North Staffordshire Combined Healthcare NHS Trust

Inspection report

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

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

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

Ratings

Overall rating for this trust	Good
Are services safe?	**Requires improvement**
Are services effective?	**Good**
Are services caring?	**Good**
Are services responsive?	**Good**
Are services well-led?	**Good**

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

Summary of findings

Background to the trust

North Staffordshire Combined Healthcare NHS Trust was established in 1994. The trust provides services across North Staffordshire to a population of 476,574 people. The trust provides a range of inpatient and community mental health services to adults, older people and children.

The trust provides the following core services:

- Acute wards for adults of working age and psychiatric intensive care units
- Wards for older people with mental health problems
- Wards for people with learning disabilities
- Long stay/rehabilitation mental health wards for working age adults
- Children and adolescent mental health wards
- Mental health crisis services and health based places of safety
- Community-based mental health services for older people
- Specialist community mental health services for children and young people
- Community-based mental health services for adults of working age
- Community mental health services for people with learning disabilities.

The trust also provides the following specialist services:

- Substance misuse treatment services.

The trust operates from seven registered locations including one hospital site (Harplands Hospital). The trust has 190 inpatient beds across 12 wards, 15 of which are children's mental health beds. All corporate staff are based at Lawton House, the current trust headquarters.

The trust has approximately 1,400 staff serving a population of approximately 470,000 people from a variety of diverse communities across northern Staffordshire. The trust's closing income for 2016-17 was £82m, which achieved a £2m surplus. It currently does not have foundation trust status.

The trust's main NHS partners are the two clinical commissioning groups (CCGs) – North Staffordshire CCG and Stoke-on-Trent CCG. The trust has also formed partnerships with both primary care and the third sector.

The trust also works closely with agencies which support people with mental health problems, such as the North Staffs Users' Group, Approach, ASIST, Brighter Futures, Changes, EngAGE, North Staffs Huntington's Disease Association, Mind, North Staffs Carers Association, Reach and the Beth Johnson Association.

The trust has been inspected 13 times since registration. We last inspected this trust in September 2016 and we rated the provider as 'good' overall. At the time of our last inspection, we identified 28 areas of improvement. There were 13 breaches across the following five core services;

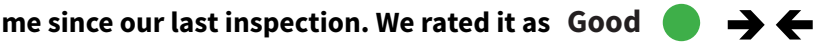
- Acute wards for adults of working age and psychiatric intensive care units.
- Community-based mental health services for adults of working age.
- Mental health crisis services and health-based places of safety.
- Specialist community mental health services for children and young people (CAMHS).

Summary of findings

- Wards for older people with mental health problems.

We told the trust that they must make improvements to: how staff use rapid tranquilisation, community CAMHS waiting list, protecting confidential information, access to psychiatrist in the Access and Home treatment teams and the storage, administration and monitoring of medicines. These breaches related to the following three regulations under the Health and Social Care Act (Regulated Activities): Regulation 12 – safe care and treatment, Regulation 17 – good governance and Regulation 18 – staffing.

Overall summary

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

What this trust does

North Staffordshire Combined Healthcare NHS Trust provides mental health services across 31 locations throughout Staffordshire. This includes a range of inpatient and community mental health services to adults, older people and children.

Key questions and ratings

We inspect and regulate healthcare service providers in England.

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

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

Where necessary, we take action against registered service providers and registered managers who fail to comply with legal requirements, and help them to improve their services.

What we inspected and why

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

We inspected six services as part of our ongoing checks on the safety and quality of healthcare services:

- Acute wards for adults of working age and psychiatric intensive care units
- Wards for older people with mental health problems
- Wards for people with learning disabilities
- Long stay/rehabilitation mental health wards for working age adults
- Specialist community mental health services for children and young people, and
- Community-based mental health services for adults of working age.

Our comprehensive inspections of NHS trusts have shown a strong link between the quality of overall management of a trust and the quality of its services. For that reason, all trust inspections now include inspection of the well-led key question at the trust level. Our findings are in the section headed Is this organisation well-led?

Summary of findings

Overall trust

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

We rated safe as requires improvement, effective and well led as good, caring and responsive as good. Following this inspection, nine of the trust's 11 services are rated as good and two as outstanding. In rating the trust, we took into account the previous ratings of the five services not inspected this time.

We rated well-led for the trust overall as good.

- The organisation had developed from a control and command to a clinically led culture with robust engagement and involvement of service users, carers and staff. Senior managers and service level managers were visible and accessible to staff. This demonstrated a better connect between clinical services and senior management.
- The overall culture of the trust was very patient centred. Staff treated patients with dignity, respect and compassion. The majority of staff experienced high morale and motivation for their work and felt valued and recognised through recognition and award schemes developed within the organisation.
- Patient and carer engagement had been sustained at a high level within this organisation.
- Teams in the majority of services worked collaboratively and effectively to best meet the needs of individual patients they cared for. Strong team cohesion on the adult acute wards had contributed to a reduction in restraint and incidents. There was strong communication through a variety of methods and meetings structures across the organisation.
- The trust had a good physical health strategy that focussed on the integration of primary health care with mental health. A new physical health team had also recently been created to support staff.
- The trust and its staff were committed to improving services by learning from when things go well and when they go wrong. We saw evidence of changes following patient and staff feedback in most services.
- The trust's investment in focus on improving care plans and risk assessment across its services was demonstrable with only minimal inconsistencies in a few services.

However:

- The trust recognised they were on a journey of embedding a new electronic recording system across the services within the organisation. Managers had employed several methods to engage and support staff in this endeavour and recognised there was further work to be undertaken in the full implementation and use of new systems.
- The medicine optimisation team was stretched to capacity only achieving 80% of medicines reconciliation within 24 hours. The Pharmacy technicians lacked professional support through structured supervision.
- The depth, rigour, testing of changes in practice following serious incidents could be further strengthened.
- The trust had a good workforce plan and had implementation of new recruitment processes. However, these had yet to come together and positively impact on the timeliness of recruitment to vacancies succession planning which were highlighted as a concern by staff across most services.
- The trust had done a lot of work around further developing their processes and structures that supported equality and diversity in their workforce. However, this was not fully represented across all of the services inspected.

Are services safe?

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

Summary of findings

- We found some issues with the safe management of medicines including unclear labelling of medicines, lack of response to fridge temperatures outside of the recommended range for safe storage, not recording the opening date of liquid medicines, and emergency drugs for treatment of anaphylaxis not stored with resuscitation equipment in line with national guidance from the Resuscitation Council.
- Risk assessment in community mental health teams varied. Staff did not always fully complete or update them and not all were thorough.

However:

- Staff followed the trust's lone working policy. Staff completed risk assessments of patients and the home environments. Staff members ensured team members knew of their where about and managers knew how to contact them in emergencies.
- Staff reported incidents and received feedback, which was shared within teams and trust wide. Staff were offered the appropriate support following serious incidents

Are services effective?

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

- The majority of assessments we looked at across services were holistic and considered the physical health needs of the patients and developed personalised, recovery orientated care plans that were updated on a regular basis.
- Staff we spoke to during our inspection had a good understanding of the Mental Health Act and Mental Capacity Act and recorded decisions appropriately.
- We observed examples of effective and efficient handovers and multi-disciplinary team meetings. Team meetings involved patients and carers in regular discussions to review and plan effective treatment options, to facilitate successful discharge.
- Staff provided a range of treatment options that were in line with national guidance. Recognised rating scales and outcome measures were used to measure individuals' recovery journey.
- Staff completed and were involved in a range of audits to identify areas of good practice and highlighted areas that required improvement. Appropriate action plans were developed and results were regularly reviewed.
- Staff assessed and monitored patient physical health regularly and used a range of tools and techniques, this involved the monitoring the side effects of medications prescribed.

However:

- Some services we inspected had supervision rates below the required trust target of 90%. Staff did not always record their supervision on the trust system.
- The trust recognised some challenges and frustrations faced by staff during the embedding phase of the new electronic recording system across all services. Staff were at times unsure of where to record information on the new electronic system which meant staff may not be aware of the most up to date patient information. The use of both electronic and paper records during this phase potentially caused risk of inaccurate or incomplete records.
- We found inconsistencies and gaps in the recording of National Early Warning Signs and the monitoring of food and fluid intake on some of the older peoples wards.
- We identified a lapse in the auditing of Mental Health Act paperwork and some omissions of re-informing young people on community treatment orders of their rights.

Summary of findings

Are services caring?

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

- We observed staff to be respectful, kind and compassionate in all interactions with patients and their families. It was clear from many conversations we observed that staff knew their patients well and had built strong relationships.
- Patients and carers were generally complimentary of staff and services. They stated they felt included and that the care delivered was of a high standard. Carers were given information and support through support groups run by the trust.
- Staff and patients we spoke to told us of the advocacy services and that were actively encouraged to use these.
- There were active youth council and service user and carers' council in the organisation. These groups attended the trust's board meetings to feedback patients and carers views, were involved in staff recruitment and changes and developments to services.

However:

- Staff did not always record in the patient care records when patients had received a copy of their care plan and if they accepted this.
- Some families highlighted that communication between staff and families could be improved in some teams.

Are services responsive?

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

- There had been significant improvement in the reduction of waiting lists in the child and adolescent mental health services and the adult community mental health services since the last CQC inspection. All teams were meeting the national waiting time standards.
- The majority of services had a range of meaningful activities available to patients and where appropriate staff focussed on supporting patients to access the local community to start to build support networks ready for discharge.
- Wards provided good facilities to support the needs of patients. Patients could personalise their bedrooms and we saw posters to prompt staff about patients' preferences.
- All services had clear criteria of whom they would offer a service. Child and adolescent mental health teams worked closely with other organisations to signpost young people to the most appropriate service to meet their needs.
- Staff we spoke with knew how to support patients to make a complaint and we saw information about how to make a complaint in all patient areas visited during inspection.

However;

- Although most patients were complimentary about the quality of food provided, the minority of patients with specific food preferences or needs told us they did not get much variety of meals.
- Not all community team bases provided enough rooms to see patients requiring appointments. Confidentiality was also identified as an issue in some locations due to poor sound proofing on rooms.
- There was no specialist child and adolescent mental health team provision for young people in crisis. Young people outside of Monday to Friday 9am to 5pm could either attend the accident and emergency department or contact the all ages access teams.

Summary of findings

Are services well-led?

- Our rating of well-led improved. We rated it as good because:
- The local management and leadership of services were both knowledgeable and visible. Staff we talked to during inspection spoke highly of their immediate and directorate managers and told us that a more positive and open culture had developed since the last inspection.
- Managers recognised staff achievements through an annual awards system and staff who had been nominated for awards felt recognised, honoured and proud.
- Staff monitored the quality of services through the use of key performance indicators, audits and staff and patient feedback. Actions plans were in place and monitored.
- A member of the youth council attended CAMHS directorate meetings and young people and family participation was embedded in every level of the service.
- Staff morale was generally positive and the majority of staff told us they felt valued and respected.
- The trust had made physical health across all services a focus for development and created a new physical health team to support staff.

However:

- Staff we spoke with across services and professional groups were concerned at the timeliness of recruitment to vacancies and the impact of this on continuity of care.
- Recommendations regarding implementation of learning following a death on an adult acute ward had not been fully actioned across all adult acute wards within the trust at the time of inspection.
- The IT system that supported the electronic patient record system was slow at times which made it difficult for staff to use it to its full potential.
- When visiting CAMHS we found there was not a diverse range of staff within teams to reflect the local population.

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

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

- We rated safe as requires improvement and effective, caring, responsive and well led as good.
- Trained staff kept patients safe by assessing their individual risks, the environment and through regular staff handovers, and putting appropriate safety plans in place. Staffing was adequate to meet patients' needs and they utilised de-escalation skills to manage aggressive incidences and managed and assessed patients physical health needs.
- A range of experienced and skilled staff provided personalised, holistic care plans and ensured patients received effective treatments and interventions to aid patients' recovery. Staff continuously developed their knowledge and skills through training and provided an efficient multidisciplinary team to monitor and review patients' care, treatment, progress and discharge plans. Patients' capacity was regularly assessed and staff had a good awareness of patients' rights under the Mental Health Act.
- Staff were caring and compassionate and understood their patients' individual needs and the majority of patients told us they had been involved in their care. Patients and carers had opportunity to give feedback about the services and staff offered carers assessments when appropriate.

Summary of findings

- The service had improved on patient length of stay through the initiation of a new care pathway where staff and patients worked collaboratively together to achieve successful discharge, improved patient access to a range of activities to aid recovery and the staff ability to cater for patients who required adaptation since on our last inspection.
- Managers were passionate about providing a high quality service and used various methods to monitor and improve the care they provided. Staff told us they were proud to work in the service and morale had improved; they felt valued and respected by senior managers who provided them with feedback and information related to their service and recognised staff achievements.

However:

- Emergency medicines were kept in locked cupboards in the locked clinic room, which meant not all staff had easy access to them in the event of emergency. Guidance suggests these should be stored with the emergency grab bag locked within the clinic room of a ward.
- Staff found it difficult to navigate the electronic patient care records and could not always find the most up to date information required to provide effective care for their patients.
- Responsible clinicians did not always fully complete Mental Health Act paperwork to authorise treatment.
- Staff received supervision although it fell short of the trust target of 90%.

Long-stay or rehabilitation mental health wards for working age adults

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

- We rated safe, effective and well led as good and caring and responsive as outstanding.
- The wards had improved on the three areas where it had been identified they should make improvements during the last inspection. This included staff having a better understanding of the Mental Capacity Act. We found staff now had an improved understanding of how to apply this and where to go for additional support if they needed it. Section 17 leave forms had been appropriately invalidated following expiry and staff ensured escorted leave and community activities took place.
- Wards focussed on forward planning and discharge with patients. This was personal and individual to patient's needs. Continued support of former patients through allowing them to visit the wards helped to prevent readmissions to the ward.
- Staff and patients worked together in a way that made patients feel that the relationship was equal. Staff treated patients with dignity and respect and in return, patients showed the same level of respect to staff. Patients had been included in decision-making on the wards and felt staff valued their opinion.
- Staff had a high level of respect for the managers. They said they received support as and when they needed it. There was a focus on staff development, which meant staff felt valued and this enabled them to do their jobs to high standard so that patients received the highest level of care and support.

However:

- Staff had not fully adjusted to the new way of recording patients' notes on the electronic system and this meant that there were gaps in dates on some risk assessments and advance decisions had not been recorded although daily progress notes reflected a lot of this information.

Wards for people with a learning disability or autism

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

Summary of findings

- We rated safe, effective, caring, responsive and well led as good.
- The environment on the unit was welcoming and homely. It was well maintained and all fixtures, fittings and furniture were in good condition. Risk assessments were undertaken upon admission and updated regularly thereafter. All patients had support plans in place that had been created in collaboration to ensure that they were individualised. The service was trialling a new electronic medication record which, when fully developed, will streamline processes and reduce the risk of errors.
- Care plans were recovery orientated and person centred. They were developed using national learning disability specific guidance. There were a range of treatment options available and staff had experience in working with the patient group to select the most effective strategies.
- We observed staff to be extremely supportive and caring towards patients. They had taken the time to develop working relationships with each patient. This meant that they had good knowledge of individuals' likes and dislikes and could tailor their interaction to be positive and helpful. All patients and carers we spoke with told us that the service delivered at the unit was of a very high standard and were extremely complimentary of staff. Patients and carers were engaged by the trust and their opinions taken into account when planning improvements.
- All patients had discharge plans that were individualised and needs specific. Patients were encouraged to take ownership over the environment at the unit. We saw this in session rooms and bedrooms where patients had decorated walls with their own artwork and pictures to suit their tastes. There was a wide range of activities available at the unit and we saw that patients were engaged.
- Staff morale at the unit was high. Everyone we spoke with spoke highly of local managers and felt proud of the work that they were doing at the service. Managers at a ward level were knowledgeable about the service and had a clear strategy about future developments. They were knowledgeable of national guidance in learning disability services and could state how this was being used in future planning.

However:

- Emergency medication was not stored with the emergency bag. Any emergency medication was stored in locked cupboards in the locked clinic room. which meant not all staff had easy access to them in the event of emergency. However, all staff we spoke with knew how to access this and where it was stored, it was not clear how this information was passed to agency or bank staff that were not familiar with the unit. It was also felt that this could slow down treatment in an emergency situation.

Community-based mental health services for adults of working age

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

- We rated safe as requires improvement and effective, caring, responsive and well led as good.
- All locations that we visited were clean, tidy and well maintained. Staff carried out environmental audits to ensure that the service was safe and clean for patients to use.
- Patients had access to evidence based treatment, including psychological therapy, prescribing and meaningful activity. Staff monitored patients' physical health and the effects of medication. Staff completed clinical audits to assess activity and outcomes for patients' care.
- Staff reported incidents and managers reviewed these. Staff reviewed incidents; ensured learning took place and made changes following incidents. Staff understood the trust's duty of candour policy and managers told us of how they had followed this to ensure that they communicated with families and patients when things went wrong.
- There was a range of skilled staff who received regular management and clinical supervision. There were training opportunities for staff, in addition to their statutory and mandatory training.

Summary of findings

- Patients were happy with their care and staff responded to patients respectfully. Patients were involved in decisions about their treatment and care. Care records showed patients were involved in care planning. Carers were involved in the treatment of the people they cared for. The trust offered specific advice and support for carers.
- At every team we visited, there was a good range of information about a wide range of services available. This was accessible to patients and informative. Staff were able to communicate with patients who had communication needs including using British sign language.
- Managers were experienced and suitably skilled for their roles. Staff told us that they were well supported by their managers and that their managers were visible. Staff told us they felt comfortable to raise concerns. All staff knew how to whistle blow. There were opportunities for staff to raise concerns anonymously if they wished and the trust had a 'freedom to speak up guardian' that was widely advertised throughout all teams we visited.

However:

- Staff did not always follow medicine management policy. At Moorlands community mental health team staff had not responded to fridge temperatures that were regularly outside of the recommended safe range. At Moorlands we also found medicine for three patients that went out of date in 2016. This medicine had not been given to patients.
- We reviewed 29 care records. Not all risk assessments and care plans were up to date and thorough. We found one risk assessment was missing; seven risk assessments that were not sufficiently detailed and five that were not up to date. We found six care plans that were not up to date and five of these were not sufficiently detailed.
- Staff did not always check equipment in the emergency bags. At City team, we found a pocket mask that went out of date in 2012. At Moorlands team, staff had not checked the emergency bag for over a month; therefore staff could not be sure that equipment was working properly and within its expiry date.
- At the early intervention team, nurses did not carry anaphylaxis kits in the community; this meant they did not have medication to respond to patients if they had an allergic reaction to an injection.
- Staff in community mental health teams did not re-inform patients who were on a community treatment order of their rights. Seven of the 13 care records that we reviewed indicated this. There had not been regular audits of Mental Health Act paperwork with actions in community mental health teams and staff were unsure who completed audits of mental capacity act paperwork.

Specialist community mental health services for children and young people

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

- We rated safe, effective, caring, responsive and well led as good.
- There was significant improvement from the last inspection. There were no long waiting lists and all children and young people open to the service could be tracked and monitored at any stage during their pathway.
- All of the environments visited were clean and furnishings and fittings well maintained. There were alarms fitted in therapy rooms or staff carried personal alarms. The waiting areas were bright and cheerful and contained information relevant to young people, including how to make a complaint.
- Managers monitored clinicians' caseloads using a caseload management tool and there was effective tracking of patients during their time within the service.
- Staff completed comprehensive, holistic mental health assessments and developed care plans that were person centred and recovery orientated. They also monitored and reviewed patients' physical health needs in line with guidance.

Summary of findings

- There was a good range of evidence based psychological therapies offered by a range of staff disciplines and routine outcome measures were used to monitor the effectiveness of treatment.
- All staff received regular clinical, managerial and safeguarding supervision. There were weekly multidisciplinary team meetings and evidence of joint working with external organisations.
- Mental Health Act paperwork was correct and young people's rights had been explained to them.
- All staff displayed positive attitudes and were caring towards young people and their families. Parents of young people told us they felt involved in their care and the staff they worked with had a good understanding of the young people's needs.
- There was good participation of young people in service delivery and development and young people were involved in recruitment of staff.
- All staff spoke positively about their managers and service director. They felt valued and supported by senior staff and all staff were proud to have been nominated for the recognising excellence and achievement in combined healthcare awards.
- There was a good governance framework and all staff knew how to raise incidents and how they would be fed back and lessons learnt and shared.

However:

- The electronic recording system was not able to plot height and weight on growth charts, so clinicians' were recording it in the young person's old paper file. This was not accessible unless staff were at that particular base where the file was held.
- All staff said the electronic records system was slow and not easy to navigate. It did not have full functionality and this impacted on the time it took to complete notes and the length of sessions with young people completing their care plans or outcome measures.
- The Community Treatment Order paperwork in one out of two cases was not present at the base at the time of inspection and was requested to be sent over.
- Staff had their office doors open in one of the bases. This meant confidentiality could have been breached as young people could hear what was being discussed as they walked past on their way to their session.

Wards for older people with mental health problems

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

- We rated safe as requires improvement and effective, caring, responsive and well led as good.
- Ward environments had been developed to suit the needs of the patient group and supported mobility and safety from potential ligatures.
- On wards 6 and 7, there were established multidisciplinary teams delivering effective evidence based interventions to improve the well being of their patients. Ward 4 was in the process of developing a team since re-opening in the summer of 2017 and both occupational and physical therapists had recently joined the nursing team.
- Managers had invested in the development of a specialist physical health nursing team to support the particular needs of the patients on the wards
- Staff were caring and attentive to the needs and preferences of the patients they looked after

Summary of findings

- Activity workers on all three wards provided patients with a range of activities to occupy their time and maintain skills during their time in hospital
- Hospital managers were working with the local general hospital and social services to reduce delays for patients waiting for discharge. One focus of this work was for staff to help patients and families in making decisions around long-term care placements. Each ward had a discharge coordinator to support the earliest possible discharge from hospital.

However:

- We found issues with the safe management of medicines that could introduce an infection risk or meant that staff would not know when they were no longer effective and required disposal.
- Emergency medicines required to treat anaphylaxis were not stored with the rest of emergency equipment. Only the qualified nurse had access to the medicines, which could have a delayed effective response.
- The trust had not notified CQC about an application for authorisation of Deprivation of Liberty Safeguards that they had applied for.
- Medical care on ward 4 was inconsistent and dependent on the duty doctor medical cover.
- Staff were inconsistent in their recording and review of physical health observations and food and fluid intake.
- Specialist dementia training for staff on the older adult wards still fell below the level of trust target of 90%.

Ratings tables

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

Outstanding practice

We found examples of outstanding practice in the acute wards for adults of working age and psychiatric intensive care units, long-stay or rehabilitation mental health wards for working age adults, community-based mental health services for adults of working age and specialist community mental health services for children and young people.

For more information, see the outstanding practice section of this report.

Areas for improvement

We found areas for improvement including four breaches of legal requirements that the trust must put right. We found 28 things that the trust should improve to comply with a minor breach that did not justify regulatory action, to prevent breaching a legal requirement, or to improve service quality.

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

Action we have taken

We issued four requirement notices to the trust. That meant the trust had to send us a report saying what action it would take to meet these requirements.

Our action related to breaches of one legal requirement in three services.

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

Summary of findings

What happens next

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

Outstanding practice

We found the following outstanding practice:

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

- The wards' cohesive and knowledgeable multidisciplinary team and the instigation of the acute care pathway ensured that a wide range of activities, therapies and interventions were available to actively engage patients and carers, which reduced the amount of time patients needed to stay in hospital.
- A staff member trained in complementary therapies offered this service to patients on ward three, and taught patients how relaxation techniques and treatment could help coping with anxiety.

Long-stay or rehabilitation mental health wards for working age adults

- The introduction of a support time and recovery worker who normally worked within a community team to the wards has enhanced the community programme offered to patients. This support started before admission and continued for a short time after a patient was discharged.
- The range of activities available to patients was extensive and allowed them to have choice over their recovery and activity programmes. Staff members' commitment to finding new opportunities and to fund raise for the ward with patients further supported this.

Community-based mental health services for adults of working age

- The early intervention team had worked with patients to develop a specific dual diagnosis pathway for patients who used drugs and alcohol and experienced psychosis. They had developed a set of 'change cards' to assess where patients were in the cycle of change so that they could assess the most suitable interventions for patients.

Specialist community mental health services for children and young people

- We found one example of outstanding practice in this service; the service recently launched a new mental health and wellbeing strategy in schools across Stoke on Trent.

Wards for older people with mental health problems

- Activities were involving and purposefully led by a dynamic team of activity workers supported by the rest of the multidisciplinary team.
- The service manager had led on a project to identify causes of delayed transfers of care from the service alongside commissioners, local authority and NHS partners. An action plan had been in put in place that had reduced the numbers of patients delayed in their discharge. They had also linked local actions into a broader local health and social care effort to improve the care experience of older adults throughout Stoke and North Staffordshire.

Summary of findings

Areas for improvement

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

Action the trust MUST take to improve

We told the trust that it must take action to bring services into line with four legal requirements. This action related to three services.

In acute wards for adults of a working age and psychiatric intensive care units:

- The trust must ensure that topical medicines are clearly labelled for the use of a single patient to reduce infection risks and that opening dates of the medicines are monitored.

In wards for older people with mental health problems:

- The trust must ensure that topical medicines are clearly labelled for the use of a single patient to reduce infection risks and that opening dates of the medicines are monitored.

In community-based mental health services for adults of working age:

- The trust must ensure that staff follow medicine management processes properly to ensure that fridge temperatures are not outside of the recommended safe range medicine so that medicine is safe to use.
- The trust must ensure that staff regularly check and record that emergency equipment is safe to use for the care and treatment of patients.

Action the trust SHOULD take to improve

We told the trust that it should take action either to comply with a minor breach that did not justify regulatory action, to avoid breaching a legal requirement in future or to improve services. These 42 actions related to the whole trust and six services.

Trust wide

- The trust should ensure regular formal supervision and appraisal across all staff groups.
- The trust should ensure Equality Impact Assessments are routinely undertaken for all relevant decisions.
- The trust should ensure equality representation on service user council and within its engagement networks.
- The trust should ensure there is a process for the review of Mental Health Act managers' suitability for the role following each three year contract.
- The trust should ensure robust processes are in place for the administrative receipt and scrutiny of Mental Health Act detention papers for out of hours admissions.
- The trust should ensure systems of assurance for embedding learning and changes in practice from serious incidents are robust.
- The trust should consider improving staff and vacancy management timeliness for all professions.
- The trust should continue to support improved engagement for professionals who feel isolated and of low morale.

Summary of findings

- The trust should consider ensuring full evaluation and the engagement of the workforce when embedding the new electronic patient record.
- The trust should consider reviewing medicines optimisation staffing in line with the pharmacy business and continuity plan to ensure sufficient staff to undertake dispensary, clinical and e-prescribing roles across the organisation.

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

- The trust should ensure that the accessibility of emergency medicines for anaphylaxis use is immediately accessible when needed in an emergency as recommended in the Resuscitation Council (UK) guidelines.
- The trust should ensure all staff receive and record supervision and meet their target of 90%.
- The trust should ensure staff record and escalate to senior staff when the fridge temperatures exceed optimum temperatures.
- The trust should ensure all clinical items are safe to use and all out of date items are disposed of.
- The trust should consider recording when staff offer patients a copy of their care plan and whether they accept it.
- The trust should consider recording the responsible clinician changes, and update relevant paperwork such as certificates authorising treatment.

Long-stay or rehabilitation mental health wards for working age adults

- The trust should ensure all staff have the training and skills to record patient's information in the correct places on the electronic records.
- The trust should ensure that the accessibility of emergency medicine for anaphylaxis use is immediately accessible when needed in an emergency as recommended in the Resuscitation Council (UK) guidelines.

Wards for people with a learning disability or autism

- The trust should ensure that the accessibility of emergency medicine for anaphylaxis use is immediately accessible when needed in an emergency as recommended in the Resuscitation Council (UK) guidelines.
- The trust should ensure that its electronic systems have the correct IT systems that work effectively.
- The trust should consider involvement in national accreditation schemes as a method of quality monitoring.

Community-based mental health services for adults of working age

- The trust should ensure that staff consistently record detailed care plans and update them regularly.
- The trust should ensure that staff complete relevant audits in relation to the mental health act and mental capacity act.
- The trust should ensure that risk assessments consistently demonstrate a detailed description of risk and how this will be managed and that staff update these regularly.
- The trust should ensure that staff re-inform patients on a community treatment order of their rights in line with trust policy.
- The trust should ensure that staff follow medicine management processes properly and dispose of out of date medication.

Specialist community mental health services for children and young people

Summary of findings

- The trust should ensure the electronic records system is able to plot height and weight on growth charts or there should be a robust system in place that ensures all records are accessible to the eating disorder team when it has a central base at the Hub.
- The trust should ensure privacy and dignity is not compromised when using scales and height measure in the corridor.
- The trust should consider seeking opportunities to participate in research and become part of the Quality Network for Community CAMHS.

Wards for older people with mental health problems

- The trust should ensure that there is appropriate decision making in place to support the transfer of patients lacking mental capacity to consent to admission to the hospital where this constitutes a more restrictive option to the place they were admitted from.
- The trust should ensure staff update all records at the same time to ensure consistency across paper and electronic care records.
- The trust should ensure that staff fully record physical observation and calculations in the national early warning signs. Staff should record refusals in line with practice on ward 7 to evidence attempts to perform physical observations.
- The trust should ensure regular audit are carried out consistently and fully complete recording of food and fluid intake and act to ensure these records can meaningfully inform clinical decision-making.
- The trust should ensure the accessibility of emergency medicine for anaphylaxis use is immediately accessible when needed in an emergency as recommended in the Resuscitation Council (UK) guidelines.
- The trust should ensure applications made for authorisation of Deprivation of Liberty Safeguards are notified to the CQC.
- The trust should ensure specialist dementia training attains the level of the trust target of 90%. This is a continuing requirement not achieved since the last inspection.
- The trust should consider review of the medical cover available on ward 4 to ensure it is consistent and skilled to support the complex physical and mental health needs of patients.

For more information, see sections on individual services and on Regulatory action.

Is this organisation well-led?

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

We rated well-led at the trust as good because:

- The trust had strong and engaged leadership at board level. The board was unified and committed to the provision of high-quality services. There was a very high level of awareness of the priorities and challenges facing the trust and

how these were being addressed. Leaders spoke with insight about the key priorities for the organisation being staffing, stability of finances and the development of new models of care. They recognised the leadership development needs of managers at all levels through the provision of leadership programme and the development of a black ethnic minority leadership programme in partnership with the sustainability transformational programme.

- The board and senior leadership team had set a clear vision and values that were at the heart of all the work within the organisation. They worked hard to make sure staff at all levels understood them in relation to their daily roles.
- The organisation had developed from a control and command to a clinically led culture with robust engagement and involvement of patients, carers and staff. The innovation programme involving patients and staff in the role as 'value makers' was innovative.
- Working towards integration, the trust had been central to the establishment and development of the North Staffordshire and Stoke-on-Trent Alliance ("the Alliance") Board. The trust provided strategic leadership, programme management support of change projects and facilitated the clinical leadership programme that underpinned new care models.
- The physical health strategy focussed on the integration of primary health care with mental health. It was a comprehensive strategy including infection control, hydration / nutrition, falls, reportable diseases and estates across mental health and learning disabilities inpatient and community settings. Innovations such as 24 hour jab-a-thons led to the trust being a national leader in flu vaccinations for mental health organisations.
- The overall culture of the trust was very patient centred. Staff were highly motivated by desire to provide the best possible care for patients. Staff said they felt proud to work for the trust and were able to articulate the contribution made by themselves and their teams.
- The trust's development of their Workforce Race Equality Standard (WRES) action plan was noted to include a number of good practice and innovative actions which promoted the diversity of staff working in the trust.
- The trust reviewed listening and responding to Patient Advice and Liaison Services (PALS) and complaints policy and related processes showed demonstrable improvement in timeliness through the engagement of complainants experience feedback, staff training and review of workforce.
- The trust recognised the challenges and risks created by the introduction of new electronic patient record system in services. Staff managed these risks well at ward level.
- Plans for emergencies and any disruption to business continuity were in place and recently tested through the organisation experiencing cyber-attacks and flooding of an inpatient ward during routine maintenance. On these occasions, the staff were responsive and managed these events promptly and safely with the compassion patients and their families required at the time.
- The trust was committed to improving services by learning from when things go well and when they go wrong, promoting training, research and innovation. There were numerous examples of the methods of sharing and communication lessons learned across services within the trust.
- The trust had a good strategic overview of the learning from death recommendations. A good committee structure was in place for review, scrutiny and overview of the process. The trust's involvement of families and carers in the process was in line with guidance and trust policy.

However:

Summary of findings

- Although medicines safety was well-integrated into the governance structure of the trust, there were limited resources to share and learn from other trusts experiences. Due to the lack of resources for the medicine optimisation team this had impacted in some areas of medicine safety. However, the team were aware of this and were working together to minimise the risk.
- Senior leadership recognised there was further work to be done to ensure equality and diversity was fully embedded. To have Equality Impact Assessments routinely undertaken for all relevant decisions and for the service user council and engagement networks to be representational of all the protected characteristics.
- The Mental Health Act was predominantly in line with the Code of Practice with the exception of a review of suitability process for Mental Health Act managers following each three year contract and the robust process for the administrative receipt and scrutiny of Mental Health Act detention papers for out of hour admissions.
- Despite many ways employed by the trust to communicate and share lessons across the services, the action plans completed did not always have actions/changes that were fully implemented in practice as planned.
- The trust were aware that new systems introduced for electronic patient records and staff recruitment were proving to present some challenges and frustration to staff in the stabilisation period of embedding into practice.
- The board did not receive complete oversight of workforce supervision and appraisal as not all staff groups received formal supervision and appraisal and some professional groups felt isolated and disconnected with low morale.

Ratings tables

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

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

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

Ratings for the whole trust

Safe	Effective	Caring	Responsive	Well-led	Overall
Requires improvement →← Feb 2018	Good →← Feb 2018	Good →← Feb 2018	Good →← Feb 2018	Good →← Feb 2018	Good →← Feb 2018

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

Ratings for mental health services

	Safe	Effective	Caring	Responsive	Well-led	Overall
Acute wards for adults of working age and psychiatric intensive care units	Requires improvement ↓ Feb 2018	Good →← Feb 2018	Good →← Feb 2018	Good ↑ Feb 2018	Good →← Feb 2018	Good →← Feb 2018
Long-stay or rehabilitation mental health wards for working age adults	Good →← Feb 2018	Good →← Feb 2018	Outstanding ↑ Feb 2018	Outstanding ↑ Feb 2018	Good →← Feb 2018	Outstanding ↑ Feb 2018
Child and adolescent mental health wards	Good Sept 2016	Good Sept 2016	Good Sept 2016	Good Sept 2016	Good Sept 2016	Good Sept 2016
Wards for older people with mental health problems	Requires improvement →← Feb 2018	Good →← Feb 2018	Good →← Feb 2018	Good →← Feb 2018	Good →← Feb 2018	Good →← Feb 2018
Wards for people with a learning disability or autism	Good →← Feb 2018	Good →← Feb 2018	Good →← Feb 2018	Good →← Feb 2018	Good →← Feb 2018	Good →← Feb 2018
Community-based mental health services for adults of working age	Requires improvement →← Feb 2018	Good →← Feb 2018	Good →← Feb 2018	Good →← Feb 2018	Good →← Feb 2018	Good →← Feb 2018
Mental health crisis services and health-based places of safety	Good Sept 2016	Good Sept 2016	Good Sept 2016	Good Sept 2016	Good Sept 2016	Good Sept 2016
Specialist community mental health services for children and young people	Good ↑ Feb 2018	Good →← Feb 2018	Good →← Feb 2018	Good ↑ Feb 2018	Good ↑ Feb 2018	Good ↑ Feb 2018
Community-based mental health services for older people	Good Sept 2016	Good Sept 2016	Outstanding Sept 2016	Outstanding Sept 2016	Good Sept 2016	Outstanding Sept 2016
Community mental health services for people with a learning disability or autism	Good Sept 2016	Good Sept 2016	Good Sept 2016	Good Sept 2016	Good Sept 2016	Good Sept 2016
Substance Misuse Services	Good Sept 2016	Good Sept 2016	Good Sept 2016	Good Sept 2016	Good Sept 2016	Good Sept 2016
Overall	Requires improvement →← Feb 2018	Good →← Feb 2018	Good →← Feb 2018	Good →← Feb 2018	Good →← Feb 2018	Good →← Feb 2018

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

Long stay or rehabilitation mental health wards for working age adults

Outstanding ☆ ↑

Key facts and figures

Summers View and Florence House are specialised community rehabilitation services for patients aged 18 – 65 years. They cover the North Staffordshire geographical area. Both wards take male and female patients who suffer from severe and enduring mental health problems.

Summers View has 10 beds and takes patients who have been placed out of county in low secure units and patients from the acute mental health wards at Harplands Hospital. The average length of stay is six months to two years.

Florence House has eight beds and takes patients from the acute wards at Harplands Hospital and patients in the community where time on this type of ward can prevent admission to acute wards. The average length of stay is six months to 12 months.

The wards worked closely together with shared staff working in the multidisciplinary team. These include a psychologist, occupational therapist, occupational therapy technician, a support time and recovery worker and a consultant. The support the wards offer is recovery focussed and therapeutic.

During the inspection, we visited both wards which are spread over two sites.

At the last inspection, the wards were rated as good in all key questions (safe, effective, caring, responsive and well led). We re-inspected in all key questions to see if they had made improvements towards a rating of outstanding.

Our inspection on 10 and 11 October was unannounced (staff did not know we were coming) to enable us to observe routine activity.

Before the inspection visit, we reviewed information that we held about these services and information requested from the trust.

During the inspection, the inspection team:

- looked at the quality of the ward environment
- observed how staff were caring for patients
- spoke with nine patients who were using the service
- spoke with two carers of patients who were using the service
- interviewed 12 members of staff who cared for patients of the service
- looked at care records for 10 patients
- reviewed 13 medication charts of patients
- looked at eight sets of Mental Health Act paperwork.

Summary of this service

Our rating of this service improved. We rated it as outstanding.

A summary of our findings about this service appears in the Overall summary.

Long stay or rehabilitation mental health wards for working age adults

Is the service safe?

Good ➔➔

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

- The wards were clean and had been maintained to a high standard. Staff had assessed the wards for ligature points and ensured patients had been individually risk assessed for areas that had ligatures.
- Patients had access to medical cover during the day and out of hours and this happened in a timely manner. The manager had reduced the high use of bank staff on both wards and this ensured patients received care by staff that knew them well. The wards reported low numbers of incidents.
- Staff had been trained to use de-escalation techniques, which meant that restraint of patients was rarely used.

However:

- The trust had moved to an electronic recording system and staff were still adjusting to this. This meant that not all risk assessments at Summers View showed a date when it had been reviewed.
- Emergency medicine such as adrenaline was not kept with the resuscitation bag which could mean that it would be difficult to access in an emergency.

Is the service effective?

Good ➔➔

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

- The wards were clean and had been maintained to a high standard. Staff had assessed the wards for ligature points and ensured patients had been individually risk assessed for areas that had ligatures.
- Patients had access to medical cover during the day and out of hours and this happened in a timely manner. The manager had reduced the high use of bank staff on both wards and this ensured patients received care by staff that knew them well. The wards reported low numbers of incidents.
- Staff had been trained to use de-escalation techniques, which meant that restraint of patients was rarely used.

However:

- The trust had moved to an electronic recording system and staff were still adjusting to this. This meant that not all risk assessments at Summers View showed a date when it had been reviewed.
- Emergency medicine such as adrenaline was not kept with the resuscitation bag which could mean that it would be difficult to access in an emergency.

Is the service caring?

Outstanding ☆ ➔

Our rating of caring improved. We rated it as outstanding because:

- The wards employed staff with a range of skills to ensure patients had holistic support that was recovery focussed. Staff had the experience and qualifications to fulfil their roles.
- Staff received regular supervision and had an annual appraisal, which focussed on their personal and professional development. This meant staff felt valued by their managers.
- Handovers on the ward took place three times a day. These were detailed and thorough discussing issues such as risk management so staff could offer patients support and care according to their individual needs.
- All staff had completed Mental Health Act and Mental Capacity Act training. They showed a good understanding of both acts and knew where to go for advice and guidance

Is the service responsive?

Outstanding ☆ ↑

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

- Staff showed a high level of care and support to patients. This continued after patients had been discharged when they would be invited to events and for meals on the wards. Staff encouraged former patients' to share their recovery journey with current patients so that they received the support of their peers. This led to low re-admission rates.
- The service provided extensive pre-admission assessment to ensure that patients were fully prepared for the ward environment. This included giving patients the opportunity to visit the wards and meet staff before deciding if rehabilitation was right for them.
- Staff knew patients extremely well and had extensive knowledge of patients care needs on both wards. Staff worked in a way that was very person-centred and they were encouraging and highly motivational in the support they provided. We saw that staff had a warm and friendly approach towards patients and there were extremely high levels of interaction between them and the patients. It was clear that patient care came first and each staff member saw this as their priority when at work.
- Staff organised informal family and carer events in a way that encouraged greater attendance and involvement. This included barbecues and afternoon tea events. This supported carers and patients to form wider support networks other than those within the wards. Carers stated that they felt extremely well supported and included in all aspects of their loved ones care.
- We saw examples of patient feedback being taken seriously and acted upon. Patients felt able to talk to staff or managers whenever they needed to and would know that they would be listened to. All patients we spoke with said the staff were kind, caring and treated them with dignity. All patients said that staff took extra time to make sure that patients understood their choices about their care and respected decisions made by patients. Staff talked about accessing information for individual patient's and then sitting with the patient to support them to understand it and think about what the information would mean for them.
- Staff involved patients in care planning and ensured this was done in a holistic and recovery focussed way. The use of the recovery star encouraged active participation by patients and staff worked collaboratively with them on this to set goals for the future.
- Staff supported patients to access their personal, social, cultural and spiritual needs. Patients spoke positively about staff attending places of worship with them in the community so that they could understand the patient's beliefs and allow them the opportunity to keep links going within their local community.

However:

- Although staff knew and understood patients' wishes for the future these had not been recorded on the new electronic system.

Is the service well-led?

Good 

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

- The ward manager and deputies were well known, respected and spoken highly of by all staff. They had a visible presence on the wards and knew both staff and patients well.
- Staff knew the vision and values of the trust and this was incorporated into the way they supported patients on a daily basis.
- The staff across the two wards worked closely together and this cross working meant they had good access to support from each other. Staff morale was high and staff stated that they enjoyed their work and would not want to work anywhere else. Patients knew that staff had a high level of commitment to their work and felt valued and respected because of this.

Outstanding practice

We found two examples of outstanding practice in this service. See the Outstanding practice section above.

Areas for improvement

We found two areas for improvement in this service. See the Areas for improvement section above.

Wards for people with a learning disability or autism

Good

Key facts and figures

The Assessment and Treatment unit is based at Harplands hospital and provides specialist interventions for community based patients who require short term support as a result of acute health care needs. The ward has six in-patient places offering short term assessment and treatment for a maximum of six months.

The ward provided short term assessment and treatment for individuals when community placements have broken down due to acute health care needs. The multidisciplinary team carried out an assessment and designed an individually person centered plan or developed a care program. This enabled the patient to return to their own home to be supported successfully within the community.

At the last inspection the ward was rated as good in all key questions (safe, effective, caring, responsive and well led). We re-inspected in all key questions to see if they had made improvements towards a rating of outstanding.

Our inspection on 10 October was unannounced (staff did not know we were coming) to enable us to observe routine activity.

Before the inspection visit we reviewed information that we held about this service and information requested from the trust.

During the inspection, the inspection team:

- visited the ward and looked at the quality of the ward environment and observed how staff were delivering care to patients
- spoke with three patients who were using the service
- spoke with one carer of patients using the service
- spoke with the ward manager and modern matron
- spoke with seven members of staff including nurses, health care assistants, a psychologist and a psychiatrist
- looked at six sets of care records and six medication charts.

Summary of this service

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

A summary of our findings about this service appears in the Overall summary.

Is the service safe?

Good

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

- The environment was clean and well maintained. All furniture and equipment were in visibly good condition and the ward was laid out in such a way that it was comfortable and welcoming for patients. Though there were ligature risks throughout the unit, these had been effectively mitigated by risk assessment, observation and care planning.

Wards for people with a learning disability or autism

- Staff completed risk assessments upon admission and updated them as and when required. All risk assessments were reviewed regularly by a multidisciplinary team. All patients also had a positive behaviour support plan linked to identified risks. These were created in collaboration with each patient. They were individualised and needs specific and identified the most effective ways to mitigate risks. They also gave staff several strategies to use should risk behaviours occur.
- The ward had enough staff to meet the needs of the patient group. Though we did receive some comments that there were not enough staff to facilitate sessions due to the loss of two of the three session co-ordinators, we saw that sessions were being developed and delivered. All patients had taken part in sessions and there was evidence of a high level of engagement from the patient group.
- The service was trialling an electronic medication record system. Though this appeared to be an improvement on the previous system, it was hampered by a slow internet connection. We were told that there were plans in place to install a "hard wired" internet connection and this would solve this issue. The system enabled staff to access and update the patient's electronic record from the clinic.

However:

- Emergency medication was not stored with the emergency bag. Any emergency medication was stored in locked cupboards in the clinic room. Though all staff we spoke with knew how to access this and where it was stored, it was not clear how this information was passed to agency or bank staff that were not familiar with the unit. It was also felt that this could slow down treatment in an emergency situation.

Is the service effective?

Good ➔➔

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

- Alongside risk assessments staff undertook a range of assessments in a timely manner for all patients upon admission. These were undertaken using nationally recognised tools and included assessments of physical healthcare requirements.
- Care plans were recovery orientated and individualised. We saw care plans that were linked to positive behaviour support which was developed by the British Institute of Learning Disabilities (BILD) which is a national body that issues guidance on the care of individuals with a learning disability. All care plans we looked at had been reviewed regularly and had clear goals linked to clinical outcomes.
- Staff provided a range of treatment options and these were in line with national guidance. All patients had a physical healthcare plan and access to specialist care if required. Recognised ratings scales were used to measure the severity of outcomes and this information was being used to develop ongoing care plans and strategies.
- Staff applied the Mental Health Act and Mental Capacity Act correctly. We did not find any errors in Mental Health Act paperwork or documentation relating to detention and medication.
-

Is the service caring?

Good ➔➔

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

Wards for people with a learning disability or autism

- We observed staff interacting with patients. They treated them with dignity and respect. It was clear from their interactions that they had built strong relationships with patients and had good knowledge of their likes and dislikes. They were able to tailor interactions so that the patient was engaged.
- Patients and carers were complimentary of staff and the service. They stated that they felt included and that the care delivered was of a high standard. We were also told that staff encouraged patients and carers to become actively involved in developing care and make decisions.
- Staff used strategies linked to positive behaviour support to engage patients and involve them in the development of their own care plans. The ward also gathered the views of patients and carers when making decisions about their service.
- There was access to advocacy services and staff and patients told us that they were encouraged to use these services.

Is the service responsive?

Good ➔➔

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

- All patients had discharge plans in place that were reviewed regularly at multidisciplinary team meetings. Any discharges that happened took place during business hours and patients always had access to a bed upon return from leave.
- All patients had their own bedrooms that they could personalise to their own taste. They had access to hot and cold drinks and snacks 24/7 and there was space set aside on the ward for patients to meet with visitors and have quiet time. There was a choice of food available daily as part of the menu and patients fed back to us that the food was of a good quality.
- There was a wide range of meaningful activity available to the patients seven days a week though some patients told us that this had reduced since the service lost two of its three activities co-ordinators.
- Staff provided patients with easy read information about their treatment and care. Information was also available about how the service was run, complaints, advocacy services, legal rights and local services.

Is the service well-led?

Good ➔➔

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

- The management team were knowledgeable and provided leadership and support to staff and patients. They were able to talk in detail about long term plans and goals for the unit which included strategies as to how these would be achieved. They were proud of the work that they and the team were doing and could demonstrate how they were using national guidance to direct local improvements.
- Staff reported that morale on the unit was extremely high. All staff we spoke to were eager to speak with us and were positive. They could talk us through improvements and were able to demonstrate how these linked to everyday delivery of care.

Wards for people with a learning disability or autism

- All staff we spoke with knew how to use the complaints procedure and stated that they were confident that, if they needed to raise a concern, they would be supported to do so. They also stated that they felt that they could raise concerns or make complaints without fear of retribution.

However:

- The Information Technology (IT) system that supported the electronic patient record system was slow and often connection was lost. This meant that it was difficult for staff to use the system to its full potential.
- The ward was not involved with or participating in the accreditation scheme specific to its service type. There were no plans to undertake this at the time of our inspection.

Areas for improvement

We found four areas for improvement in this service. See the Areas for improvement section above.

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

Good ➔➔

Key facts and figures

The acute wards for adults of working age provided by North Staffordshire Combined Healthcare NHS Trust are part of the trust's acute division. Services are provided for patients admitted informally and or detained under the Mental Health Act 1983. The trust does not have a psychiatric intensive care unit (PICU).

There are three acute wards based at Harplands Hospital:

- Ward one is a mixed-sex ward with 14 beds, although at the time of inspection was all male
- Ward two is a male ward with 22 beds
- Ward three is a female ward with 22 beds.

During the inspection, we visited all three acute wards on the site.

At the last inspection, the wards had one key question (safe) rated as requires improvement and the other key questions (effective, caring, responsive and well led) rated as good. We re-inspected all of the key questions to see if they had made improvements.

Our inspection between 2 and 4 October 2017 was unannounced (staff did not know we were coming) to enable us to observe routine activity.

Before the inspection visit, we reviewed information that we held about these services and information requested from the trust.

During the inspection visit, the inspection team:

- spoke with 24 patients who were using the service
- talked with two relatives of patients who were using the service
- interviewed 20 members of staff
- observed how staff were caring for patients
- looked at care records for 21 people.

Summary of this service

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

A summary of our findings about this service appears in the Overall summary.

Is the service safe?

Requires improvement ➔➔

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

- Emergency medicines were kept in locked cupboards in the clinic room, which meant not all staff had easy access to them.
- We found some out of date items in the clinic room and staff had not signed razors back in on three occasions.
- Topical medicines were not clearly labelled for the use of a single patient to reduce infection risks and opening dates of the medicines were not consistently monitored.

However:

- Staff assessed patients' risks and put appropriate interventions in place to alleviate identified risks for the individual and had action plans for any risks detected in the environment. All staff were provided with a patient and environment safety up-date at each handover.
- There was a sufficient number of staff to keep patients safe. The majority of staff had received and were up to date with training requirements.
- Staff used de-escalation techniques to good effect and incidences of patient restraint, rapid tranquilisation and seclusion had decreased.
- Staff were aware of what and when they needed to report incidents. Staff, patients and managers received appropriate feedback. Incidents were reviewed by senior managers and lessons learnt were cascaded to staff regularly.

Is the service effective?

Good 

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

- Staff completed holistic assessments of patient needs and developed personalised, recovery orientated care plans, which were updated on a regular basis.
- A range of experienced and skilled staff provided nationally recommended interventions and treatments, to aid patients' recovery.
- Staff completed a range of audits to identify areas of good practice and highlighted areas that required improvements. Staff developed appropriate action plans and senior managers reviewed the results regularly at performance meetings.
- Staff had access to opportunities to improve their knowledge and enhance their skills, through continuous personal development sessions, training courses and formulation meetings.
- An effective and efficient multidisciplinary team discussed patients' care regularly and met with patients and carers to review and plan effective treatment options, to facilitate successful discharge into the community.
- Staff had a good understanding of the Mental Health Act and the Mental Capacity Act, and recorded decisions made appropriately. Staff assessed patients' mental capacity on a regular basis and recorded the outcome in the patient care records.
- Staff assessed and monitored patients' physical health regularly using a range of tools and techniques. Staff had received physical health training and had access to a range of equipment and resources.

However:

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

- The average rate of supervision across all four teams in this service was 83%, below the required trust target of 90%. Ward 1 was 68% and ward 3 was 67%. Staff did not always record their supervision on to the trust system.
- Responsible clinicians did not always fully complete Mental Health Act certificates to authorise treatment and did not record when there had been a change of responsible clinician.
- Staff were sometimes unsure where to record and find information within the electronic care record system, which meant staff may not be aware of the most up to date patient information.

Is the service caring?

Good 

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

- Staff were caring and compassionate to their patients, and they understood and were responsive to their individual needs.
- Patients' named professional and co-worker had allocated time for one to one conversation, and offered practical help and advice, referring patients to appropriate services when needed.
- The majority of patients told us they had been involved in planning their care and most had received a care plan. We saw staff discussing care plans in multidisciplinary team meetings and updated them regularly.
- Patients had opportunity to feedback on the services they received staff had responded to this feedback and made adjustments when appropriate.
- Staff engaged families and carers and involved them in patients' care and offered carers assessments when appropriate.

However:

- Staff did not always record in the patient care records when patients had been offered a copy of their care plan, and if they accepted this.

Is the service responsive?

Good 

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

- When patients returned from leave, they always had a bed; this had improved since our last inspection.
- On our last inspection, patients and visitors could see confidential patient information on boards in the staff office. This had now been resolved and boards had covers which staff kept closed.
- The wards had instigated a pathway that included all people involved in the patients' care at an early stage of admission. We saw that patient length of stay had improved and reason for admission was more clearly defined.
- Regular bed management meetings ensured that staff were aware of and could plan for any potential obstacles that could prevent patients' discharge. Trained staff could provide practical help and support for patients who needed help with housing, work or benefits to enable discharge from the ward.

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

- Patients had access to a number of activities and therapies to aid their recovery facilitated by a range of highly skilled professionals.
- The ward could cater for patients with disabilities, food preferences or needs and communication problems, and staff could provide interpreters, signers and easy read documents when required.
- Patients knew how to make a complaint and received appropriate feedback. Staff knew how to handle complaints and tried to resolve any issues quickly.

However:

- Some patients who had specific food preferences or needs said they did not get much variety of meals.

Is the service well-led?

Good 

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

- The ward managers were knowledgeable, skilled and passionate about providing high quality care to their patients and were involved in projects aimed at improving the service they provided.
- Staff we spoke with were aware of the trust's vision and values and told us they felt the culture of the organisation had changed over the last two years and they felt respected and valued.
- Staff morale had improved and managers supported an open and transparent culture; staff received feedback on complaints, incidents and changes being made to the service.
- Staff monitored the quality of the service through the use of key performance indicators, audits and staff and patient feedback. Action plans were in place and senior managers monitored and scrutinised results in regular manager meetings.
- Managers recognised staff achievements through an annual awards system, and staff who had previously been nominated for awards had felt honoured and proud to have won.

However:

- Recommendations regarding the implementation of a resuscitation trolley following a death on ward three had not been actioned across all wards within the trust at the time of inspection.

Outstanding practice

We found two examples of outstanding practice in this service. See the Outstanding practice section above.

Areas for improvement

We found nine areas for improvement in this service. See the Areas for improvement section above.

Wards for older people with mental health problems

Good

Key facts and figures

The trust's wards for older people with mental health problems care for people with both organic and functional mental health disorders.

Organic mental illness is usually caused by disease affecting the brain, such as Alzheimer's. Functional mental illness has predominantly a psychological cause. It may include conditions such as depression, schizophrenia, mood disorders or anxiety.

We inspected three wards all based at Harplands Hospital:

- Ward 4 has 19 beds and is a mixed gender ward for patients with physical and mental illnesses as part of a shared care initiative with the local acute hospital. Ward 4 was closed at the time of our last inspection. Managers had reopened the ward in November 2016 to provide a nursing assessment facility to support the local acute hospital. There was then an agreement that the ward would remain open and operate a model of shared care with the acute trust. Commissioners agreed ongoing funding from June 2017 and the trust set about recruiting for a permanent care team. Initially commissioned on the basis of 15 shared care beds. At the time of our inspection, there were an additional four beds in operation to support capacity pressures at the acute hospital trust.
- Ward 6 has 16 beds and is a mixed gender ward for patients with organic mental illness which included dementia.
- Ward 7 has 20 beds and is a mixed gender ward for patients with functional mental illnesses such as anxiety or depression.

During the inspection, we visited all three wards on the site.

At the last inspection, the wards had one key question (safe) rated as requires improvement and the other key questions (effective, caring, responsive and well led) rated as good. We re-inspected all of the key questions to see if they had made improvements.

Our inspection between 2 and 4 October 2017 was unannounced (staff did not know we were coming) to enable us to observe routine activity.

Before the inspection, we reviewed information that we held and asked other organisations to share what they knew about the trust. These included the Clinical Commissioning Group, Health Education England, the General Medical Council, local authorities and the local Healthwatch organisations.

During the inspection visit, the inspection team:

- spoke with eight patients who were using the service
- spoke with eight relatives of patients who were using the service
- interviewed 30 members of staff
- observed care and treatment
- looked at care records for 36 people.
- interviewed key members of staff including the service manager, governance lead and quality assurance manager.

Wards for older people with mental health problems

Summary of this service

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

A summary of our findings about this service appears in the Overall summary.

Is the service safe?

Requires improvement 

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

- We found some issues with the safe management of medicines. Staff had not clearly labelled topical medicines (creams) for the use of one patient introducing a potential infection risk. Staff had failed to record the opening date of some liquid medicines that meant they would not know when they were no longer effective and required disposal.
- Emergency drugs for treatment of anaphylaxis were not stored with resuscitation equipment in line with national guidance from the Resuscitation Council.
- Managers failed to maintain staffing to the levels planned for qualified nursing staff for day shifts on ward 4 for three months from June to August 2017 (an average of 76% of shifts filled). Wards 6 and 7 also fell short of planned numbers of qualified staff during the day in one month during that period. Existing nursing staff filled the gaps through working additional unplanned hours or staff from other wards provided support to maintain safe staffing.

However:

- All wards were safe and clean with up to date risk assessments to mitigate environmental hazards. Staff considered ligature risks in balance with falls risk appropriate to the settings.
- Ward staff managed mix sex accommodation within national guidance recognising the need to respect the dignity and privacy of patients.
- The teams had introduced a multidisciplinary approach to the assessment and management of falls risks. Ward 4 was introducing personal falls alarms for individual patient alerts.
- Staff used distraction and other techniques to effectively de-escalate incidents of aggression resulting in low numbers of recorded restraints and use of rapid tranquilisation
- The service shared and learnt lessons from incidents they had reported and incidents across the trust and those reported nationally.

Is the service effective?

Good 

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

- There was evidence of multidisciplinary assessments of the needs of patients on all three wards.
- Wards 6 and 7 had well established clinical teams delivering interventions in line with the National Institute for Health and Care Excellence guidance. On both wards, there was psychology input appropriate to the patient groups and they offered support to staff and carers.

Wards for older people with mental health problems

- All wards had good links with the outreach team for nursing homes, city social work team and discharge planning and community mental health teams.
- Staff had a good understanding of both the Mental Health and Mental Capacity Acts and worked within the relevant code of practice.

However:

- We found inconsistencies in the monitoring of physical health monitoring, some gaps in or incomplete recording of National Early Warning Signs (NEWS) most significantly on Ward 6. However, we found complete records and good practice in recording refusals on Ward 7.
- Staff on all wards failed to effectively monitor food and fluid intake. We found gaps on each ward where staff had not calculated a final daily total and no evidence that when totals fell short of the target action they took action.
- A newly introduced electronic care record was slow and unresponsive leaving staff unable to view information when they needed it and not always complete. Staff had not kept paper notes, held as a backup to the electronic care record, up to date. For example, falls risk assessments and action plans were completed on electronic record but not the paper action plan.

Is the service caring?

Good 

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

- There was evidence of multidisciplinary assessments of the needs of patients on all three wards.
- Wards 6 and 7 had well established clinical teams delivering interventions in line with the National Institute for Health and Care Excellence guidance. On both wards, there was psychology input appropriate to the patient groups and they offered support to staff and carers.
- All wards had good links with the outreach team for nursing homes, city social work team and discharge planning and community mental health teams.
- Staff had a good understanding of both the Mental Health and Mental Capacity Acts and worked within the relevant code of practice.

However:

- We found inconsistencies in the monitoring of physical health monitoring, some gaps in or incomplete recording of National Early Warning Signs (NEWS) most significantly on Ward 6. However, we found complete records and good practice in recording refusals on Ward 7.
- Staff on all wards failed to effectively monitor food and fluid intake. We found gaps on each ward where staff had not calculated a final daily total and no evidence that when totals fell short of the target action they took action.

Is the service responsive?

Good 

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

Wards for older people with mental health problems

- Managers were working to overcome problems of delayed transfer of care with partner agencies. The introduction of the 'red to green' strategy had meant that there was a daily focus on overcoming any blocks to discharge. Early evidence showed this and other changes were having a positive effect on reducing the number of patients delayed in their discharge.
- The wards provided very good facilities to support the needs of patients. We saw some personalisation in bedrooms and clear prompts to staff about patient preferences. All wards reflected elements of dementia friendly design. (Apart from some issues of signage on ward 4)
- On each ward, activity workers provided a wide range of activities each day. They intended their activity programmes to entertain, engage and provide therapeutic value to participants.

However:

- Some admissions to Ward 7 were not in line with the target group of older adults with functional mental health problems. Ward staff felt this undermined their ability to deliver agreed model of care.
- Ward 4 staff did not identify there was always a reasonable rationale in place to transfer a patient unable to give consent due to mental incapacity on to the ward.

Is the service well-led?

Good 

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

- The service manager had engaged effectively with other agencies to develop a strategy to reduce the number of delayed transfers of care from the wards.
- Ward leaders were visible and approachable to all staff.
- Staff were positive about the open culture on the wards and felt confident to express concerns.
- Managers had created a robust governance system built around peer review and a quality framework specific to the inpatient environment.
- The organisation supported development of teams, through development days and ongoing use of reflective practice groups on wards 6 and 7.
- The trust had made physical health on these wards, and across the hospital, a focus for development and created a new physical health team to support ward staff
- Managers ensured the wards were information rich environments providing guidance and performance data for staff, patients and carers.

However;

- On ward 4 the clinical team was still in development with outstanding vacancies that affected the continuity of care.
- Staff identified problems with the newly introduced electronic patient record that made it difficult to complete reports and audits.

Outstanding practice

We found two examples of outstanding practice in this service. See the Outstanding practice section above.

Wards for older people with mental health problems

Areas for improvement

We found nine areas for improvement in this service. See the Areas for improvement section above.

Specialist community mental health services for children and young people

Good ➔➔

Key facts and figures

North Staffordshire Combined Healthcare NHS Trust Specialist Community Child and Adolescent Mental Health Service provide the following services Monday to Friday 9am to 5pm;

- Specialist community mental health services for children and young people 0-18 years old throughout North Staffordshire and Stoke on Trent.
- A Central Referral and Priority Hub with input from partnership services. Their role was to triage all referrals and ensure the referrals are signposted to the most appropriate service to meet the needs of the referred young person and their family. The team also responded to all emergency and urgent referrals including seeing young people who attended the local acute hospital for mental health needs.
- An Autistic Spectrum Disorder team that provided assessment for preschool and school age children and young people.
- A team for Looked After Children called Yellow House.

A paediatric psychology service that provided psychological assessment and intervention to children and young people who have experienced acute or chronic illness or traumatic injury. We did not inspect this team during this inspection.

The service was part of the National Children and Young Peoples' Improving Access to Psychological Therapies transformation programme (CYP-IAPT). The programme had five main principles; participation, evidence based, awareness, accountable and accessible. This meant the service offered evidence based interventions, used outcome measures to show if the treatments used were effective and would change the intervention if it was not working and involved children and young people in the development and delivery of the service.

During the inspection, we visited all teams that were spread over four sites.

At the last inspection, the Specialist community mental health services for children and young people had three key questions (safe, responsive and well led) rated as requires improvement and the other two key questions (effective and caring) rated as good. We re-inspected all of the key questions to see if they had made improvements.

Our inspection between 2 and 4 October 2017 was unannounced (staff did not know we were coming) to enable us to observe routine activity.

Before the inspection visit, we reviewed information that we held about these services and information requested from the trust.

During the inspection visit, the inspection team:

- visited all four bases
- spoke with 26 staff including; nurses, social workers, family therapists, administrators, managers and psychiatrists
- looked at 24 care and treatment records
- looked at 15 prescribing records
- spoke with six young people who were using the service

Specialist community mental health services for children and young people

- spoke with 14 parents or carers of young people who were using the service
- observed one anxiety group
- observed five team meetings.

Summary of this service

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

A summary of our findings about this service appears in the Overall summary.

Is the service safe?

Good 

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

- All of the bases were bright and cheerful and fittings and fixtures were well maintained. There were separate waiting areas for young people and cleaning records showed the environment and toys in the waiting rooms were cleaned regularly.
- There were alarms fitted in therapy rooms or staff had access to personal alarms.
- All of the equipment had been recently safety tested and had up to date clean stickers.
- We saw posters reminding staff of good handwashing technique.
- Managers regularly monitored case load sizes using a recognised tool.
- The service had rapid access to a psychiatrist within the services hours.
- Staff were up to date with their mandatory training.
- We saw risk assessments had been completed using the trust wide tool and were updated regularly or following an incident.
- Staff gave examples of when they followed personal safety protocols including lone working practices.
- Staff were trained in safeguarding adults and children and had a good understanding of how to recognise and report abuse.
- There were no serious incidents in the last 12 months prior to inspection.
- Staff knew what incidents to report and how to report them. There was evidence of lessons learned being shared externally and internally to the service and staff received feedback.

Is the service effective?

Good 

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

Specialist community mental health services for children and young people

- All of the assessments we looked at were holistic and considered the physical health needs of the young person.
- The majority of the care plans were up to date, personalised and recovery orientated.
- The service provided a range of care and treatment interventions, in line with National Institute for Health and Care Excellence guidance.
- Staff used routine outcome measures as part of the Children's and Young People's Improved Access to Psychological Therapies programme and were members of the Child Outcomes Research Consortium.
- Staff received regular managerial supervision from their service manager and clinical supervision from their peers and in line with their own professional guidance. Staff also received bimonthly safeguarding supervision.
- Each team held weekly multidisciplinary team meetings where they discussed clinical and business issues.

However:

- Staff were unable to electronically plot height and weight on growth charts using the new electronic record system. These were being recorded on paper charts and stored in the young people's old paper file.

Is the service caring?

Good

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

- The staff's attitudes and behaviours when interacting with young people and their families showed they were respectful to the young people and had a good understanding of their needs.
- All of the young people and 13 parents and carers we spoke with said they had been treated well by child and adolescent mental health staff.
- All of the young people and parents and carers we spoke with said they had felt involved in their care planning and had access to their care plan if required.
- There was an active youth council who collected feedback from the feedback boxes in the waiting areas as well as holding face to face meetings at all of the bases. The youth council attended board and commissioner meetings and fed back the young people's views.
- There were parent support groups across the service and the parents we spoke to knew how to give feedback about the service they had received.

However:

- One parent had felt they had not been treated well by some of the staff in the past as the intervention offered did not meet their expectation.
- Two parents had not been informed of the transition process and which if any adult service their child would be accessing once they turned 18 years in six months' time.

Is the service responsive?

Good 

Specialist community mental health services for children and young people

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

- There had been a significant improvement in the reduction of waiting lists since the last inspection. There were no children and young people waiting longer than the national target of 18 weeks to be seen.
- There was a clear criterion for which young people would be offered a service and the service worked closely with other organisations to understand their criterion so young people could be signposted to the most appropriate service to meet their needs.
- Urgent and emergency referrals could be seen within 48 hours or sometimes on the same day, within the opening hours of the service. There was rapid access to a psychiatrist during the hours of the service.
- There were processes in place to ensure each young person open to the service could be tracked through their pathway and deterioration in their mental health could be responded to quickly.
- All of the bases were accessible for people requiring wheelchair access and staff told us they could request leaflets in languages other than English upon request.
- Staff knew how to handle complaints and there was information about how to make a complaint in all of the waiting rooms.

However:

- The service operated Monday to Friday 9am to 5pm. Out of these hours children and young people in a mental health crisis can either attend their local A and E or contact the all ages access team.
- There was a risk confidentiality could have been breached as staff had their office doors open so could have been overheard talking about cases as young people walked past on their way to their session.
- The height and weight scales at Dragon Square were located in the corner of a corridor, which could compromise privacy and dignity.

Is the service well-led?

Good  

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

- The service managers and the service director were visible within all of the teams. The staff spoke positively about the leadership of the service. They felt it was now stable and the managers were supportive and approachable.
- All staff felt there had been significant and positive change in staff morale during the past six months and they now felt valued and respected. They were pleased and proud to have been complimented by the chief executive for the hard work and recognised for the contribution they have made to the team by being nominated for the Recognising Excellence and Achievement in Combined Healthcare awards.
- There was a clear framework in place to ensure incidents and issues were shared and discussed at both team and directorate level.
- The work the service had done to eradicate the waiting times whilst ensuring that all of the young people on the waiting lists received the right service to meet their needs and kept safe was impressive. The communication to the families and staff members during this time meant the changes had not led to an increase in complaints from young people and their families and staff were on board.

Specialist community mental health services for children and young people

- The service had implemented robust policies and procedures to ensure each young person had an identified care coordinator. Service managers monitored caseloads using a recognised tool to ensure the continued throughput of young people in order to prevent an accumulation of a waiting list in the future.
- The service managers responded to the results of the staff survey by introducing 'go engage'. The previous staff survey indicated staff did not feel engaged and communication was poor. Go engage noticeboards were in every base and contained updated information about the service delivery and development including; vacancy rates, training needs, service development and waiting times.
- A member of the youth council attended monthly directorate meetings as well as commissioning meetings and young people and family participation was embedded in every level of the service.
- Service managers said they plan on making an application to the Quality Network for Community CAMHS (QNCC) scheme in 2018/2019. Their application to be a research site for the study; Development and validation of a questionnaire to assess mental health and concerning behaviours in autism spectrum disorder has been successful and the service is hoping to undertake a research project about young people's experiences of dialectical behavioural therapy.

However:

- There was not a diverse range of staff within the teams and this did not reflect the local population.

Outstanding practice

We found one example of outstanding practice in this service. See the Outstanding practice section above.

Areas for improvement

We found three areas for improvement in this service. See the Areas for improvement section above.

This section is primarily information for the provider

Requirement notices

Action we have told the provider to take

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

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

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

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

Regulated activity	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

Our inspection team

This inspection was chaired by James Mullins, Head of Hospitals Inspections, Care Quality Commission and led by Kathryn Mason, Inspection Manager, Care Quality Commission. An executive reviewer, Ros Alsted, Director of Nursing, supported our inspection of well-led for the trust overall.

The team included 11 (further) inspectors, 22 specialist advisers, six experts by experience, Mental Health Act reviewers, planning coordinators and assistant inspectors.

Executive reviewers are senior healthcare managers who support our inspections of the leadership of trusts. Specialist advisers are experts in their field who we do not directly employ. Experts by experience are people who have developed expertise in health services by using them or through contact with those using them – for example, as a carer.