North Staffordshire Combined Healthcare NHS Trust

Evidence appendix

Trust Headquarters
Bellringer Road, Trentham Lakes South
Stoke On Trent
Staffordshire
ST4 8HH

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This evidence appendix provides the supporting evidence that enabled us to come to our judgements of the quality of service provided by this trust. It is based on a combination of information provided to us by the trust, nationally available data, what we found when we inspected, and information given to us from patients, the public and other organisations. For a summary of our inspection findings, see the inspection report for this trust.

Facts and data about this trust

The trust had seven locations registered with the CQC (on 22 November 2018).

Registered location	Code	Local authority
Darwin Centre	RLY86	Stoke-on-Trent
Dragon Square Community Unit	RLY36	Staffordshire
Florence House	RLY39	Stoke-on-Trent
Harplands Hospital	RLY88	Stoke-on-Trent
Stoke Heath Young Offenders Institute	RLYX1	Shropshire
Summer View	RLY87	Stoke-on-Trent
Trust Headquarters	RLY00	Stoke-on-Trent

The trust had 180 inpatient beds across 12 wards, 21 of which were children's mental health beds. The trust also had 224 community mental health clinics and eight community physical health clinics per week.

Total number of inpatient beds	180
Total number of inpatient wards	12
Total number of day case beds	N/A
Total number of children's beds (MH setting)	21
Total number of children's beds (CHS setting)	N/A

Total number of acute outpatient clinics per week	N/A
Total number of community mental health clinics per week	224
Total number of community physical health clinics per week	8

The methodology of CQC provider information requests has changed, so some data from different time periods is not always comparable. We only compare data where information has been recorded consistently.

Is this organisation well-led?

Leadership

The trust board consisted of the chair, chief executive, five non-executive directors, six executive directors and a GP associate director. There were no vacant posts at the time of inspection. The chair had been in post for almost two years and the chief executive for four years.

The chief executive was leaving the trust and the trust had made a new appointment in the week before our inspection visit. The new chief executive was an experienced leader in a community health trust and had experience acting up as a chief executive. His new position would be his first permanently in that role.

The finance director was also leaving the trust and their replacement was coming into post the month following our well led visit. They had been able to work together to ensure an effective handover before the existing director of finance let the trust.

The non-executive directors had the appropriate range of skills, knowledge and experience. They all had experience as senior leaders in a range of organisations and brought skills including finance, strategic development and partnership working to their roles in the organisation. The trust had appointed to a non-executive director vacancy, this individual was due to start in March 2019. The new non-executive director whose experience whose experience in implementing equality, diversity and inclusion strategies matched the board's current priorities.

The executive board had one (14%) black and minority ethnic (BME) members and five (71%) women. The non-executive board had one (17%) black and minority ethnic member and two (33%) women. The balance of the board would remain the same following the planned changes to executive and non-executive members.

The trust supported the non-executive directors with their learning and development. Each person had an annual appraisal; there were regular board development days and development workshops. With the changes within the executive team there was an opportunity to develop the role of the non-executive directors in informing the performance review process for executives.

The senior leadership team consisted of the chief executive, a director of nursing, quality and Allied Health Professionals, director of finance, performance and digital, medical director, director of operations, director of leadership and workforce and a director of partnerships and strategy and development. The chief executive, the director of nursing and medical director had been in post at our last inspection.

Since our last inspection the trust had undergone a major reorganisation. The trust had changed its internal operational structure reducing the number of operational directorates to four; Staffordshire community, Stoke on Trent community, acute & urgent care and specialist services directorates.

A clinical director supported by senior staff representing the different professional groups within the directorate and service managers led each new directorate. The trust had also introduced a new post of quality improvement lead to each directorate.

The trust had strengthened its historically strong links with primary care through an agreement to take two GP practices into the trust in December 2018. The trust had developed a model of providing support to GP contract by taking on workforce, administrative and estates management for their practices. This development was still at an early stage.

We reviewed five board members personnel files. All five of these files demonstrated consistent processes undertaken to evidence fitness of executives with external agencies, annual self-

declarations regarding fitness for a board level role within the organisation and annual appraisals. Disclosure and barring service (DBS) checks were in line with current trust policy.

We interviewed all but one of the permanent board members. The executive team demonstrated a very high level of awareness of the priorities and challenges facing the trust and how these were being addressed. People were able to speak with insight about the key priorities for the organisation being staffing, stability of finances and the recent management of change process. The non-executive directors were all well briefed on their particular area of responsibility but some lacked the overall awareness of priorities and challenges of the executive team. The chairperson of the trust was aware of this and told us that annual appraisals of the non-executive directors were an opportunity to identify area of strength and weaknesses to be developed.

We were impressed by the extent of the loyalty that was conveyed and demonstrated to us by everyone we met on the board to their individual colleagues and the organisation. The chairperson saw the changes in the management team as an opportunity for the board to refresh strategic aims and reflect on developments to date. There was a commitment to continue the journey from an assurance led organisation to a more improvement led organisation; extending the empowerment of staff at all levels within the organisation and collaboration with stakeholders, partners and regulators within the system at all levels.

All of the board were involved in a programme of visits to services. Staff we spoke with during our core service inspections knew who the senior leadership team was and told us that they came to visit regularly. In addition, there was a formal programme of quality visits involving executives, non-executive directors, service users or carers and clinical staff visiting teams to explore and discuss issues and leadership within the team. Executive members had made themselves available to question and answer sessions with staff during the management of change process.

Leadership development opportunities were available for staff at different levels of the organisation linked to their appraisals and person development plans. The trust had invested in the development of a black and minority ethnic (BME) leadership programme with wider healthcare providers. This programme was underway and staff who participated told us of their positive experience of being given time to commit the training and the direct support of the executive team

The board also received feedback directly from front line services and staff through case presentations and clinical updates at board meetings, where individual teams spoke at board level. The CQC attended two board meetings in the previous year and the found the executive members to be very appreciative of the work of staff and always asking what extra support or help they could give.

Senior leadership recognised the national clinical workforce challenges and the importance of succession planning and had a strong recruitment and retention strategy in place. The organisations recruitment and retention strategy presented a robust analysis of the current workforce and identified high-risk areas of the workforce. The trust had implemented plans to improve recruitment and retention for all three major clinical groups; medical, nursing and allied health professionals. Attempts to speed the recruitment process through streamlining processes however, staff within the core services and at executive level acknowledged further improvement was necessary.

Vision and strategy

The trust's vision was "to be outstanding" in all they do and how they do it. The trust's values were: Compassionate, Approachable, Responsible and Excellent. Both the vision and values reflected

the trusts board's prioritisation of clinical quality and sustainability. The trust board closely questioned the potential impact on quality of cost improvement programmes and the trust conducting post implementation evaluations on all cost improvements to ensure the quality and safety of services had been unaffected.

During our focus groups and during core service visits we found staff were aware and shared the trust's vision and values and had good knowledge of how they applied these in the work of their teams. The organisations values were embedded within staff appraisals, which ensured staff, knew how they applied to their work. Staff in most services had had an opportunity to contribute to discussions the major management of change process in the previous year. We found evidence that elements of the original proposal had changed and the timetable adjusted to allow more time for staff to comment because of their feedback. The vast majority of staff we spoke with felt that the process had been well managed and their voices heard.

The organisation was also developing value based recruitment within the recruitment and retention strategy to support the consolidation of shared values.

The trust had four quality priorities that were unchanged from the previous year. This was represented by SPAR that stood for services being consistently safe, care to be personalised to the individual needs of service users', processes and structures guaranteeing access to services for service users' and their carers, and the focus would be on the recovery needs of those with mental illness. Within the core service inspections the staff consistently emphasised the importance of personalising care to the individual. Although there was some good practice the personalisation of care plans it was not fully consistent.

The trust embedded its vision, values and strategy in corporate information received by staff. Both the trust's values and quality priorities were included on information to staff. The trust also had a communication strategy that emphasised examples of the values being put into practice and quality priorities being achieved in a series of posters on display throughout the trust.

The trust aligned its strategy to local plans in the wider health and social care economy. This reflected their active involvement in sustainability and transformation plans. The strategic aims of the trust focused on the development of an integrated care system and they had worked on a range of local initiatives to move the system in that direction.

The trust had planned services to take into account the needs of the local population. The four largest ethnic minorities within the trust's catchment population are: Asian or Asian British (4.8%), White (Other / non-British) (1.9%), mixed heritage (1.4%) and Black or Black British (1.0%). They trusts community engagement strategy recognised all local minority groups. Their action plan included joint initiatives with local mosques and a black elders group.

The trust had a strong physical healthcare strategy to meet the needs of patients that encompassed infection control, hydration / nutrition, falls, reportable diseases and estates across mental health and learning disabilities inpatient and community settings. The trust had provided staff with training around the management of physical health care problems and around prevention through courses on reducing smoking and alcohol amongst their patients. The trust had now recruited physical health care lead nurses in the inpatient areas who could be a source of expert advice.

Culture

The overall culture of the trust was very patient centred. Staff were highly motivated by wanting 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.

Staff working in the services we visited felt respected and valued at a local level. At our previous inspection, allied health professionals (AHP) had not felt valued within the trust. In a focus group, allied health professional staff told us that this situation had improved. In response, the trust had set out a development strategy for allied health professional staff that addressed their concerns around professional practice and career progression. A professional lead for allied health professionals was being recruited to each of the four new directorates. Members of the focus group praised the leadership of the director of nursing actively listening to and addressing their concerns.

In the 2018 staff survey 77.7 % of staff reported receiving the respect they believed they deserved from other staff inside the trust. This was above the national average.

In the 2017 NHS Staff Survey, the trust had better results than other similar trusts in 10 key areas:

Key finding	Trust score	Previous trust average	Trend
11 - Percentage of staff appraised in last 12 months	93%	91%	=
20 - Percentage of staff experiencing discrimination at work in the last 12 months	12%	10%	=
21 - Percentage of staff believing that the organisation provides equal opportunities for career progression or promotion	91%	88%	=
28 - Percentage of staff witnessing potentially harmful errors, near misses or incidents in last month	22%	20%	=
17 - Percentage of staff feeling unwell due to work related stress in the last 12 months	37%	39%	=
26 - Percentage of staff experiencing harassment, bullying or abuse from staff in last 12 months	18%	19%	=
30 - Fairness and effectiveness of procedures for reporting errors, near misses and incidents	3.84	3.82	=
19 - Organisation and management interest in and action on health and wellbeing	3.80	3.71	=
14 - Staff satisfaction with resourcing and support	3.39	3.41	=
32 - Effective use of patient / service user feedback	3.81	3.76	=

In the 2017 NHS Staff Survey, the trust had worse results than other similar trusts in seven key areas:

Key finding	Trust score	Previous trust average	Trend
29 - Percentage of staff reporting errors, near misses or incidents witnessed in the last month	91%	96%	=
7 - Percentage of staff able to contribute towards improvements at work	70%	70%	=
3 - Percentage of staff agreeing that their role makes a difference to patients / service users	85%	87%	=
22 - Percentage of staff experiencing physical violence from patients, relatives or the public in last 12 months	24%	22%	=
27 - Percentage of staff / colleagues reporting most recent experience of harassment, bullying or abuse	57%	57%	=
13 - Quality of non-mandatory training, learning or development	3.99	4.02	=
31 - Staff confidence and security in reporting unsafe clinical practice	3.60	3.61	=

The Workforce Race Equality Standard (WRES) became compulsory for all NHS trusts in April 2015. Trusts have to show progress against nine measures of equality in the workforce.

1. The percentages of White and BME staff in each of the Agenda for Change (AfC) pay bands 1 to 9, and at Very Senior Manager (VSM) level (including executive board members), compared with the percentage of staff in the overall workforce: Six percent of the clinical workforce is BAME, reducing to 4% when medical staff are excluded. In addition to this, only 2.2% of the non-clinical workforce is BAME. A total of 6.66% of the trust's workforce (excluding bank) is BAME (5.90% in 2017) when 'ethnicity not known' are excluded (ie as per WRES template data). This is a little less than the local population BAME population (Stoke-on-Trent, Staffordshire Moorlands and Newcastle-Under-Lyme) which is 7.6% BAME (based on 2011 census). The population of Staffordshire as a whole is just over 8% BAME (8.19%). Excluding medical staff, most BAME clinical staff are in bands 5, 6 and 7 (predominantly band 5). There remain very few non-clinical BAME staff (most BAME people who are in this group are in bands 3, 4 and 5). BAME workforce varies across the different Trust directorates (see and it is noted that this will change further to the locality working restructuring that is underway at the time of writing.

2. In 2018, White candidates were 1.96 times more likely than BME candidates to get jobs for which they had been shortlisted. The trust performance against this measure has worsened from 1.20 times more likely in 2017.

3. In 2018, BME staff were (ten times) more likely to be disciplined[1] when compared with White staff. This has increased from 1.77 times more/less likely in 2017.

4. In 2018, White staff were 10 times less likely to take part in voluntary training than BME staff.

5. 43% of BME staff experienced harassment, bullying or abuse from patients, relatives and the public in the past year (2017 NHS staff survey). This increased from 37% in 2016 and was worse than the national average for similar trusts (36%). The figure for White staff decreased from 32% in 2016 to 31% in 2017. This was similar to the national average for similar trusts (32%). The difference between White and BME Staff was not statistically significant in 2017.

6. 37% of BME staff experienced harassment, bullying or abuse from staff in the past year (2017 NHS staff survey). This increased from 25% in 2016 and was worse than the national average for similar trusts (26%). The figure for White staff decreased from 19% to 16%. This was better than the national average for similar trusts (21%). The difference between White and BME Staff was statistically significant in 2017.

7. 64% of BME staff believed that the trust provided equal opportunities for career progression and promotion (2017 NHS staff survey). This decreased from 86% in 2016 and was worse than the national average for similar trusts (77%). The figure for White staff increased from 89% to 91%. This was better than the national average for similar trusts (87%). The difference between White and BME Staff was statistically significant in 2017.

8. 7% of White staff experienced discrimination from a colleague or manager in the past year (2017 NHS staff survey). This increased from 5% in 2016 and was similar to the national average for similar trusts (6%). Figures for BME staff increased from 17% in 2016 to 21% in 2017. This was worse than the national average for similar trusts (14%). The difference between White and BME Staff was statistically significant in 2017.

9. The percentage of BME staff on the board was 8.9% "which is greater than the proportion of the overall workforce". The percentage figure for 2017 was 5.8%.

[1] RLY NHS Staff Survey

The trust had fully engaged with the negative findings within the Workforce Race Equality Standard (WRES). The report and action plan had been discussed in detail at board and directorate levels. Executive members offered open door, 'tea with ...', sessions with black and minority ethnic staff to hear what working for the organisation was like. The trust had also continued to promote and act on its zero tolerance policy for verbal and physical abuse of staff reported on at our last inspection.

Staff felt that managers promoted equality and diversity in their day to day work. However, there was still a significant gap between white and black and minority ethnic staff when looking at opportunities for career progression. The positive impact of the board led initiatives, such as the black and minority ethnic leadership course, reverse mentoring and protected time for black and ethnic minority staff to engage in networks were not yet consistently evidenced. The trusts Workforce Race Equality Standard (WRES) action plan included a number of good practice and innovative actions that promoted the diversity of staff working in the trust.

Staff networks were in place promoting the diversity of staff. In addition to the black and minority ethnic staff council there was also networks to support lesbian, gay, bisexual and transsexual staff.

The Patient Friends and Family Test asks patients whether they would recommend the services they have used based on their experiences of care and treatment.

The trust scored better than the England average for patients recommending it as a place to receive care for five of the six months in the period (April 2018 – September 2018).

The trust was better than the England average in terms of the percentage of patients who would not recommend the trust as a place to receive care in five of the six months.

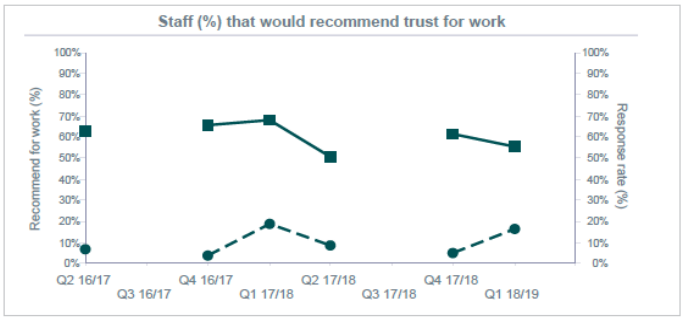
	Trust wide responses				**England averages**	
	Total eligible	**Total responses**	**% that would recommend**	**% that would not recommend**	**England average recommend**	**England average not recommend**
Apr 2018	1719	349	90.8%	1.7%	88.7%	4.2%
May 2018	1878	357	91.6%	3.4%	88.9%	3.7%
Jun 2018	1759	315	91.1%	4.4%	88.8%	3.8%
Jul 2018	1780	336	91.1%	3.6%	88.9%	3.9%
Aug 2018	1770	325	90.8%	3.1%	90.0%	3.5%
Sept 2018	1931	260	87.3%	3.5%	89.6%	3.7%

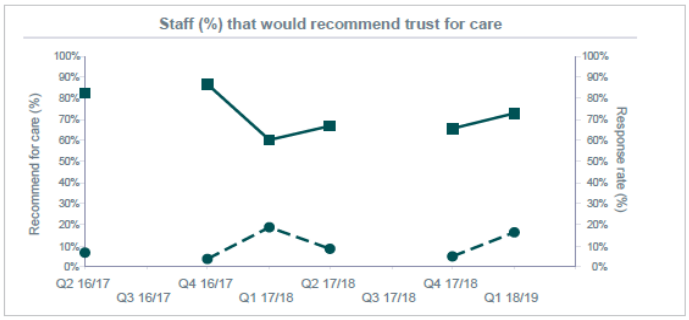
The Staff Friends and Family Test asks staff members whether they would recommend the trust as a place to receive care and also as a place to work.

The percentage of staff that would recommend this trust as a place to work in Q1 2018/19 decreased when compared to the same time last year.

The percentage of staff that would recommend the trust as a place to receive care in Q1 2018/19 increased when compared to the same time last year.

There is no reliable data to enable comparison with other individual trusts or all trusts in England.





This trust

Response rate for this trust

Please note: Data is not collected during Q3 each year because the Staff Survey is conducted during this time

The trust recognised staff achievements through their annual 'Reach' awards. The trust used the event celebrate achievement from teams across the trust. The event was very popular with staff who felt awards reflected real achievements. This meant there was considerable competition among staff to be nominated for an award and the trust had received 300 nominations for individuals and teams for the 2018 awards.

The staff side chair sat on the board as a non-voting member. Managers consulted trade unions on change and staff side representatives had access to senior managers to raise issues of concern.

Managers across the trust said they were able to address poor staff performance where needed and received guidance from the human resources team when required.

The trust had appointed a Freedom to Speak Up Guardian and provided them with sufficient resources and support to help staff to raise concerns. This included the time to attend a regional network of guardians and the commitment to resource the development of freedom to speak up champions. Most staff said that they felt able to raise concerns with their line manager without fear of retribution. Staff were aware of the Freedom to Speak Up Guardian (FSUG) that encouraged and enabled all staff to speak up safely, in an open and transparent culture if they needed to. The trust board had completed the NHS Improvement Freedom to Speak Up self-review tool for NHS trusts to provide assurance of their compliance with national guidance.

In addition, staff knew they could also contact the chief executive directly through the 'Dear Caroline' email scheme with their concerns or worries. A combined 'Being Open' report summarising concerns raised through both routes was presented quarterly to the trust board for review of themes. It also summarised the actions taken as a result of concerns for example the review of staffing in identified areas where concerns were raised.

In the previous year staff attending the black and minority ethnic (BME) focus group told us they were not clear where to go with issues and concerns relating to race. The creation of a black and minority ethnic staff council had provided a regular forum for those staff to meet and discuss their concerns. They could then be raised directly to executive member responsible for the relevant work stream resulting from the trusts equalities action plan.

The trust had also appointed a Guardian of Safe Working Hours for junior doctors. They have oversight of the working practices of junior doctors within the trust to ensure doctors in training are working safely and within the hours set out in their contracts. We spoke with the Guardian who told us of her regular liaison with junior doctors within the trust. There had been no exception reports made in the previous year flagging the departure from agreed works plans of junior doctors within the trust.

The trust applied Duty of Candour appropriately. The quality committee received a report on all duty of candour cases to ensure overview and monitoring. During our inspection, we looked at four

serious incidents to see how the trust applied duty of candour. In all but one case it was from the record if family / carers had contributed to the terms of reference and been given opportunity to feedback. The trust took appropriate learning and action because of concerns raised

All staff had the opportunity to discuss their learning and career development needs at appraisal. This included agency and locum staff and volunteers.

Staff had access to support for their own physical and emotional health needs through occupational health service. This service provided counselling services, and access to assistance with physical health needs. The service also provided support through proactive stress management and promoting resilience though trying to target stress flash points with in the trust and providing debriefs to staff after incidents.

Between September 2017 and February 2018, 72.1% of healthcare workers involved with direct patient care were vaccinated against seasonal influenza, which was better than the national average of 62.2%. However, the trust had declined from the previous period where 79.7% of workers had been vaccinated.

The trust sickness and absence average was 5.2%. This was slightly higher than both the national average for NHS mental health and learning disability providers at 4.52% and the trust target at 4.95%.

Teams had positive relationships, worked well together and addressed any conflict appropriately.
This provider has reported a vacancy rate for all staff of 14% as of 31 July 2018. This was similar to the 13% reported at the last inspection[2] (as of May 2017).

This provider reported an overall vacancy rate of 16% for registered nurses at 31 July 2018. The vacancy rate for registered nurses was higher than the 12% reported at the last inspection[3]. The trust had substantively improved this situation through the recruitment of a cohort of newly qualified nurses in October 2018. 29 newly qualified nurses commenced work that month mainly in inpatient areas.

This provider reported an overall vacancy rate of 9% for nursing assistants. The vacancy rate for healthcare assistants was lower than the 14% reported at the last inspection[4].

	Registered nurses			Health care assistants			Overall staff figures		
Core service	Vacancies	Establishment	Vacancy rate (%)	Vacancies	Establishment	Vacancy rate (%)	Vacancies	Establishment	Vacancy rate (%)
MH - Mental health crisis services and health-based places of safety	12.92	69.81	19%	1.73	6.13	28%	20.87	100.55	21%
MH - Wards for people with learning disabilities or autism	4.23	13.43	31%	3.08	18.72	16%	7.31	34.95	21%
MH - Wards for older people with mental health problems	11.32	40.92	28%	6.09	48.69	13%	18.43	96.81	19%

[2] Previous Inspection Data
[3] Previous Inspection Data
[4] Previous Inspection Data

	Registered nurses			Health care assistants			Overall staff figures		
Core service	**Vacancies**	**Establishment**	**Vacancy rate (%)**	**Vacancies**	**Establishment**	**Vacancy rate (%)**	**Vacancies**	**Establishment**	**Vacancy rate (%)**
MH - Substance misuse	5.33	29.80	18%	0.96	11.28	9%	8.46	53.75	16%
MH - Acute wards for adults of working age and psychiatric intensive care units	11.00	48.00	23%	3.03	48.23	6%	15.12	100.12	15%
MH - Community-based mental health services for older people	6.00	46.16	13%	1.90	12.43	15%	10.65	72.35	15%
MH - Community-based mental health services for adults of working age	5.45	83.02	7%	4.00	25.60	16%	19.94	161.04	12%
MH - Other Specialist Services	7.72	32.62	24%	-0.66	25.89	-3%	10.20	96.48	11%
MH - Specialist community mental health services for children and young people	-1.45	23.38	-6%	1.16	1.16	100%	7.76	68.15	11%
MH - Community mental health services for people with a learning disability or autism	2.30	23.80	10%	0.60	7.60	8%	6.10	59.51	10%
MH - Child and adolescent mental health wards	3.61	24.05	15%	0.20	21.43	1%	4.92	55.49	9%
MH - Long stay/rehabilitation mental health wards for working age adults	1.80	16.80	11%	1.06	20.23	5%	2.45	42.98	6%
Other – ASC Service	0.00	1.00	0%	0.00	0.00	-	1.06	22.14	5%
Trust total	**70.23**	**452.79**	**16%**	**23.15**	**247.39**	**9%**	**133.27**	**964.72**	**14%**

NB: All figures displayed are whole-time equivalents

Between September 2017 and August 2018, of the (589590) total working hours available, 38213 were filled by bank staff to cover sickness, absence or vacancy for qualified nurses.

The main reason for bank and agency usage for the wards/teams was vacancies.

In the same period, agency staff covered 13425 hours qualified nurses and 45636 available hours were unable to be filled by either bank or agency staff.

We are unable to provide details about the proportion of bank and agency usage as all available hours for all core services and teams were not provided by the trust.

Core service	**Total hours available**	**Bank Usage**		**Agency Usage**		**NOT filled by bank or agency**	
		Hrs	**%**	**Hrs**	**%**	**Hrs**	**%**
MH - Acute wards for adults of working age and psychiatric intensive care units	72332	8383	N/A	908	N/A	734	N/A
MH - Wards for older people with	62003	5824	N/A	9510	N/A	1273	N/A

Core service	Total hours available	Bank Usage		Agency Usage		NOT filled by bank or agency	
		Hrs	%	Hrs	%	Hrs	%
mental health problems							
MH - Other Specialist Services	47802	3606	N/A	178	N/A	2063	N/A
MH - substance misuse	53488	2925	N/A	387	N/A	7998	N/A
MH - Wards for people with learning disabilities or autism	18803	5304	N/A	11	N/A	217	N/A
MH - Child and adolescent mental health wards	12657	400	N/A	106	N/A	335	N/A
MH - Long stay/rehabilitation mental health wards for working age adults	24251	1301	N/A	32	N/A	8	N/A
MH - Mental health crisis services and health-based places of safety	102681	6179	N/A	1733	N/A	6467	N/A
MH - Specialist community mental health services for children and young people	77371	779	N/A	510	N/A	11363	N/A
MH - Community-based mental health services for older people	41048	2172	N/A	12	N/A	5954	N/A
MH - Community-based mental health services for adults of working age	77156	1339	N/A	40	N/A	9225	N/A
Trust Total	**589590**	**38213**	**N/A**	**13425**	**N/A**	**45636**	**N/A**

Between September 2017 and August 2018, of the (359531) total working hours available, 130535 hours were filled by bank staff to cover sickness, absence or vacancy for nursing assistants.

The main reason for bank and agency usage for the wards/teams was vacancies.

In the same period, agency staff covered 3037 hours and 24283 hours were unable to be filled by either bank or agency staff.

We are unable to provide details about the proportion of bank and agency usage as all available hours for all core services and teams were not provided by the trust. However, for 2018/19 the trust planned agency expenditure was in line with the ceiling set by NHS Improvement. At the end of October 2018 the trust has spent £0.032m less than the ceiling and based on the current forecast and run-rate projections the full-year expenditure would be within the allocated ceiling.

Core service	Total hours available	Bank Usage		Agency Usage		NOT filled by bank or agency	
		Hrs	%	Hrs	%	Hrs	%
MH - Acute wards for adults of working age and psychiatric intensive care units	77387	35386	N/A	331	N/A	5690	N/A
MH - Wards for older people with mental health problems	79943	49430	N/A	2020	N/A	6375	N/A
MH - Other Specialist Services	37620	18145	N/A	194	N/A	2098	N/A
MH - substance misuse	17899	3252	N/A	52	N/A	236	N/A
MH - Wards for people with learning disabilities or autism	26802	12160	N/A	136	N/A	2342	N/A
MH - Child and adolescent mental health wards	19938	6600	N/A	281	N/A	2018	N/A
MH - Long stay/rehabilitation mental health wards for working age adults	33638	1773	N/A	0	N/A	149	N/A

Core service	Total hours available	Bank Usage		Agency Usage		NOT filled by bank or agency	
		Hrs	%	Hrs	%	Hrs	%
MH - Mental health crisis services and health-based places of safety	6948	312	N/A	0	N/A	174	N/A
MH - Specialist community mental health services for children and young people	19350	595	N/A	0	N/A	1539	N/A
MH - Community-based mental health services for older people	11977	2543	N/A	0	N/A	2572	N/A
MH - Community-based mental health services for adults of working age	28030	341	N/A	24	N/A	1090	N/A
Trust Total	**359531**	**130535**	**N/A**	**3037**	**N/A**	**24283**	**N/A**

This provider had 79.9 (9%) staff leavers between September 2017 and August 2018. This was lower than the 15% reported at the last inspection[5] (from June 2016 to May 2017).

Core service	Substantive staff (at latest month)	Total substantive staff leavers over the last 12 months	Average % staff leavers over the last 12 months
MH - Child and adolescent mental health wards	48.3	5.5	11%
MH - Long stay/rehabilitation mental health wards for working age adults	39.1	6.2	15%
MH - Mental health crisis services and health-based places of safety	78.0	8.4	10%
MH - Wards for people with learning disabilities or autism	27.6	6.4	23%
MH - Specialist community mental health services for children and young people	78.1	10.0	13%
MH - Acute wards for adults of working age and psychiatric intensive care units	73.3	4.8	7%
MH - Wards for older people with mental health problems	76.3	8.0	11%
MH - Other Specialist Services	95.7	9.2	9%
MH - Community-based mental health services for adults of working age	143.2	5.0	3%
MH - Community mental health services for people with a learning disability or autism	53.6	5.4	10%
MH - Substance misuse	45.4	7.7	18%
MH - Community-based mental health services for older people	78.3	3.3	5%
Other - ASC service	20.1	0.0	0%
Other - PMS service	1.4	0.0	0%
Trust Total	**858.3**	**79.9**	**9%**

The sickness rate for this provider was 5.2% between 1 September 2017 and 31 August 2018. The most recent month's data [August 2018] showed a sickness rate of 3.9%. This was lower than the sickness rate of 4.8% reported at the last inspection[6] (May 2017).

[5] Previous Inspection Data
[6] Previous Inspection Data

Core service	Total % staff sickness (at latest month)	Ave % permanent staff sickness (over the past year)
MH - Long stay/rehabilitation mental health wards for working age adults	6.4%	8.3%
MH - Wards for people with learning disabilities or autism	6.6%	6.9%
MH - Substance misuse	6.7%	6.5%
MH - Other Specialist Services	2.4%	6.1%
MH - Acute wards for adults of working age and psychiatric intensive care units	6.6%	6.0%
Other - ASC service	10.0%	5.7%
MH - Community-based mental health services for adults of working age	1.8%	5.6%
MH - Child and adolescent mental health wards	4.4%	5.3%
MH - Community-based mental health services for older people	3.8%	4.6%
MH - Mental health crisis services and health-based places of safety	4.5%	4.6%
MH - Wards for older people with mental health problems	3.0%	4.2%
MH - Community mental health services for people with a learning disability or autism	1.9%	3.4%
MH - Specialist community mental health services for children and young people	2.5%	2.6%
Other - PMS service	-	-
Trust Total	**3.9%**	**5.2%**

Senior managers recognised the challenging healthcare economy and its impact on workforce recruitment and maintaining safe and quality care. In the year since our last inspection, there had been improvements in the recruitment of clinical staff, retention rates and sickness absences. The directors responsible for each of the main clinical professions within the trust had developed plans to secure these improvements.

The director of nursing had developed a comprehensive action plan to support nurse recruitment and retention. The trust was developing links with educational partners and had made early offers of employment to student nurses who had committed to the mental health pathway. The trust had strengthened the its preceptorship programme for new nurses and in the two years before January 2019 only one newly qualified nurse had left the trust. Changes in the working patterns for some nurses and an e-rostering initiative had increased flexibility of the nursing workforce to address any shortfalls. There was also encouragement to other non-qualified staff to advance themselves though access to a nursing associate training programme.

The medical director had a similar detailed programme to secure the recruitment and retention of both senior and junior medical staff. They had considered why although they were a popular choice for training posts recruitment post training had been historically poor. They had started working with junior doctors earlier in the training scheme to identify issues of concern. As a result,

student feedback had improved and the trust now had the highest conversion rates of junior doctors to psychiatry as a speciality within the region. The attractiveness of the trust to middle grade doctors was addressed by enhancing job roles in the development of four senior lecturer post in primary care with a local university. The board had also been supportive in authorising support, including relocation packages, to the recruitment to consultant roles inside the trust.

The trust had developed an allied health professions strategy that set out its commitment to give the allied health professionals throughout the organisation a clear role in management and governance structures. It also committed the senior leadership team to use allied health professionals as major contributors to the development of a recovery focused culture of care inside the trust. This initiative had been developed with the active involvement of allied health professionals who at our last inspection had felt alienated as a group within the trust and without a voice in the organisation. At a very well attended focus group we heard that allied health professionals now believed the trust to have listened to their concerns and were more likely to remain with a trust that valued their contribution.

We also reported at our last inspection of challenges within the pharmacy team to meet demand for their services. The problems of recruitment to pharmacy technician's posts remained a challenge and were the sole entry for the service on the directorate risk register. The chief pharmacist report had also highlighted these shortages as a threat to the implementation of the trust medicines optimisation strategy including the roll out of electronic prescribing.

The compliance for mandatory and statutory training courses at 31 August 2018 was 87%. Of the training courses listed, seven failed to achieve the trust target and of those, four failed to score above 75%.

The trust set a target of 85% for completion of mandatory and statutory training and 95% for Information Governance training.

The trust reports training on a rolling month by month basis and was unable to provide year end data as requested, therefore we cannot compare compliance to previous years.

The training courses at 75% or below were brief advice on alcohol, brief advice on smoking, Prevent and the Mental Capacity Act. The trust had introduced the two sessions on advice for alcohol and smoking had been introduced in 2018 as new mandatory training sessions as part of their physical health strategy. The trajectory for the full implementation of this strategy was 2020. They were confident of meeting their own target within 2019.

The PREVENT strategy is a national initiative to alert staff to the causes of radicalisation.

The training rate for the Mental Capacity Act was reported as 26% for the trust in August 2018. This was the first month that a standalone Mental Capacity Act e learning model had been introduced into the trust. Previously the Mental Capacity Act had formed part of a Mental Health Law training session. The trust told us they expected to report on the compliance of the new module as a shadow rating for six months after implementation and then from February 2019 all teams were expected to meet the trust target of 85%. In an update on training compliance in December 2018 the overall rate of take up across the trust was 79.8%.

Key:

Below CQC 75%	**Met trust target** ✓	**Not met trust target** ✗

Training module	**Number of eligible staff**	**Number of staff trained**	**YTD compliance**	**Trust target met?**

Clinical Risk Assessment	486	479	99%	✓
Dementia Awareness Level 1	884	860	97%	✓
Equality and Diversity	886	860	97%	✓
Suicide Awareness Level 1	734	706	96%	✓
Safeguarding Children & Adults level 1 & 2	886	852	96%	✓
Mental Health Act	480	456	95%	✓
Moving and Handling	854	814	95%	✓
Management of Actual or Potential Aggression MAPA	311	294	95%	✓
Health & Safety	885	843	95%	✓
Safeguarding Children (Level 3)	474	444	94%	✓
Medicine management training	312	290	93%	✓
Conflict Resolution	826	772	93%	✓
Resuscitation	759	665	88%	✓
Effective Care Planning	495	437	88%	✓
Fire	878	754	86%	✓
Fraud, Bribery & Code of Conduct	886	764	86%	✓
Information Governance	886	742	84%	✘
Infection, Prevention & Control	890	705	79%	✘
Manual Handling - People	281	218	78%	✘
Brief Advice on Smoking	677	509	75%	✘
PREVENT	885	654	74%	✘
Brief Advice on Alcohol	324	232	72%	✘
Mental Capacity Act Level 1	476	123	26%	✘
Trust Total	**15455**	**13473**	**87%**	

The trust's target rate for appraisal compliance is 85%. At the end of last year (1 April 2017 – 31 March 2018), the overall appraisal rate for non-medical staff was 91%. This year so far, the overall appraisal rate was 50% (as at 31 August 2018). Thirteen of the 14 core services achieved the trust's appraisal target in the last financial year (April 2017 – March 2018).

The rate of appraisal compliance for non-medical staff reported during this inspection is higher than the 84% reported at the last inspection[7] (31 May 2017).

Core Service	**Total number of permanent non-medical staff requiring an appraisal**	**Total number of permanent non-medical staff who have had an appraisal**	**% appraisals (as at 31 August 2018)**	**% appraisals (1 April 2017 – 31 March 2018)**
Other - ASC service	22	22	100%	100%
MH - Community mental health services for people with a learning disability or autism	58	49	84%	95%
MH - Substance misuse	48	35	73%	89%
MH - Community-based mental health services for adults of working age	98	69	70%	86%
MH - Other Specialist Services	89	56	63%	89%
MH - Mental health crisis services and health-based places of safety	79	43	54%	95%
MH - Child and adolescent mental health wards	60	31	52%	86%

[7] Previous Inspection Data

Core Service	Total number of permanent non-medical staff requiring an appraisal	Total number of permanent non-medical staff who have had an appraisal	% appraisals (as at 31 August 2018)	% appraisals (1 April 2017 – 31 March 2018)
MH - Wards for older people with mental health problems	78	38	49%	91%
MH - Wards for people with learning disabilities or autism	31	15	48%	93%
MH - Community-based mental health services for older people	67	23	34%	95%
MH - Acute wards for adults of working age and psychiatric intensive care units	85	19	22%	83%
MH - Specialist community mental health services for children and young people	79	17	22%	96%
MH - Long stay/rehabilitation mental health wards for working age adults	50	2	4%	98%
MH - Other PMS Service	0	0	-	-
Total	**844**	**419**	**50%**	**91%**

The trust's target rate for appraisal compliance is 85%. At the end of last year (1 April 2017 – 31 March 2018), the overall appraisal rate for medical staff was 100%. This year so far, the overall appraisal rate was 18% (as at 31 August 2018). All 11 of the core services (which have medical staff) achieved the trust's appraisal target in the last financial year (April 2017 – March 2018).

The rate of appraisal compliance for medical staff reported during this inspection is higher than the 67% reported at the last inspection[8] (31 May 2017).

Core Service	Total number of permanent medical staff requiring an appraisal	Total number of permanent medical staff who have had an appraisal	% appraisals (as at 31 August 2018)	% appraisals (1 April 2017 – 31 March 2018)
MH - Wards for people with learning disabilities or autism	1	1	100%	100%
MH - Specialist community mental health services for children and young people	4	2	50%	100%
MH - Community mental health services for people with a learning disability or autism	3	1	33%	100%
MH - Substance misuse	8	2	25%	100%
MH - Community-based mental health services for adults of working age	10	1	10%	100%
MH - Acute wards for adults of working age and psychiatric intensive care units	3	0	0%	100%
MH - Community-based mental health services for older people	2	0	0%	100%
MH - Mental health crisis services and health-based places of safety	2	0	0%	100%
MH - Other Specialist Services	3	0	0%	100%

[8] Previous Inspection Data

Core Service	Total number of permanent medical staff requiring an appraisal	Total number of permanent medical staff who have had an appraisal	% appraisals (as at 31 August 2018)	% appraisals (1 April 2017 – 31 March 2018)
MH - Wards for older people with mental health problems	4	0	0%	100%
MH - Child and adolescent mental health wards	0	0	-	100%
Total	**40**	**7**	**18%**	**100%**

The trust target for clinical supervision for all* staff is 85% of the sessions required. Between 1 September 2017 and 31 August 2018, the average rate across all core services was 81%.

Caveat: there is no standard measure for clinical supervision and trusts collect the data in different ways, so it's important to understand the data they provide.

Core service	Clinical supervision sessions required	Clinical supervision delivered	Clinical supervision rate (%)
Other - ASC service	219	211	96%
MH - Community-based mental health services for older people	583	539	92%
MH - Community mental health services for people with a learning disability or autism	640	568	89%
MH - Other Specialist Services	1170	1020	87%
MH - Specialist community mental health services for children and young people.	690	597	87%
MH - Long stay/rehabilitation mental health wards for working age adults	413	332	80%
MH - Mental health crisis services and health-based places of safety	906	721	80%
MH - Community-based mental health services for adults of working age	1436	1130	79%
MH - Wards for older people with mental health problems	794	623	78%
MH - Substance misuse	427	323	76%
MH - Child and adolescent mental health wards	564	424	75%
MH - Wards for people with learning disabilities or autism	301	217	72%
MH - Acute wards for adults of working age and psychiatric intensive care units	941	642	68%
Other - PMS service	0	0	-
Trust Total	**9084**	**7347**	**81%**

*All staff – medical and non-medical breakdowns were not provided

For both medical and non-medical staff appraisal rates had improved in the last year. The only core service not reaching the trust target of 85% was the acute wards for adults of a working age for appraisals. It was also the core service with the lowest levels of supervision. Staff vacancies

had contributed to the poor performance in this area and a significant effort had been made to recruit to this service. The cohort of newly qualified nurses, who joined this service in October 2018, were in receipt of regular supervision and additional peer support as part of their preceptorship programme. The provider believed targeting support at the early stages of a nurse's career would help long term retention.

Governance

The trust had effective structures, systems and processes in place to support the delivery of its strategy including sub-board committees, divisional committees, team meetings and senior managers. The trust board had four sub-committees that were the quality committee, people and culture committee, finance, performance and digital committee and the business development committee.

Leaders regularly reviewed these structures. Reviews of the effectiveness of each of the four board sub committees were taking place supported by the trust's development partner. Each committee produced an annual effectiveness report and had been the subject of a broader external review of the effectiveness of the board and its functions. An initial focus was to clarify the roles of each committee and ensure no unnecessary overlap. The quantity of papers submitted and length of agendas were raised as potential obstacles to the effectiveness of the committees. A comprehensive action plan had been developed in response and was being implemented by the board.

Non-executive chaired the board sub-committees and were not always clear about their areas of responsibility. The chair and chief executive acknowledged there were some gaps and individual development plans were in development.

The trust had clear structures and procedures for ensuring the implementation of the Mental Health Act (MHA) and Mental Capacity Act (MCA). The Mental Health Act team were knowledgeable with specific training in the administration of the act. The team reported to the medical director who was the executive lead for Mental Health Act. The trust was responsive to the visits and reports of the Mental Health Act reviewers and provided detail action plans in answer to any concerns. The team also produced a local action plan around the CQC's annual review of the use of the Mental Health Act nationally.

The Mental Health Law governance group, which reported to the quality committee monitored the use of both acts. This group discussed results of audits, reviewed incidents relating to the Mental Health Act, Mental Capacity Act and deprivation of liberty safeguards (DoLS). The group had overall oversight of the application and compliance with the MHA and the Code of Practice.

The trust had systems in place for receipt and scrutiny of detention documents. The Mental Health Act team had provided training to clinical staff to improve the scrutiny of detention paperwork out of hours and resolve any errors at the earliest opportunity.

We found that on the older adult wards that mental capacity assessments were very detailed, demonstrated repeated attempts to engage the person in discussion, where clear where a power of attorney was in place and gave consideration to the fluctuating nature of capacity around some decisions. These findings reflected good practice around the use of the act. The trust had not notified the CQC of the applications they had made for standard authorisations of the deprivation of liberty safeguards (DoLS).

A clear framework set out the organisations meeting structure. Managers used meetings to share essential information such as learning from incidents and complaints and to take action as needed. These processes had been reviewed as part of the shift to four directorates and the new organisational chart clearly represented lines of responsibility from ward to board.

Staff at all levels of the organisation understood their roles and responsibilities and what to escalate to a more senior person. All staff we interviewed during our core service inspections knew the reporting systems.

The trust was working with third party providers effectively to promote good patient care. This was demonstrated in the continued development of an older adult care pathway out of the acute hospital to Ward 4 at Harplands hospital and discharge to home or a community placement.

A partnership arrangement was in place for the provision of psychiatric liaison services with appropriate governance arrangements. Trust staff supported colleagues in the acute hospital in identifying patients suitable for an earlier discharge through the Ward 4 pathways. Professional within the liaison team had also delivered additional training in the recognition, identification and management of mental health problems to acute hospital staff.

The trusts physical health strategy was focused on the integration of primary care with mental health and this had moved forward with the trusts integration of two GP practices. Practice development around physical health was being developed in clinical areas and the trust had introduced further training around physical health promotion in relation to alcohol use and smoking.

On 6 September 2018, the trust was categorised as being 'offered targeted support' by the NHS Improvement Single Oversight Framework.

The trust was asked to comment on their targets for responding to complaints and current performance against these targets for the last 12 months. These are shown in the table below:

Question:	**In Days**	**Current Performance**
What is your internal target for responding to* complaints?	3	100%
What is your target for completing a complaint?	40	100%
If you have a slightly longer target for complex complaints please indicate what that is here	40	100%

* Responding to defined as initial contact made, not necessarily resolving issue but more than a confirmation of receipt

**Completing defined as closing the complaint, having been resolved or decided no further action can be taken

Question:	**Total**	**Date range**
Number of complaints resolved without formal process*** in the last 12 months	328	Sept 2017 – 31 Aug 2018
Number of complaints referred to the ombudsmen (PHSO) in the last 12 months	2	Sept 2017 – 31 Aug 2018

**Without formal process defined as a complaint that has been resolved without a formal complaint being made. For example PALS resolved or via mediation/meetings/other actions

The content of complaints and any developing themes were reviewed alongside serious incidents in the monthly clinical safety improvement group. The trust recognised that complaints could be an early warning of a developing clinical risk and this committee monitored action plans resulting from complaints.

This trust received 2247 compliments during the last 12 months from 1 September 2017 to 31 August 2018. This was higher than the 540 reported at the last inspection (1 June 2016 to 31 May 2017). 'MH - Acute wards for adults of working age and psychiatric intensive care units' had the highest number of compliments with 379 (17%) followed by 'MH - Community-based mental health services for older people' with 352 (16%) and 'MH - Specialist community mental health services for children and young people' with 304 (14%).

North Staffordshire Combined Healthcare NHS Trust has submitted details of one external review commenced or published in the last 12 months.

Management of risk, issues and performance

The trust had systems in place to identify learning from incidents, complaints and safeguarding alerts and make improvements. The governance team regularly reviewed the systems. The patient and organisational safety team managed the trusts serious incident process. and dissemination of learning was managed centrally through. The clinical safety improvement group was responsible for disseminating any learning and report to the board. Learning from serious incidents was included in a bi monthly learning from experience report, and at across directorate meeting. This report was also shared with trust commissioners who told us that the general quality of investigations and the implementation of lessons learned to be high.

We found that common themes from serious incident investigation action plans were grouped and disseminated across the organisation as part of the closing the loop action project. For example, a generalised lesson in regard to involving families was that 'family/carer involvement should be established at initial assessment and throughout the period of on-going care. Where there is little/no family involvement, this should be clearly documented'

Senior management committees and the board reviewed performance reports. Leaders regularly reviewed and improved the processes to manage current and future performance.

Leaders were satisfied that clinical and internal audits were sufficient to provide assurance. Teams acted on results where needed.

Staff had access to the risk register either at a team or division level and were able to effectively escalate concerns as needed. Staff concerns matched those on the risk register.

The trust board had sight of the most significant risks and mitigating actions were clear.

The board defined its objectives on an annual basis and identified the risks which could pose a threat to those objectives. Once identified, the risks form the strategic risk register (the Board Assurance Framework). Risks were grouped together under the board subcommittee that held the particular risk. Although we saw an effective two page summary of the highest level risk the full poard assurance framework ran to over 70 pages This made the Board Assurance Framework very comprehensive, however some items contained such a great deal of detail of assurance it blunted the effectiveness of the report to present the priority areas for action.

An external review of the Board Assurance Framework provided significant assurance but recommended some minor improvements. The trust was asked to review the ownership of risk

following the reorganisation into four directorates and was also recommended to consolidate responsibility for managing risk to fewer risk owners to consolidate expertise of risk management within the trust.

The organisation sought to involve public stakeholders in managing risks which impact on them. This involvement was facilitated through board visits, patient stories, attendance at the Council Overview and Scrutiny Committees and the service user and carer council.. The trust also invites a range of organisations, including Healthwatch, to review and comment on performance.

There were plans in place for emergencies and other unexpected or expected events. For example adverse the unexpected collapse of domestic and maintenance services supplier at the main hospital had been effectively managed without any disruption to business continuity. The trust had effectively planned for the end of a Section 75 with on local authority in October 2018..The change had been communicated in advance to service users, carers and their families. The trust had made provision for the transfer of care coordinator roles to social services staff as appropriate. Where a patients needs required input from both health and social care joint reviews were held to determine future care plans. The trust board had received assurance that impact on patients had been minimised and to the end of January 2019 there had been no formal incidents or complaints arising from the process.

Where cost improvements were taking place there were arrangements to consider the impact on patient care. Managers monitored changes for potential impact on quality and sustainability.

The trust has submitted details of two serious case reviews commenced or published in the last 12 months.

Reference Number	Core service	Recommendations	Actions Taken	Outstanding Actions
SAR/EM	MH - Specialist community mental health services for children and young people	No specific Trust recommendations. Health & Social Care Economy action: Workforce awareness of coercion and control, blaming and belittling as an indicator of abuse, valuing friends and family concerns and encouraging confidence to raise concerns. Encouraging reflective practice/supervision. Professional understanding of financial abuse.	Learning lessons face to face session held, learning shared with clinical team involved. Learning shared through safeguarding governance processes across all clinical areas. All clinical areas contacted to remind them of the importance of reflective practice/supervision.	Internal adult safeguarding face to face training session to be developed as an addition to current eLearning (Level 1 and 2). This will be in place by the end of Quarter 3.
SAR/MM	MH - Community mental health services for people with a learning disability or autism	No specific Trust recommendations. Health & Social Care Economy action: Quality of written and verbal communication, lack of holistic approach to care, confusion regarding roles and responsibilities including MCA responsibilities. A lack of awareness regarding choking risks and information regarding quality inspections and concerns re care providers being escalated appropriately.	Learning lessons face to face session held, learning shared with clinical team involved. Learning shared through safeguarding governance processes across all clinical areas. Information shared regarding the role of the Quality Team at the local authority.	

We analysed data about safety incidents from three sources: incidents reported by the trust to the National Reporting and Learning System (NRLS) and to the Strategic Executive Information System (STEIS) and serious incidents reported by staff to the trust's own incident reporting system. These three sources are not directly comparable because they use different definitions of severity and type and not all incidents are reported to all sources. For example, the NRLS does not collect information about staff incidents, health and safety incidents or security incidents.

Between 1 September 2017 and 31 August 2018, the trust reported 84 serious incidents to STEIS. The most common type of incident was 'Apparent/actual/suspected self-inflicted harm' with 51. Twenty-three of these incidents occurred in the substance misuse core service. The trust had recognised this significant rise in incidents and was investigating the root causes. They had proposed a formal review with their academic partner that would review the potential impact of substantial cuts in funding for substance misuse services and the consequent reduction in opportunities for engagement with clients.

We reviewed the serious incidents reported by the trust to the Strategic Information Executive System (STEIS) over the same reporting period. The number of the most severe incidents recorded by the trust incident reporting system was not comparable with STEIS with 85 reported. An incident was reported by the trust (under STEIS ID 2018/707) relating to the substance misuse core service involving a suspected drug related death. This was not present on a version of STEIS held by CQC, nor are we able to locate it. The detail was confirmed with the trust and they remain confident that the STEIS ID provided is accurate.

Never events are serious incidents that are entirely preventable as guidance, or safety recommendations providing strong systematic protective barriers, are available at a national level, and should have been implemented by all healthcare providers. The trust reported no never events during this reporting period.

The number of serious incidents reported during this inspection was higher than the 61 reported at the last inspection (1 June 2016 to 31 May 2017).

Incident type	**Substance misuse**	**Community-based mental health services for adults of working age**	**Acute wards for adults of working age and psychiatric intensive care units**	**Wards for older people with mental health problems**	**Mental health crisis services and health-based places of safety**	**Other Specialist Services**	**Wards for people with learning disabilities or autism**	**Community-based mental health services for older people**	**Total**
Apparent/actual/suspected self-inflicted harm meeting SI criteria	23	14	4		7	1	1	1	**51**
Slips/trips/falls meeting SI criteria	1		2	9					**12**
Pending review (a category must be selected before incident is closed)	5	3				1	1		**10**
Abuse/alleged abuse of adult patient by staff			1	1		1			**3**
Disruptive/ aggressive/ violent		1	2						**3**

behaviour meeting SI criteria									
Pressure ulcer meeting SI criteria			1						**1**
Abuse/alleged abuse of adult patient by third party		1							**1**
Accident e.g. collision/scald (not slip/trip/fall) meeting SI criteria						1			**1**
Failure to obtain appropriate bed for child who needed it			1						**1**
Adverse media coverage or public concern about the organisation or the wider NHS		1							**1**
Total	**29**	**20**	**11**	**10**	**7**	**4**	**2**	**1**	**84**

Providers are encouraged to report patient safety incidents to the National Reporting and Learning System (NRLS) at least once a month. The average time taken for the trust to report incidents to NRLS was 54 days which means that it is considered not to be a consistent reporter.

The highest reporting categories of incidents reported to the NRLS for this trust for the period 1 September 2017 to 31 August 2018 were 'self-harming behaviour', 'Disruptive, aggressive behaviour (includes patient-to-patient)' and 'Patient accident'. These three categories accounted for 1934 (70%) of the 2777 incidents reported. 'Other' category accounted for 54 of the 75 deaths reported.

Ninety-six percent of the total incidents reported were classed as no harm (74%) or low harm (22%).

Incident type	**No harm**	**Low harm**	**Moderate**	**Severe**	**Death**	**Total**
Self-harming behaviour	532	340	20		21	**913**
Disruptive, aggressive behaviour (includes patient-to-patient)	553	39	2			**594**
Patient accident	246	166	14	1		**427**
Access, admission, transfer, discharge (including missing patient)	335	10	1			**346**
Treatment, procedure	157	11	1			**169**
Patient abuse (by staff / third party)	64	6				**70**
Medication	66	2	1			**69**
Other	1	11	2		54	**68**
Consent, communication, confidentiality	49		1			**50**
Implementation of care and ongoing monitoring / review	15	3	2			**20**
Clinical assessment (including diagnosis, scans, tests, assessments)	7	9	1			**17**
Documentation (including electronic & paper records, identification and drug charts)	14					**14**
Infrastructure (including staffing, facilities, environment)	8	2				**10**
Infection Control Incident	4	1				**5**
Medical device / equipment	5					**5**
Total	**2056**	**600**	**45**	**1**	**75**	**2777**

Organisations that report more incidents usually have a better and more effective safety culture than trusts that report fewer incidents. A trust performing well would report a greater number of incidents over time but fewer of them would be higher severity incidents (those involving moderate or severe harm or death).

The trust reported slightly more incidents from 1 September 2017 to 31 August 2018 compared with the previous 12 months, although the proportion of moderate harm incidents increased and the proportion of deaths more than doubled.

Level of harm	1 September 2016 – 31 August 2017	1 September 2017 – 31 August 2018
No harm	2042	2056
Low	638	600
Moderate	33	45
Severe	2	1
Death	35	75
Total incidents	**2750**	**2777**

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

In the last two years, there have been no 'prevention of future death' reports sent to North Staffordshire Combined Healthcare NHS Trust.

Information Management

The board received holistic information on service quality and sustainability.

Leaders used meeting agendas to address quality and sustainability sufficiently at all levels across the trust. Staff had access to all necessary information and were encouraged to challenge its reliability. At our last inspection, staff had told us there were problems with the newly introduced electronic patient record system. They were experiencing problems with speed and with data. Managers had told us that not all the information was up to date or correct. The trust had dedicated additional support to the implementation. However, the results of a pulse check survey in the summer of 2018 remained mixed when repeated at the end of the year staff confidence in the system had substantially increased. The network of local champions, developed to support the implementation of the new system, planned a further training needs analysis for each team in spring 2019. In addition, the trust had provided new equipment to overcome identified bottlenecks in access and connectivity.

The trust was aware of its performance through the use of Key Performance Indicators and other measures. This data fed into a board assurance framework.

Team managers had access to a range of information to support them with their management role. This included information on the performance of the service, staffing and patient care. An inpatient safety matrix has been in place at our last inspection, which presented in a dashboard format key clinical indicators for the inpatient wards. Managers could easily identify trends in the data and recovery action plans were required for any areas were performance was rated red. However, further work was needed to improve both the validity and reliability of the community safety matrix

which had been introduced as an expansion of the inpatient project. The sampling protocol and frequency of reporting were under review to improve the tool.

Since the last inspection, the trust had completed implementation of a new electronic patient record system. This has improved the quality of clinical data available to support managers in the form of dashboards and reports.

The board and senior staff expressed confidence in the quality of the data and welcomed challenge. An improvement in the data and information available to the trust was outlined in the latest digital action plan completed in January 2019. Data quality improvement was monitored through the board assurance framework (BAF).

Information was in an accessible format, timely, accurate and identified areas for improvement.

Systems were in place to collect data from wards/service teams and this was not over burdensome for front line staff.

IT systems and telephones were working well and they helped to improve the quality of care.

Staff had access to the IT equipment and systems needed to do their work. The digital action plan highlighted request for new and replacement equipment and all outstanding requests had been met by January 2019.

Leaders submitted notifications to external bodies as required with the following exceptions:

- When a patient is detained under the Mental Health Act (MHA) in hospital, the provider is required to submit a record to the Mental Health Services Data Set each month until the detention ends. Between October 2016 and September 2017, the trust only provided end dates for 90.0% of Mental Health Act episodes for detentions, which had ended. This gives an incomplete picture about the provider's use of the MHA and indicates there may be problems with recording or sharing data externally.
- When a patient is admitted to hospital, the provider is required to submit a record to the Mental Health Services Data Set each month until their inpatient admission ends. Between October 2016 and September 2017, the trust only provided end dates for 95.8% of inpatient episodes, which had ended. This gives an incomplete picture about discharges from hospital and patients length of stay and indicates there may be problems with recording or sharing data externally.
- The requirement to notify CQC about applications to deprive a person of their liberty (when the outcome is known) is a registration regulation. This information is important to CQC and supports inspectors to monitor the use of the Deprivation of Liberty Safeguards during their inspections and to ensure that people's rights are being protected. It also helps CQC to fulfil its duty to monitor the use of the Safeguards and produce an annual report.'

  The trust had declared that they had made 202 concurrent applications for urgent and standard authorisation between September 2017 and August 2018. No statutory notifications were made to the CQC in regard to any applications and their outcome in that time. The regulation requires that notifications should be made without delay. However, we found that following any application to the local authority to approve a standard authorisation of the deprivation of liberty safeguards (DoLS) the trust had failed to inform the CQC when the outcome was known.

We had also identified this failing at our previous inspection. The trust had been requested to bring their practice into line with the regulation: 'The trust should ensure applications made for authorisation of Deprivation of Liberty Safeguards are notified to the CQC.'

Full information about our regulatory response to the concerns we have described will be added to a final version of this report, which we will publish in due course.

The trust had completed the Information Governance Toolkit assessment. An independent team had audited it and the trust took action where needed. The trust had also worked on the development of additional information governance standards.

Information governance systems were in place including confidentiality of patient records. The trust was compliant with the General Data Protection Regulations. The trust had an appointed Caldicott guardian and senior information risk officer and they knew their responsibilities.

The Finance, Performance and Digital Committee monitored any breaches and a digital risk register recorded any risks and mitigation.

Engagement

The trust had a structured and systematic approach to engaging with people who use services, those close to them and their representatives. Staff in all services encouraged feedback about the quality of care received and there was central process for recording comments, complaints and compliments.

Staff working in services had access to feedback from patients, carers and staff and were using this to make improvements. We saw in team meeting minutes that patient feedback was a permanent agenda item and staff acted to learn lessons from it.

Communication systems such as the intranet and newsletters were in place to ensure staff, patients and carers had access to up to date information about the work of the trust and the services they used.

The trust sought to actively engage with people and staff in a range of equality groups. Staff networks for equality groups were widely promoted within the trust and in the last year two black and minority ethnic staff had been released from clinical duties to engage directly with individual members of staff.

The trust had a structured and systematic approach to staff engagement. There were regular events for professional groups including annual conferences for staff groups which expanded in the last year to include a conference for non-registered care workers within the trust.

The listening into action programme and a routine of visits by board members to clinical areas provided regular opportunities for staff to talk directly with leaders inside the trust.

The new directorate structure identified leads for each of the main clinical groups to strengthen the voice of professional groups within the organisation.

Throughout the recent management of change process, the trust set out its commitment to design its new structures in collaboration with our staff. The trust's communications team had developed a dedicated website to keep staff informed of the planned changes. It invited staff to ask questions about the plans and provided easily accessible information about the proposed changes. We saw evidence that the executive took into account feedback received to refine elements of the structure

and extend timescales and the period of consultation. The chief operating officer had based themselves in one of the community team officers during the consultation period to be more accessible to staff.

Overall staff feedback, through our focus groups and core service inspections, was quite positive about the way managers had communicated change. They acknowledged they had had the opportunity to make their own views known.

However, we did hear from a few staff that they had not felt involved in the process and that feedback was not encouraged.

Psychologists as a group told us that they had felt alienated from the process and overall their experience of being in the trust was of feeling unsupported and their professional concerns unacknowledged. In addition to the broader management of change process, managers had not sought their professional input into the development of new clinical services (the PICU, urgent care centre and new child and adolescent mental health teams). They allied these concerns to changes in the professions profile within the trust and the loss of some clinical posts in an ongoing restructure.

The trust responded to these concerns by acknowledging there had been a lack of leadership and direction for the profession in the wake of change, absence and some resignations. They told us appointments made in January 2019 of psychology leads for each of the new directorates would start to rebuild the professions profile and voice within the organisation. A trust wide psychology strategy was in development that would focus on addressing workforce issues such as recruitment, retention and career development. The strategy would align with the nursing, allied health professional and medical strategies.

Patients, staff and carers were able to meet with members of the trust's leadership team to give feedback. As well as visiting clinical areas the board ensured that each meeting was open to staff to bring concerns, examples of best practice and requests to support for projects directly to them.

Managers, on behalf of front line staff, engaged with external stakeholders such as commissioners and Healthwatch. The trust had been very actively involved in a commissioner led consultation on community health services

The trust was actively engaged in leading, influencing and shaping local sustainability and transformation plans. The chief executive and director of finance had taken up leading roles within the local sustainability plan (STP). The chief executive led on developing the cross-sector action plan in response to the CQC's local system review of Stoke on Trent in 2017. Their positive role in delivering the plan was highlighted in the December 2018 follow up report .Their leadership and the commitment of the trust as a whole to developing integrated local care systems was commended by all three local Stoke MPs who spoke with us during the inspection period.

With their departure, consideration will be required on how to balance maintaining this commitment to system wide initiatives with ensuring continuity of leadership within the trust whilst going through a period of change of membership. The directors of operation and nursing had already taken on some of the responsibilities the trust had taken on within the sustainability and transformation plan.

External stakeholders said they received open and transparent feedback on performance from the trust. Quality leads from the local commissioners reported that the trust was quick in providing verbal assurances and transparent in discussions. However, there were sometimes concerns about the timeliness of following up conversation with written evidence and assurance. Both the CQC and NHS Improvement, the two main regulators of the trust, had also raised concerns about

the responsiveness to information requests to the chair and chief executive. As a result it had been agreed that the trust should try and provide an initial written response within 48 hours of a request made to a designated trust manager. As a result, communication had improved and less formal routes of communication had developed to give commissioners and the CQC early notice of any concerns.

Learning, continuous improvement and innovation

The trust actively sought to participate in national improvement and innovation projects.

Staff were encouraged to make suggestions for improvement and gave examples of ideas which had been implemented. The trust had diversified its approach to leaning and sharing lessons across teams through the introduction of regular monthly Schwartz rounds. Schwartz rounds are an evidence-based forum for hospital staff from all backgrounds to come together to talk about the emotional and social challenges of caring for patients. The aim is to offer staff a safe environment in which to share their stories and offer support to one another. We heard in staff focus groups positive experiences of those who had attended. One reason discussion had focused on the impact of working through the Christmas holidays on family and professional relationships.

The trust had a planned approach to take part in national audits and accreditation schemes and shared learning. NHS trusts can take part in accreditation schemes that recognise services' compliance with standards of best practice. Accreditation usually lasts for a fixed time, after which the service must be reviewed.

The table below shows services across the trust awarded an accreditation.

Accreditation scheme	Core service	Service accredited	Comments and Date of accreditation / review
AIMS – WA (Working Age Units)	MH - Acute wards for adults of working age and psychiatric intensive care units	Ward 1 Ward 2 Ward 3	September 2016
AIMS – OP (Wards for Older People)	MH – Ward for older people with mental health problems	Ward 6 Ward 7	March 2018
AIMS – Rehab (Rehabilitation Wards)	MH – Long stay / rehabilitation mental health wards for working age adults	Florence House Summers View	September 2016
ECT (ECTAS)	MH – Other Specialist Services	Harplands ECT	September 2016
Quality Network for Inpatient Learning Disability Services (QNLD)	MH – Wards for people with learning disabilities or autism	Assessment and Treatment	Submission planned for October 2018
Quality Network for Inpatient CAMHS (QNIC)	MH – Child and adolescent mental health wards	Darwin	Submitted for final review in May 2019

The trust was actively participating in clinical research studies. There had been a steady growth in the number of research studies undertaken. The trust was striving to develop more opportunities for research particularly for medical staff through the creation of four new senior clinical lecturer

posts at Keele University in primary care. This development aligned to the strategic intentions of the trust in building links with primary care.

There were organisational systems to support improvement and innovation work. The trust was developing a quality improvement curriculum for staff in line with their quality strategy. Some senior staff had already received training in quality improvement methods. However, recognisable quality improvement tools and models were already in place within many teams and had been used to guide local projects. For example, staff used a recognised improvement cycle (Plan, Do, Study, Act (PDSA)) in the continuous evaluation of projects within the trust. The new role of a quality improvement lead within the leadership team of each of the four new directorates would be responsible for championing quality improvement with their clinical areas.

Effective systems were in place to identify and learn from unanticipated deaths. The trust had demonstrated they had robust systems in place for the review of any unexpected deaths in their response to an identified theme of rising numbers of reported deaths of users of the substance misuse service.

Staff had time and support to consider opportunities for improvements and innovation and this led to changes. The trust's nursing conference in May 2018 had been held under the banner of 'leading change and adding value at combined' in response to the challenge set out by the Chief Nursing Officer. The director of nursing had encouraged a culture of staff identifying and tackling local challenges to the quality of care.

The trust's first 'Innovation Nation' event in October 2018 saw clinical staff of all disciplines share innovative ideas, research and audits. It also included an introduction that encouraged staff to have the confidence to work locally on improvement projects with the support of the senior managers.

External organisations had recognised the trust's improvement work. Individual staff and teams received awards for improvements made and shared learning.

Aside from recognition of good clinical practice, the trust has a culture of learning and development in its finance department. In 2017 the trust won a Healthcare Finance Management Association (HFMA) award for training and development, which recognised the team's engagement outside of finance with clinical colleagues, service users and other stakeholders and noted a 'holistic and dynamic' approach which used multiple examples of best practice from around the system.

Staff were aware of their contribution to cost improvement objectives. There is an ongoing scheme and award at the trust for Value Makers where staff can submit ideas and give examples of things that are not adding value and their suggestions for change.

Staff used data to drive improvement. We saw an example of this within the older adult inpatient service. Staff had examined themes around the frequency and location of falls drawn from incident reports to put in place interventions to reduce future risk.

Mental health services

MH – Wards for older people with mental health problems

Facts and data about this service

Location site name	Ward name	Number of beds	Patient group (male, female, mixed)
Harplands Hospital	Ward 4	19	Mixed
Harplands Hospital	Ward 6	15	Mixed
Harplands Hospital	Ward 7	20	Mixed

The methodology of CQC provider information requests has changed, so some data from different time periods is not always comparable. We only compare data where information has been recorded consistently.

Is the service safe?

Safe and clean care environments

Safety of the ward layout

All wards were safe, well equipped, furnished and fit for purpose. The corridors were fitted with grab rails to support mobility and well positioned chairs for rest periods for patients walking around the ward.

Staff carried out regular assessments of the care environment. They knew about any ligature anchor points and blind spots and used observations and risk assessment to mitigate risks to patients who might try to harm themselves. Mirrors were placed at points throughout the ward to remove blind spots around corners. There were ligature risks on all three wards within this service. All of the wards had undertaken a ligature risk assessment in the last 12 months.

Ward / unit name	Briefly describe risk - one sentence preferred	High level of risk? Yes/ No	Summary of actions taken
Ward 4	The age, mobility and dexterity of the client group reduces the potential for the risk of ligatures.	No	Management plans and control measures are in place, which have been shared with all staff to reduce the risk from ligatures. Additional measures include staffing levels and observations which are adjusted accordingly to the risk presented.
Ward 6	The age, mobility and dexterity of the client group reduces the potential for the risk of ligatures.	No	Management plans and control measures are in place, which have been shared with all staff to reduce the risk from ligatures. Additional measures include staffing levels and observations which are adjusted accordingly to the risk presented.
Ward 7	The age, mobility and dexterity of the client group reduces the potential for the risk of ligatures.	No	Management plans and control measures are in place, which have been shared with all staff to reduce the risk from ligatures. Additional measures include staffing levels and observations which are adjusted accordingly to the risk presented.

Wards complied with guidance on eliminating mixed-sex accommodation. Over the 12-month period prior to inspection, there were no mixed sex accommodation breaches within this service. Males and females were accommodated on separate corridors. All wards had a separate female-only lounge, which provided a private and secure space for female patients.

Staff on all wards had access to alarms used to call for assistance or in an emergency and tested them regularly to make sure they were working. There were alarm call buttons in all patient bedrooms. If risk assessed as appropriate, patients were offered a nurse call lanyard to wear so they could call for assistance if they were not near a nurse call button in their rooms as an added safety measure in case of a fall.

Maintenance, cleanliness and infection control

All wards were clean and well maintained. Cleaning records were up to date and areas were visibly clean. Wards had a housekeeper and domestic staff to keep wards clean.

Staff adhered to infection control principles. All wards had handwashing facilities and access to antibacterial hand sanitiser. For the most recent Patient-Led Assessments of the Care

Environment (PLACE) (2017), the location scored higher than similar trusts for cleanliness and scored higher than similar trusts for condition, appearance and maintenance.

Site name	Core services	Cleanliness	Condition appearance and maintenance
Harplands Hospital	Acute wards for adults of working age and psychiatric intensive care units Other Specialist Services Substance misuse Wards for older people with mental health problems Wards for people with learning disabilities or autism	99.3%	98.8%
Trust overall		**99.5%**	**98.9%**
England average (Mental health and learning disabilities)		**98.4%**	**95.4%**

Clinic room and equipment

Wards were fully equipped with accessible resuscitation equipment and emergency drugs that staff checked regularly. Staff routinely checked equipment to ensure they were in date and fit to use. Each ward had its own emergency trolley. This had been implemented since our last inspection in November 2017 to ensure staff on each ward could access to emergency equipment without delay.

Safe staffing

Nursing staff

The service had enough nursing and medical staff, who knew the patients and had received basic training to keep people safe from avoidable harm. Bank and agency staff were given appropriate induction to the ward. Bank staff were familiar to the ward and had experience in working with the patient group.

There was a qualified nurse on every shift. The trust had made good progress in the recruitment of nursing staff and healthcare support workers across all three wards. Managers could adjust staffing levels based on patient needs and used bank and agency staff to fill vacant shifts. Ward 4 had eliminated the use of agency staff on the ward. The service was due to complete a biannual safer staffing review for all wards to ensure there were appropriate establishment levels. Ward 7 had identified additional funding for a nurse post and six healthcare assistants for the ward. This core service reported a vacancy rate for all staff of 19% as of 31 July 2018. This was lower than the 29% reported at the last inspection[9] (May 2017).

This core service reported an overall vacancy rate of 28% for registered nurses as of 31 July 2018.

[9] Previous Inspection Data

This core service reported an overall vacancy rate of 13% for healthcare assistants as of 31 July 2018.

		Registered nurses			Health care assistants			Overall staff figures		
Location	Ward/Team	Vacancies	Establishment	Vacancy rate (%)	Vacancies	Establishment	Vacancy rate (%)	Vacancies	Establishment	Vacancy rate (%)
Harplands Hospital	Ward 4	7.2	16.4	44%	3.4	17.0	20%	10.9	36.8	30%
Harplands Hospital	Ward 7	2.8	10.4	27%	0.4	15.2	3%	3.6	26.6	14%
Harplands Hospital	Ward 6	1.3	14.1	9%	2.3	16.5	14%	3.9	33.4	12%
	Core service total	11.3	40.9	28%	6.1	48.7	13%	18.4	96.8	19%
	Trust total	70.2	452.8	16%	23.2	247.4	9%	133.3	964.7	14%

NB: All figures displayed are whole-time equivalents

Ward managers could adjust staffing levels daily to take account of the needs of patients and used bank and agency staff to fill shifts. Managers met weekly on a Monday to review staffing levels and projected needs over the coming week to ensure there were enough staff. Where there were gaps on shifts, these were filled by existing nursing staff working additional unplanned hours, bank staff or staff from other wards provided support to maintain safe staffing. During the day shifts other members of the multidisciplinary team, such as health care support workers, occupational therapists and activity workers, were available to support the safe care of patients on the ward and supported nursing staff in their duties.

Between 1 September 2017 and 31 August 2018, of the 62003 total working hours available, 9% were filled by bank staff to cover sickness, absence or vacancy for qualified nurses.

The main reason for bank and agency usage for the wards was vacancies.

In the same period, agency staff covered 15% of available hours for qualified nurses and 2% of available hours were unable to be filled by either bank or agency staff.

We are unable to provide details about the proportion of bank and agency usage at a trust wide level as all available hours for all teams was not provided by the trust.

Wards	Total hours available	Bank Usage		Agency Usage		NOT filled by bank or agency	
		Hrs	%	Hrs	%	Hrs	%
Ward 4	21085	3144	15%	6196	29%	764	4%
Ward 6	23020	1280	6%	1269	6%	347	2%
Ward 7	17899	1401	8%	2044	11%	161	1%
Core service total	62003	5824	9%	9510	15%	1273	2%
Trust Total	589590	38213	N/A	13425	N/A	45636	N/A

Between 1 September 2017 and 31 August 2018, of the 49430 total working hours available, 62% were filled by bank staff to cover sickness, absence or vacancy for nursing assistants.

The main reasons for bank and agency usage for the wards were vacancies.

In the same period, agency staff covered 3% of available hours and 8% of available hours were unable to be filled by either bank or agency staff.

We are unable to provide details about the proportion of bank and agency usage at a trust wide level as all available hours for all teams was not provided by the trust.

Wards	Total hours available	Bank Usage		Agency Usage		NOT filled by bank or agency	
		Hrs	%	Hrs	%	Hrs	%
Ward 4	33904	17521	52%	727	2%	2175	6%
Ward 6	23020	19956	87%	896	4%	2255	10%
Ward 7	23020	11953	52%	397	2%	1944	8%
Core service total	79943	49430	62%	2020	3%	6375	8%
Trust Total	359531	130535	N/A	3037	N/A	24283	N/A

This core service had 8 (11%) staff leavers between 1 September 2017 and 31 August 2018. This was the same proportion of leavers as the 11% reported during the previous inspection[10] (May 2017).

Location	Ward/Team	Substantive staff (at latest month)	Substantive staff Leavers over the last 12 months	Average % staff leavers over the last 12 months
Harplands Hospital	Ward 6	27.48	4.00	14%
Harplands Hospital	Ward 4	26.80	3.00	13%
Harplands Hospital	Ward 7	22.00	1.00	5%
	Core service total	76.3	8.0	11%
	Trust total	858.3	79.9	9%

The sickness rate for this core service was 4% between 1 September 2017 and 31 August 2018. The most recent month's data (August 2018) showed a sickness rate of 3%. This was higher than the sickness rate of 2% reported at the last inspection[11] (May 2017).

Location	**Ward/Team**	**Total % staff sickness (at August 2018)**	**Ave % permanent staff sickness (1 September 2017 – 31 August 2018))**
Harplands Hospital	Ward 6	3.2%	5.4%
Harplands Hospital	Ward 7	0.7%	4.3%

[10] Previous Inspection Data
[11] Previous Inspection Data

Location	Ward/Team	Total % staff sickness (at August 2018)	Ave % permanent staff sickness (1 September 2017 – 31 August 2018))
Harplands Hospital	Ward 4	4.8%	2.5%
	Core service total	**3.0%**	**4.2%**
	Trust Total	**3.9%**	**5.2%**

The below table covers staff fill rates for registered nurses and care staff during June, July and August 2018.

All wards had below 90% of the planned registered nurses for all day shifts for all months reported.

Key:

> 125%	< 90%

	Day		Night		Day		Night		Day		Night	
	Nurses (%)	Care staff (%)	Nurses (%)	Care staff (%)	Nurses (%)	Care staff (%)	Nurses (%)	Care staff (%)	Nurses (%)	Care staff (%)	Nurses (%)	Care staff (%)
	June 2018				**July 2018**				**August 2018**			
Ward 4	63.3	150.0	66.7	115.3	75.8	131.9	87.8	116.5	60.9	124.2	103.2	109.6
Ward 6	71.5	107.5	123.4	91.3	68.5	115.9	105.9	99.6	58.3	123.0	110.0	106.8
Ward 7	79.8	98.4	100.0	97.9	75.5	105.9	103.4	92.4	83.4	113.0	100.0	96.4

Health care support workers were present in communal areas of the ward at all times and could summon nurses on shift quickly, if required. There were enough staff to carry out physical interventions safely and to allow patients to have one to one time with a nurse.

Activities and escorted leave were rarely cancelled due to staff shortages, though may be delayed on occasion if staff were required to carry out unplanned interventions with patients.

Medical staff

There was adequate medical cover day and night and a duty doctor could attend the ward quickly in an emergency. All wards had consultant cover and access to duty doctors out of hours. Ward 4 had an advanced nurse practitioner who worked full time for the ward and facilitated the admission process.

Between 1 August 2017 and 31 July 2018, of the (953) total working hours available, none were filled by bank staff to cover sickness, absence or vacancy for medical locums.

The main reason for bank and agency usage for the wards was vacancies.

In the same period, agency staff covered all 953 available hours and none of the available hours were unable to be filled by either bank or agency staff.

We are unable to provide details about the proportion of medical locum usage as all available hours for all teams was not provided by the trust.

Ward/Team	Total hours available	Bank Usage		Agency Usage		NOT filled by bank or agency	
		Hrs	%	Hrs	%	Hrs	%
Ward 4	865	0	N/A	865	N/A	0	N/A
Ward 6	88	0	N/A	88	N/A	0	N/A
Core service total	**953**	**953**	**N/A**	**953**	**N/A**	**0**	**N/A**
Trust Total	**63808**	**7194**	**N/A**	**23653**	**N/A**	**2640**	**N/A**

Mandatory training

The service provided mandatory training in key skills to all staff and made sure everyone completed it. Staff were supported to complete mandatory training and ward managers monitored compliance. The trust provided staff with time and cover to allow staff to complete training that was imminent.

The compliance for mandatory and statutory training courses at 31 August 2018 was 85%. Of the training courses listed, nine failed to achieve the trust target and of those, five failed to score above 75%. Where training was below 75% staff were booked on to the next available training date. Staff working with dementia patients completed dementia training in line with National Institute for Health and Care Excellence Quality Standard 1/S1; people with dementia receive care from staff appropriately trained in dementia care; and brief alcohol awareness in line with Quality Standard 11/S1; health and social care staff receive alcohol awareness training that promotes respectful, non-judgmental care of people who misuse alcohol

We reviewed mandatory training compliance and staff knowledge in areas that had failed to reach the trust target. The trust had increased compliance across all wards and staff demonstrated good knowledge in all areas at the time of inspection. Mental Capacity Act training had been combined with Mental Health Act training, therefore compliance with Mental Capacity Act training within the table below was not an accurate reflection of staff compliance.

Key:

Below CQC 75%	Met trust target ✓	Not met trust target ✗

Training Module	Number of eligible staff	Number of staff trained	YTD Compliance (%)	Trust Target Met
Dementia Awareness Level 1	78	77	99%	✓
Clinical Risk Assessment	31	30	97%	✓
Mental Health Act	30	29	97%	✓
Equality and Diversity	78	75	96%	✓
Moving and Handling	78	75	96%	✓
Health & Safety	78	75	96%	✓
Safeguarding Children & Adults level 1 & 2	78	73	94%	✓
Suicide Awareness Level 1	69	65	94%	✓
Conflict Resolution	77	72	94%	✓
Medicine management training	27	25	93%	✓

Training Module	Number of eligible staff	Number of staff trained	YTD Compliance (%)	Trust Target Met
Safeguarding Children (Level 3)	28	26	93%	✓
Fraud, Bribery & Code of Conduct	78	70	90%	✓
Management of Actual or Potential Aggression MAPA	68	61	90%	✓
Effective Care Planning	30	26	87%	✓
PREVENT	78	65	83%	✗
Information Governance	78	64	82%	✗
Fire	74	60	81%	✗
Resuscitation	73	58	79%	✗
Brief Advice on Smoking	73	54	74%	✗
Manual Handling - People	72	52	72%	✗
Infection, Prevention & Control	77	55	71%	✗
Brief Advice on Alcohol	27	15	56%	✗
Mental Capacity Act Level 1	30	1	3%	✗
Total	**1410**	**1203**	**85%**	

Assessing and managing risk to patients and staff

Assessment of patient risk

Staff assessed and managed risks to patients and themselves. They developed crisis plans when this was necessary, and responded promptly to sudden deterioration in a patient's health. We reviewed 25 patient records, all contained an up to date risk assessment. Staff completed risk assessments in a timely manner following admission to the wards. Risk assessments included physical health risk assessment in line with National Institute for Health and Care Excellence QS80/S6; adults with psychosis or schizophrenia have specific comprehensive physical health assessments; and assessment of falls risk in line with National Institute for Health and Care Excellence Quality Standard 86/S2; older people at risk of falling are offered a multifactorial falls risk assessment.

Management of patient risk

Staff were aware of and managed specific risk issues or changes to risks. This included patients' physical health needs and staff put plans in place to manage any risks, for example, nutrition, risk of falls and pressure ulcers. Staff showed a good awareness of falls risk in relation to individual patients and took action to reduce risks. Staff supported patients with access to mobility aids, non-slip socks and shoes.

Staff followed the trust policy and procedure for use of observation. When staff had identified risks, they used observations and other interventions to minimise harm. We saw staff engaging in meaningful contacts with patients they were observing to support patients to feel at ease with observations levels.

Staff applied blanket restrictions on patients' freedom only when justified. Blanket restrictions are rules or restrictions placed on all patients within a ward with no individual assessment considered.

The Mental Health Act Code of Practice defines blanket restrictions as "rules or policies that restrict a patient's liberty and other rights, which staff routinely applied to all patients, without individual risk assessments to justify their application. We found staff on the individual wards applied some restrictions that were justified by reference to the risks posed by individuals rather than as a group. Staff applied other restrictions to the whole group. For instance, staff restricted access to making hot drinks on Ward 4 and staff would make these for patients frequently. On Ward 6, patients were individually risk assessed whether able to make their own drinks. The wards had risk assessed this as appropriate due to increased trends in risk of burns and spillages.

Informal patients could leave the ward and received information on their rights and ability to leave the ward at their request. Wards displayed signs on the ward door advising informal patients of the rights to leave the ward.

Use of restrictive interventions

All three wards participated in the trust's reducing restrictive practice programme. Staff monitored incidents of use of restraint. Staff used restraint only after de-escalation had failed and used correct techniques. Staff were aware of all the relevant cautions in using restraint on an older adult. For example, staff used diversion techniques such as making use of creative resources and selected hobbies (CRASH) boxes, which contained materials to support activities known to calm an individual patient or 'rempod' rooms that created a calming environment with use of pictures or music. Staff used techniques individual to the patient based on their knowledge and understanding of the persons personality. For example, dementia patients had 'what I like' boards displayed in their rooms to enable staff to adapt their care to the individual needs of the patient.

This service had 38 incidences of restraint (on 27 different service users) and no incidences of seclusion between 1 September 2017 and 31 August 2018. The below table focuses on the last 12 months' worth of data: 1 September 2017 to 31 August 2018.

Ward name	Seclusions	Restraints	Patients restrained	Of restraints, incidences of prone restraint	Of restraints, incidences of rapid tranquilisation
Ward 4	0	2	2	0	2 (100%)
Ward 6	0	10	9	0	9 (100%)
Ward 7	0	26	16	0	25 (96%)
Core service total	**0**	**38**	**27**	**0 (0%)**	**36 (95%)**

There were no incidences of prone restraint. Over the 12 months, incidences of restraint ranged from none to nine per month. The number of incidences (38) had decreased from the previous 12-month period (57).

Staff followed The National Institute for Health and Care Excellence guidance when using rapid tranquilisation and took into account the impact of its sedative effects on falls risk and other aspects of physical frailty.

There were 36 incidences of rapid tranquilisation over the reporting period. Incidences resulting in rapid tranquilisation for this service ranged from none to eight per month between 1 September 2017 and 31 August 2018. The number of incidences (36) had decreased from the previous 12-month period (45).

There have been no instances of mechanical restraint over the reporting period. The number of incidences (0) was the same as the number of incidences from the previous 12-month period (0).

The number of restraint incidences reported during this inspection was lower than the 103 reported at the time of the last inspection (1 June 2016 to 31 May 2017). This is a very substantial reduction in the use of restraint. The current number of restraints (38) relates very closely to the use of rapid tranquilisation. This implies that restraint is only being used as a last resort.

There have been no instances of seclusion over the reporting period.

There have been no instances of long-term segregation over the 12-month reporting period.

Safeguarding

Staff understood how to protect patients from abuse and the service worked well with other agencies to do so. Staff had training on how to recognise and report abuse and they knew how to apply it. Staff we spoke with knew how to recognise abuse and when and how to report it.

A safeguarding referral is a request from a member of the public or a professional to the local authority or the police to intervene to support or protect a child or vulnerable adult from abuse. Commonly recognised forms of abuse include: physical, emotional, financial, sexual, neglect and institutional.

Each authority has their own guidelines as to how to investigate and progress a safeguarding referral. Generally, if a concern is raised regarding a child or vulnerable adult, the organisation will work to ensure the safety of the person and an assessment of the concerns will also be conducted to determine whether an external referral to Children's Services, Adult Services or the police should take place.

This core service made 20 safeguarding referrals between 1 September 2017 and 31 August 2018, all of which concerned adults. The number of safeguarding referrals reported during this inspection was lower than the 26 reported at the last inspection[12] (June 2016 to May 2017).

Number of referrals		
Adults	**Children**	**Total referrals**
20	**0**	**20**

Staff followed safe procedures for children visiting the ward. The trust had a policy for visitors to the ward and the staff followed this. If children visited the ward, there was a separate visiting room where they could meet with the patient.

Staff access to essential information

Staff kept detailed records of patients' care and treatment. Records were clear, up-to-date and easily available to all staff providing care. Patient records were kept electronically and could be accessed by all staff.

Medicines management

Staff followed best practice when storing, dispensing, and recording the use of medicines. Staff recorded fridge and room temperatures where medicines were kept and took action when temperatures went out of safe storage ranges. We checked 42 prescription charts across all three wards. Medication administration records were in good order and recorded in line with the trust

[12] Previous Inspection Data

medication policy. Controlled drugs were stored and monitored appropriately. Staff followed good protocols for ordering and disposal of medications. However, we found two prescription cards on Ward 4 contained non-recommended abbreviation when recording dosage in 'micrograms'. We discussed this with the ward manager and nurse prescriber on the ward. They confirmed it previously been identified in a pharmacy team audit and was being addressed with staff. Both the ward manager and nurse prescriber confirmed that the error was not made by staff from Ward 4. There was no impact on patient safety following this error.

Staff regularly reviewed the effects of medications on each patient's physical health. Staff conducted physical health checks on all patients on admission and before commencing medicines. Care records demonstrated that staff regularly monitored patients' physical health, and completed, ECG tests, general observations such as blood pressure and pulse, and blood tests as required.

Track record on safety

The teams had a good track record on safety. Between 1 September 2017 and 31 August 2018 there were 11 serious incidents reported by this service. Of the total number of incidents reported, the most common type of incident was 'Slips/trips/falls' with nine. Ward 4 had the highest amount of falls out of all three wards we visited. The trust had implemented a falls prevention strategy to reduce the risk and frequency of falls across all three wards. This included improvement in screening and monitoring of physical health issues, identification of risk from the point of admission and ensuring patients at risk were easily identified and offered additional support at times where risk of falls was higher, for example, when using the toilet or getting in and out of bed. Ward 6 had completed an investigation of an alledged abuse and managers had completed timely and appropriate actions to safeguard patients.

We reviewed the serious incidents reported by the trust to the Strategic Executive Information System (STEIS) over the same reporting period. The number of the most severe incidents recorded by the trust incident reporting system was comparable with STEIS with 10 reported.

A 'never event' is classified as a wholly preventable serious incident that should not happen if the available preventative measures are in place. This service reported no never events during this reporting period.

	Slips/trips/falls	**Abuse/alleged abuse of adult patient by staff**	**Total**
Ward 4	8	0	**8**
Ward 6	1	1	**2**
Total	**9**	**1**	**10**

Reporting incidents and learning from when things go wrong

The service managed patient safety incidents well. Staff recognised incidents and reported them appropriately. Managers investigated incidents and shared lessons learned with the whole team and the wider service. All staff we spoke with knew what incidents they needed to report and how to report them. Staff received feedback from investigation of incidents, both internal and external to the service through supervision, individual feedback and team meetings. The trust promoted the embedding of lessons learnt from incidents through regular learning lessons sessions.

Staff shared learning from incidents across all three wards and could demonstrate a change of practice following incidents. For example, as part of the fall improvement programme the trust

introduced increased physiotherapy and exercise regimes to improve stability and strength in pateints at risk. They had introduced coloured wrist bands for patients to identify for staff who was a risk of falls. The trust had introduced a leaflet called 'on your feet duck' that was given to patients on admission and described how the ward would assess, support and identify what is important to patients to prevent falls. Staff on Ward 4 identified meal times as a risk time for falls and implemented an order system so patients most at risk were individually supported into the dining area one at a time when meals were ready. Staff on Ward 6 had made changes following a medication recording omission, they had put additional safeguards in place to ensure it did not reoccur.

Staff we spoke with understood the duty of candour. When things went wrong, staff apologised and gave patients honest information and suitable support. Duty of candour guidance was contained within the incident reporting system, so when staff entered an incident that would meet the criteria an alert would appear to follow the duty of candour procedure.

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

In the last two years, there have been no 'prevention of future death' reports sent to North Staffordshire Combined Healthcare NHS Trust.

Is the service effective?

Assessment of needs and planning of care

Staff assessed the mental health needs of all patients. They developed individual care plans and updated them when needed. Most care plans reflected the assessed needs, were personalised, holistic recovery-oriented and staff updated them when appropriate. We reviewed 25 care records across the three wards and found all patients had an up to date care plan, each reflected individual needs and preferences. Care plans showed multidisciplinary team contribution. However, on Ward 6 we found three records where parts of the care plan had been duplicated across three different patient's care plans, including the wrong patients name. This meant that those care plans were not individualised to the patient but still relevant to the patient. On Ward 4, we found two records that did not demonstrate how physical health risks had fed into the care plans. For example, one record indicated the patient had multiple falls and we could not find a falls prevention specific care plan in place. Another record showed the patient had diabetes and there was no specific care plan in relation to foot care despite identification of a skin integrity risk.

Best practice in treatment and care

Staff provided a range of care and treatment interventions suitable for the patient group delivered in line with guidance from the National Institute for Health and Care Excellence. Patients on Wards 6 and 7 had access to psychological interventions through a clinical psychologist. The psychologist facilitated reflective practice sessions with staff and supported them with techniques to manage behaviours that challenge.

Activity workers on Wards 6 and 7 facilitated individual and group activities tailored to the needs of the patient group. There was an activity programme in place on all wards with activities in place 7 days a week. We observed patients and staff engaging in activities while on the ward. For example, patients attending bingo and others playing games.

Occupational therapy assistants supported patients to maintain independent living skills through participation in breakfast and lunch clubs. Patients could make simple snacks and drinks in a separate kitchen area used for this type of activity on the wards.

Staff monitored physical healthcare using recognised tools and enabled patients to access specialist health professionals as required. Staff used the National Early Warning Score to assess the well-being of patients through basic physical observations, for example blood pressure and pulse. Staff took the action if results fell outside of expected range and escalated concerns to nursing, medical or emergency service staff. During our last inspection in November 2017, we found National Early Warning Score documentation was not being properly completed. The trust had addressed this following our last inspection.

Staff routinely assessed patients' nutrition needs on admission. If required, staff on the ward referred and worked with dieticians and a speech and language therapy staff to develop plans to meet their needs. During our last inspection in November 2017, we found staff had not regularly completed food and fluid charts and had not recorded why they were necessary. The trust had addressed this following our last inspection.

Staff supported patients to live healthier lives. The trust offered participation in smoking cessation schemes, encouraged exercise and carried out cognitive stimulation. This was in line with National Institute for Health and Care Excellence Quality Standard80/S7; adults with psychosis or schizophrenia are offered combined healthy eating and physical activity programmes and help to stop smoking. Physiotherapy staff had created exercise stations around the ward using pictures and instructions for patients to follow a simple set of exercises. These helped patients to maintain balance and strength to reduce the risk of falls. Occupational therapy and activity staff provided exercises, such as puzzles and discussions, to maintain cognitive skill and orientation to time, place and person.

Staff used recognised rating scales to assess and record severity and outcomes (for example, Health of the Nation Outcome Scales). Staff rated the overall severity of a patients' problems using the Health of the Nation Outcome Scales at admission and then again at discharge. The Health of the Nation Outcome Scales were embedded into the care cluster allocation tool used to place a patient into an appropriate care pathway.

Staff used technology to support patients. On all wards we saw staff used movement sensors attached to beds or chairs to alert them to the movement of a patient at risk of falls. Staff told us these were particularly useful at night as it meant they could remotely monitor patients rather than constantly observing them. This method preserved their dignity and privacy whilst they slept. Quiet lounges had screens with moving imagery to support a calming environment, for example an image of a live fish tank. The service also had access to Reminiscence Interactive Activity Therapies software, where patients and families could upload video messages, photos and play interactive games to provide cognitive stimulation.

Staff undertook and participated in local clinical audit. Ward managers, deputy ward managers and staff shared the completion of audits on the wards. The service participated in a cross-ward auditing programme where staff from other wards within the trust completed care record audits to provide an outside perspective. Actions from these audits were discussed at team meetings and completed.

Skilled staff to deliver care

All wards had access to the full range of specialists required to meet the needs of patients under their care. Wards had access to doctors, nurses, care assistants, occupational therapy staff,

activity workers and psychology staff. Ward 4 had an advanced nurse prescriber who supported admissions throughassessment and prescribing around physical health as well as mental health issues.

Staff had a range of skills need to provide high quality care. Staff we spoke with were experienced and qualified in working with the patient group. All staff we spoke with had completed dementia awareness training and could confidently and competently discuss the needs of the patient group.

Managers supported staff with completion of appraisals, supervision, and opportunities to update and further develop their skills. Staff we spoke with received regular management supervision, clinical supervision and peer group supervision. The trust's target rate for appraisal compliance is 85%. At the end of last year (1 April 2017 to 31 March 2018), the overall appraisal rate for non-medical staff within this service was 91%. This year so far, the overall appraisal rate was 49% (as at 31 August 2018). The ward with the lowest appraisal rate at 31 March 2018 was 'Ward 4' with an appraisal rate of 78% - the other wards had appraisal rates of between 85% or more.

The rate of appraisal compliance for non-medical staff reported during this inspection (as of 31 August 2018) was lower than the 75% reported at the last inspection[13] (31 May 2017).

Ward name	Total number of permanent non-medical staff requiring an appraisal	Total number of permanent non-medical staff who have had an appraisal	% appraisals (as at 31 August 2018)	% appraisals (1 April 2017 – 31 March 2018)
Ward 6	28	20	71%	100%
Ward 4	27	10	37%	78%
Ward 7	23	8	35%	95%
Core service total	**78**	**38**	**49%**	**91%**
Trust wide	**844**	**419**	**50%**	**91%**

The trust's target rate for appraisal compliance is 85%. At the end of last year (1 April 2017 to 31 March 2018), the overall appraisal rate for medical staff within this service was 100%. This year so far, the overall appraisal rates this was 0% (as at 31 August 2018).

Ward / Team Name	Total number of permanent medical staff requiring an appraisal	Total number of permanent medical staff who have had an appraisal	% appraisals (as at 31 August 2018)	% appraisals (April 2017 – March 2018)
Ward 4	1	0	0%	100%
Ward 6	1	0	0%	100%
Ward 7	2	0	0%	100%
Core service total	**4**	**0**	**0%**	**100%**
Trust wide	**40**	**7**	**18%**	**100%**

[13] Previous Inspection Data

The trust target for clinical supervision for all* staff is 85% of the sessions required. Between 1 September 2017 and 31 August 2018, the average rate across all three wards in this service was 78%.

Caveat: there is no standard measure for clinical supervision and trusts collect the data in different ways, so it's important to understand the data they provide.

Team name	Clinical supervision sessions required	Clinical supervision delivered	Clinical supervision rate (%)
Ward 7	245	214	87%
Ward 6	315	252	80%
Ward 4	234	157	67%
Core service total	**794**	**623**	**78%**
Trust Total	**9084**	**7347**	**81%**

*All staff – medical and non-medical breakdowns were not provided

Wards provided an induction programme for new staff. Staff were orientated to the ward and the patient group and completed a structured induction before commencing activities on the ward. The trust had a mandatory induction and training programme for new staff.

Managers dealt with poor staff performance promptly and effectively. Ward managers were able to discuss how poor performance was managed, though at the time of our inspection there were no staff subject to performance management.

Multidisciplinary and interagency team work

Staff from different disciplines worked together as a team to benefit patients. They supported each other to make sure that patients had no gaps in their care. Staff held regular multidisciplinary team meetings, which included all ward staff involved in the patients care and where appropriate, involved the patient and their family.

Staff held effective hand overs between shifts and shared appropriate information in a structured and thorough manner.

Ward staff had effective working relationships with other relevant teams within the organisation and with relevant services outside the organisation. Staff had developed good links with acute services and worked closely with a local cancer charity to improve palliative and end of life experience for patients in their care. Staff had access, through specialist referral, to the full range of specialist services e.g. dentistry, wound care and hearing reviews. Wards had good links with local authority social workers.

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

Staff understood their roles and responsibilities under the Mental Health Act 1983 and the Mental Health Act Code of Practice. As of 31 August 2018, 97% of the workforce in this service had received training in the Mental Health Act. The trust stated that this training is mandatory for all services and renewed every three years.

Staff could access administrative support and legal advice on implementation of the Mental Health Act and the Code of Practice. Staff knew who their Mental Health Act administrators were. The trust had an up to date policy on the Mental Health Act and Code of Practice.

Patients on all wards had access to an Independent Mental Health Advocate (IMHA) and an Independent Mental Capacity Advocate (IMCA). Trained advocates represent people under the Mental Health Act and Mental Capacity Act. Wards displayed information on the availability of advocates.

Staff we spoke with, and on review of patient records we found patients had their rights under the Mental Health Act explained to them on admission and routinely throughout their treatment. There were patient information leaflets displayed on the wards about the Mental Health Act.

Staff ensured patients could take Section 17 leave (permission for patients to leave hospital) when this has been granted. All patients on all wards had a responsible clinician to grant patients detained under the Mental Health Act, section 17 leave from hospital. Staff told us they encouraged patients to leave the ward for family visits if appropriate and supported them and encouraged them to take their leave.

All records for patients' detention papers and associated records were stored correctly and securely on the electronic patient record.

Wards displayed a notice information for informal patients of their right to leave the ward. There was clear signage on or near the ward exit door that provided information on why staff had locked the door and the procedure for the door to be unlocked to allow exit from the ward if this was appropriate under the Mental Health Act.

Care plans referred to identified Section 117 aftercare services to be provided for those who had been subject to section 3 or equivalent Part 3 powers authorising admission to hospital for treatment. All wards had a discharge worker and shared a common approach to discharge planning.

Staff completed audits to ensure the Mental Health Act was being applied correctly on all wards.

Good practice in applying the Mental Capacity Act

Staff supported patients to make decisions on their care for themselves. Most staff we spoke with understood the Mental Capacity Act 2005 and its five principles. However, six staff we spoke with did not demonstrate a clear understanding. All staff knew where they could get support and guidance on the Mental Capacity Act within the trust. The training rate for the Mental Capacity Act was reported as 3% for this core service in August 2018. This was the month that a stand alone Mental Capacity Act e learning model had been introduced into the trust. Previously the Mental Capacity Act had formed part of a Mental Health Law training session. The trust told us they expected to report on the compliance of the new module as a shadow rating for six months after implementation and then from February 2019 all teams would be expected to meet the trust target of 85%. In an update on training compliance in December 2018 the overall rate of take up across the trust was 79.8%.Staff assessed and recorded capacity clearly for patients who might have impaired mental capacity.

On Ward 4 any concerns about a persons lack of mental capcity to make a specific decision to consent to admission to the ward and accept treatment were highlighted in the referral from the local general hospital. This allowed staff made an early application for a standard authroisation of the Deprivation of Liberty Safeguards. This was good practice in line with the code of practice.

On all wards we saw evidence of staff completing assessments of mental cacpity in relation to specific decisions as appropriate. In 12 out of 14 cases we looked at in detail on Ward 4 the capacity assessments were very detailed, demonstrated repeated attempts to engage the person

in discussion, where clear where a power of attorney was in place and also gave consideration to the fluctuating nature of capacity around some decisions.

However in two cases the assessments reported a global lack of mental capcity and were not decision specific which was against the priinciples of the Act. We highlighted the two assessments for urgent review to the ward manager.

The trust told us that 202 Deprivation of Liberty Safeguard (DoLS) applications were made to the Local Authority for this service between 1 September 2017 and 31 August 2018, 175 (87%) of these were made by this core service.

The greatest number of DoLS applications were made in January 2018 and June 2018 with 21 each.

CQC received no direct notifications from the trust between 1 September 2017 and 31 August 2018.

We asked the trust to tell us why the number of standard applications made matched exactly the number of urgent applications and the response was that when a standard authorisation is applied for, and application is also made for an urgent authorisation. The urgent authorisation is granted for 14 days while waiting for the standard authorisation to come through.

Number of 'Standard' DoLS applications made by month													
	Sep 2017	Oct 2017	Nov 2017	Dec 2017	Jan 2018	Feb 2018	Mar 2018	Apr 2018	May 2018	Jun 2018	Jul 2018	Aug 2018	Total
Standard applications made	16	16	14	17	21	11	19	9	12	21	7	12	175
Standard applications approved	2	0	0	0	2	2	0	1	2	1	0	1	11

Number of 'Urgent' DoLS applications made by month													
	Sep 2017	Oct 2017	Nov 2017	Dec 2017	Jan 2018	Feb 2018	Mar 2018	Apr 2018	May 2018	Jun 2018	Jul 2018	Aug 2018	Total
Urgent applications made	16	16	14	17	21	11	19	9	12	21	7	12	175
Urgent applications approved	16	16	14	17	21	11	19	9	12	21	7	12	175

Staff we spoke with demonstrated awareness that patients should make decisions on their care and treatment for themselves. If a patient did not have capacity to make decisions, then staff would make a decision in their best interests to keep them safe. Staff recorded best interests' decisions appropriately. On Ward 7, we saw good examples within patient records of rationale in line with the Mental Capacity Act, for best interests' decisions, taking into account the patient's preferences and individual circumstances. We observed staff discuss decisions with patients during ward rounds, where reviews of the care of each patient took place with the doctor, nurses, occupational therapist, physiotherapist and older people's outreach team leader. Family members

were included in best interest decision making as they were often the most familiar with the patient's background.

Staff completed audits to ensure the Mental Capacity Act was being applied correctly on all wards.

Is the service caring?

Kindness, privacy, dignity, respect, compassion and support

Staff treated patients with compassion and kindness. They respected patients' privacy and dignity and supported their individual needs. Staff offered emotional support to patients and carers at a time when they needed it. We observed staff on all wards responding to patients in distress, they treated them with dignity and respect. We observed staff engaging in conversations and activities individual to the patient they were with and patients appeared happy and to be enjoying their interactions with staff.

Staff supported patients to understand and manage their care. We observed staff advising patients about aspects of their care when they enquired and supporting them to understand their own circumstances on the ward. All staff demonstrated a patient, friendly and caring attitude in their manner. Staff showed good knowledge of individual patient needs and personal preferences.

Patients we spoke with told us staff treated them well. They told us staff were supportive and thoughtful. However, one patient told us staff did not always knock when entering their room and another patient told us they did not feel listened to by their consultant.

The 2017 Patient-Led Assessments of the Care Environment (PLACE) score for privacy, dignity and wellbeing at the service location scored higher than similar organisations.

Site name	Core service(s) provided	Privacy, dignity and wellbeing
Harplands Hospital	Acute wards for adults of working age and psychiatric intensive care units	97.2%
	Other Specialist Services	
	Substance misuse	
	Wards for older people with mental health problems	
	Wards for people with learning disabilities or autism	
Trust overall		97.1%
England average (mental health and learning disabilities)		91.0%

Involvement in care

Involvement of patients

Staff involved patients and those close to them in decisions about their care and treatment. Staff orientated patients and carers to the ward and gave them information about the service on admission. Staff involved patients and carers in their multidisciplinary team reviews and sought their views and adhering, where clinically appropriate, to their wishes. However, care plans did not always record the views and contribution of patients and carers. For example, in one care plan we

reviewed, staff recorded ‘not applicable’ under patient and carer views and did not show whether these had attempted to be sought. We found one care plan did not demonstrate how the patient could be supported in the least restrictive way before escalating to increased restrictive techniques.

Staff used effective communication techniques to ensure patients understood their care as far as possible. Patients with dementia and those with communication difficulties were supported to understand their care through staff routinely revisiting their rights with them and using pictorial aids.

Staff routinely sought feedback from patients about their care, their experience on the ward and any changes they might want to make. We observed ‘you said, we did,’ boards on all wards detailing the feedback from patients and what staff had changed as a result. All boards contained positive feedback about the wards, including about staff attitude and the quality of food and activities.

Staff enabled patients to make advance decisions (to refuse treatment, sometimes called a living will) when appropriate. However, many of the patients across the wards were not able to contribute to advance decisions as staff had assessed them lacking mental capacity to do so. In those cases, staff did try to determine the previous wishes of patients from family members and care records and represented them in any best interests’ decision making.

Staff supported patients to access advocacy services. The details of local advocacy services were displayed on posters on the ward and patients had easy access to information about advocacy services.

Involvement of families and carers

Staff informed and involved families and carers appropriately and provided them with support when needed. Families and carers we spoke with gave overwhelmingly positive feedback about staff on all wards and the support and care they gave their loved ones. They told us they were kept informed about their relatives’ care and treatment and were invited to and included in multidisciplinary team reviews. They told us staff ensured they explained everything clearly and in a way they could understand and gave them the opportunity to contribute to discussions.

Staff enabled families and carers to give feedback on the service they received. Families and carers were encouraged to give feedback and suggestions directly to staff, through ward comments boxes or the friends and family test. All wards promoted family and carer involvement.

Staff provided carers with information about how to access a carer’s assessment. Social work staff regularly attended the wards and Ward 4 had a dedicated social worker from the local authority. All wards had a discharge co-ordinator who was integral in supporting families, carers and patients to understand the treatment and discharge process and to help carers access continuing support.

All wards had set up a family and carers group. The carers group on Ward 4 had been well established. While facilitated by staff on the ward, the group had grown and flourished into a successful peer support for carers of patients both on the ward and previously on the ward. From the success of the carers group carers had offered, and the the trust had supported them, to offer voluntary services on the ward.

Is the service responsive?

Access and discharge

Bed management

The trust had good arrangements to admit, treat and discharge patients that were in line with good practice. All wards employed a discharge co-ordinator who was instrumental in ensuring patients were discharged to the right place with the appropriate level of support in place. They were involved in supporting patients and families in making choices about future care, ensuring. They updated patients' discharge care plan and input at multidisciplinary team meetings.

Ward 4 had a social worker from the local authority visit the ward daily and Wards 6 and 7 had regular visits from social workers to support patient discharge plans.

The trust provided information regarding average bed occupancies for tall three wards in this service between 1 August 2017 and 31 July 2018.

All of the wards within this service reported average bed occupancies ranging above the nationally recommended minimum benchmark of 85% over this period.

Ward name	Average bed occupancy range (1 August 2017 – 31 July 2018) (current inspection)
Ward 4	75% - 98%
Ward 6	66% – 100%
Ward 7	81% – 102%

The trust provided information for average length of stay for the period 1 August 2017 to 31 July 2018.

Ward name	Average length of stay range (1 August 2017 – 31 July 2018) (current inspection)
Ward 4	31 - 91
Ward 6	42 - 108
Ward 7	26 - 70

This service reported one out area placements between 1 August 2017 and 31 July 2018. The placement lasted six days and was due to capacity issues.

Number of out of area placements	Number due to specialist needs	Number due to capacity	Range of lengths (completed placements)	Number of ongoing placements
1	0	1	6 days	0

This service reported three readmissions within 28 days between 1 August 2017 and 31 July 2018. Two of the readmissions were readmissions to the same ward as discharge. The average number of days between discharge and readmission was eight days. There were two instances whereby patients were readmitted on the same day as being discharged.

Ward name	Number of readmissions (to any ward) within 28 days	Number of readmissions (to the same ward) within 28 days	% readmissions to the same ward	Range of days between discharge and readmission	Average days between discharge and readmission

Ward name	Number of readmissions (to any ward) within 28 days	Number of readmissions (to the same ward) within 28 days	% readmissions to the same ward	Range of days between discharge and readmission	Average days between discharge and readmission
Ward 7	3	2	67%	0 – 25	8

Patients were not moved between wards during an admission episode unless it was justified on clinical grounds. When staff moved or discharged patients this happened at an appropriate time of day. However, staff on Ward 4 expressed concerns about admissions to the ward when they occurred after 5pm as they understood this was distressing to the patient. When this occurred, it was under circumstances beyond their control and they had fed their concerns back to the referring service.

Discharge and transfers of care

Staff planned for discharge well and showed good liaison with other members of the multidisciplinary team. Staff always supported patients to settle in to new placements prior to discharge by accompanying them to visit and orientate themselves to the next service, and by escorting them when they are ready to be discharged from the ward.

Between 1 August 2017 and 31 July 2018 there were 344 discharges within this service, 182 (53%) of which were delayed.

Delayed discharges across the 12-month period ranged from 10 to 23 per month.

The proportion of delayed discharges reported during this inspection cannot be compared to that of the previous inspection as the data was collected in a different way.

Facilities that promote comfort, dignity and privacy

Patients had their own rooms where they could keep personal belongings safe. There were quiet areas for privacy and where patients could be independent of staff. The ward had a range of rooms to support care, therapeutic and spiritual needs and access to outside space. However, on Ward 7, there were two dormitory style rooms containing four beds each. Bed areas were separated by a curtain for privacy. One patient we spoke with told us they did not like residing in the dorm room.

There were quiet areas on the wards and rooms where patients could meet visitors and staff encouraged families and carers to make use of facilities off the ward where appropriate. All wards had sensory rooms decorated in a manner to promote relaxation and reflection and used technology to support this. For example, Ward 4 had a room with calming colours and a virtual fish tank on the wall. Ward 6 had a room designed like a garden with a garden shed. All wards were in the process of refurbishment of rooms and the environment to make them a more homely, less clinical, environment for patients.

Patients could personalise their rooms and many had chosen to do so. There was somewhere secure to store their possessions and staff could keep valuable items in the ward safe on the patient's behalf.

Patients had access to food and drink on the wards although due to risk assessment, some wards staff made hot drinks for patients on request, if outside the usual regular tea times.

Patients could not always make a phone call in private. Some patients had access to their own phones and Ward 7 had a pay phone on the ward. Staff assisted patients to use the ward phone is

needed, though controlled access for patients who were not well enough to understand and limit their own use.

The 2017 Patient-Led Assessments of the Care Environment (PLACE) score for ward food at the locations scored higher than similar trusts.

Site name	Core service(s) provided	Ward food
Harplands Hospital	Acute wards for adults of working age and psychiatric intensive care units Other Specialist Services Substance misuse Wards for older people with mental health problems Wards for people with learning disabilities or autism	98.0%
Trust overall		**98.5%**
England average (mental health and learning disabilities)		**92.2%**

Patients' engagement with the wider community

Staff supported patients with activities outside the service, such as attendance at places of religious worship, activities and maintaining family relationships. Staff encouraged visits with family to maintain familiarity and actively involved family members in activities on the ward, in line with National Institute for Health and Care Excellence Quality Standard30/S4; people with dementia are enabled, with the involvement of their carers, to take part in leisure activities during their day based on individual interest and choice. We observed patients leaving the ward to attend a bingo game. Visiting times across all wards were 24 hours, only visits at meal times were discouraged to allow staff and patients to focus on supporting nutritional needs. However,families were welcomed at meal times if They could help support these needs.

Meeting the needs of all people who use the service

The service was accessible to all who needed it and took account of patients' individual needs. All wards were accessible for wheel chair users and handrails were available on the main corridors to assist patients and visitors with mobility problems. All wards had equipment available for patients with mobility difficulties to allow toileting, bathing, showering and safe transfers between areas of the wards. There was dementia friendly signage in use on Ward's 4 and 6 that identified the purpose of rooms using words and symbols. Ward 4 had themed bedroom corridors with street names and was in the process of redecorating all patient bedroom doors to look like house front doors. Staff had made use of high colour contrast in providing equipment to improve identification by patients with dementia. For the most recent Patient-Led Assessments of the Care Environment (PLACE) (2017) the location scored higher than similar trusts for the environment being dementia friendly and scored higher than similar trusts for the environment supporting those with disabilities.

Site name	Core service(s) provided	Dementia friendly	Disability
Harplands Hospital	Acute wards for adults of working age and psychiatric intensive care units Other Specialist Services	92.0%	98.0%

	Substance misuse Wards for older people with mental health problems Wards for people with learning disabilities or autism		
Trust overall		**92.0%**	**98.2%**
England average (Mental health and learning disabilities)		**88.3%**	**87.7%**

All wards displayed a range of information leaflets and notice boards providing information about patients' rights, how to make a comment or complaint, treatments and the performance of the ward for patients and visitors to read. Information was available in languages other than English on request and staff could print on demand from an online library. If required information could also be provided in enlarged type or in easy read formats. For patients with more significant communication difficulties interpreters for languages other than English and sign language were available on request.

The service provided a variety of choice in food menus and were able to meet the dietary requirements of religious and ethnic groups on request. All wards had sought feedback from patients regarding quality of the food and received positive feedback. Menus were displayed prominently at eye level for the patients and contained a pictorial menu to enable patients to make informed choices.

All wards supported patients to access religious and spiritual support and hospital chaplains made regular visits to all wards.

Listening to and learning from concerns and complaints

This service received two complaints between 1 September 2017 and 1 August 2018. Both complaints were not upheld.

Ward Name	Total Complaints	Fully upheld	Partially upheld	Not upheld	Other	Under Investigation	Withdrawn	Referred to Ombudsman
Ward 4	1	0	0	1	0	0	0	0
Ward 7	1	0	0	1	0	0	0	0

This service received 102 compliments during the last 12 months from 1 September 2017 to 31 August 2018 which accounted for 5% of all compliments received by the trust as a whole.

The service treated concerns and complaints seriously. While the service had received two formal complaints in the stated period,neither of which was upheld. Staff informed us how they would manage concerns and complaints and we saw 'you said, we did,' boards displayed on all wards with actions staff had taken to address comments and concerns. Staff discussed concerns raised by patients or families during weekly team meetings and staff handovers.

Is the service well led?

Leadership

Managers at all levels in the trust had the right skills and abilities to run a service providing high-quality sustainable care. Ward managers were experienced in the care of older adults with mental health problems. Staff reported that ward managers were supportive and approachable. The modern matron for the service was in an acting post and was experienced in the care of people with mental health problems and visited all wards regularly. Staff on the wards knew the service governance lead and manager.

Leadership development opportunities were available, including opportunities for staff below team manager level. The trust provided opportunities for personal and professional development within the organisation and encouraged staff to access internal and external development opportunities, for example, leadership courses.

Vision and strategy

The trust had a vision for what it wanted to achieve and workable plans to turn it into action developed with involvement from staff, patients, and key groups representing the local community. Staff we spoke with were aware of the trust's vision – 'To be Outstanding - in all we do and how we do it' and the journey 'towards outstanding'. Staff had the opportunity to contribute to the strategy for their service through internal consultations, especially where the service was changing.

Culture

Managers across the trust promoted a positive culture that supported and valued staff, creating a sense of common purpose based on shared values. Staff shared the values (compassionate, approachable, responsible and excellent) of the organisation and these were embedded in care and culture on all wards. Staff we spoke with told us they enjoyed their roles and valued their work. Staff we spoke with on Ward 4 showed excitement and passion about the continuing improvements made on the ward since the previous inspection. These included work around environment and management of risks to patients.

Staff we spoke with knew how to raise concerns with managers and told us they felt able to do so without fear of retribution. Staff knew how to use the whistle-blowing process and about the role of the Speak Up Guardian. The chief executive of the trust was directly available for staff to raise any concerns or promote positive ideas through the 'Dear Caroline' email scheme.

During the inspection and reporting period there were no cases where staff have been suspended or placed under supervised practice. Staff we spoke with told us teams worked well together and that there was an open culture and staff felt able to raise any issues each other without concern.

Sickness levels for the core service were 4.2%, which was below the average sickness level for the trust at 5.2% between September 2017 and August 2018. Staff had access to support for their own physical and emotional health needs through an occupational health service. Managers monitored staff sickness and offered support in line with trust policy. The trust provided workshops to promote staff wellbeing that included building resilience sessions.

The provider recognised staff success within the service. Managers organised annual Recognising Excellence and Achievement in Combined Healthcare (REACH) awards to recognise staff and teams, as well as volunteers and service user representatives who had made an outstanding contribution in the previous year. All wards had staff who had been nominated for recognition awards throughout 2018.

Governance

The trust used a systematic approach to continually improve the quality of its services. All wards used a common framework of what must be discussed at a ward, team or directorate level in team meetings to ensure that essential information, such as learning from incidents and complaints, was shared and discussed. The trust had a board assurance framework and documented as part of their risk register. No risks related to this service.

The service governance lead managed the ongoing monitoring of incidents and this included a learning lessons programme and a regular meeting with clinical staff on the wards. Staff had access to monthly lessions learnt sessions within the hospital.

Staff understood the arrangements for working with other teams, both within the provider and external, to meet the needs of the patients. Staff had good working relationships with the local acute trust and showed good liaison with services the patients came into contact with during or following on their treatment.

Management of risk, issues and performance

The trust had effective systems for identifying risks, planning to eliminate or reduce them, and coping with both the expected and unexpected. Staff maintained and had access to the risk register at ward or directorate level. Staff at ward level could escalate concerns when required. Staff concerns matched those on the risk register.

The service had plans for emergencies. Ward managers were aware of trust contingency plans and gave examples of where these had been applied in the past – for example, fire evacuation procedures.

Information management

The trust collected, analysed, managed and used information well to support all its activities, using secure systems with security safeguards. The service used systems to collect data from wards and directorates that were not overburdensome for frontline staff. Managers shared outcomes from audits on each ward with staff through a shared dashboard that used a simple three point (red, amber and green) system to rate performance.

Staff had access to the equipment and information technology needed to do their work. The information technology infrastructure, including the telephone system, worked well and helped to improve the quality of care. The trust maintained the intranet with information and resources staff could use in their roles. The service used an electronic case note system to store patient notes on a password protected secure system.

Team managers had access to information to support them with their management role. This included information on the performance of the service, staffing and patient care. Managers used dashboards displaying information to support oversight and management of the ward including, bed occupancy, staffing, performance data and risk incidents. The service used a RAG (red, amber, and green) rating system made it easy to identify the areas requiring action and track progress over time.

Staff did not make the appropriate statutory notifications to CQC. The CQC received no direct notifications from the trust between 1 September 2017 and 31 August 2018. At out last inspection we had reminded the trust of their obligation to make these notifications and requested that they should do going forward. We found that the trust had still not made the required notifications following that report. Full information about our regulatory response to the concerns we have described will be added to a final version of this report, which we will publish in due course.

Engagement

Staff, patients and carers had access to up-to-date information about the work of the provider and the services they used. Wards shared and displayed service level data regarding such key performance indicators, incidents and complaints across the wards for staff, patients and visitors to see. The trust had a website with up to date information for the public.

Staff had access to a weekly blog by the chief executive regarding the organisation's progress. Staff had access to bulletins, newsletters and emails for news, changes and other information relating to the trust. The trust made minutes of board meetings, policies and procedures available.

Patients and carers had opportunities to give feedback on the service they received in a manner that reflected their individual needs. All wards had a comments box available for visitors and patients and offered feedback through the national friends and family test. Patients and carers could feedback through the patients' advice and liaison service or weekly ward community meetings.

Staff had access to the feedback from patients, carers and staff and used it to make improvements to the ward. We saw examples of changes made to food, environment and activities as a result of direct feedback from patients.

Service managers involved patients and carers in consultation about changes to the service. Patients and staff could meet with members of the provider's senior leadership team and governors to give feedback at engagement events regularly organised by the trust.

Service level managers engaged with external stakeholders – such as commissioners and Healthwatch. The service manager had worked closely with local commissioning groups. We received positive feedback from commissioners about the safety of care on the older adult wards and the initiatives to reduce risk and restrictions..

Learning, continuous improvement and innovation

Staff were given the time and support to consider opportunities for improvements and innovation and this led to changes. Innovations were taking place in the service, for example the implementation of a falls prevention strategy.

Staff were not involved in any active research within the service at the time we inspected.

NHS trusts can participate in a number of accreditation schemes whereby the services they provide are reviewed and a decision is made whether or not to award the service with an accreditation. A service will be accredited if they are able to demonstrate that they meet a certain standard of best practice in the given area. An accreditation usually carries an end date (or review date) whereby the service will need to be re-assessed in order to continue to be accredited.

The table below shows which services within this service have been awarded an accreditation together with the relevant dates of accreditation.

Accreditation scheme	Service accredited	Comments
AIMS - OP (Wards for older people)	Ward 6 in March 2018	-
AIMS - OP (Wards for older people)	Ward 7 in March 2018	-

MH - Community-based mental health services for adults of working age

Facts and data about this service

Location site name	Team name	Number of clinics per month	Patient group (male, female, mixed)
Lawton House	Approved Mental Health Professional and Best Interest Assessor Service	-	-
Lawton House	Resettlement & Review Team	1	-
Lawton House	Early Intervention Team	7	-
Lawton House	City Integrated Community Mental Health Teams (made up of Greenfields CMHT and Sutherland CMHT)	247	-
Lawton House	Newcastle Integrated Community Mental Health Teams (made up of Lymebrook CMHT and Ashcombe CMHT)	117	-
Lawton House	Moorlands Community Mental Health Team	51	-

The methodology of CQC provider information requests has changed, so some data from different time periods is not always comparable. We only compare data where information has been recorded consistently.

The community mental health teams for adults of working age are part of the trust's services that provide mental health services to adults across North Staffordshire. The service is for adults of working age (16-65) with mental health-related difficulties. The services provided are based upon a recovery orientated model which enables adults with mental health related issues and their families, friends and significant others to live and maintain their optimum social roles. Assessment, treatment and care is provided through a process known as Care Coordination and each person using services will be appointed a Care Coordinator. The services are based at Greenfield Centre in Stoke-on-Trent, Sutherland Centre in Stoke-on-Trent, Lyme Brook Centre in Newcastle and Ashcombe Centre in Leek.

Is the service safe?

Safe and clean environment

Staff did regular risk assessments of the care environment. Although there was a ligature risk assessment in place that identified potential ligature anchor points, the management plan on what actions were in place to reduce the risk was not robust enough and did not clearly identify how the risk was to be reduced. The one at Sutherland dated June 2018 had some areas of high risk not completed. However, staff were able to explain how they managed the risk.

All Interview rooms were fitted with alarms and there were staff on all locations to respond to alarms.

In our last inspection in November 2017 we asked the trust they must ensure that staff regularly checked and record that emergency equipment was safe to use. On this inspection we found that staff regularly checked the emergency medicines but the trust had removed some emergency equipment from all locations. After the inspection the trust told us that they would put them back in all locations the following week.

Clinic rooms were well-equipped with the necessary equipment to carry out physical examinations. The locations had emergency medicines for anaphylaxis and oxygen masks and cylinders that were checked regularly. This was in line with the trust's risk assessment for depot injection clinics that were carried out every week. However, Lyme Brook and Ashcombe Centres did not have easy access to an automated external defibrillator. Sutherland Centre had access to all emergency equipment from an inpatient unit next door. But they had not carried out a drill to check how long it may take to get the equipment if needed in an emergency. Staff had mixed views on what to do in case of emergency, some said they would dial 999, some would get equipment from next door and some thought the equipment was still available in the clinic room. That emergency equipment was removed had not been clearly communicated to staff and they were left unsure about what to do in the event of an emergency.

In response to our concern the trust agreed to provide automated external defibrillators to the two stand-alone community units accepting this as good practice.

All areas were clean, had good furnishings and were well-maintained. Although the clinic rooms were very clean, there were no cleaning schedules in place that demonstrated the premises were cleaned regularly.

Staff adhered to infection control principles, including handwashing. They demonstrated awareness of this in their practice.

Staff maintained equipment well and kept it clean. All equipment had clean stickers that were visible and in date.

Safe staffing

Nursing staff

The teams had enough staff to meet the patients' needs although at Sutherland Centre they relied on contracted agency staff to fill shifts to cover sickness, absence or vacancies. Staff told us although they felt stretched at times there were enough staff to cover the caseloads.

The provider had determined safe staffing levels by calculating the number and grade of members of the multidisciplinary team required using a systematic approach. Staffing levels took account of the population covered and demography of the area.

The number, profession and grade of staff in post were closely linked to the provider's staffing plan. The trust had a recruitment plan and drive to fill up all the vacant posts. They had recruited nurses that were due to start induction.

This core service reported a vacancy rate for all staff of 12% as of 31 July 2018. This was higher than the 9% reported at the last inspection[14] (May 2017).

This core service reported an overall vacancy rate of 7% for registered nurses as of 31 July 2018.

This core service reported an overall vacancy rate of 16% for healthcare assistants as of 31 July 2018.

		Registered nurses			Health care assistants			Overall staff figures		
Location	Ward/Team	Vacancies	Establishment	Vacancy rate (%)	Vacancies	Establishment	Vacancy rate (%)	Vacancies	Establishment	Vacancy rate (%)
Lawton House	Newcastle Integrated Community Mental Health Teams	6.1	17.5	35%	0.8	5.4	15%	11.0	38.2	29%
Lawton House	Moorlands Community Mental Health Team	3.0	13.4	22%	0.0	2.8	0%	5.7	28.0	20%
Lawton House	Early Intervention Team	-1.0	14.8	-6%	0.2	4.6	4%	1.6	23.7	7%
Lawton House	City Integrated Community Mental Health Teams	0.1	29.1	0%	2.0	11.8	17%	3.3	57.8	6%
Lawton House	Approved Mental Health Professional and Best Interest Assessor Service	0.4	4.6	9%	1.0	1.0	100%	0.4	8.6	5%
Lawton House	Resettlement & Review Team	-3.2	3.7	-86%	-	-	-	-2.2	4.7	-46%
Core service total		5.5	83.0	7%	4.0	25.6	16%	19.9	161.0	12%
Trust total		70.2	452.8	16%	23.2	247.4	9%	133.3	964.7	14%

NB: All figures displayed are whole-time equivalents. Negative values indicate an over establishment of staff.

Between 1 September 2017 and 31 August 2018, of the 77,156 working hours available, 1,339 were filled by bank staff to cover sickness, absence or vacancy for qualified nurses.

The main reason for bank and agency usage for the teams was vacancies. Only Sutherland Centre used agency staff as it had the highest vacancy rate for nurses. All other teams did not use agency staff and were managing the caseloads with available permanent staff.

[14] Previous Inspection Analysis

In the same period, agency staff covered 40 available hours for qualified nurses and 9,225 of available hours were unable to be filled by either bank or agency staff.

We are unable to provide details about the proportion of bank and agency usage as all available hours for all teams was not provided by the trust. This is still ongoing and we hope to provide this asap.

Wards	Total hours available	Bank Usage		Agency Usage		NOT filled by bank or agency	
		Hrs	%	Hrs	%	Hrs	%
Greenfields OT*	25,562	288	N/A	0	N/A	4631	N/A
Hillcrest Recovery and Resettlement Team	488	0	N/A	10	N/A	0	N/A
Newcastle CMHT ASD	27,495	625	N/A	0	N/A	2782	N/A
Sutherland Resources Centre*	23,611	426	N/A	30	N/A	1813	N/A
Core service total	77,156	1,339	N/A	40	N/A	9,225	N/A
Trust Total	589,590	38,213	N/A	13,425	N/A	45,636	N/A

*Part of the City Integrated Community Mental Health Teams

Between 1 September 2017 and 31 August 2018, of the 20,030 working hours available, 341 were filled by bank staff to cover sickness, absence or vacancy for healthcare assistants. The teams did not use agency staff for healthcare assistants.

The main reasons for bank and agency usage for the teams were vacancies and short sickness.

In the same period, agency staff covered 24 available hours and 1,090 available hours were unable to be filled by either bank or agency staff.

Wards	Total hours available	Bank Usage		Agency Usage		NOT filled by bank or agency	
		Hrs	%	Hrs	%	Hrs	%
Greenfields OT*	7590	0	N/A	0	N/A	638	N/A
Hillcrest Recovery and Resettlement Team	1418	341	N/A	24	N/A	69	N/A
Newcastle CMHT ASD	9857	0	N/A	0	N/A	326	N/A
Sutherland Resources Centre*	9166	0	N/A	0	N/A	58	N/A
Core service total	28.030	341	N/A	24	N/A	1,090	N/A
Trust Total	359,531	130,535	N/A	3,037	N/A	24,283	N/A

*Part of the City Integrated Community Mental Health Teams

This core service had 5 (3%) staff leavers between 1 September 2017 and 31 August 2018. This was lower than the 17% (28.7 staff leavers) reported during the previous inspection[15] (May 2017).

Location	Ward/Team	Substantive staff (at latest month)	Substantive staff Leavers over the last 12 months	Average % staff leavers over the last 12 months
Lawton House	Newcastle Integrated Community Mental Health Teams	27.4	3.0	10%

[15] Previous Inspection Analysis

Location	Ward/Team	Substantive staff (at latest month)	Substantive staff Leavers over the last 12 months	Average % staff leavers over the last 12 months
Lawton House	Early Intervention Team	23.2	2.0	9%
Lawton House	Approved Mental Health Professional and Best Interest Assessor Service	8.2	0.0	0%
Lawton House	City Integrated Community Mental Health Teams	55.4	0.0	0%
Lawton House	Moorlands Community Mental Health Team	22.1	0.0	0%
Lawton House	Resettlement & Review Team	6.9	0.0	0%
	Core service total	143.2	5.0	3%
	Trust total	858.3	79.9	9%

The sickness rate for this core service was 5.6% between 1 September 2017 and 31 August 2018. The most recent month's data (August 2018) showed a sickness rate of 1.8%.

The sickness rate reported at the time of the previous inspection[16] was 6.6%. (June 2016 to May 2017).

Location	**Ward/Team**	**Total % staff sickness (at August 2018)**	**Ave % permanent staff sickness (over the past year)**
Lawton House	Moorlands Community Mental Health Team	4.5%	8.1%
Harplands Hospital	Early Intervention Team	0.0%	6.7%
Lawton House	Newcastle Integrated Community Mental Health Teams	3.6%	5.9%
Lawton House	City Integrated Community Mental Health Teams	0.8%	5.1%
Harplands Hospital	Approved Mental Health Professional and Best Interest Assessor Service	0.0%	1.4%
Lawton House	Resettlement & Review Team	0.0%	0.1%
	Core service total	**1.8%**	**5.6%**
	Trust Total	**3.9%**	**5.2%**

The managers assessed the size of the caseloads of individual staff regularly and helped staff manage their caseloads. The service used an electronic caseload management system to determine a manageable caseload for individual staff taking into account acuity, risk and number of patients. The size of caseloads varied according to how the system calculated the workload capacity.

[16] Previous Inspection Analysis

The teams had cover arrangements for sickness, leave, vacant posts and so on, that ensured patient safety.

The service used locum/bank/agency staff appropriately.

Medical staff

Between 1 August 2017 and 31 July 2018, of the (5,500) total working hours available, no hours were filled by bank staff to cover sickness, absence or vacancy for medical locums.

The teams at Lyme Brook and Ashcombe Centre had a stable medical team. The Sutherland Centre team had difficulties in recruiting permanent medical staff for the past two years and relied heavily on locum medical staff. A permanent consultant had recently been appointed and was to start in January 2019. Patients reported that they always saw a new doctor on their appointments but it was now getting better.

In the same period, agency staff covered 5,500 available hours and 1,068 hours were unable to be filled by either bank or agency staff.

We are unable to provide details about the proportion of medical locum usage as all available hours for all teams was not provided by the trust. This is still ongoing and we hope to provide this asap.

Ward/Team	Total hours available	Bank Usage		Agency Usage		NOT filled by bank or agency	
		Hrs	%	Hrs	%	Hrs	%
Early Intervention Team	256	0	N/A	256	N/A	88	N/A
City Integrated Community Mental Health Teams	5,244	0	N/A	5244	N/A	980	N/A
Core service total	**5,500**	**0**	**N/A**	**5,500**	**N/A**	**1,068**	**N/A**
Trust Total	**63,808**	**7,194**	**N/A**	**26,353**	**N/A**	**2,640**	**N/A**

The service had rapid access to a psychiatrist when required. There was adequate medical cover that could attend quickly to patients.

Mandatory training

Staff had received and were up to date with appropriate mandatory training. The compliance for mandatory and statutory training courses at 31 August 2018 was 84%. Of the training courses listed, seven failed to achieve the trust target and of those, four failed to score above 75%.

Mental Capacity Act training was included in the figures below 75%. However, this training was previously included within the Mental Health Law training module before the trust introduced a stand-alone Mental Capacity Act training in August 2018 and it was still being rolled out to all staff in stages. This meant all staff had received this training before through the Mental Health Law training.

At the same time, the trust also introduced Prevent training as three yearly renewal training for all staff rather than a one off training and they expect all staff to attend by February 2019.

The trust set a target of 85% for completion of mandatory and statutory training and 95% for Information Governance Training.

The trust reports training on a rolling month by month basis and was unable to provide year end data as requested, therefore we cannot compare compliance to previous years.

Key:

Below CQC 75%	Met trust target ✓	Not met trust target ✗

Training Module	Number of eligible staff	Number of staff trained	YTD Compliance (%)	Trust Target Met
Suicide Awareness Level 1	140	138	99%	✓
Clinical Risk Assessment	99	96	97%	✓
Safeguarding Children (Level 3)	99	96	97%	✓
Mental Health Act	90	84	93%	✓
Equality and Diversity	180	168	93%	✓
Dementia Awareness Level 1	180	166	92%	✓
Safeguarding Children & Adults level 1 & 2	180	166	92%	✓
Health & Safety	180	162	90%	✓
Conflict Resolution	165	147	89%	✓
Medicine management training	57	50	88%	✓
Moving and Handling	179	158	88%	✓
Effective Care Planning	104	91	88%	✓
Resuscitation	146	128	88%	✓
Infection, Prevention & Control	178	151	85%	✓
Fire	178	150	84%	✗
Information Governance	180	147	82%	✗
Fraud, Bribery & Code of Conduct	180	144	80%	✗
Brief Advice on Smoking	145	106	73%	✗
PREVENT	180	117	65%	✗
Brief Advice on Alcohol	67	40	60%	✗
Mental Capacity Act Level 1	92	19	21%	✗
Total	**2999**	**2524**	**84%**	

Assessing and managing risk to patients and staff

Assessment of patient risk

In our last inspection in November 2017 we asked the trust they should ensure that risk assessments were consistently detailed about risk and how it was to be managed and that staff updated them regularly. We found that improvements had been made. We looked at 21 care records of patients and staff carried out a detailed risk assessment on every patient at the initial assessment and updated it regularly, including after any incident.

Staff used a recognised risk assessment tool. Staff assessed all patients and identified any risks associated with the patient.

When appropriate, staff created and made good use of crisis plans and advance decisions. However, staff at Sutherland Centre and Lyme Brook did not consistently complete the crisis plans. Five out of 21 care records inspected did not have crisis plans completed.

Management of patient risk

Staff responded promptly to sudden deterioration in a patient's health. The teams had a system that supported patients to get help when required anytime.

Staff monitored patients on waiting lists to detect and respond to increases in level of risk. They had risk monitoring systems in place and acted accordingly to reflect any changes in risk.

The service had developed good personal safety protocols, including lone working practices, and there was evidence that staff followed them.

Safeguarding

A safeguarding referral is a request from a member of the public or a professional to the local authority or the police to intervene to support or protect a child or vulnerable adult from abuse. Commonly recognised forms of abuse include: physical, emotional, financial, sexual, neglect and institutional.

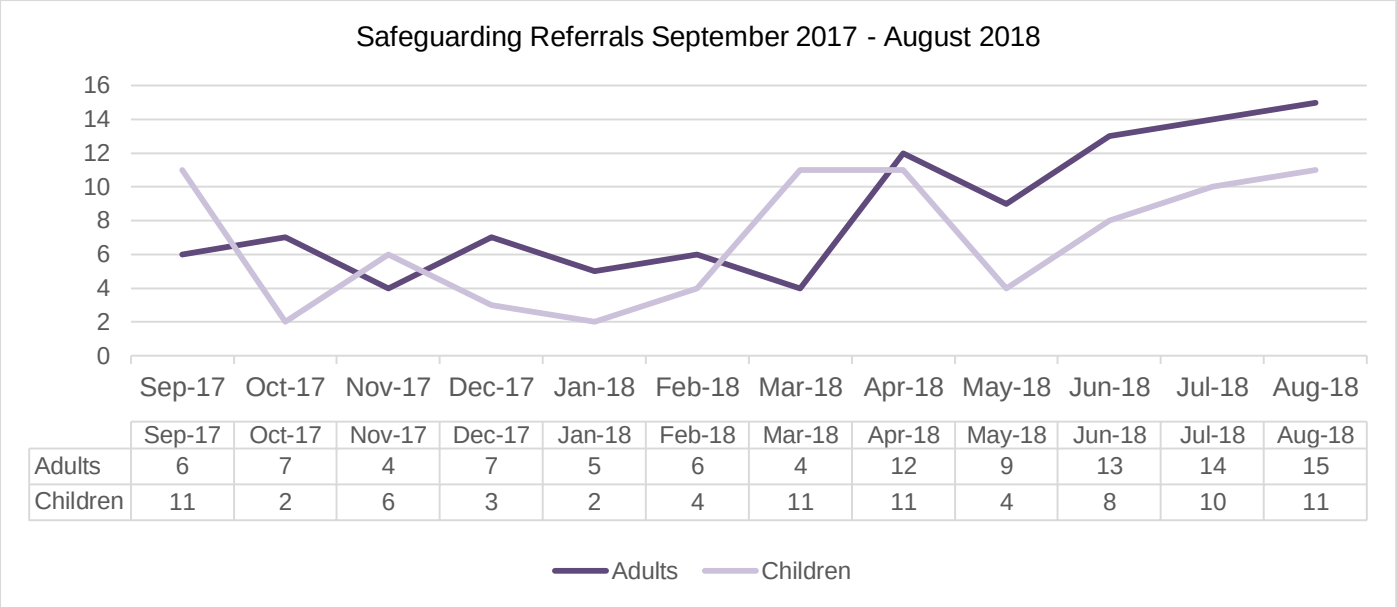
Each authority has their own guidelines as to how to investigate and progress a safeguarding referral. Generally, if a concern is raised regarding a child or vulnerable adult, the organisation will work to ensure the safety of the person and an assessment of the concerns will also be conducted to determine whether an external referral to Children's Services, Adult Services or the police should take place.

This core service made 185 safeguarding referrals between 1 September 2017 and 31 August 2018, of which 102 concerned adults and 83 children.

Number of referrals		
Adults	**Children**	**Total referrals**
102	83	185

The number of adult safeguarding referrals per month ranged from four to 15 (as shown below).

The number of child safeguarding referrals per month ranged from two to 11 (as shown below).



	Sep-17	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18	Apr-18	May-18	Jun-18	Jul-18	Aug-18
Adults	6	7	4	7	5	6	4	12	9	13	14	15
Children	11	2	6	3	2	4	11	11	4	8	10	11

The trust submitted details of two serious case reviews commenced or published in the last 12 months (1 September 2017 to 31 August 2018). None related to this service.

Staff understood how to protect patients from abuse and the service worked well with other agencies to do so.

Staff could give examples of how to protect patients from harassment and discrimination, including those with protected characteristics under the Equality Act.

Staff had training on how to recognise and report abuse and they knew how to apply it. Staff knew how to identify adults and children at risk of, or suffering, significant harm.

Staff access to essential information

Staff used electronic patient records and they kept detailed records of patients' care and treatment.

Records were clear, up-to-date and easily available to all staff providing care including agency staff. It was also accessible to all relevant staff when patients moved between teams. However, we found that the electronic system used was very slow and staff reported it could take a long time to access the records.

Medicines management

In our last inspection in November 2017 we told the trust that they must ensure that medicine management processes were properly followed by monitoring safe range of medicines fridge temperatures. On this inspection we found that improvements had been made. Staff followed good practice when storing, transporting, dispensing, administering, disposing and recording the use of medicines. This was done in line with national guidance.

Although staff regularly reviewed the effects of medications on each patient's physical health they did not consistently complete the Glasgow side effects monitoring forms and the drug indication on drug charts.

Track record on safety

Between 1 September 2017 and 31 August 2018 there were 20 serious incidents reported by this service. Of the total number of incidents reported, the most common type of incident was 'Apparent/actual/suspected self-inflicted harm' with 10 reported.

We reviewed the serious incidents reported by the trust to the Strategic Executive Information System (STEIS) over the same reporting period. The number of the most severe incidents recorded by the trust incident reporting system was comparable with STEIS with 20 reported.

A 'never event' is classified as a wholly preventable serious incident that should not happen if the available preventative measures are in place. This service reported no never events during this reporting period.

Number of incidents reported					
Team	**Apparent/actual /suspected self-inflicted harm**	**Pending review**	**Disruptive/ aggressive/ violent behaviour**	**Adverse media coverage or public concern about the organisation or the wider NHS**	**Total**
Sutherland*	4	1	1	0	7
Greenfield*	2	1	0	0	3
Lymebrook*	2	1	0	0	3
Ashcombe *	1	1	0	0	2
EI Team	0	1	0	1	2
Recovery and Resettlement	0	2	0	0	**2**
Moorlands CMHT Brandon	1	1	0	0	1
Total	**10**	**8**	**1**	**1**	**20**

*Part of the City Integrated Community Mental Health Teams

**Part of the Newcastle Integrated Community Mental Health Teams

The teams had a good track record on safety. The service learnt lessons from previous serious incidents to put measures in place that prevented same mistakes happening again. They followed national safety guidance systems to prevent serious incidents such as never events happening.

Reporting incidents and learning from when things go wrong

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

In the last two years, there have been no 'prevention of future death' reports sent to North Staffordshire Combined Healthcare NHS Trust.

The service managed patient safety incidents well. Staff knew what incidents to report and how to report them.

Staff recognised incidents and reported them appropriately. Staff reported all incidents that should be reported.

When things went wrong, staff apologised and gave patients honest information and suitable support. Staff understood the duty of candour. They were open and transparent, and explained to patients and families a full explanation if and when something went wrong.

Managers investigated incidents and shared lessons learned with the whole team and the wider service. Staff received feedback from investigation of incidents both internal and external to the service. Staff had regular meetings to discuss that feedback.

The service made changes to practice as a result of learning from incidents. The teams changed how triage and referrals were dealt with to reduce the risk of patients waiting for assessment or treatment.

Staff were debriefed and received support after a serious incident. The service had a number of ways to support staff after an incident.

Is the service effective?

Assessment of needs and planning of care

We looked at 21 patients' care records and staff assessed the mental health needs of all patients. Staff completed a comprehensive mental health assessment of each patient. The level of detail contained in the assessments demonstrated a clear holistic approach that identified all patients' needs.

Staff ensured that any necessary assessment of the patient's physical health had been undertaken and that could have been through GPs. Staff were aware of that and recorded any physical health problems.

In our last inspection in November 2017 we asked that the trust should ensure that staff consistently record detailed care plans and update them regularly. On this inspection, we found that an improvement had been made. Care plans reflected the assessed needs. Staff developed care plans that met the needs identified during assessment. The care plans showed an in-depth understanding of how patient's needs were to be addressed.

Staff developed individual care plans, regularly reviewed and updated them when needed. Care plans were personalised, holistic and recovery-oriented. The care plans had patients' views and clear goals.

Best practice in treatment and care

We looked at 21 patients' care records. Staff provided a range of care and treatment interventions suitable for the patient group. The interventions were delivered in line with National Institute for Health and Care Excellence guidance. These included medication and psychological therapies and, when needed, support for employment, education, housing and benefits, and interventions that enable patients to acquire living skills.

They ensured that patients had good access to physical healthcare. Staff ensured that patients' physical healthcare needs were being met, including their need for an annual health check. If the GP was responsible for that, staff checked with the GP that it was done.

Staff supported patients to live healthier lives. The patients had access or signposted to smoking cessation advice, acting on healthy eating advice, managing cardiovascular risks, screening for cancer, dealing with issues relating to substance misuse.

Staff ensured that patient progress and recovery were monitored. Staff used a range of recognised rating scales and other approaches to rate severity and to monitor outcomes.

Staff used technology to support patients effectively (for example, online access to therapies and other resources, timely access to blood test results and so on).

Although staff participated in clinical audit, benchmarking and quality improvement initiatives the dashboard summary was not robust enough to effectively monitor the clinical safety of services. This community patient safety matrix was in development, from a tool used successfully in inpatient settings, and only recently implemented for the community teams. The trust agreed to take note of our concerns in their ongoing review of the effectiveness of the tool.

This service participated in two clinical audits as part of their clinical audit programme 2017 - 2018.

Audit name	Audit scope	Audit type	Date completed	Key actions following the audit
CQUIN: Physical health - Communication with GPs	CMHTs	Clinical	23/04/2018	Continued development of communication processes and collaborate with primary care colleagues in respect of physical health assessment and treatment, in line with the 2017-19 CQUIN programme.
National Early Intervention in Psychosis Audit 2017	Early Intervention Team	Clinical	21/08/2018	The team's psychologist will attend top-up training to deliver Cognitive Behavioural Therapy for psychosis. Dedicated Care Coordinator time complete physical health assessments have been introduced. The team have developed a project through Closing the Gap to support healthy lifestyle and weight management.

Skilled staff to deliver care

The teams included or had access to the full range of specialists required to meet the needs of patients under their care. This included doctors, nurses, occupational therapists, clinical psychologists, social workers, recovery support workers.

Managers made sure they had staff with a range of skills needed to provide high quality care. Staff were experienced and qualified, and had the right skills and knowledge to meet the needs of the patient group.

All new staff were provided with appropriate induction. The service had a structured comprehensive induction programme for all new staff including agency staff. Healthcare assistants had access to training equivalent to care standards certificate.

Managers identified the learning needs of staff and provided them with opportunities to develop their skills and knowledge. Managers ensured that staff received the necessary specialist training for their roles.

Poor staff performance was dealt with promptly and effectively. The managers had readily available support from human resources department to deal with this.

Volunteers were recruited when required, and trained and supported them for their roles.

Managers provided staff with supervision where they discussed case management, personal support and professional development, reflected on and learnt from practice and appraisal of their work performance. Managers ensured that staff had access to regular team meetings.

The trust's target rate for appraisal compliance is 85%. At the end of last year (1 April 2017 to 31 March 2018), the overall appraisal rate for non-medical staff within this service was 86%. This year so far, the overall appraisal rate was 70% (as at 31 August 2018). The team with the lowest appraisal rate at 31 March 2018 was 'Newcastle Integrated Community Mental Health Teams' with an appraisal rate of 84%, the other teams had appraisal rates of between 85% or more.

The rate of appraisal compliance for non-medical staff reported during this inspection (as of 31 August 2018) was lower than the 81% reported at the last inspection[17] (31 May 2017).

Ward name	Total number of permanent non-medical staff requiring an appraisal	Total number of permanent non-medical staff who have had an appraisal	% appraisals (as at 31 August 2018)	% appraisals (previous year 1 April 2017 – 31 March 2018)
Resettlement & Review Team	8	8	100%	100%
Approved Mental Health Professional and Best Interest Assessor Service	9	4	89%	89%
Moorlands Community Mental Health Team	25	22	86%	85%
Newcastle Integrated Community Mental Health Teams	29	21	72%	84%
Early Intervention Team	27	14	52%	86%
City Integrated Community Mental Health Teams	0	0	-	-
Core service total	**98**	**69**	**70%**	**86%**
Trust wide	**844**	**419**	**50%**	**91%**

The trust's target rate for appraisal compliance is 85%. At the end of last year (1 April 2017 to 31 March 2018), the overall appraisal rate for medical staff within this service was 100%. This year so far, the overall appraisal rate was 10% (as at 31 August 2018).

Ward / Team Name	Total number of permanent medical staff requiring an appraisal	Total number of permanent medical staff who have had an appraisal	% appraisals (as at 31 August 2018)	% appraisals (April 2017 – March 2018)
Newcastle Integrated Community Mental Health Teams	5	1	20%	100%
City Integrated Community Mental Health Teams	4	0	0%	100%
Moorlands Community Mental Health Team	1	0	0%	100%
Core service total	**10**	**1**	**10%**	**100%**

[17] Previous Inspection Analysis

Ward / Team Name	Total number of permanent medical staff requiring an appraisal	Total number of permanent medical staff who have had an appraisal	% appraisals (as at 31 August 2018)	% appraisals (April 2017 – March 2018)
Trust wide	**40**	**7**	**18%**	**100%**

The trust's target of clinical supervision for all* staff is 85% of the sessions required. Between 1 September 2017 and 31 August 2018, the average rate across all six teams in this service was 79%.

Caveat: there is no standard measure for clinical supervision and trusts collect the data in different ways, so it's important to understand the data they provide.

Team name	Clinical supervision sessions required	Clinical supervision delivered	Clinical supervision rate (%)
Resettlement & Review Team	66	60	91%
Approved Mental Health Professional and Best Interest Assessor Service	107	95	89%
Early Intervention Team	247	213	86%
Moorlands Community Mental Health Team	252	209	83%
City Integrated Community Mental Health Teams	479	364	76%
Newcastle Integrated Community Mental Health Teams	285	189	66%
Core service total	**1436**	**1130**	**79%**
Trust Total	**9084**	**7347**	**81%**

*All staff – medical and non-medical breakdowns were not provided

Multi-disciplinary and interagency team work

Staff from different disciplines worked together as a team to benefit patients. Staff held regular and effective multidisciplinary team meetings.

Staff supported each other to make sure that patients had no gaps in their care. They shared information about patients at effective daily and weekly team meetings within the teams.

The teams had effective working relationships with other relevant teams within the organisation. They worked well, including good handovers, with the access team, crisis team, early intervention team and inpatient services.

The community teams had effective working relationships with relevant services outside the organisation. They had good working links, including effective handovers, with primary care, social services, charity organisations and other teams external to the organisation.

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

Staff understood their roles and responsibilities under the Mental Health Act 1983 and the Mental Health Act Code of Practice. As of 31 August 2018, 93% of the workforce in this service had received training in the Mental Health Act. The trust stated that this training was mandatory for all services and renewed every three years.

Staff had easy access to administrative support and legal advice on implementation of the Mental Health Act and its Code of Practice. Staff knew who their Mental Health Act administrators were.

The provider had relevant policies and procedures that reflected the most recent guidance.

Staff had easy access to local Mental Health Act policies and procedures and to the Code of Practice.

In our last inspection in November 2017 we asked the trust they should ensure that staff re-inform patients on a Community Treatment Order of their rights in line with Code of Practice. On this inspection we found that staff explained patients' rights to those subjected to Community Treatment Order in a way that they could understand, repeated it as required, and recorded that they had done so.

Patients subjected to a Community Treatment Order had easy access to information about independent mental health advocacy (IMHA) services.

Staff completed Community Treatment Order paperwork correctly and it was up to date and stored appropriately.

Patients that had been subject to section three or equivalent Part three powers authorising admission to hospital for treatment had care plans that referred to identified Section 117 aftercare services to be provided.

In our last inspection in November 2017 we asked the trust they should ensure that staff completed relevant audits in relation to the Mental Health Act and Mental Capacity Act. We found that improvements had been made. Staff carried out regular audits on Community Treatment Order to ensure that the Act was being applied correctly and there was evidence of improvements made from the audits.

Good practice in applying the Mental Capacity Act

Staff were trained in and had a good understanding of the Mental Capacity Act 2005, particularly the five statutory principles

The training rate for the Mental Capacity Act was reported as 23% for this core service in August 2018. This was the month that a stand alone Mental Capacity Act e learning model had been introduced into the trust. Previously the Mental Capacity Act had formed part of a Mental Health Law training session. The trust told us they expected to report on the compliance of the new module as a shadow rating for six months after implementation and then from February 2019 all teams would be expected to meet the trust target of 85%. In an update on training compliance in December 2018 the overall rate of take up across the trust was 79.8%.

Staff understood the trust policy on the Mental Capacity Act 2005. The provider had a policy on the Mental Capacity Act. Staff were aware of the policy and had access to it.

Staff knew where to get advice from within the provider regarding the Mental Capacity Act. The trust had a Mental Capacity Act lead.

Staff supported patients to make decisions on their care for themselves. Staff assisted patients by any means possible to make a specific decision for themselves before they assumed that the patient lacked the mental capacity to make it.

For patients who might have impaired mental capacity, staff assessed and recorded capacity to consent appropriately. They did this on a decision-specific basis with regard to significant decisions. However, three out of ten records of patients on Community Treatment Order did not demonstrate how mental capacity to treatment was assessed.

When patients lacked capacity, staff made decisions in their best interests, recognising the importance of the person's wishes, feelings, culture and history.

The service has arrangements to monitor adherence to the Mental Capacity Act.

Staff audited the application of the Mental Capacity Act and took action on any learning that resulted from it.

Is the service caring?

Kindness, privacy, dignity, respect, compassion and support

Staff treated patients with compassion and kindness. Staff showed that they were, polite, respectful and responsive when interacting with patients. They provided patients with help, emotional support and advice at the time they needed it.

Staff supported patients to understand and manage their care, treatment or condition. They gave patients information required to understand the importance of their treatment.

The teams gave patients the right support they needed. Staff directed patients to other services when appropriate and, if required, supported them to access those services.

Patients said staff treated them well and behaved appropriately towards them. All patients we spoke with spoke positively about the way staff treated them.

Staff understood the individual needs of patients, including their personal, cultural, social and religious needs.

Staff said they could raise concerns about disrespectful, discriminatory or abusive behaviour or attitudes towards patients without fear of the consequences.

Staff maintained the confidentiality of information about patients.

Involvement in care

Involvement of patients

Staff involved patients in care planning and risk assessment and participation in Care Programme Approach and treatment reviews. Patients had access to a copy of their care plan and had signed to say that they were involved in care planning.

Staff communicated with patients so that they understood their care and treatment, including finding effective ways to communicate with patients with communication difficulties.

Staff involved patients when appropriate in decisions about the service. Patients were involved in staff recruitment and board meetings.

Staff enabled patients to give feedback on the quality of care provided. Patients had access to surveys, feedback forms and patient council.

Staff enabled patients to make advance decisions (to refuse treatment, sometimes called a living will) when appropriate.

Staff ensured that patients could access advocacy. Information on advocacy was readily available to patients.

Involvement of families and carers

Staff informed and involved families and carers appropriately and provided them with support when needed. Staff gave families an information pack about the service when first in contact.

Staff enabled families and carers to give feedback on the service they received. Feedback forms were available in receptions and they had access to surveys and carers meetings.

There was support for carers. The teams provided carers were with information about how to access a carer's assessment.

Is the service responsive?

Access and waiting times

The trust identified the below services in the table as measured on 'referral to initial assessment' and 'referral to treatment'. The service met the referral to assessment target in two of the four targets listed. The service met the referral to treatment target in all three of the targets listed.

Name of hospital site or location	Name of Team	Please state service type	Days from referral to initial assessment		Days from referral to treatment	
			Target	Actual (median)	Target	Actual (median)
Lawton House	City Integrated Community Mental Health Teams	A06	28	69	98	54
Lawton House	Early Intervention Team	A14	14	9	Not given	Not given
Lawton House	Moorlands Community Mental Health Team	A06	28	28	98	19
Lawton House	Newcastle Integrated Community Mental Health Teams	A06	28	49	98	28

Staff assessed and treated people who required urgent care promptly and people who did not require urgent care did not wait too long to start treatment.

The service was easy to access. Referral criteria did not exclude people who would have benefitted from care.

The provider had set a target for time from referral to triage/assessment of 28 days and from assessment to treatment of 98 days.

The team was able to see urgent referrals quickly and non-urgent referrals within an acceptable time. The teams had a very good approach to prioritising referrals. Those with urgent needs were seen quicker and patients were invited to walk in or call the centres if they had urgent needs. There was always a staff member allocated each day to deal with any urgent cases.

The team responded promptly and adequately when patients telephoned the service. The teams had a duty system which was readily available to deal with any patient concerns immediately.

The team tried to engage with people who found it difficult or were reluctant to engage with mental health services. The teams were flexible and used different methods and tactics to ensure patients were seen by professionals.

Staff followed up people who missed appointments. The service had a clear process that they followed on each patient that did not attend an appointment.

Where possible, staff offered patients flexibility in the times of appointments. Staff gave patients options of times that were best suitable to them.

Staff rarely cancelled appointments. Staff cancelled appointments only when necessary and when they did, they explained why and helped patients to access treatment as soon as possible.

Appointments usually ran on time and patients were kept informed when they did not.

Staff supported patients during referrals and transfers between services. Staff ensured patients got the right care and treatment when they were going to be looked after by crisis team or inpatient units.

The facilities promote comfort, dignity and privacy

The service had a range of rooms and equipment to support treatment and care. All locations had well equipped clinic rooms to examine patients, sufficient chairs in the waiting area, interview and therapy rooms.

Interview rooms at Lyme Brook did not have adequate soundproofing. Staff said the interviews rooms were located in a locked area away from the reception area and could only be accessed by staff. They used interview rooms that were not close to each other every time.

Patients' engagement with the wider community

When appropriate, staff ensured that patients had access to education and work opportunities. The teams had strong links with charity organisations that arranged vocational courses and job opportunities for patients.

Staff supported patients to maintain contact with their families and carers. Staff knew details about people that were important to their patients.

Staff encouraged patients to develop and maintain relationships with people that mattered to them, both within the services and the wider community.

Meeting the needs of all people who use the service

The teams met the needs of all people who use the service – including those with protected characteristics and vulnerable circumstances. Staff helped patients with communication, advocacy and cultural support.

The service made adjustments for disabled patients. All locations had disabled toilets and disabled people's access to premises and were meeting patients' specific communication needs. The service had staff that used British Sign Language.

Staff ensured that patients could obtain information on treatments, local services, patients' rights and so on. The teams made all information available to all patients in the reception areas. Some information provided was in easy-read form.

Staff made some information leaflets available in languages spoken by patients. Staff knew how to obtain further information in different languages if needed.

Managers ensured that staff and patients had easy access to interpreters and/or signers if needed.

Listening to and learning from concerns and complaints

This service received 30 complaints between 1 September 2017 and 1 August 2018. Eight of these were upheld, eight were partially upheld, four were not upheld and two were withdrawn. Eight were categorised as 'other' which are either ongoing or resolved. None were referred to the Ombudsman.

Ward Name	Total Complaints	Fully upheld	Partially upheld	Not upheld	Other	Under Investigation	Withdrawn	Referred to Ombudsman
ICMHT (City) Greenfields*	11	2	3	1	4	0	1	0
ICMHT (County) Lymebrook**	9	3	2	0	4	0	0	0
ICMHT (City) Sutherland Centre*	7	3	2	1	0	0	1	0
ICMHT (County) Ashcombe**	2	0	1	1	0	0	0	0
Early Intervention	1	0	0	1	0	0	0	0

*Part of the City Integrated Community Mental Health Teams

**Part of the Newcastle Integrated Community Mental Health Teams

This service received 191 compliments during the last 12 months from 1 September 2017 to 31 August 2018 which accounted for 9% of all compliments received by the trust as a whole.

Patients knew how to complain or raise concerns. Staff gave patients information on how to make complaints.

The service treated concerns and complaints seriously. When patients complained or raised concerns, they received feedback.

Staff had a good understanding of the complaints procedure and knew how to handle complaints appropriately. They protected patients who raised concerns or complaints from discrimination and harassment.

The service investigated complaints and learned lessons from the results, and shared these with all staff. Staff received feedback on the outcome of investigation of complaints and acted on the findings.

Is the service well led?

Leadership

Leaders had the skills, knowledge and experience to perform their roles. They demonstrated good understanding of the needs of their teams and patient group.

Leaders had a good understanding of the services they managed. They could explain clearly how the teams were working to provide high quality care.

Leaders were visible in the service and approachable for patients and staff. Staff and patients spoke highly of the support they received from the managers.

Leadership development opportunities were available, including opportunities for staff below team manager level. The service offered leadership training as part of staff's ongoing professional development plan.

Vision and strategy

Staff knew and understood the provider's vision and values and how they were applied in the work of their team**.** Staff told us they were working towards outstanding care.

The provider's senior leadership team had successfully communicated the provider's vision and values to the frontline staff in this service. The leaders were clear about the future service they wanted to build.

Staff had the opportunity to contribute to discussions about the strategy for their service, especially where the service was changing. They reported that they were involved in how the service was run.

Staff could explain how they were working to deliver high quality care within the budgets available**.**

Culture

Staff felt respected, supported and valued. Staff reported feeling positive and proud about working for the trust and their teams.

Staff felt able to raise concerns without fear of retribution. The leaders took all concerns seriously, listened to their staff and supported them.

Staff knew how to use the whistle-blowing process and about the role of the freedom to speak up guardian. They felt confident to do so when required.

Managers dealt with poor staff performance when needed. There was support from the human resources team if required.

Teams worked well together and where there were difficulties managers dealt with them appropriately. The teams had good working relationships, were well-coordinated and dedicated to support each other to deliver high quality patient care.

Staff appraisals included conversations about career development and how it could be supported. Staff were able to tell us some examples of training and courses they had been involved in to support this.

Staff reported that the provider promoted equality and diversity through the inclusion work streams in its day-to-day work and in providing opportunities for career progression. The provider had sub groups of equality and diversity that represent different protected characteristics to ensure their views were equally represented.

The service's staff sickness and absence rate of 5.6% was slightly higher than the average for the provider of 5.2%.

Staff had access to support for their own physical and emotional health needs through an occupational health service. Managers could signpost staff to occupational health for well-being support if needed.

The provider recognised staff success within the service. The trust had a staff awards system to recognise staff and team achievements.

Governance

The service had robust governance processes to manage quality and safety. The teams demonstrated that governance processes operated effectively at team level.

There was a clear framework of what must be discussed at team or directorate level in team meetings to ensure that essential information, such as learning from incidents and complaints, was shared and discussed.

Staff had implemented recommendations from reviews of deaths, incidents, complaints and safeguarding alerts at the service level. All key information was reported to senior management and was investigated and analysed.

Staff undertook and participated in clinical audits. However, the audit programme in place was work in progress that needed improvements and was not sufficient enough to provide assurance and that staff could act appropriately on the results.

Staff understood arrangements for working with other teams, both within the provider and external, to meet the needs of the patients.

Management of risk, issues and performance

The service managed performance and risk well. Staff maintained and had access to the risk register either at a team or directorate level and could escalate concerns when required from a team level.

The service had plans for emergencies that explained measures the service would take to ensure safety of patients in the event of an emergency or adverse weather conditions. However, the managers did not clearly share the information with staff that emergency equipment was removed and what to do in the event of an emergency.

There were no cost improvements in place at the time of inspection.

Information management

Teams had access to the information they needed to provide safe and effective care and used that information to good effect. The service used systems to collect data from teams and directorate that were not over-burdensome for frontline staff.

Staff had access to the equipment and information technology needed to do their work. Staff at Ashcombe Centre had laptops that helped them to work from any point with internet connection. However, the information technology system used for patient records was very slow to access information and staff found it very frustrating.

Information governance systems included confidentiality of patient records. Patient records were managed in a secure way.

Team managers had access to information to support them with their management role. This included information on the performance of the service, staffing, caseload management and

patient care. The caseload management system allowed managers to review and allocate work to staff in a balanced way.

Information was in an accessible format, and was timely, accurate and identified areas for improvement.

Staff made notifications to external bodies as needed. Records of notifications included safeguarding alerts and reportable incidents according to national guidance.

Engagement

Staff, patients and carers had access to up-to-date information about the work of the provider and the services they used. The trust used a wide range of methods such as website, newsletters and forums to keep their staff, patients and carers well informed and up to date about the service. However, the managers did not clearly share the information with staff that emergency equipment was removed and what to do in the event of an emergency.

Patients and carers had opportunities to give feedback on the service they received in a manner that reflected their individual needs. The trust used a variety of methods such as suggestion box, surveys, forums, meetings, open discussion, friends and family tests, and the patients' advice and liaison on how patients and carers could give feedback to the service.

Managers and staff had access to the feedback from patients, carers and staff and used it to make improvements. Staff were able to give examples of improvements made as a result of feedback from patients.

Patients and carers were involved in decision-making about changes to the service. Patients were invited to meetings that consulted them about changes in the service.

Patients and staff could meet with members of the provider's senior leadership team and governors to give feedback.

Directorate leaders engaged with external stakeholders such as commissioners and Healthwatch.

Learning, continuous improvement and innovation

Staff were given the time and support to consider opportunities for improvements and innovation and this led to changes.

Staff started to use quality improvement methods in April 2018 and were still learning how to apply the method effectively.

Staff participated in two national audits relevant to the service as part of their clinical audit programme 2017 - 2018.

NHS trusts are able to participate in a number of accreditation schemes whereby the services they provide are reviewed and a decision is made whether or not to award the service with an accreditation. A service will be accredited if they are able to demonstrate that they meet a certain standard of best practice in the given area. An accreditation usually carries an end date (or review date) whereby the service will need to be re-assessed in order to continue to be accredited.

None of the teams in this core service were awarded an accreditation.

MH – Mental health crisis services and health-based places of safety

Facts and data about this service

Location site name	Team name	Number of clinics	Patient group (male, female, mixed)
Harplands Hospital	Place of Safety	-	-
Harplands Hospital	Access Team	1	-
Harplands Hospital	Home Treatment	0	-
Harplands Hospital	Mental Health Liaison Team	17	-

The methodology of CQC provider information requests has changed, so some data from different time periods is not always comparable. We only compare data where information has been recorded consistently.

The access, home treatment team and the health-based placed place of safety were based at Harplands Hospital. The mental health liaison team was based at the Royal Stoke University Hospital.

The access team was the single point of contact and access for all North Staffordshire Combined Healthcare NHS Trust services. It provided 24/7 cover for all mental health services across Stoke-on-Trent and North Staffordshire. The team consisted of qualified health and social care staff who provided assessment, advice, sign-posting and assistance to individuals to access the right services. The team also provided out of hours support to people experiencing a mental health illness who were in crisis. The team operated an open referral system which meant people could contact the team directly. The team also took referrals from other professional groups, such as GPs, health visitors, the local emergency department and police.

The home treatment team helped people experiencing a mental health crisis to avoid admission to the mental health inpatient wards by supporting them in their homes. The team was made up of doctors, nurses, social workers and support workers who were available to support patients, carers and their families. It also worked with people in hospital, as they prepared for their discharge home and those who had been discharged, helping them make the transition back into the community. The home treatment team worked closely with the access team when providing support to people in crisis.

The mental health liaison team assessed patients who presented with mental health crisis in the Royal Stoke University Hospital emergency department or on the wards in the acute general hospital. Assessed patients were referred to GPs in primary care, the access and home treatment teams or to the community mental health teams. The team consisted of mental health nurses and psychiatrists.

The health based place of safety, a one-bed facility currently based on ward 2 at Harplands Hospital accommodated patients in extreme mental distress. These patients, brought in by police officers, had been detained people for their own safety or the safety of others, under Section 136

of the Mental Health Act. People could be detained for assessment for up to 24 hours under this legal authority. Staff then helped people to receive the right treatment and care as quickly as possible.

The crisis and access teams also provided an 'out of hours' service to the trust's Child and Adolescent Mental Health Services (CAMHS), Neurological and Old Age Psychiatry(NOAP) and learning Difficulty (LD) teams.

The Care Quality Commission (CQC) last inspected the service in 2016 as part of a comprehensive inspection of North Staffordshire Combined Healthcare NHS Trust. Our inspection was announced two working days before we visited (staff knew we were coming) to ensure that everyone we needed to talk to was available. Following the 2016 inspection, we rated the service as Good

Is the service safe?

Safe and clean environment

The access and home treatment teams were based in the same department within Harplands Hospital. Where patients came to the team base for assessment, rooms were clean, safe and well maintained, and ensured privacy and dignity. Staff carried personal alarms and could call for assistance in an emergency. Staff always escorted patients through the building from the waiting area and they were not left alone.

Staff adhered to infection control protocols and we observed that hand-washing posters were displayed. Basic physical health equipment such as blood pressure machines and thermometers, were kept at the base and taken for use in to patients' homes. Staff monitored the equipment and we saw that it had been cleaned regularly and serviced within the last 12 months prior to inspection.

Heath-based place of safety

The suite used for patients detained under section 136 of the mental health act contained equipment and furniture that met with current safety standards. No ligature points were observed. Staff had personal alarms for use and other staff from ward two were available to attend to in an emergency. The place of safety had equipment for monitoring and assessing patients' physical health needs, including resuscitation equipment. The unit was visibly clean, well maintained and safe.

The trust's mental health assessment room at the Royal Stoke University Hospital accident and emergency department was not in use, at the time of inspection, due to organisational difficulties between trust estates departments, alterations to the safety features on an access door to the suite. Staff from the mental health liaison team were in contact with estates departments for both trusts to ensure the problem was resolved as soon as possible. However, alternative arrangements to use other rooms was in place.

Safe staffing

All services had staff with the right qualifications, skills, training and experience to keep people safe from harm and abuse and to provide the right care and treatment. Staff managed vacancies safely and new staff had been recruited to fill current vacancies. The teams employed regular agency staff that had been previously employed by the trust and had worked in the home treatment team. All agency staff were trained in the trust's recording and care planning systems. Teams also used bank staff, and overtime had been granted for seven weeks as a temporary measure until vacancies were filled. The teams held a team caseload and patients had a named professional responsible for their care, although all staff had an overview of all patients through handovers and clinical meetings. Managers and staff worked to manage team caseloads effectively. At the time of inspection, the home treatment team held a caseload of 26. The mental health liaison team did not hold a caseload but we were told that occasionally there were delays in waiting for the completion of mental health act assessments by local authority approved mental health professionals.

Health-based place of safety

One qualified nurse, based on ward 2 worked within the place of safety on each shift. All ward staff were available to assist in an emergency to keep people safe from harm and to provide the right care and treatment. The service did not use agency staff.

This core service has reported a vacancy rate for all staff of 21% as of 31 July 2018.

This core service reported an overall vacancy rate of 19% for registered nurses as of 31 July 2018.

This core service reported an overall vacancy rate of 28% for nursing assistants as of 31 July 2018. Staff told us that vacancies did occasionally have an impact on service cover. However, recruitment and selection processes were advanced and new staff were due to start their employment soon. Staff mandatory training compliance was good and all staff were supervised and appraised regularly and to a high standard.

		Registered nurses			Health care assistants			Overall staff figures		
Location	Ward/Team	Vacancies	Establishment	Vacancy rate (%)	Vacancies	Establishment	Vacancy rate (%)	Vacancies	Establishment	Vacancy rate (%)
Harplands Hospital	Place Of Safety	0.0	0.0	0%	0.7	0.7	100%	0.7	0.7	100%
Harplands Hospital	Mental Health Liaison Team	7.9	29.1	27%	2.0	2.0	100%	11.9	36.2	33%
Harplands Hospital	Access Team	5.5	25.0	22%	-1.0	0.0	0%	8.7	42.5	21%
Harplands Hospital	Home Treatment	-0.5	15.8	-3%	0.0	3.4	0%	-0.4	21.2	-2%
	Core service total	12.9	69.8	19%	1.7	6.1	28%	20.9	100.6	21%
	Trust total	70.2	452.8	16%	23.2	247.4	9%	133.3	964.7	14%

NB: All figures displayed are whole-time equivalents

Between 1 September 2017 and 31 August 2018, of the (102681) total working hours available, 6179 were filled by bank staff to cover sickness, absence or vacancy for qualified nurses.

The main reason for bank and agency usage for the wards was vacancies.

In the same period, agency staff covered 1733 hours for qualified nurses and 6467 hours were unable to be filled by either bank or agency staff. During the process of recruiting new full-time staff, existing staff covered shifts when bank or agency staff were not available. The inspection team found that these difficulties had not affected the treatment patients received because of the flexibility and willingness of staff to cover shifts when necessary.

We are unable to provide details about the proportion of bank and agency usage as all available hours for all teams was not provided by the trust.

Ward/Team	Total hours available	Bank Usage	Agency Usage	NOT filled by bank or agency

		Hrs	%	Hrs	%	Hrs	%
Access Team	44429	1703	N/A	394	N/A	3119	N/A
Home Treatment Team Stoke	32239	713	N/A	1339	N/A	1194	N/A
Mental Health Liaison Team	26013	3763	N/A	0	N/A	2154	N/A
Core service total	102681	6179	N/A	1733	N/A	6467	N/A
Trust Total	589590	38213	N/A	13425	N/A	45636	N/A

Between 1 September 2017 and 31 August 2018, of the (6948) total working hours available, 312 hours were filled by bank staff to cover sickness, absence or vacancy for healthcare assistants.

The main reasons for bank and agency usage for the wards/teams were vacancies.

In the same period, agency staff covered none of the available hours and 174 hours were unable to be filled by either bank or agency staff.

We are unable to provide details about the proportion of bank and agency usage as all available hours for all teams was not provided by the trust.

Wards	Total hours available	Bank Usage		Agency Usage		NOT filled by bank or agency	
		Hrs	%	Hrs	%	Hrs	%
Access Team	496	234	N/A	0	N/A	174	N/A
Home Treatment Team Stoke	6452	77	N/A	0	N/A	0	N/A
Mental Health Liaison Team	0	0	N/A	0	N/A	0	N/A
Core service total	6948	312	N/A	0	N/A	174	N/A
Trust Total	359531	130535	N/A	3037	N/A	24283	N/A

This core service had 8.4 (10%) staff leavers between 1 September 2017 and 31 August 2018. This was similar to the 9% reported during the previous inspection[18] (May 2017).

Location	Ward/Team	Substantive staff (at latest month)	Substantive staff leavers over the last 12 months	Average % staff leavers over the last 12 months
Harplands Hospital	Home Treatment	20.6	2.6	12%
Harplands Hospital	Mental Health Liaison Team	21.8	2.0	10%
Harplands Hospital	Access Team	33.9	3.8	9%
Harplands Hospital	Place Of Safety	1.7	0.0	0%
Core service total		78.1	8.4	10%
Trust total		858.3	79.9	9%

[18] Previous Inspection Data

The sickness rate for this core service was 4.6% between 1 September 2017 and 31 August 2018. The most recent month's data (August 2018) showed a sickness rate of 4.5%. This was lower than the sickness rate of 5.1% reported at the last inspection[19] (May 2017).

Location	Ward/Team	Total % staff sickness (at latest month)	Ave % permanent staff sickness (over the past year)
Harplands Hospital	Home Treatment	0.5%	6.7%
Harplands Hospital	Access Team	4.8%	4.4%
Harplands Hospital	Mental Health Liaison Team	7.7%	2.7%
	Core service total	**4.5%**	**4.6%**
	Trust Total	**3.9%**	**5.2%**

Medical staff

Between 1 August 2017 and 31 July 2018, of the (176) total working hours available, none were filled by bank staff to cover sickness, absence or vacancy for medical locums.

The main reason for agency usage for the teams was vacancies.

In the same period, agency staff covered all 176 of available hours and none of the available hours were unable to be filled by either bank or agency staff.

We are unable to provide details about the proportion of medical locum usage as all available hours for all teams was not provided by the trust.

Health based place of safety

Staff had access to a psychiatrist out of hours through an on-call system and staff told us there were rarely delays in a doctor attending.

Ward/Team	Total hours available	Bank Usage		Agency Usage		NOT filled by bank or agency	
		Hrs	%	Hrs	%	Hrs	%
Home Treatment	176	0	N/A	176	N/A	0	N/A
Core service total	**176**	**0**	**N/A**	**176**	**N/A**	**0**	**N/A**
Trust Total	**63808**	**7194**	**N/A**	**23653**	**N/A**	**2640**	**N/A**

Mandatory training

The compliance for mandatory and statutory training courses at 31 August 2018 was 86%. Of the training courses listed, five failed to achieve the trust target and of those, three failed to score above 75%. The training rate for the Mental Capacity Act was reported as 9% for this core service in August 2018. This was the month that a stand alone Mental Capacity Act e learning model had been introduced into the trust. Previously the Mental Capacity Act had formed part of a Mental Health Law training session. The trust told us they expected to report on the compliance of the new module as a shadow rating for six months after implementation and then from February 2019 all teams would be expected to meet the trust target of 85%. In an update on training compliance in December 2018 the overall rate of take up across the trust was 79.8%.

The trust set a target of 85% for completion of mandatory and statutory training and 95% for Information Governance Training.

The trust reports training on a rolling month by month basis and was unable to provide year end data as requested, therefore we cannot compare compliance to previous years.

Key:

Below CQC 75%	Met trust target ✓	Not met trust target ✗

Training Module	Number of eligible staff	Number of staff trained	YTD Compliance (%)	Trust Target Met
Clinical Risk Assessment	66	66	100%	✓
Manual Handling - People	1	1	100%	✓
Management of Actual or Potential Aggression MAPA	13	13	100%	✓
Dementia Awareness Level 1	84	83	99%	✓
Safeguarding Children & Adults level 1 & 2	86	85	99%	✓
Equality and Diversity	86	83	97%	✓
Suicide Awareness Level 1	77	75	97%	✓
Conflict Resolution	83	78	94%	✓
Moving and Handling	86	81	94%	✓
Health & Safety	86	80	93%	✓
Safeguarding Children (Level 3)	66	61	92%	✓
Medicine management training	39	36	92%	✓
Mental Health Act	65	59	91%	✓
Effective Care Planning	64	58	91%	✓
Resuscitation	77	70	91%	✓
Fraud, Bribery & Code of Conduct	86	76	88%	✓
Brief Advice on Smoking	79	69	87%	✓
Brief Advice on Alcohol	55	47	85%	✓
Information Governance	86	71	83%	✗
Fire	86	70	81%	✗
Infection, Prevention & Control	78	58	74%	✗
PREVENT	86	56	65%	✗
Mental Capacity Act Level 1	65	6	9%	✗
Total	**1600**	**1382**	**86%**	

Assessing and managing risk to patients and staff

Assessment of patient risk

We reviewed 20 home treatment team patient care records and saw that staff assessed, reviewed and updated risk assessments and risk management plans. All patients had an electronic health record as well as a basic paper file. Risk management plans were contained within both of these. Staff undertook a risk assessment on every patient at initial triage. Documentation of identified risk was also within the patient care plan, known as the intervention record. However, the intervention plans in two cases did not include physical health risks or information on follow up treatment. We also found that the care record template did not include a prompt to include a physical health plan. However, we found that the recording of risk was of a good standard and demonstrated attention to historical risks. Staff also took a standardised approach to risk by using their community safety matrix tool. Staff used this tool to assess the severity of patient risk and take the appropriate

action. Staff at the access and home treatment teams continued to monitor risk through a combination of regular phone contact and home visits.

Health-based place of safety

Staff inputted their patient risk assessment onto the trust electronic recording system and this was accessible to other professionals when the patient was followed up or received further support and treatment.

Management of risk

Protocols to ensure staff safety were in place including a lone worker policy which assured managers of the safety of staff at the end of a shift and alerted them to emergencies when staff worked away from base. Protocols to ensure staff safety were in place including a lone worker policy which assured managers of the safety of staff at the end of a shift and alerted them to emergencies when staff worked away from base. Staff were in regular contact with patients and responded promptly to a deterioration in a patient's health. They followed up on any missed appointments to ensure the safety of patients and escalated concerns to senior managers if the patient's health had deteriorated.

Safeguarding

The service made nine safeguarding referrals between 1 September 2017 and 31 August 2018, three of which concerned adults and six concerned children. The number of safeguarding referrals reported during this inspection was lower than the 52 reported at the last inspection[20] (June 2016 to May 2017).

Number of referrals		
Adults	**Children**	**Total referrals**
3	**6**	**9**

The number of adult safeguarding referrals ranged from zero to one per month. The number of children safeguarding referrals ranged from zero to two per month.

Staff understood how to protect patients from abuse and how to recognise symptoms of abuse. All staff had received training on how to report abuse and all staff we interviewed clearly understood the process for reporting abuse and for making a safeguarding referral. Staff gave us examples of when they had made safeguarding referrals and evidence of liaison with social care and health staff and of making safeguarding referrals to the local authority. Staff also knew who the trust safeguarding lead was and how to contact them for advice.

There had been no serious case reviews for these services.

Staff access to essential information

Staff kept records of patients' care and treatment using an electronic patient record. Where paper records were also kept these were regularly synchronised to ensure there were no gaps in either record. All staff received training on how to use the electronic patient records. All records we reviewed were clear, up-to-date and available to all staff providing care. This meant staff could share information fully between different services and staff could access relevant current and historical information.

[20] Previous Inspection Data

Health-based place of safety

Staff accessed the electronic health care records for existing information on patients admitted under section 136 of the Mental Health Act. In addition, forms relating to admission to the suite were completed on paper and then scanned and uploaded into the electronic patient record. Information recorded included essential information on patients' alcohol blood levels and any history of other substance misuse. Staff also recorded a full account of the detention and care up to assessment. This included contact with community triage or the access team, the outcome of assessments and any reason for delay in assessment.

Medicines management

The service followed the trust medicines management policy and stored and transported medicines securely. Staff also ensured the safe administration of medicine in patients' homes. To help maintain and improve patient's physical and mental health, staff monitored and reviewed patients' medication in the community, in line with guidance from the National Institute for Health and Care Excellence. This helped ensure people remained at home and comfortable in their own environment.

Health-based place of safety

Medicines were not stored within the unit. Doctors could prescribe medicines and staff could access medicines when required.

Track record on safety

Between 1 September 2017 and 31 August 2018 there were seven serious incidents reported by this service. All the incidents reported were categorised as 'Apparent/actual/suspected self-inflicted harm'.

We reviewed the serious incidents reported by the trust to the Strategic Executive Information System (STEIS) over the same reporting period. The number of the most severe incidents recorded by the trust incident reporting system was comparable with STEIS with three reported.

A 'never event' is classified as a wholly preventable serious incident that should not happen if the available preventative measures are in place. This service reported zero never events during this reporting period.

	Apparent/actual/suspected self-inflicted harm	Total
AHTT (Acute Home Treatment Team)	4	4
MH Liaison	1	1
Access / EDT (Emergency Duty Team)	1	1
Access	1	1
Total	**7**	**7**

Reporting incidents and learning from when things go wrong

Staff we spoke with were aware of how to report incidents and understood their duty of candour. Staff knew to be open with patients if mistakes were made. This included when staff sent a letter to a patient but to a wrong address. In this case staff made immediate contact with the patient, explained what had happened and worked with the patient to prevent the same mistake happening again. Staff received feedback from investigations at regular team meetings and managers provided individual and group feedback during management supervision to support learning from incidents. There was a system of staff debrief in place across all services and a clear process within their teams to ensure that essential information, such as learning from incidents and complaints, were shared and discussed. Staff had implemented recommendations from reviews of deaths, incidents, complaints and safeguarding. One of these recommendations resulted in the development of an assessment tool that helped prioritise patients according to risk. This helped improve access to treatment and patient evaluations showed that they found the system helpful.

In the last two years, there had been no 'prevention of future death' reports sent to North Staffordshire Combined Healthcare NHS Trust.

Health-based place of safety

Staff we interviewed knew when to report incidents and had opportunity to discuss incident with senior staff at ward team meetings. Staff understood the duty of candour and told us they were open and transparent when things went wrong.

Is the service effective?

Assessment of needs and planning of care

We looked at 20 patients' care records and found that they captured thorough assessments of the individuals mental state and had been completed in a timely manner. We found that all the care records contained up to date personalised and holistic information and care plans met the needs identified during assessment. All assessments were completed on the electronic patient record and included an initial assessment and intervention record detailing the plan of care. Small amounts of information were kept on a paper file. This information was uploaded to the electronic patient record at the end of each day. All information needed to deliver care and kept in the paper files was kept securely in locked filing cabinets.

Staff were aware of patients' physical health and responded to health issues appropriately. We found that in two cases out of 20 where staff had not documented physical health care follow up actions within the intervention record care plan. However, in all other records staff had documented physical health care conditions, and identified follow up treatment interventions with the patient and had documented these appropriately.

Staff undertook basic physical health checks, such as blood tests when commencing new medicines and completed basic physical health observations such as blood pressure, temperatures and weight.

Health-based place of safety.

Staff completed a comprehensive and thorough mental health assessment that included the assessment outcome. This was recorded on the electronic patient record and available to other professional if the patient accesses other services within the trust.

Best practice in treatment and care

Staff undertook and participated in clinical audits. Staff also followed National Institute for Health and Care Excellence (NICE) guidance. At the time of inspection, the teams were considering and discussing NICE guidance on decision-making and mental capacity.

At the time of inspection there were no psychology staff within the teams. However, the access and home treatment teams could refer to community mental health team psychology staff. We did not find that the lack of Psychology within the teams created a delay or impact for patients. All interventions provided met guidance issued by the National Institute for Health Care and Excellence.

The access and home treatment teams and could offer a wide range of support and guidance such as support for housing and benefits and regularly referred to other voluntary and statutory sector support services for substance misuse. All the teams considered the physical healthcare needs of the patients.

Clinical leads involved staff in audits and regularly audited the quality of their care plans. This included accessing the electronic patient record to ensure the inclusion of key information across assessments and care plans. Staff had regular involvement in audits of on patient consent, referral rates, advanced decisions, the community safety matrix and environmental risk assessments. Often these audits had led to quality improvement initiatives such as enhanced access and referral for diverse populations.

The teams used Health of the Nation Outcome Scales care clustering to determine which treatment pathway would meet patients' needs.

Health-based place of safety

Staff completed daily audits and checks of the resuscitation equipment. The interim director of operations had also competed a place of safety audit in March 2018. One of the conclusions of this audit was that standards should be clearly communicated to all staff for the care co-ordination of frequent users of crisis services who had a diagnosis of personality disorder.

Skilled staff to deliver care

All the teams had access to a full range of mental health disciplines including nurses, doctors, psychology, social work and pharmacists. In the access and home treatment teams, the availability of psychologists was through referral to the community mental health teams.

All staff that we spoke with were experienced and qualified for the role they were employed to undertake and clinical staff were trained to provide low level cognitive behavioural interventions for generalised anxiety and depressive disorders.

Staff received an appropriate induction when joining the trust and the teams provided a local induction for all new starters to ensure they were aware of their policies and protocols.

Managers identified the learning needs of staff and provided them with opportunities to develop their skills and knowledge. At the time of inspection staff were involved in preceptorship, specialist intervention courses and undertaking nursing degrees. Managers dealt with poor staff performance promptly and effectively and told us that when this had occurred that staff had responded positively and made the necessary changes to their practice.

The access team manager had made attempts to link in with volunteers. However further discussion was required on how to attract and use volunteers in the future.

All staff received regular management and clinical supervision every six to eight weeks, in line with trust policy. Staff also attended regular meetings of professional groups and received annual appraisal of their clinical skills and abilities for working within the access, home treatment and mental health liaison teams. Senior managers proactively encouraged all staff to attend further training and conferences to further enhance their skills and knowledge. Some staff within the teams were approved mental health professionals from the local authority whose role was to ensure patients were aware of their rights and had the involvement of their nearest relatives and carers.

Staff working within the mental health liaison team took referrals for children. Staff had completed the child and adolescent mental health services competence framework. This is a framework of learning to help staff enhance their clinical skills when working with children.

Health-based place of safety

Staff who worked within the suite were experienced, and had the right skills and knowledge to meet the needs of the patient group. Staff were provided with information and knowledge specifically about the place of safety. Staff received supervision from the team manager.

Ward name	Total number of permanent non-medical staff requiring an appraisal	Total number of permanent non-medical staff who have had an appraisal	% appraisals (as at 31 August 2018)	% appraisals (1 April 2017 – 31 March 2018)
Home Treatment	22	21	95%	95%
Mental Health Liaison Team	22	9	41%	95%
Access Team	35	13	37%	96%
Core service total	**79**	**43**	**54%**	**95%**
Trust wide	**844**	**419**	**50%**	**91%**

The trust's target rate for appraisal compliance was 85%. At the end of last year (1 April 2017 to 31 March 2018), the overall appraisal rate for medical staff within this service was 100%. This year the overall appraisal rate was 0% (as at 31 August 2018). PDR target is 85% compliance. However, at the time of inspection appraisal rates had improved, mental health liaison was at 88% and the access team 86% compliance.

Ward / Team Name	Total number of permanent medical staff requiring an appraisal	Total number of permanent medical staff who have had an appraisal	% appraisals (as at 31 August 2018)	% appraisals (April 2017 – March 2018)

Ward / Team Name	Total number of permanent medical staff requiring an appraisal	Total number of permanent medical staff who have had an appraisal	% appraisals (as at 31 August 2018)	% appraisals (April 2017 – March 2018)
Home Treatment	1	0	0%	100%
Mental Health Liaison Team	1	0	0%	100%
Core service total	**2**	**0**	**0%**	**100%**
Trust wide	**40**	**7**	**18%**	**100%**

The trust's target of clinical supervision for all* staff was 85% of the sessions required. Between 1 September 2017 and 31 August 2018, the average rate across all three wards in this service was 80%.

There is no standard measure for clinical supervision and trusts collect their data in different ways, so it's important to understand the data they provide.

Team name	Clinical supervision sessions required	Clinical supervision delivered	Clinical supervision rate (%)
Home Treatment	240	193	80%
Mental Health Liaison Team	230	183	80%
Access Team	436	345	79%
Core service total	**906**	**721**	**80%**
Trust Total	**9084**	**7347**	**81%**

*All staff – medical and non-medical breakdowns were not provided

Multi-disciplinary and interagency team work

During the inspection, we attended one clinical handover and one multidisciplinary team meeting. The incoming nurse on shift documented the handover and any specific patient risks were discussed in full. Staff also passed on information about patients' physical health, safeguarding concerns and staffing levels. At the multi-disciplinary meeting doctors, nurses and other healthcare professionals discussed the weekly caseload and updated care plans. We observed a good quality of clinical discussion where all options for patients were discussed. This included planned liaison with other professionals including GPs. Staff also invited professionals from other teams and external agencies to attend multidisciplinary team meetings to ensure effective communication. Both meetings were thorough and effective and routinely took place to ensure effective care.

The responsibility for the management of access to inpatient beds was held by the home treatment team and staff had regular discussions across the teams concerning any patients waiting for admission or discharge from inpatient services. Staff also had good working relationships with external agencies such as GPs, social services and independent organisations such as MIND and local drug and alcohol teams.

Health-based place of safety

Senior staff responsible for the place of safety attended regular multi-agency meetings with approved mental health practitioners and the police to maintain high quality professional relationships, review information and to support improvements in the quality of care provided.

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

Staff received mandatory training on the Mental Health Act and understood their roles and responsibilities under the Mental Health Act 1983 and the Mental Capacity Act 2005. All staff demonstrated respect for patients' wishes and had a good knowledge of the different sections of the Mental Health Act. As of 31 August 2018, 91% of the workforce in this service had received training in the Mental Health Act. The trust stated that this training is mandatory for all services and renewed every three years.

All teams we inspected had administrative support and legal advice was available from the Mental Health Act administrator on the implementation of the Mental Health Act. Staff also told they were aware of their responsibilities for patients under a Community Treatment Order, a legal order under which a person must accept treatment while living in the community.

Health-based place of safety

Staff were aware of, and had received training on recent changes to the Mental Health Act Code of Practice regarding Section 136. Under these changes, the maximum detention period of up to 72 hours was reduced to 24 hours. To monitor detention periods staff completed a place of safety monitoring form with the police and uploaded this to the electronic care record. The monitoring form included information on the time of detention under section 136 and the time the assessment concluded. The trust had detained three patients over 24-hour period in last 12 months prior to inspection. However, we saw that these were clinically appropriate extensions and were made under the power to extend detention by 12 hours. The trust based place of safety was used a total of 241 times in the 12 months prior to inspection.

Good practice in applying the Mental Capacity Act

All staff employed within the crisis and health based places of safety services were up to date with their mandatory Mental Capacity Act (MCA) training. However, trust compliance figures did not accurately reflect this due to a lag in the recording of compliance under the Trust's new MCA training module. The trust stated that this training was mandatory and renewed every three years. Staff told us that they could access and refer to trust's policy on the Mental Capacity Act (MCA) electronically and in the 20 care notes we reviewed the mental capacity of patients was recorded appropriately and in line with national guidance. Staff supported patients to make decisions for themselves and when a patient lacked capacity, decisions had been made in their best interest considering their wishes, feelings, culture and history. Staff told us they knew where they could get advice regarding the MCA and spoke knowledgably of the key principles of assessing patient capacity.

The access and home treatment teams dealt with children out of hours. They always consulted with the on-call doctor in such cases and used the 'Gillick Competency' guidelines to help assess whether a child under 16 had the maturity to make their own decisions.

Staff who the inspection team spoke to were knowledgeable about Independent Mental Health Advocacy IMHA services and information was available to patients on how to access advocates.

Health based places of safety

Staff we spoke with understood the Mental Capacity Act, had received training and were aware of the trust policy and where to find it. Mental health liaison team staff were also competent in using Gillick Competencies when assessing children from the Royal Stoke University Hospital emergency department.

Is the service caring?

Kindness, privacy, dignity, respect, compassion and support

We accompanied staff on three home visits made to patients in their homes. During these visits we observed staff's attitudes and behaviours when interacting with patients to be discreet, respectful and responsive. We saw staff displaying high levels of empathy whilst also making detailed assessments. The assessments we observed lasted for over an hour. However, the patients did not experience these interactions as either rushed or excessively long.

Staff supported patients to understand and manage their care, treatment or condition by spending time listening to their individual concerns. It was clear that staff took time to get to know their patients likes and dislikes when considering their care. This treatment of patients within the community in an environment in which they were familiar helped to avoid unnecessary hospital admissions. We saw good examples of staff making frequent home visits to individual patients to help them manage symptoms of depression in their home environment. During these visits we observed staff provide outstanding levels of, reassurance, encouragement, motivation, emotional support and hope. Staff took great care in all cases to establish a good rapport and to maintain this throughout all contact. Patients spoke freely about their problems and staff helped them understand that many of their issues could be overcome in small steps.

Staff directed patients to other services when appropriate and, if required, supported them to access those services and in one case we observed staff make a referral to the emotional wellbeing team. This referral appeared to be clinically safe and appropriate.

One patient we spoke to said staff treated them well and with a high-level kindness. Staff also demonstrated at interview that they had a good understanding of patients, cultural, social and religious needs.

All staff we spoke to said they would have no hesitation in raising concerns about disrespectful, discriminatory or abusive behaviour or attitudes towards patients and said they had no concerns that there would be negative consequences in doing so.

Staff maintained the confidentiality of information about patients. Information taken out of the office was anonymised as much as possible and transported securely.

Involvement in care

Involvement of patients

Staff involved patients and those close to them in decisions about their care and treatment. Patients we spoke to placed high value on the involvement they had in their care planning. They felt staff understood the importance of them making their own decisions and said they had good advanced notice of when staff would visit. All patients said they knew how to contact the team and were offered copies of their plans and signed to say when they did not want a copy. Teams asked for feedback about their service through questionnaires and an advocacy service was available for patients if they wanted it.

Health-based place of safety

We were unable to observe an assessment whilst on inspection, nor speak to any previously assessed patients. However, staff we spoke to clearly had insight into the difficulties their patients experienced on admission to the place of safety. Staff had processes in place, following assessment, to suggest alternative services and signpost patients to other helping services if appropriate. Staff could support patients to make telephone calls when needed and ensured they had relevant information to take away with them.

Staff we spoke with said they would raise concerns about others behaviour towards patients without fear of the consequences. Staff inputted all patient information in the electronic patient care record, which meant it was secure and confidential.

Staff told us they ensured people's privacy and dignity was maintained and the layout of the suite facilitated this including the entrance at the back of the suite which was discreet and private.

Involvement of families and carers

Staff informed and involved families and carers appropriately and provided them with support when needed and staff asked all carers if they would like a referral to carers team within the trust for an assessment of their needs in caring for someone experiencing mental health difficulties. Carers champions within the team had also made plans to start a carers group. However, at the time of inspection these plans were in their infancy.

Heath-based place of safety

Staff regularly sought feedback from service users and we saw that from patient feedback forms completed by patients that none had expressed dissatisfaction and that most had been very happy with the care and treatment they had received.

Is the service responsive?

Access and waiting times

This service had developed to meet the requirements of people with a more severe level of need in the local population. All teams offered access to treatment 24 hours per day. The trust measured access and home treatment team performance against a waiting time standard. The monthly target was to see 95% of new referrals within four hours. For the year, 2018 the teams exceeded this standard every month by providing, skilled staff to assess, within four hours, for 100% of its patient referrals. The mental health liaison team aimed to see patients within an hour of referral from the accident and emergency department and within 24 hours when a patient was referred from the hospital wards. The services did not have waiting lists, had clear referral criteria and did not exclude patients who needed treatment.

The trust responded promptly and proactively when patients telephoned the service. The recently enhanced telephone system, which included a dedicated line for local GPs, helped staff monitor incoming calls and allocate them according to priority. Call handlers took initial calls and noted who the patient was and the reason for their call. Other forms of referral were by letter and patients could also self-refer and walk into the centre. The call centre also had a system of providing immediate supervision to staff taking calls to ensure the highest standards of patient intervention.

Staff used a well-established risk assessment tool to prioritise all referrals as either emergency, crisis, urgent or routine. The trust used this risk stratification tool to define response times. Emergency life threatening referrals received an immediate response from a senior qualified mental health practitioner. Patients in crisis received an assessment within four hours, less urgent referrals were responded to within 72 hours and routine cases were signposted and resolved, after assessment and at first contact, wherever possible.

Clinical staff proactively engaged with patients who found it difficult to contact mental health services or who had complex needs. To help minimise the number of non-attendances for appointments the access and home treatment teams had a policy of telephoning patients the day before their appointments. Staff also followed up patients who did not attend and who they had not had contact with. Wherever possible, staff offered patients flexibility in the times of appointments. Staff rarely cancelled appointments with patients but when this did happen patients were offered alternatives as soon as possible. The home treatment team also carried out follow up appointments following discharge from hospital.

Patients we spoke with told us they knew how to complain or raise concerns. Staff protected patients who raised concerns or complaints from discrimination and harassment. Staff knew how to handle complaints appropriately.

Staff told us that they used technology to support patients by sharing web site health hyperlinks with them. The trust had adapted some of its web site information to include easy read and pictorial information.

Staff supported patients during referrals and transfers between services and worked with professionals, across other trust services to minimise difficulties for patients in accessing services. There was also a focus on high quality communication between teams and patients to help avoid unnecessary delays and repeated assessments for patients.

The high-volume user service team worked with patients with mental health problems who frequently attended the local emergency department. The team worked with individual patients,

who had a combination of physical, psychological and social problems, to reduce these attendances. The high-volume user service had developed a multi-disciplinary team approach to support patients, with complex and diverse issues, to find alternatives to presenting at the accident and emergency department. The team were successful in reducing unnecessary admissions by ensuring that all agencies worked with patients to deliver a co-ordinated package of care to the patient. Staff at the mental health liaison team, based with the Royal Stoke University Hospital emergency department, told us that the high-volume user service had made a significant impact on reducing the number of repeat patient referrals made to them. The service had also been shortlisted for a nationally recognised patient safety award.

Other professional's feedback about the high-volume user service was that it provided a high-quality service with a level of liaison and co-working that was beneficial to clients. Professionals asked by the trust to give their feedback said the service's staff had dedication, good reflective skills and a compassionate approach to working with people with complex needs. They also said they had seen a dramatic change in the reduction of their patients use of accident and emergency departments. In only one case professional feedback was that some outcomes had not been so positive, despite the hard work and commitment of the team, and this appeared to be a reflection of the limited support from other agencies.

Crisis services complied, on an individual basis, and where appropriate, with the transfer of care of children standards set out within the governments Commissioning for Quality and Innovation (CQUIN) targets. This included audits of joint agency work, patient experience surveys and specific transition meetings with children and their key workers

Health-based place of safety

There were clear criteria for this service that did not exclude any individuals. The local service standard, based on recommendations from the Royal College of Psychiatrists, was that assessments should be completed within three hours of detention at the place of safety commencing. The trust met this standard. Audits showed that delayed assessments were often due to patient intoxication with alcohol and a consequent lack of ability to engage with staff. In these cases, staff secured extensions to detention periods and assessments carried out when the patient was able.

The trust has identified the below services in the table as measured on 'referral to initial assessment' and 'referral to treatment'. The service met the referral to assessment target in all three of the targets listed.

Name of hospital site or location	Name of Team	Please state service type	Days from referral to initial assessment		Days from referral to treatment	
			Target	Actual (median)	Target	Actual (median)
Harplands Hospital	Access Team	Z01	28 (Local)	1	-	This service is measured to first contact-Urgent/Emergency
Harplands Hospital	Home Treatment	A02	1 (Local)	0	98 (Local)	Not Provided
Harplands Hospital	Mental Health Liaison Team	A11	1 (Local)	0	-	This service is measured

Name of hospital site or location	Name of Team	Please state service type	Days from referral to initial assessment		Days from referral to treatment	
			Target	Actual (median)	Target	Actual (median)
						to first contact-Urgent/Emergency

The facilities promote comfort, dignity and privacy

The access and home treatment teams saw most patients at home. However, staff saw patients who attended appointments and self-referred to the access team at the Harplands Hospital, in interview rooms. These rooms were comfortable and pleasant environments that supported the privacy and dignity of patients. All rooms used for meeting patients offered complete confidentiality.

Health-based place of safety

The place of safety suite was adjacent to a nursing office separated by clear glass. Patients wishing to shower could close the shower door out of view of staff. This was assessed on an individual case by case basis. The suite was secure and comfortable and easily observable but not soundproofed. Staff ensured patient confidentiality by limiting the number of staff present in the nursing office and by making sure clinical discussions took place away from the place of safety suite facilities. The suite contained a bed, shower and toilet. It also had blinds, a television and seating. The suite had a discreet entrance so that female patients did not access the suite from the male ward. This entrance also served patients with disabilities.

Patients' engagement with the wider community

Staff ensured that patients had access to education and work opportunities by making links and establishing sustained relationships with independent sector organisations within the local community. This included employment focused agencies as well as support services such as those for substance misuse that had their own programs to support voluntary work and employment. Staff helped patients develop skills, knowledge and confidence in their social and family relationships and to maintain links with people that mattered to them. Staff also asked patients to nominate someone the service could contact, who would be most likely to first notice if they became unwell.

Health placed place of safety

Staff signposted patients using the place of safety to contact organisations who could support them with their employment needs. Staff also ensured that if the patient wished that carers and family were contacted to support the patient at discharge and on taking up further treatment.

Meeting the needs of all people who use the service

Staff were clinically reflective in considering patients' needs and their legally protected characteristics such as age, disability, gender reassignment, marriage and civil partnership, pregnancy and maternity, race, religion or belief, gender and sexual orientation. Staff we spoke to were aware of the impact of discrimination on patients' mental health and integrated this into the care they provided. Staff also considered the social needs of patients, including homelessness

and had made adequate arrangements to liaise with partner agencies to support patients with their housing needs.

There was disabled access for patients when patients visited the teams' base. Staff could also provide information leaflets on a wide variety of mental health problems, treatments and local services. These were also on prominent display in the team base waiting areas. Many leaflets were available in different languages and staff could access interpreters and signers for patients if necessary.

Health-based place of safety

People with a disability could easily access the suite through the discreet entrance and all facilities were suitable for those with disabilities. Staff could produce information on other services as well as on patient rights and on how to complain. Information was available in other languages if needed and staff could access interpreters and signers for patients if required.

Listening to and learning from concerns and complaints

Staff told us they received feedback on the outcome of investigation of complaints and discussed these at team meetings and at team briefings from the trust. Clinical mangers ensured that recommendations were acted upon and patients we spoke to had seen posters telling them how to make a complaint. Patents also said they would feel confident to make a complaint if they needed to.

This service received seven complaints between 1 September 2017 and 1 August 2018. One was upheld, one was partially upheld, three were not upheld and one was withdrawn. One complaint was categorised as 'Other' and was ongoing.

Ward Name	Total Complaints	Fully upheld	Partially upheld	Not upheld	Other	Under Investigation	Withdrawn	Referred to Ombudsman
Access Team	4	0	0	3	0	0	1	0
Acute Home Treatment Service	2	0	1	0	1	0	0	0
MH Liaison Team	1	1	0	0	0	0	0	0

This service received 180 compliments during the last 12 months from 1 September 2017 to 31 August 2018, which accounted for 8% of all compliments received by the trust as a whole.

Is the service well led?

Leadership

Managers of all services communicated effectively with their staff and could articulate how their service operated and the benefits of their service to patients. They encouraged their staff to innovate and we saw examples of this in the high-volume user service and in the training program being developed for accident and emergency staff by one of the mental health liaison team. Leaders of the service placed a strong emphasis on relationship building with each other and with partnership agencies, for the benefit of patients. Leadership took advantage of development opportunities available to them. These opportunities included coaching, mentoring and extra training. Mangers also actively encouraged their staff to continually professionally develop by providing skilled supervisory support. Managers at all levels of the service had the right skills and abilities to run a service providing high quality sustainable care.

Vision and strategy

Staff we spoke to had participated with service users in the development of the trusts vison and values and clearly demonstrated their compassion, communication skills, empathy with service users and the need to continually develop and improve their services. This was demonstrated in their descriptions of client care and of the varied quality improvement initiatives in place along with a high level of partnership work with other agencies in the community. Leaders and managers had succeeded in delivering services in accordance with the trusts strategy of focusing on safety, access to personalised treatment and recovery orientated care.

The urgent care directorate's vision was to have a bespoke building for mental health crisis services and health-based places of safety. Plans were in place for this centre to be opened in October 2019. The development of this centre include consultation with both staff and service users. Team managers told us they had the opportunity to contribute to discussions about the strategy for their service at regular trust-wide meetings.

Health based place of safety

Managers regularly participated in multi-agency meetings with organisations involved in the operation of the section place of safety suite. These agencies included the police, commissioners and the local authority. Managers maintained good working relationships with them to ensure sustained good quality care for patients using the place of safety.

Culture

Staff we interviewed told us they felt supported and valued by senior clinical managers. We saw a positive culture throughout all services and staff communicated that they felt positive about working for the trust. The urgent care directorate senior managers supported and valued staff and promoted a positive culture. Managers of all services said they felt positive about working for the trust and we observed that the morale was good within the access, home treatment and mental health liaison teams.

Staff told us they knew how to use the whistle-blowing process and felt able to raise concerns without fear of retribution. We observed teams working well with each other and mutual respect was evident. Staff sought guidance and support from other disciplines within the team when they

needed it. Staff regularly discussed quality improvement initiatives within their teams and staff felt confident to suggest improvements and were supported to develop them.

Staff knew how to use the whistle-blowing process and knew how to contact the freedom to speak up guardian if they wanted to raise concerns with them independently about patient safety and staff wellbeing. The role of the Speak Up Guardian was advertised across all trust sites we visited.

In a small number of cases managers told us they had managed the poor performance of staff with the support of the human resources department. In all cases staff had responded well by making improvements to their work, and experienced the process as supportive.

We saw that staff understood each other's roles, worked together well as a multi-disciplinary team and sought guidance and support from each other when they needed it. Staff discussed their continued professional development with their managers during supervision and at their annual appraisal. Staff reported that the provider promoted equality and diversity in providing opportunities for career progression and 91% of staff reported this opinion in the 2018 NHS staff survey.

Staff sickness rates had decreased since the last inspection and was similar to the average for the trust and staff had access to support for their own physical and emotional health needs through an occupational health service.

The trust recognised staff success within the service through The Recognising Excellence and Achievement in Combined Healthcare (REACH) awards. These awards celebrated staff and teams who had made an outstanding contribution to their work. In 2018 staff nominated the high-volume user service for their compassion in working with their patients.

Governance

The trusts governance of crisis and health placed place of safety services ensured that premises patients visited were safe and clean.

Staff assessed patients quickly following referral and triage and there were no waiting times. Staff also knew how to report incidents and did so promptly. Learning from these took place at team meetings and through directorate level team briefs and there was a clear framework to develop and implement action plans at local level following incidents. Systems and processes therefore ensured that all staff understood the key findings from the investigations and reviews of deaths, incidents, complaints and safeguarding alerts. Staff undertook or participated in clinical audits. Most recently, these included staff involvement in audits concerning advanced decisions, patient consent, risk assessments and an audit of ligature cutters.

Staff clearly understood the necessity and arrangements for working with other teams to meet the needs of the patients. This included the pathways between access, home treatment and the mental health liaison team as well as independent health and social care partners.

The trust used a systematic approach to continually improve the quality of its services and acted on results. Individual staff professional development also met the requirements and improvements needed within the services. As an example, this included staff involvement in the implementation of risk assessment tools, supported through the trust's leadership academy.

Management of risk, issues and performance

Managers maintained a risk register that was available to all staff either at a team or directorate level. Staff we spoke to knew they could escalate concerns when required from a team level.

However, they had not raised any concerns apart from those about recent short staffing. The trust had effective systems at local level for identifying risks, planning to eliminate or reduce them, and coping with both the expected and unexpected.

The service had strong plans for dealing with emergencies and their adverse weather planning was exemplary. The services covered a wide ranging rural area with many patients living in remote outlying villages. Managers and staff monitored the weather forecasts and stood by with all-weather vehicles to give patients lifts to their appointments. Other staff took lap tops home to work from home and those staff who lived near patients would alter appointments to coincide with bad weather.

Where cost improvements were taking place, they did not compromise patient care.

Information management

Trust systems collected data from crisis and health based places of safety. Staff told us that they were familiar with these systems, did not find them burdensome and understood the importance of collecting information to improve services. Trust systems were electronic and secure and all staff received training on how to use them. This included the patient information system which staff said supported their work well and improved the organisational quality of patient care. All stored patient information was kept confidential and staff undertook regular training in information governance.

Team managers had access to the correct, up-to-date information to support their management role. This included information on the performance of the service, safe staffing and patient care. Information was in an accessible electronic format, and was timely, accurate and identified areas for improvement. Staff made notifications to external bodies as needed, such as the local authority.

Engagement

Managers and staff used the NHS wide friends and family test to get feedback from patients and their carers. The questionnaire asked whether users of the services would recommend the service they received to friends and family? Patients could complete these questionaries' at the time of their appointment. However, staff also sent the feedback forms to patients, with a stamped address envelope so they could return them with ease. Plans were also in place to give patients access to electronic tablets to complete the feedback forms.

Managers had made good efforts to involve service users and carers in the planning of services. This included the appointment of carers champions to encourage the further involvement of patient's friends and family in the services they received. Staff also informed service users that they could go directly to the senior leadership team to discuss service delivery.

The urgent care directorate staff engaged with external stakeholders such as commissioners regarding local priorities and staff regularly worked with Healthwatch, the independent consumer champion for health and social care, and made joint presentations and displays for patients. The trust also produced newsletters, bulletins and intranet information to keep staff and patients up to date with information.

Learning, continuous improvement and innovation

Staff within the crisis and health based place of safety services did not have any research projects running at the time of inspection. However, like all other trust services it had could attend the trust's research and innovation conference which was well attended by staff from across the Trust.

Staff demonstrated through various projects such as the high-volume user service, their proactive partnership work and the governance of their improved patient call centre that they were constantly working towards improving care for all their service users.