer or family)
- The trust had recently appointed a Freedom to Speak Up Guardian. Freedom to Speak Up Guardians work with trust leadership teams to create a culture where staff are able to speak up in order to protect patient safety and empower workers. The appointed trust Guardian sits within the staff engagement team and has a direct link to the trust director of nursing.
- Trust senior managers were clear about the need to be open and transparent when things went wrong and promoted this with staff. This was promoted through the trust intranet displayed in posters across trust buildings.
- Following an investigation or complaint, the trust investigating officer met with families and would offer them a copy of the report.
- Patients and carers reported that staff were open and transparent when things had gone wrong. Although staff understood the principles of recognising when things had gone wrong and were open with patients, not all could explain what the duty of candour was.

Anticipation and planning of risk

Are services safe?

- The Trust had an up-to-date business continuity plan and arrangements were developed in line with Department of Health guidance and the relevant standards of the NHS England business continuity plan. The function of the plan was to reduce the effects of any major incident that could affect the operation of normal business.
- The trust responded to the Secretary of State for Health and NHS Improvement regarding cladding on its' buildings. This was following the recent fire in London that caused multiple loss of life. The trust reported that it is 'in line' with regulatory and legislative requirements regarding fire risk assessments. There was no reported cladding or insulation issues identified that presented urgent fire risks. Fire risk assessments were carried out six monthly across inpatient areas, annually in health clinics and biennial at nine to five offices. Following a central alert system report in 2014, the trust had been surveyed by an accredited external contractor regarding fire stopping and fire dampers that caused concern.
- The trust was not affected directly from the global cyber-attack in May 2017 that had an impact across UK healthcare services. However, it reacted quickly to the threat and closed off external communications to non-trust websites and emails. Senior managers and trust executives were kept up to date alongside key external partners. The action plan to implement the general data protection regulation was being developed with an aim for completion by October 2017. The general data protection regulation was adopted by the European Parliament in April 2016. It carries provision to protect the personal data and privacy of European Union citizens for any transactions across Europe. Organisations are expected to show compliance by 25 May 2018. A trust senior member of staff told us that the pace for completion of the regulation had to increase. The trust does not audit its compliance against this regulation.

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:

- We identified significant concerns with the monitoring of physical healthcare on wards for older people with mental health problems. The trust did not provide staff with appropriate training in dementia or physical healthcare. This meant that older people did not receive appropriate healthcare.
- At the previous inspection in April 2016, the trust was issued with a requirement notice to improve staff access to clinical supervision and the recording of supervision. The trust had not met its own target with the clinical supervision rate at 71%. The lowest compliance rate was wards for older people at 42%.
- The trust had not met the requirement notice to improve staff compliance in training in the Mental Health Act.

However:

- Most care records we looked at were holistic and person centered. The trust delivered a range of specialist psychological therapies and treatment programmes.
- Most staff were skilled and experienced and patients had access to multidisciplinary teams. The trust delivered a range of specialist psychological therapies and treatment programmes.
- Staff were skilled and knowledgeable in the Mental Capacity Act and Deprivation of Liberty Safeguards.
- The trust had a programme of audit and shared learning across the trust.

- We examined 285 care records across the services that we inspected. Most treatment records contained the trust's initial comprehensive assessment completed on patient's first treatment.
- In most services, we found that physical health was monitored on an ongoing basis and that this was reflected in the care records that we viewed. However, on the wards for older people with mental health problems, we have issued a warning notice as a result of the poor standard of physical health monitoring that we found. Care plans were not routinely completed in health-based places of safety and crisis teams.
- We found that most care plans included the views of patients and carers. Care plans reflected the diverse treatment needs of patients, in particular, in specialist services such as learning disability and forensic services. Since the last CQC inspection, the trust had undertaken work to improve upon the standards of care plans and safe storage. Most services used electronic health care records that meant information was easier to access and storage of records was safer. However, there were some services where we found it difficult to access patients' records in one place.

Best practice in treatment and care

- The trust had a policy in place to support delivery of the National Institute for Health and Care Excellence (NICE) guidance across its services. The National Institute for Health and Care Excellence is the organisation responsible for providing guidance and advice to improve health and social care. The trust policy was developed in December 2012 and was due for review in March 2017. The trust monitors compliance to NICE guidance through a monthly safety and quality performance report. In the minutes we reviewed of February 2017, 80% of services had completed a baseline assessment related to NICE guidance. Across most trust services, staff were knowledgeable about National Institute for Health and Care Excellence guidance and told us they used it in their everyday practice. For example, community dental services

Our findings

Assessment and delivery of care and treatment

Are services effective?

followed guidance for preventative and specialised care. However, staff in older people's wards were not following National Institute for Health and Care Excellence guidance on dementia and falls.

- There was consistent access to psychological assessments and interventions across the trust. Psychologists were key in developing positive behaviour support plans for people in learning disability services. This had supported a reduction in the use of restraint and seclusion across the trust. Patients could access individual and group therapy. A range of interventions were offered including; cognitive behavioural therapy (CBT), narrative therapy, cognitive analytical therapy, mindfulness and compassionate focussed solution focussed therapy. The trust had supported nurses to develop psychological skills to support treatment programmes.
- The trust had developed a physical complexity pathway and were clear they would only admit patients when mental health was a patients primary need. The trust had an agreement with three local NHS trusts to transfer patients when their physical health was the primary need. In most trust services, we found good processes in place to support the physical health of patients. Patients were routinely assessed on admission to a service and a care plan was developed to meet their specific needs. However, we were concerned with how physical healthcare was delivered in older people's mental health wards.
- The trust used a variety of outcome measure tools and all services, apart from older people's wards, used them effectively. Across the trust, core services used the health of the nation outcome scale (HoNOS) to measure outcomes and identify the correct care pathway for patients. Occupational therapy staff used the Model of Human Occupation Screening Tool (MoHOST).
- The trust had a programme of audit and undertook 36 audits across core services. Audits were monitored by the trust quality and safety team. The trust audited ward cleanliness, infection control, mattress hygiene and food safety. Staff in core services participated in clinical audit. and shared learning. Learning from audits was consistently applied throughout the trust except in older people's wards. The national audit of schizophrenia was carried out in 2014. Since 2014, the trust monitored the use of prescribing more than one anti-psychotic medication and increased access to the use of Clozapine.

Skilled staff to deliver care

- The trust had a range of skilled and experienced staff to meet the needs of most patients in most services. Staff worked in multidisciplinary teams to deliver safe and effective care and treatment. However, registered nurses and health care assistants, who worked in older people's mental health wards, did not have the necessary training and skills in dementia and physical healthcare to meet the needs of patients. Services also had access to trust staff such as dieticians and pharmacists.
- All new permanent staff had access to a trust induction. The induction introduced staff to the trusts vision and values, policies and procedures, and relevant information so they can undertake their role. A local induction was in place in most trust services. The trust had introduced the care certificate. The care certificate is a set of standards that social care and health workers adhered to in their daily working life. They are the new minimum standards that should be covered as part of induction training of new care workers. Between April 2016 and June 2017, 166 staff had started the care certificate however, only 41 had completed. The trust offered a range of apprenticeships for staff aged 16 and above in clinical and non-clinical settings. This is in line with the national 'Talent for Care' strategy, NHS Health Education England 2014. Between April 2016 and June 2017, 72 people had started their apprenticeship and nine had completed.
- At the last trust inspection, the trust was issued with a requirement notice to improve access to clinical supervision to its staff and that staff should record supervision. The trust had set a target of 95%. Between 1 February 2016 and 31 January 2017, the trust clinical supervision rate for inpatient wards was 71%. For the whole trust, including community health and community mental health services, the rate was 92.1%. The services with the lowest rate was older people's mental health wards at 42%, forensic wards at 79% and, wards for learning disabilities at 80%. All other services were above 90% and nine out of 14 core services reported 100% of its staff had received clinical supervision. The trust was recording and monitoring supervision regularly.
- The trust target for appraisal compliance was 95%. As at January 2017, appraisal rates for non-medical staff was 82% and medical staff was 88%. This was an increase

Are services effective?

from the previous inspection of April 2016. The lowest appraisal rates for non-medical staff were found in crisis services and health-based places of safety (74%), community mental health services for older people (74%) and community mental health services for adults of working age (78%). Community dental services and end of life care achieved 100% compliance. In the NHS Staff Survey 2016, the percentage of staff appraised and the quality of appraisals was comparable to similar trusts nationally.

- The trust had revalidated 91% of its whole time equivalent doctors however, the figure was below 100% because one case was deferred. The trust provided figures that showed 100% of nurses had been revalidated.
- Managers across the trust regularly addressed staff performance in line with trust policies and procedures. Poor performance of staff was managed promptly and effectively at a local level. Managers knew how to escalate issues of poor performance and would use the support of the trusts human resources department if a more formal process was required. However, the trust had disproportionately more staff from a black and minority ethnic (BME) background affected by the disciplinary process. The integrated workforce committee received reports to explore the rationale of why BME staff were disproportionately affected and concluded no concerns in processes applied.

Multidisciplinary and inter-agency team work

- The NHS staff survey of 2016 showed the trust had improved effective team working since the previous staff survey in 2015. Effective team working for this trust was comparable to combined mental health, learning disability and community trusts nationally.
- We attended multidisciplinary team (MDT) meetings across trust services. They took place weekly or fortnightly dependent on patient need. Acute mental health wards and psychiatric intensive care units held meetings three times a week. Multidisciplinary team meetings across the trust were well attended and well run. They had regular attendance from clinical staff determined by patient need including doctors, nurses, psychologists, occupational therapists, social workers and pharmacists. Further specialist clinical staff were embedded in some core teams, for example, speech and language therapists in community learning disability teams and family therapists in specialist

community mental health teams for children and young people. We observed staff engaged in discussions about the holistic needs of patients such as safeguarding, risk, mental and physical health, and recovery planning. Patients and families had the opportunity to attend most meetings and they could see clinical staff independently of these meetings.

- We observed regular handovers in core services across the trust. Community teams held daily meetings to support handover of patient information. The trust had introduced a ten-minute handover to wards. Staff were concerned about the level of detail that could be communicated to staff taking over from them, especially when discussing new patients. Staff said handovers often ran over the ten-minute mark and they completed them in their own time. We were not assured about the quality of handovers when patients were asked to 'sleepover' in mental health rehabilitation wards from acute mental health wards. There was no reference to clinical care or risk.
- Trust services worked well internally and had established relationships with agencies external to the trust. For example, health-based places of safety had monthly meetings with the police, ambulance services and the local authority that improved communication. The trust had effective links with clinical commissioning groups and local authorities to support the transforming care programme. This programme supports quality care for people with a learning disability and transition back to the community from hospital.

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

- At the previous inspection in April 2016, we had concerns about the way the Mental Health Act was implemented across the trust.. Not enough staff were trained in the Mental Health Act, patients were not routinely referred to an Independent Mental Health Act advocate, and Mental Health Act and Ministry of Justice records and reports were not always accessible to staff. We found at this inspection that there were still not enough staff trained in the Mental Health Act. However, there was improved referrals to an independent mental health act advocate and better access to Mental Health Act paperwork.
- Training figures for the Mental Health Act across the trust were low. However, across services we saw most staff were knowledgeable about the Mental Health Act.

Are services effective?

Staff demonstrated how they applied their understanding when working with patients. Staff had access to professionals who were knowledgeable with the Mental Health Act, including administrators, approved mental health practitioners, social workers and section 12 Mental Health Act approved doctors. Section 12 approved doctors had specialised training and they were approved to carry out duties under the Mental Health Act. Documentation related to the Mental Health Act was in good order and stored correctly. Staff understood and adhered to consent to treatment and capacity requirements. Consent to treatment forms across the trust were routinely attached to medication charts. Patients were informed of their rights on admission to services and updated when appropriate. There was accessible information in an easy read format across learning disability services and information on the Mental Health Act was displayed across trust services.

- Patients had access to independent mental health advocacy services. Staff knew how to make a referral and supported patients to make contact when they need to. Information about advocacy services was accessible and posters detailed information about advocacy services.

Good practice in applying the Mental Capacity Act and Deprivation of Liberty Safeguards

- Most staff were trained in and had a good understanding of Mental Capacity Act 2005, in particular the five statutory principles. The training was mandatory for clinical staff and the trust target for compliance was 95%. The overall trust compliance rate for training was 93%. The core service with the lowest compliance rate was specialist community mental health services for children and young people with 87%.

- The trust had an up-to-date policy on the Mental Capacity Act that included information and guidance on the Deprivation of Liberty Safeguards. It was ratified in December 2015 and the next review was due in December 2018. Staff across the trust were aware of the policy and knew where to access it.
- Across trust services, we saw evidence of good practice where patients may have impaired capacity. Staff demonstrated they were knowledgeable in the principles of the Mental Capacity Act and applied them appropriately. Capacity to consent was assessed when needed and decisions were recorded. This was done on a decision specific basis and patients and carers were supported through this process. Staff working with children and young people under 16 years of age, where the Mental Capacity Act does not apply, were knowledgeable about Gillick competence. Gillick Competence is a term originating in England and is used in medical law to decide whether a child (under 16 years of age) is able to consent to his or her own medical treatment, without the need for parental permission or knowledge. Documentation to consider capacity and Gillick competence at the initial assessment of children under 16 was in place. Staff were able to describe situations where it may be used.
- Staff demonstrated that they understood the Mental Capacity Act definition of restraint. Staff told us that this was covered in the trust violence and personal safety training.
- The trust had a Mental Capacity Act lead and trust staff knew where they could get advice from if needed.
- Between 1 April 2016 and 31 March 2017, the trust reported they had made 146 Deprivation of Liberty Safeguards (DoLS) applications. Of these, 54 were approved. Older people's mental health wards had the highest number of applications in the last 12 months (80) and had the highest number approved.

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:

- Throughout the trust, we found staff to be caring, kind and considerate towards patients. Feedback from patients, carers and families during the inspection was consistently positive in how staff treated them.
- Feedback from the 2017 family and friends test showed that over 95% of patients would recommend the trust as a place to receive care and treatment.
- The trust, in partnership with patients, families, staff and the third sector, had introduced an equal partner's strategy. Patients and carers were involved trust and service developments. Patients were involved in the recruitment of staff. The trust had improved media communications with patients and carers.

Our findings

Kindness, dignity, respect and support

- Patient led assessments of care environments (PLACE) assessments are self-assessments undertaken by NHS and private/ independent health care providers, 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. The 2016 PLACE score was higher than the England average for privacy, dignity and wellbeing.
- Between January 2017 and June 2017, the trust had 2,562 responses to its family and friends test (FTT) when considering if the trust was a place you would recommend for care and treatment. Of those who responded, 71% would be extremely likely to recommend the trust and 23.3% likely to. Of those who were extremely unlikely or unlikely to recommend, 2.3% responded. Staff in specialist community mental health

teams for children and young people said they had a poor response to the 2016 survey. As a result, they used the Commission for Health Improvement service users experience of service questionnaire to gather feedback.

- We observed examples of staff treating patients with kindness, compassion and communicating effectively. We saw staff engaging with patients in a kind and respectful manner.
- Most teams had welcome packs and were told of trust services at the first point of contact. We saw some services go above and beyond in delivering care and treatment to patients. Staff had increased patient activity in one core service and supported social inclusion work in the community.
- Across most trust services, staff maintained confidentiality in trust buildings and when working in the community. The introduction of an electronic patient care record system that was password protected increased patient confidentiality.

The involvement of people in the care they receive

- The trust had updated and refreshed their equal partners strategy in 2016. The trust had worked towards improving governance around patient experience and had developed an equal partners group in collaboration with patients and carers. This group is attended by third sector organisations and the assistant director of operational safety and quality for the trust. To support this strategy the trust had an engagement team that employed two full-time and one part-time member of staff. The trust was proud of the achievements of the equal partners strategy and the first annual report following its implementation is on the trust website. The equal partners strategy had seen collaboration with Healthwatch to review trust services, promotion of a 'You Said/We Did' campaign and, increased patient involvement in the recruitment of staff.
- The trust had improved the way they engage with the public digitally. The trust relaunched its website in 2016 and had made it more user friendly. The amount of 'hits' per month had risen from 50 to 10,000. The trust involvement officer ran the trust twitter account and

Are services caring?

posted content specifically about mental health and dementia. The child and family directorate used the twitter account to promote positive mental health during a mental health week campaign in 2016.

- The trust had improved access to their services for veterans of armed services and the person who initiated this project is now a national lead. The trust had engaged with the Asian community to improve their understanding and experience of services and this was run in partnership with other NHS organisations, the voluntary sector and fire service.

- Across the trust, we found most patients and carers were involved in risk assessments, care planning and their recovery. Staff across the trust supported engagement with patients and carers in their care and treatment. Patients who found it difficult to communicate were provided with care plans in a format that they could understand and with their involvement.

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:

- At the time of the previous inspection of April 2016, we found long waiting lists for children and young people to access treatment for their mental health. One hundred and seventeen had waited between 25 to 49 weeks. At this most recent inspection, we found serious concerns relating to the triage of children and young people in mental health services and the waiting times for access to treatment in neurodevelopment services. We found a backlog of 600 referrals that required clinical triage at the time of this inspection.
- Staff, patients, families and carers told us of long waits for specific treatment interventions to begin within specialist community mental health service for children and young people. On the anxiety/depression pathway, children and young people would wait up to 49 weeks and 82 weeks for the attention and hyperactivity disorder pathway.
- Across adult mental health acute and rehabilitation wards, we found the practice of 'sleepovers' had grown significantly since the last inspection. Bed occupancy beds for adult acute mental health beds were consistently above 100%.

However:

- Following the previous CQC inspection in April 2016, the trust had improved waiting times in community dental services.
- Across the trust, urgent referrals were seen quickly. The trust reported that 99% of patients received at minimum, a phone call within four hours of referral, this met the trusts targets.
- Staff in core services understood their patient group and adapted their approach dependent on patient need. Services also looked at local demographics to support vulnerable patients groups. There was easy

access to a range of interpreters and signor's across the trust. Many staff was able to speak diverse languages or sign when working in particular services.

Our findings

Service planning

- Trust services were planned to meet the needs of a diverse and populated area that contained health inequalities and deprivation in some local areas. The trust delivered services to the highly populated and diverse city of Coventry, and the mainly rural areas of north and south Warwickshire, including the towns of Warwick, Nuneaton, Rugby and Leamington Spa.
- The trust was a partner in the local sustainability and transformation plan (STP). The trust did not lead on this plan but were well represented by the trust chief executive and other senior managers.
- The trust was a key partner in the MERIT vanguard, a model of providing crisis care in partnership with three other NHS trusts in the West Midlands. The trust had included patients, carers and staff in this new model of care and had worked towards change. Although much work had taken place internally in the trust and with external partners, there was no clear evidence at the time of the inspection of change to the delivery of trust services
- The trust met regularly with NHS England who commissioned specialised mental health services. The trust planned, alongside NHS England and other partners, a programme of care to deliver the Transforming Care programme. The aim is to improve standards of care for people with a learning disability or for people who have challenging behaviours, and plan for life living in the community. The trust meet with clinical commissioning groups locally, regionally and nationally to support the Transforming Care programme.

Access and discharge

Are services responsive to people's needs?

- The trust reported a significant increase over the past 12 months in the number of referrals for adults, children and young people in need of urgent or crisis care. Across the trust, urgent referrals were seen quickly. The trust target to respond to an urgent referral to initial contact was four hours. The trust reported that 99% of patients received at minimum, a phone call within four hours of referral. A single point of entry triage system was in place to manage referrals. The trust were meeting their target of over 90% when assessing patients with mental health problems in acute hospital emergency departments. However, in specialist community mental health service for children and young people, we found a backlog of 600 referrals that needed clinical triage.
- A single point of entry team triaged and referred patients to community mental health teams for adults of working age. The trust had an 18-week target from referral to treatment for wellbeing, early intervention and recovery teams. Overall, between May 2016 and April 2017, the trust were well within the 18-week target for patients to be offered assessment and treatment. The early intervention team had the additional target of 50% of patients receiving treatment within two weeks. However, the two-week target was not met in nine out of 12 months.
- The trust had responded to the long waiting times we found in community dental services at the last inspection in April 2016. The dental waiting list had over 400 patients waiting for treatment and that there was no oversight of the risks associated with this. During this inspection, we found that there was a risk assessment for patients on the waiting list and a system in place that ensured dental managers were fully aware of their waiting times. However, the trust had not addressed long waiting times for children and young people to access treatment for their mental health. Staff, patients, families and carers told us of long waits for specific treatment interventions.
- Following the last inspection in April 2016, the trust had reduced the number of inpatient wards from 25 to 21. The trust provided details of bed occupancy rates of its 21 wards from 1 March 2016 to 28 February 2017. Of the 21 wards, 16 had a bed occupancy rate of over 85%. There were eight wards with total bed occupancy above 100%, six of which were acute adult mental wards or psychiatric intensive care units. Across adult mental health acute and rehabilitation wards, we found the practice of 'sleepovers' had grown significantly since the

last inspection. This meant that when patients required an acute mental health bed, inpatients were transferred, as a sleepover, to a rehabilitation ward. Between 1 March 2017 and 30 June 2017, there had been 211 'sleepovers' to adult mental health rehabilitation wards. Although there is a trust policy and trust oversight of this practice, on many occasions, we found there was no clinical justification for transfer to another service.

- Between 1 March 2016 and 28 February 2017, a total of 30 readmissions within 30 days were reported by the trust. Of these readmissions, 97% were to acute adult mental health wards and 44% were readmitted to the ward they were discharged from.
- Between 1 March 2016 and 28 February 2017, there were 55 patients placed out of area. Twenty-six patients (47%) were transferred to acute adult mental health wards or psychiatric intensive care units and, 22 patients (40%) placed in crisis services or health-based places of safety.
- The trust recorded the number of people on the care programme approach who were followed up seven days after discharge from an inpatient admission. The trust maintained above England average figures for follow up from the previous inspection.
- There were a total of 139 delayed discharges reported by the trust between 1 March 2016 and 28 February 2017. Of these, most delayed discharges were reported in learning disability wards. The trust and local teams were working with NHS England, clinical commissioning groups (CCGs) and local authorities, as part of the transforming care programme, to support timely discharge. The main reasons provided for delays were a shortage of specialist placements outside of hospital and delays in the assessment process.

The facilities promote recovery, comfort, dignity and confidentiality

- Following the inspection of April 2016, the trust had repaired minor environmental damage on Rowans ward. Access to keys for bedrooms remained individually risk assessed and processes were in place to store patient possessions.
- The majority of trust services had the quantity and range of rooms and equipment needed to support treatment and care. The trust supported local teams to adapt environments and space to meet the needs of specific patient groups. We saw large activity spaces had been created and rooms adapted to meet the sensory needs of people with a learning disability.

Are services responsive to people's needs?

- There was a full range of accessible information across trust services that provided detail on treatments, local services, how to complain and support services. There were easy read versions of information and leaflets in different languages.
- In relation to food, PLACE data (self-assessments undertaken by NHS and private/independent health care providers), the trust scored 97.8%. This was 5.9% higher than the England average of 91.9%. Six out of seven of trust sites scored above the England average, and the Manor Hospital scored slightly below at 91.7%.
- Inpatient wards had accessible outside space and quiet areas. Patients had the ability to make hot drinks and snacks however, this was risk assessed dependent on individual need. Most patients had the ability to personalise their bedrooms but this was minimised when the building was built using a private finance initiative. Although there were agreed trust processes in place to safely store possessions, we were told that possessions did not always follow patients on a 'sleepover'. Activities for patients were planned through the week but not at weekends. Staff working weekends used their initiative to organise activities at weekends around the needs of patients.
- We found no concerns related to the sound proofing of interview rooms across community mental health services.
- There was a range of leaflets in different languages available across all core services. Staff provided patients and carers with leaflets on request and in some core services, leaflets were available. Staff within, specialist community mental health services for children and young people, had worked in partnership with Warwickshire youth council and youth parliament to develop mental health information leaflets aimed at young people. Easy read leaflets were available across all learning disability services.
- There was easy access to a range of interpreters and signor's across the trust. Many staff were able to speak diverse languages or sign when working in particular services.
- There was a choice of food to meet the dietary requirements of patients who used trust services. Food was supplied to meet religious and ethnic groups, such as Halal meals. There was also vegetarian, vegan and gluten free diets readily available. Across some services, patients were encouraged to plan and prepare their own diets.
- Patients across trust services were supported to access appropriate spiritual support. Inpatient wards had dedicated space for prayer and reflection. The trust provided access to spiritual leads and guides, and supported patients to visit community based religious services of their choice.
- All core services we reviewed made reasonable adjustments to allow disabled access to its services.

Meeting the needs of all people who use the service

- The trust had developed and was rolling out two strategies to meet the diverse needs of the population and plan services to meet patient needs. The human resource and organisational development strategy and the equal partners strategy. Each strategy included the viewpoints of patients, families, carers, and third sector organisations that reflected the diverse needs of Coventry and Warwickshire. In addition, the trust were a partner in the development of the local sustainability and transformation plan that supports delivery of health and social care services to the wider population. The trust understood the diverse needs of its population.
- Staff in core services understood their patient group and adapted their approach dependent on patient need. Services also looked at local demographics to support vulnerable patients groups. Trust services had supported the mental health of students at a local university and, had developed a veterans' health pathway and ran a veterans' project.

Listening to and learning from concerns and complaints

- The trust had a formal process to listen and learn from complaints. The majority of complaints and concerns were managed at a local level and resolved quickly. The trust target for completing and responding to complaints is 45 working days. Of the 112 complaints received by the trust between April 2016 and February 2017, 99.1% were acknowledged within the required timeframe of three days. Of the 112 complaints, 99 (90%) were closed within the 45 day target and 110 had been completed. As part of this inspection, we reviewed seven complaints and all were responded to within the timescale in the trust policy. All complainants received an apology in a letter from the trust. Each letter included investigation information from the investigating officer and all included recommendations that the trust would need to action.

Are services responsive to people's needs?

- Between April 2016 and March 2017, eight complaints were referred to the Public Health Service Ombudsman. Of these, three were closed with no further investigation, four are ongoing and the findings had been received by the trust with the last one.
- Overall, patients and carers knew how to complain although some were unsure of the role of the Patient and Advisory Service (PALS). Staff knew how to support patients to complain and knew the process.
- The trust shared learning from complaints through emails and trust bulletins. Learning was also shared through team and business meetings. Core services gave us examples of learning from complaints. The dental service, following an informal complaint, now informed all patients where there may be a delay in their treatment whilst in the waiting area. In specialist community mental health services for children and young people, a self-harm referral form was reviewed and amended based on a complaint.
- The trust had received 902 compliments. Community mental health teams for adults of working age received the most compliments with 210 (23%).

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:

- We were not assured that the trust board had sufficient oversight of all governance arrangements to fully understand the risks and support care and treatment across its services. We concluded that there was a lack of collective leadership across the trust.
- The trust did not complete disclosure and barring checks for non-executive directors.
- Although the trust had addressed a number of the requirement notices following the previous inspection in April 2016, we found a number of new problems during this inspection that required attention.
- The trust did not have robust arrangements in place to assess, monitor and treat patients in wards for older people. Staff were not adequately trained and provided with sufficient supervision to undertake their role effectively. The physical healthcare of patients did not meet appropriate standards for care and treatment.
- The trust had not completed all the environmental works to sufficiently reduce ligature risks in acute mental health wards.
- Staff trained in the Mental Health Act was very low. Not all services across the trust had sufficient staff undertaking and recording clinical supervision.

However:

- Although not embedded across core services, the trust had developed strategies to promote patient and carer inclusion, and recruit and retain staff. Staff across the trust knew and promoted the trust vision and values. Senior and middle managers were more visible across the trust.
- The trust had reduced the use of restraint across its services.

- The trust had increased the number of staff that participated in the NHS staff survey 2016 and more staff recommended the trust as a place to work and receive care. Staff were positive, motivated and worked well together across the trust.

Our findings

Vision, values and strategy

- The trust vision was “To improve the wellbeing of the people we serve and to be recognised for always doing the best we can”. The trust statement was updated in January 2014 following feedback from patients, carers, staff and stakeholders.
- The trust had four overarching values; compassion in action, working together, respect for everyone and seeking excellence.
- Compassion in action should be seen and felt throughout the organisation; compassionate care will be experienced by our patients, service users and carers, but we will also treat one another in a compassionate manner.
- Working Together means embracing our ‘equal partners’ approach to work together as patients, service users, carers and staff to ensure the engagement and involvement of all.
- Respect for Everyone means celebrating and respecting difference, and all contributions of all. It means putting our patients, service users and carers at the heart of the services we provide. It also means recognising and valuing all of our staff in the contributions they make to the delivery of high quality care.
- Seeking Excellence means aiming to achieve the best possible outcomes for our patients, service users and carers using innovation and evidence-based care. It embraces continuous service improvement, innovation, and the most effective use of resources.
- The vision and values were known across the trust. Staff we spoke to across the trust were aware of the vision

Are services well-led?

and values of the trust. Posters were on display across trust services promoting the vision and values. We were told on many occasions that staff believed in the values of the trust and demonstrated them in practice.

- The four strategic objectives in the board assurance framework of January 2017 were; Our sustainability; Playing an active role in system leadership for the benefit and well-being of our communities; Our patients; Exceptional patient experience first time, every time AND Our services – Delivery of integrated care, ensuring effective person centred clinical outcomes. Our sustainability: Driving sustainability through innovation, collaboration and transformation. Our People: To be an employer for whom good people choose to work for.
- Following the previous CQC inspection in April 2016, the trust had introduced a new strategy to align itself with the NHS England Five Year Forward View. To support this, the trust had launched a workforce and organisational development strategy in July 2016. The strapline for the new strategy was “great place for care, great place to care, great place to work”. Trust board members, senior staff and local managers were able to tell us about this strategy. However, we found that at the time of the inspection, this was not yet fully embedded amongst clinical staff.
- Trust board members were visible across many of the trust services, in particular, the chief executive. Staff knew who the senior managers were in the trust. Staff were very positive about the support they received locally from managers, including modern matrons.

Good governance

- The trust board and senior managers had recognised staffing issues as a risk across the trust and as such, recruitment and retention was on the trust risk register. The trust had developed and launched a new workforce and organisational development strategy that was aligned to the NHS Five Year Forward View (2014). The trust was working with Coventry University to support recruitment and ensure transition of student nurses to qualified nursing roles. We spoke with student nurses across trust services who were positive about their placement and were looking forward to working within the trust. The trust had also held joint recruitment fairs with local NHS trusts as part of their work in the MERIT vanguard.

- The board assurance framework detailed the trust risk register to ensure oversight and management of risk. The trust produced a monthly quality and safety dashboard report. The performance report detailed serious incidents requiring investigation (SIRI), health and safety alerts, audits including food safety and clean mattresses and compliance against National Institute for Health and Care Excellence guidance in core services. The quality and safety group reported bi-monthly to the trust board and disseminated lessons learnt to clinical areas.
- Across trust services, most staff were clear about their roles and took professional and personal accountability for patients. However, we were concerned that staff did not monitor patients’ physical health in older people’s mental health wards.
- The trust had increased the number of staff who had received mandatory training since the last CQC inspection. Ninety per cent of trust staff were up-to-date with mandatory training. However, Mental Health Act training was not a trust mandatory training course. Trust training figures in the Mental Health Act were low across the trust. Most trust staff received specialist training to undertake their role. However, not all staff who worked in older people’s mental health wards had received training in dementia or physical healthcare.
- The trust had increased the number of staff who had received an appraisal from the previous inspection in April 2017. The trust target was 95% compliance. In comparison to similar trusts nationally, the trust was comparable in the numbers who were appraised and of their quality.
- At the last trust inspection, the trust was issued with a requirement notice to improve access to clinical supervision to its staff and that staff should record supervision. The trust had improved access to clinical supervision and the trust compliance rate was 92.1%. However, not all core services were meeting the requirements for its staff to undertake regular clinical supervision.
- Across most trust services, there was sufficient multiprofessional staff of the right experience and grades to meet the needs of patients and carers.
- Staff regularly participated in clinical audit. The trust had an audit programme that staff in core services

Are services well-led?

report into and learnt lessons. Staff undertook local audits specific to their core service. There was learning from audits that were shared in team meetings and through the trust intranet.

- Across most trust services, staff knew how and what to report with regards to incidents. However, we were told by staff working in specialist community mental health team for children and young people that not all incidents were reported. Lessons learnt were shared in a variety of ways through supervision, team meetings, team briefings and the trust intranet.
- The trust had a designated lead for safeguarding, a named nurse for safeguarding children and a team to support staff across trust services. The team comprised of nine staff who were either nurses or named professionals, including a doctor. Safeguarding procedures were followed across the trust and there were good links with local authority safeguarding teams. However, the trust safeguarding policy, updated in 2016, referenced out of date national guidance. The Department of Education document 'Working Together to Safeguard Children' updated its guidance in 2015. At the time of the inspection, the safeguarding policy referenced outdated guidance from 2013. The policy did state the organisations requirements for mandatory safeguarding training, which was verbally reported by the safeguarding team as three-yearly. The trust and its safeguarding team contributed to six safeguarding boards locally with three covering children and three covering adults. The advice and support to clinical staff was a key aspect of the safeguarding teams' duties. The evidence showed that the team was well resourced and there was provision for the safeguarding team to engage with all trust services.
- The trust had a Mental Health Act operations group that provided oversight to the board. The trust had a Mental Health Act and Mental Capacity Act lead and they ensured the trust had oversight of arrangements to assure the specific powers and duties of hospital managers were discharged according to provision of the Mental Health Act. Mental Health Act administrators across the trust accessed specific training by a legal team and external national training. The trust monitored and audited Mental Health Act paperwork and learning was cascaded through the clinical audit and effectiveness group.
- The trust had a lead executive to provide assurance that the trust complied with the Equality Act 2010 and in

particular, the workforce race equality scheme (WRES) and the NHS equality delivery system (EDS2). The workforce race equality scheme required organisations to demonstrate progress against a number of indicators of workforce equality. There were nine indicators; four of the indicators focused on workforce data; four were based on data from the national NHS staff survey questions and one indicator focuses upon black and minority ethnic (BME) Board representation. The trust had reported on the nine indicators, specific strategic directions related to action plans and objectives to address the workforce race equality indicators in relation to EDS2 had been developed by the trust. Of the 13 policies we reviewed from the trust intranet, nine lacked an adequate equality impact analyses. Out of the four we requested to view, we reviewed two, and the assessments had been completed thoroughly to reflect a record of how "due regard" under the Equality Act 2010 had been demonstrated. There was black and minority ethnic representation at board and non-executive level. The equality delivery system was commissioned by the national Equality and Diversity Council in 2010. It was a system that helped NHS organisations improve the services they provide for their local communities and provide better working environments, free of discrimination, for those who work in the NHS, while meeting the requirements of the Equality Act 2010. A refreshed equality delivery system was introduced nationally in November 2013 and is known as the EDS2. The trust was in the process of implementing EDS2 and there was evidence of engagement with patient groups in step one and two of the plan. We were told that engagement with staff had taken place this was via the trust web and intranet sites, trust all user communication and discussion at committee and board level. Assessment of leadership for EDS2 was in place however, the trust was unable to outline what evidence the board had provided for this and what learning had been made. The trust equality and diversity group met every two months and the chief executive and chair of the trust attended. They discussed the NHS equality delivery system (EDS2) and impact on staff. The NHS staff survey in 2016 reported that 30% of staff from a black and minority background experienced harassment, bullying or abuse from staff in the previous 12 months, in comparison to 21% of white staff. The staff survey further reported that overall, white staff believed the organisation provided equal

Are services well-led?

opportunities for career progression or promotion in comparison with 76% of black and minority ethnic staff. We had mixed feedback from staff of a black and minority ethnic background about the trust's intention to encourage and enable black and minority ethnic (BME) staff to progress. There was limited opportunity for progression of black and minority ethnic staff with career development, for example, we were told there was not enough black and minority ethnic staff representation on interview panels. We were told the trust was not a culturally aware organisation by some BME staff. Staff reported the lack of black and minority ethnic staff working in the psychology department and access to the improving access to psychological therapies (IAPT) staff development pathway was raised with us. However, the trust had organised black history month events and a human rights week, with over 100 attendees from clinical and non-clinical backgrounds. The trust launched its own training programme for black and minority ethnic leadership after its staff had not been successfully appointed onto the Step Up (BME National Leadership course). Additionally, to increase number of black and minority ethnic staff in the workforce, the trust had launched a video to promote opportunities in the organisation. The trust had arranged a staff network black and minority ethnic focus group. Although staff we spoke to said they were not released to attend, between 15 to 20 people had attended. The trust reported that their release was dependant on the needs of the service. The trust had recently introduced a cultural ambassador's programme however, we had not seen any impact of this initiative at the time of this inspection.

- The trust and local managers used key performance indicators and metrics systems to monitor and measure performance. This was in an accessible format and the trust used the data to improve the quality and safety of services. A safety and quality dashboard was produced monthly to inform all levels of the trust, from board to clinical services. The dashboard reported on serious incidents requiring investigation (SIRI) breaching expected closure, a breakdown of incidents trustwide, health and safety incidents, training compliance, security incidents, fire safety, central alert systems (CAS) reporting, trust safety audit, compliance with National Institute for Health and Care Excellence guidance, complaints, mixed sex accommodation breaches, freedom of information requests, and information

security breaches. The trust met regularly with external agencies to monitor key performance indicators and compliance with health and safety regulation, including NHS England, NHS Improvement, clinical commissioning groups (CCGs), and the CQC.

- The trust had a programme of clinical and internal audit. The outcomes of audits monitored quality and was used to identify where actions should be taken. The outcomes of audits were available through the trust intranet and shared across the trust.
- The trust recorded 34 risks in the March 2017 trust risk register. The trust risk register reflected what we mostly found at the time of this inspection. This included waiting times to access neurodevelopment services, fire safety and risk of cyber-attack, non-achievement of capital programme and capital resourcing, ligature risk across inpatient wards, clinical capacity in community mental health children and young people's services and impact on waiting times, and the trust being able to achieve cultural change required to sustain effective team working. The trust nursing, quality and safety team monitored risk that supported managers working across clinical services. The team reported to the trust quality and safety committee. The board had oversight of the risk register, however, we were not assured that in some cases the quality and detail of information had reached the trust board once it had passed through trust committee structures. We told the trust of our findings and concerns regarding physical healthcare in older people's wards and the backlog of referrals in specialist community mental health teams for children and young people.

Leadership and culture

- The trust board comprised of 13 members including the chief executive, chair and vice-chair. The board had five non-executive directors and one associate non-executive director. Key roles at trust board level were shared amongst four executive trust members. The medical director also worked as the deputy chief executive. The director of nursing had a dual role which combined as the director of operations. There was a director of finance, performance and information and a director of strategy and business development. To support the board, a number of committees had been established. Each of the committees was chaired by a non-executive director. The committees were accountable to the board for the work they undertook

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and met monthly. The trust employed a range of management teams to work with trust services. They included a human resources team, safeguarding team, professional development team, complaints, and a nursing, safety and quality team. The management teams aimed to support trust services and inform the board of performance, quality, and safety across the trust.

- Although the trust had developed new organisational development and equal partnership strategies and addressed a number of the requirement notices from the April 2016 inspection, we found the trust had not acted fully to address all the issues previously found. This was particularly relevant in relation to ligatures. We were not assured there was sufficient challenge to the board to govern all of its services. We observed a the trust board meeting and viewed several papers from previous meetings and did not see sufficient challenge from non-executive directors to the executive directors of the trust. Our inspection team summarised that there was a lack of collective or strong leadership across the trust. We found pockets of good local and senior leadership but this was the inconsistent and as a result, there were significant gaps found in the safety and quality of some services that should have been identified at an early stage.
- 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 asked 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 2016 NHS staff survey compared trust staff responses to similar mental health/learning disability and community trusts. Staff engagement with the 2016 survey had increased from the 2015 survey however, the trust's score of 3.71 was below average for England.
- Trust staff recommending the organisation as a place to work had increased from 48% in the 2015 staff survey, to 51% in 2016; however, this was below the 57% average across England average of similar trusts. The 2016 staff survey had seen an improvement in the following trust scores from 2015; Staff recommendation of the organisation as a place to work or receive treatment; Care of patients / service users is my organisation's top priority; My organisation acts on concerns raised by patients /service users; If a friend or relative needed treatment, I would be happy with the standard of care provided by this organisation; and Staff recommendation of the organisation as a place to work or receive treatment. However, all scores were below the average for combined trusts across England. Compared to similar trusts across England, the trust scored negatively in the following key findings; percentage of staff witnessing potentially harmful errors, near misses or incidents in last month; staff motivation at work; percentage of staff satisfied with the opportunities for flexible working patterns; staff recommendation of the organisation as a place to work or receive treatment and percentage of staff experiencing physical violence from patients, relatives or the public in last 12 months.
- The Trust was aware of its need for improvement in the area of business intelligence and improving the experience of staff. It had introduced the human resources and organisational development strategy that supports “a great place to work” and “a great place to care”. Staff across the trust had influenced and developed this strategy. The trust board and senior managers were positive about the engagement with staff. However, it was too early to assess the impact of this strategy at the time of this inspection.
- The trust was financially well managed. The chief executive and chair of the board told us that the quality and safety of services would not be compromised by cost. The trust had oversight of its financial position and understood challenges moving into the future. The trust was working with NHS Improvement with its capital programme. However, there is a future costing challenge to maintain old building stock but the trust were working to manage this risk. The trust was working with commissioners on new contracts and tenders. One of the financial risks was the amount of money spent on out of area placements for patients. The trust was working with commissioners to understand demand and how patients' could be re-patriated to trust services. The pressure may have had an impact on the increase of ‘sleepovers’ in mental health acute and rehabilitation wards for adults of working age.
- The trust helped develop the local sustainability and transformation plan (STP) in partnership with other agencies. Each sustainability and transformation plan covered a ‘place’ footprint, reflecting the whole population and future delivery of healthcare from primary care to specialist services. The trust was actively engaged in this process but were not leading on the plan.

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- Senior managers across the trust told us that morale was good. Staff consistently told us that support from their immediate managers was good. There was consistent and positive feedback from clinical staff about the support from the chief executive and chair of the trust. Senior clinical staff across multidisciplinary groups and senior managers told us of the positive support from the medical director and director of nursing.
- The trust had held a men's' mental health week to encourage men to talk about their mental health. The trust provided written information on mental health, engaged men in exercise and sport activities, took physical health observations and provided sexual health advice. The trust was proud of 'it takes balls to talk' campaign. It was an idea generated from a female staff nurse that worked in the trust. 'The campaign was launched on 10 September 2016 for suicide prevention day. The trust had worked with other organisations to get the message across to men in sporting venues and male dominated environments to share the message that it is okay to talk about how you feel. We saw this campaign widely publicised across trust services and on the trust internet.
- We saw no formal forums for disability groups or lesbian, gay, bi-sexual or transgender (LGBT) groups. However surgery meetings have taken place with LGBT staff supported by the head of equality and diversity and the head of staff engagement.
- We found that the trust chief executive, chair and other senior staff in the organisation were open and honest. They also encouraged trust staff to be open with us. This was reflected in focus groups and services we inspected. Across the trust, we found staff worked to the principles of the duty of candour, even if on occasion, they could not name them. Across most services, staff were able to take their concerns to their managers and speak openly without fear of victimisation.
- We reviewed files of all directors, executive and non-executive. We found that non-executive directors did not have a disclosure and barring service (DBS) check. The disclosure and barring service helps employers make safer recruitment decisions and prevent unsuitable people from working with vulnerable groups, including children. We raised this with the trust and were advised that there was no requirement because non-executive directors were never in contact with people who accessed services unaccompanied. This was at odds with feedback from non-executive directors who said, as part of their role, they occasionally met with patients unaccompanied. We further raised our concerns with the trust during the inspection.

Engaging with the public and with people who use services

- The trust was pro-active in engaging with the public and people who use services. There was a range of events that developed the equal partnerships strategy. The trust invited patients, families, diverse ethnic groups and third sector organisations to develop this strategy. The trust had an engagement team to facilitate partnership working.
- Although the trust was not a foundation trust, a council of shadow governors had been developed to hold the trust to account and support development of its services.
- At each trust board meeting, a patient story was heard at the start, with consent from the patient. The trust had developed a format to capture patient stories more widely across the trust.
- The trust participated in national surveys such as the friends and family test, the national audit of schizophrenia and community mental health survey. The trust collated the information from these surveys and shared with staff internally and with the wider public through the trust website.

Fit and proper persons test

- Healthcare providers are required to ensure that all directors are fit and proper persons (FPPT) for their senior roles within healthcare organisations. The CQC requires trusts to check that all senior staff meet the stated requirements on appointment and set up procedures and policies to give continuous assurance that senior remained fit for role throughout their employment.

Quality improvement, innovation and sustainability

- The trust board and senior managers told us they were committed to quality improvement, innovation and sustainability. However, we found that at the time of the inspection, the trust had few governance arrangements in place to roll out a programme of quality improvement. We found that improvement and innovation was led through core services as opposed to a trust wide model.

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- The trust was one of four trusts across the West Midlands to form the Mental Health Alliance for Excellence, Resilience, Innovation and Training (MERIT) vanguard programme. This was part of the new care models programme developed by NHS England that formed part of the NHS Five Year Forward View. The MERIT programme reviewed the following areas: seven day working in acute services, crisis care and the reduction of risk, and promoting a recovery culture. The trust board were updated on progress and they retained oversight. At the time of the inspection, It was unclear as to the level of progression that had been made, both in terms of the impact upon those using services and for staff working within the relevant teams.
- The trust had delivered first aid mental health training sessions to young people at local universities and colleges.
- The specialist community mental health services for children and young people core service was a member of the Quality Network for Community Child and Adolescent Mental Health Services.
- The forensic wards core service was a member of the Quality Network for Forensic Mental Health Services accreditation.
- Acute mental health wards for adults of working age had accreditation for inpatient mental health services (AIMS) schemes.
- The Psychiatric intensive care units were a member of NAPICU (National Association of Psychiatric Intensive Care Units).
- The Arden mental health acute team had applied to become a member of the Psychiatric Liaison Accreditation Network. The Psychiatric Liaison Accreditation Network (PLAN) works with services to assure and improve the quality of psychiatric liaison in hospital settings.
- Jade ward had accreditation for learning disability services AIMS-LD approved in March 2017. Amber ward had accreditation for the Quality Network for Inpatient Learning Disability Services (QNLDD) until February 2019.
- Learning disability staff delivered presentations, facilitated training workshops and shared effective practice with external stakeholders. This had resulted in a reduction in readmission rates.
- Brooklands learning disability team had a special interest group of cognitive analytic practitioners taking part in a national research project in partnership with Liverpool University.
- Specialist community mental health services for children and young people had developed an electronic tool called Dimensions. The Dimensions tool is an internet platform on which anyone can rate levels of personal functioning. Staff were in the process of completing a second test pilot during the inspection.
- In Specialist community mental health services for children and young people, the primary mental health team had secured extra funding to offer an enhanced model of service within two schools in Coventry.
- Long stay rehabilitation mental health wards was working with the MERIT vanguard to develop recovery practices.
- The North Warwickshire team crisis service were participating in two research projects – ‘achieving quality and effectiveness in managing dementia in a crisis team’ and ‘outcomes of patients using day hospitals versus crisis teams’.
- Dental services continued to work with the Public Health England to carry out epidemiology surveys when required. Epidemiology surveys look at the health of a group of patients and the results help to inform the planning of future services.
- Specialist community mental health teams for adults of working age had a number of examples of innovative practice and research. Stratford wellbeing team worked jointly with the local MIND and IAPT services to develop and offer group-based therapies. The team planned to publish a paper on this approach. Trust psychiatrists had contributed to the published paper and research on the flexible assertive community treatment (FACT) model, which the community teams had adopted. North Warwickshire early intervention team hosted research assistants who were researching cognitive remedial therapy (CRT). The team had won the trust’s ‘Q’ award for their active participation in the project.
- The trust ran ‘Think Ahead’, a fast-track two year programme for training new social workers. Both Coventry and Warwickshire wellbeing teams had four students placed in their team during 2016-17, and a new cohort of eight students had been selected to start in September 2017.

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- North Warwickshire early intervention team worked with the trust's IT department to pilot a new secure, live care-planning tool that supported agile workers.
- In older people's wards, the trust was involved in a project to trial the remote monitoring of patients vital signs through ceiling mounted monitors in a selection of the bedrooms at Manor hospital. The sensors had been fitted but were not operational at the time of our inspection.
- Community mental health services for older people were working to achieve the Memory Services National Accreditation Programme. Accreditation helps improve the quality of memory services for people with memory problems and dementia and their carers. Accreditation was not complete at the time of inspection and therefore the outcome was unknown.

This section is primarily information for the provider

Requirement notices

Action we have told the provider to take

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

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 18 HSCA (RA) Regulations 2014 Staffing <ul style="list-style-type: none">• Staff were not up-to-date with training in the Mental Health Act.• Not all staff were trained to undertake the roles they are employed to do in wards for older people with mental health problems.• Staff did not have regular access to and record one-to-one supervision. This was a breach of regulation 18(2)(a)

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment <ul style="list-style-type: none">• The trust had not completed all environmental works to reduce the risk of patients tying ligatures on wards.• Patients and staff were placed at risk when using the seclusion room in Sherbourne ward.• Staff did not re-assess patients' risks as required or keep risk assessments up-to-date.• There was a backlog of referrals that required clinical triage specialist community mental teams for children and young people.• There was long waiting lists for patients to access treatment specialist community mental teams for children and young people.• Patients in acute mental health beds were routinely asked to sleepover on another ward or hospital to manage a shortage of inpatient beds.• Out-of-date equipment was not routinely replaced across the trust.

This section is primarily information for the provider

Requirement notices

- There was no consistent monitoring to ensure safe medicines management across the trust.
- Across the trust, there was high temperatures in clcni rooms that could affect medicines and potentially place patients at risk.

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

Regulated activity

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

Diagnostic and screening procedures

Treatment of disease, disorder or injury

Regulation

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

- Care plans were not up-to-date or personalised, and did not reflect progress towards recovery and discharge.

This was a breach of regulation 9 (3)(b)

Regulated activity

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

Diagnostic and screening procedures

Treatment of disease, disorder or injury

Regulation

Regulation 13 HSCA (RA) Regulations 2014 Safeguarding service users from abuse and improper treatment

- The trust did demonstrate due regard to the Mental Health Act Code of Practice guidelines for patients nursed in long-term segregation or seclusion. Internal and independent medical reviews did not routinely take place in a timely manner.

This was a breach of Regulation 13 (1), (2) (3), (4) (b), (5), (7) (b) of the Health and Social Care Act 2008 (Regulated Activities) 2014

This section is primarily information for the provider

Enforcement actions

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	<p>Section 29A HSCA Warning notice: quality of health care</p> <ul style="list-style-type: none">• We required the trust to make the significant improvements in the areas identified below regarding the quality of healthcare by 4 September 2017.• The trust's systems and processes do not effectively monitor the physical healthcare of patients and reduce identified risks. <p>This was breach of Regulation 12 Safe care and Treatment (1) (2) (a) and (b).</p> <ul style="list-style-type: none">• There is insufficient management oversight and governance to ensure the effective management of the physical healthcare needs of patients. This means patients are potentially placed at unnecessary risk. <p>This was breach of Regulation 17 Good governance (1) (2) (a) (b) and (c).</p>
Diagnostic and screening procedures	
Treatment of disease, disorder or injury	